Ref: MA/TH

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

You are invited to attend a **public (Part 1) meeting of the Board of Directors** to be held on **30th November 2022** at **8.30 am to 12.15pm** at **Vespasian House, Bridport Road, Dorchester, DT1 1TG** and via **MS Teams**.

The agenda is as set out below.

Yours sincerely

Mark Addison
Trust Chair

AGENDA

1.	**Staff Story**	Presentation	Emma Hallett	Note	8.30-08.55
2.	**FORMALITIES** to declare the meeting open.	Verbal	Mark Addison Trust Chair	Note	08.55-9.00
	a) Apologies for Absence:	Verbal	Mark Addison	Note	
	b) Conflicts of Interests	Verbal	Mark Addison	Note	
	c) Minutes of the Meeting dated 26th September 2022	Enclosure	Mark Addison	Approve	
	d) Matters Arising: Action Log	Enclosure	Mark Addison	Approve	
3.	**COVID Update**	Verbal	Anita Thomas	Note	9.00-9.05
4.	**CEO Update**	Enclosure	Nick Johnson	Note	9.05-9.35
5.	**Balanced Scorecard**	Enclosure	Nick Johnson	Note	9.35-10.00
6.	**Board Sub-Committee Escalation Reports** (Oct and Nov 2022) a) Finance and Performance Committee b) People and Culture Committee c) Quality Committee d) Risk and Audit Committee e) System Performance Update		Committee Chairs and Executive Leads	Note	10.00-10.25
Coffee Break 10.25-10.40					
7.	**Board Assurance Framework and Corporate Risk Register** (November RAC)	Enclosure	Paul Lewis Phil Davis Mandy Ford	Approve	10.40-10.55
8.	**Maternity Update** (November QC)	Enclosure	Jo Howarth Jo Hartley	Note	10.55-11.05

9.	**Review of Report into East Kent Maternity and Neonatal Services** (November QC)	Enclosure	Jo Howarth Jo Hartley	Note	11.05-11.20
10.	**Strategy Update**	Enclosure	Nick Johnson Paul Lewis Phil Davis	Noted	11.20-11.30
11.	**Guardian of Safe Working Report** (November PCC)	Enclosure	Alastair Hutchison Kyle Mitchell	Note	11.30-11.40
12.	**Well Led Review – Action Plan Update**	Enclosure	Nick Johnson	Note	11.40-11.50
13.	**Social Value Bi-Annual Report**	Enclosure	Simon Pearson	Note	11.50-12.00
14.	**Trust Green Spaces Showcase**	Presentation	Mark Addison	Note	12.00-12.05
15.	**Questions from the Public**	Verbal	Mark Addison	Note	12.05-12.10
	CONSENT SECTION				12.10-12.15
	The following items are to be taken without discussion unless any Board Member requests prior to the meeting that any be removed from the consent section for further discussion.				
16.	**Learning from Deaths Q2 Report** (November QC)	Enclosure	Alastair Hutchison	Approve	-
17.	**Communications Team Activity Report** (deferred from September)	Enclosure	Susie Palmer	Note	-
18.	**ICB Board Minutes Part 1** (Standing Item) Not received	Enclosure	Nick Johnson	Note	-
19.	**Any Other Business** Nil notified	Verbal	Mark Addison		-
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 25th January 2023 at the Dorford Centre, Bridport Road, Dorchester** via MS Teams. TBC				

Minutes of a public meeting of the Board of Directors of Dorset County NHS Foundation Trust held at 8.30am on 28th September 2022 at Vespasian House, Bridport Road, Dorchester and via MS Teams videoconferencing.

Present:		
Mark Addison	MA	Trust Chair (Chair)
Sue Atkinson	SA	Non-Executive Director
Claire Abraham	CA	Deputy Finance Director
Ruth Gardiner	RG	Interim Chief Information Officer
Emma Hallett	EHa	Interim Chief People Officer
Alastair Hutchison	AH	Chief Medical Officer
Nick Johnson	NJ	Interim Chief Executive
Eiri Jones	EJ	Non-Executive Director
Stuart Parsons	SP	Non- Executive Director
Dhammika Perera	DP	Associate Non-Executive Director
Anita Thomas	AT	Chief Operating Officer
David Underwood	DU	Non-Executive Director
Attended via Videoconference:		
Margaret Blankson	MB	Non-Executive Director
Emma Hoyle	EHo	Deputy Chief Nurse
Stephen Tilton	ST	Non-Executive Director
In Attendance:		
Sonia Critchley	SC	Patient Experience Team *(Patient Story)*
Phil Davis	PD	Head of Strategy and Corporate Planning *(item BoD22/058)*
Trevor Hughes	TH	Head of Corporate Governance *(Minutes)*
Paul Lewis	PL	Deputy Director of Strategy, Transformation and Partnerships
Paul Murray	PM	Director of Medical Education *(item BOD22/060)*
Laura Symes	LS	Corporate Business Manager
Julia Woodhouse	JW	Patient Experience Team *(Patient Story)*
Members of the Public:		
Lynne Taylor	LT	Public Governor
Kathryn Harrison	KH	Public Governor
Apologies:		
Nicky Lucey	NL	Chief Nursing Officer / Interim Deputy Chief Executive Officer

BoD22/050	**Patient Story**	
	EHo introduced SC and JW, members of the Patient and Public Engagement Team, who discussed the work that had been undertaken to identify carers needs better and represent the 'carer's voice'; an important aspect in supporting patients. SC summarised project work undertaken and in train that would give (paid and unpaid) carers a voice throughout a patient's stay in hospital and after discharge. A Carers' Passport was being launched in collaboration with partners to promote a consistent of approach to communication and information sharing. Staff training and awareness raising of the scheme was also underway. The passport would a visible aid that staff would recognise and would ensure that appropriate discussions about care took place to signpost where carers could obtain further advice and support. The programme	

	would be regularly monitored and information would be triangulated with PALS and complaints feedback. The Board observed a video and heard from a carer about their experience; acknowledging the importance and benefits of early carer involvement to clinical understanding of patient needs and care. The Board noted the wide use of the Carer's Passport within DCH and acknowledged the extensive work that had taken place to get to the current point. Staff training had been successful in altering staff behaviours and reducing resistance to the scheme from staff and further work would be undertaken to further promote the scheme and its benefits to carers to ensure that they were aware of how to access support. The Board noted the importance of asking carers about their support needs also and in maintaining effective communication with carers, particularly where the patient did not have capacity, to ensure carers were able to continue to support the patient. NJ noted that communication was a key feature in complaints and he hoped the programme would have a positive impact on this. The Board were reminded that many staff were also carers and noted the importance of taking the time to talk to staff who were carers, particularly as economic and winter period service pressures increased. MA thanked the team for this excellent work and noted the system working approach to this programme.	
	Resolved that: the Patient Story be heard and noted.	
BoD22/051	**Formalities**	
	The Chair declared the meeting open and quorate and welcomed Governors to the meeting. Apologies were received from Nicky Lucey. MA noted recent changes within the Board, particularly: • Thanking PG for his contribution and service and wishing him well in his retirement. • Welcoming CA to the meeting on PG's behalf and noting the new Chief Finance Officer, Chris Hearn was due commence in post the following week. • Welcoming EHo to the meeting on behalf of NL and noting that Jo Howarth would commence in November in the Interim Chief Nursing Officer role. • Welcoming RG to her first public meeting of the Board. • Congratulating Abigail Baker on her appointment to the Deputy Trust Secretary role and thanking Liz Beardsall who had joined the ICB for her many years of excellent service to DCH.	
BoD22/052	**Declarations of Interest**	

	There were no conflicts of interest declared in the business to be transacted on the agenda.	
BoD22/053	**Minutes of the Meeting held on the 27th July 2022**	
	The Minutes of the meeting dated 27th July were approved as an accurate reflection of the meeting.	
	Resolved: that the minutes of the meeting held on 27th July 2021 were approved.	
BoD22/054	**Matters Arising: Action Log**	
	The action log was considered and updates were noted with approval given for the removal of completed items.	
	Resolved: that updates to the action log be noted with approval given for the removal of completed items.	
BoD22/055	**COVID Update**	
	AT advised that the Trust was liaising with the Integrated Care Board on their response to the COVID Inquiry. Following an initial decline in the number of in-patients with COVID, cases were increasing again with over 20 in-patients at the time of reporting. Masks continued to be worn in clinical areas and the incident Management Team continued to meet weekly. The Board heard about increases in the number of flu cases in Australia and noted that testing for respiratory viruses had commenced in the Emergency Department and local cases were being monitored daily. A staff vaccination programme, offering Flu and COVID vaccines, would commence in two weeks' time.	
	Resolved that the COVID Update be noted.	
BoD22/056	**CEO Update**	
	NJ highlighted the following key points from the report: • A new Prime Minister and the new Secretary of State's statement the previous week outlining £500m for discharge support, although there would be no new funding to support the NHS over the winter period. The emphasis would be around system partnerships to identify solutions to ongoing pressures. • Positive conversations were taking place within the ICB in respect of discharge and patient flow. • DCH remained at level OPEL 4 and the Incident Control Centre remained open. There were currently over 100 inpatients with No Reason to Reside and work continued to support patient flow. • Our long waiters continued to reduce although cancer referrals continued to increase. • The Trust awaited the final Inspection Report following the CQC inspection of services for children with mental health needs. • The Multi-storey Car park had opened, easing onsite parking pressures and teething issues in respect of the entry and exit barrier were being resolved.	

	• Staff were delivering mutual aid to partners to help with gynaecology waiting lists • Ward accreditations continued • 'Thank You Fortnight' to thank staff for their work and commitment had commenced and a number of gestures of appreciation were in place. • The Going the Extra Mile staff awards were to be held the following Friday. • DCH and Dorset HealthCare Boards had separately approved the decision to proceed with the appointment of a joint Chair and a joint CEO posts. Further updates on the timetable would be provided as the recruitment process progressed. The Board extended its thanks to staff and colleagues. MB left the meeting. SA noted that a new approach was being taking in Oxfordshire to address the high numbers of inpatients with No Reason to Reside and agreed to share this. The Board noted the current funding for stroke services and that a Full Business Case was to be presented to the ICB during October and November seeking a further £2.8m for acute stroke services. West Dorset continued without Out of Hospital services currently. Some funding for the current year pay award had been received but a cost pressure remained. Should all vacancies be fully established, the cost pressure would amount to circa £600k. Inflationary pressures amounted to circa £500k impact. There was an additional £250k risk and the Trust continued manage matters within its control and to monitor this, providing submissions to NHSI on a monthly basis. Some money had previously been further identified centrally to support with inflationary pressure and no additional support funding was expected. Inflationary pressures were also impacting the Capital Programme. Further figures were to be provided outlining the Trust's arrangements to utilise local food producers, reducing food miles and costs in line with the Trust's Social Value commitment,. PL reported that the Trust had recently acquired a tool to capture social value data and the tool would be used to produce this type of information and would be included in future Social Value updates.	**SA** **CA**
	Resolved: that the CEO Update be received and noted.	
BoD22/057	**Performance Scorecard and Board Sub-Committee Escalation Reports**	
	The following committee Escalation Reports for August and September 2022 were received, and key points were highlighted:	

	Finance and Performance Committee ST drew attention to the following: • Deterioration of the financial position • Agency spend • The Cost Improvement position would be reviewed by the Finance Sub Group and would also continue to review forecasts • The capital issue relating to the Multi-storey Car Park remained an issue and was as yet, unresolved • Two-week cancer waiting time performance • Approval to progress the Southern Counties Pathology case to Full Business Case although there were concerns that decisions would be taken away from the Trust and further judgement on the programme from the Trust was reserved. The Board heard that the ICB Chief Finance Officer was leading system discussions on the capital issue. It was clarified that the matter was an accounting issue and did not impact the cash position. Whilst the capital costs of the car park had contributed to the issue within the system, other system partner schemes had also contributed to the system exceeding the Capital Development Expenditure Limit. The Oral Maxillo-Facial service remained closed to new referrals as the staffing position across the system remained unchanged. New staff would commence in post in November within the Gastroenterology service when referrals were expected to resume. The increase in the number of cancer referrals was noted and the Board was informed that once diagnosis had been made, subsequent treatment was taking place in a timely manner. **People and Culture Committee** EH escalated: • Positive movement in both the WRES and WDES reports which were to be published on the Trust's external website. • The GMC Survey Action Plan • A request to review agency expenditure in further detail at the next committee meeting. Workforce remained a significant challenge. The Board noted focussed discussion by the Risk and Audit Committee regarding the agency position and recruitment. Further review by the People and Culture Committee was planned in October and triangulation with the Finance and Performance Committee on costs was noted. Further discussion would be had by the Board at the October Board Development Session. **Quality Committee** EJ summarised that the Board was sighted on the key issues contained within the Escalation Report and noted that the committee continued to monitor the clinical letter backlog.	**TH**

	EJ highlighted that the new national patient safety standard had been published and was to be embedded by the end of 2023. The committee triangulated with the Finance and Performance Committee on patient flow and with the People and Culture Committee on staffing pressures. EJ concluded that there was good sight of the key issues across all three committees. **Risk and Audit Committee** SP reported limited assurance provided by the Internal Audit Sub-Contracting Governance Report which had been requested by the Executive Team. The outcome was as expected and an Improvement Plan had been developed. Some pressures were expected to arise from the nationally mandated HFMA audit that would now include all elements. The additional work had potential impact on the Audit Fee. **Remuneration and Terms of Service Committee** MA noted approval of the appointment of Jo Howarth to the Interim Chief Nursing Officer role. **Balanced Scorecard** EJ sought clarity on actions taken to ensure harm avoidance within the 104 week waiting list. The Board noted that the number of people in this group had reduced significantly and that there were now 12 people waiting in excess of 104 weeks, mostly within the gastroenterology service. Regular discussions with the Regional Office were taking place regarding this group. The Trust continued to take action within its controls to address matters regarding 104 day waits. However, waiting time delays often related to tests that were outside of the Trust's control. The Board noted that a number of performance metrics were RAG rated red and were reminded about the additional metrics currently in place nationally against which NHS performance was being measured. The number of in-patients in hospital with No Reason to Reside (NRTR) equated to one third of the hospital's bed capacity and the Board were reminded of the huge constraining influence this had on service and staffing capacity. Greater visibility and reflection of this against other indicators within the report was requested alongside the potential harmful impact that the situation was having for other organisations such as SWAST (ambulance handover delays etc). AT reiterated that the NRTR impact on the Emergency Department and SWAST was known within the system. However, patients in hospital were in a safe place although this may not be the most appropriate care environment. Patient harm arising from inappropriate	**AT / AS**

	placement, and the patient voice, needed to also be reflected in reports. The Board noted the extensive work in place across the Trust to monitor and address the high numbers of patients that remained in hospital awaiting packages of care and that the Finance Sub Group were to review consequential costs and the available savings that could be made if beds were used differently. DCH currently had more beds occupied than were funded. Harm arising from elective waits was to be reported to the Quality Committee including the potential increased risk of exposure to COVID and the increased risk of falls. Waiting lists remained under regular review and the focus continued to be on those high risk patients in most urgent need. AH reported that some high-risk patient groups were being discharged from the Emergency Department due to the lack of available beds whilst low risk patients with No Reason to Reside remained in hospital. The Board were reminded of the Deep Dive of NRTR presented to the Finance and Performance Committee in August which would be circulated to all Board members. MA summarised that NRTR figures would be made more visible at Board and committee meetings to ensure that the focus on harms continued, including those harms resulting from elective care delays. PL added the impact on carers and staff also. **System Performance Update** NJ advised that the ICB Part 1 Board Minutes had been provided for the Board's information and highlighted the focus on Child and Adolescent Mental Health Services, waiting lists and Emergency Department pressures. He noted the financial deficit forecast and reported that system Chief Finance Officers were seeking to identify solutions. MB rejoined the meeting.	**TH**
	Resolved that: the Performance Scorecard and Sub-Committee Escalation Reports be received and noted.	
BoD22/058	**Board Assurance Framework (BAF) and Corporate Risk Register**	
	PD joined for this item. PL noted further development of the report which had been presented to the Risk and Audit Committee the previous week. The historic risk summary was useful in outlining risk movement and the Board noted that the BAF was being used purposefully by committees. Board sub committees were focussing on the risks relevant to their Terms of Reference. PD reported that there had been limited movement and that five risks remained rated at 20 or higher and a common theme being failure to attract and retain staff. Whilst	

	mitigations were being implemented, the position overall was deteriorating. The Board was reassured by committees reports that risks were being appropriately identified and mitigated. Following discussion of the inflationary pressure, the Board agreed that this risk should be added to the Corporate Risk Register. Discussion followed which noted the potentially adverse impact of the UK economic situation on overseas recruitment and on existing staff, particularly those that were lower paid. NJ noted the Agenda item Hancock House that outlined provision of affordable rental accommodation for staff which would be discussed in the Part 2 session of the meeting. He noted the need to keep the offer to staff under review again in order to ensure it remained attractive and continued to support the recruitment and retention programme. MA summarised that the risk position remained challenged and that deteriorating external factors beyond the Trust's control had impacted despite active mitigations being in place. He noted the wider economic impact on staff, housing and overseas recruitment and the need to ensure these were appropriately reflected in the BAF and Corporate Risk Register. PD left the meeting. **Corporate Risk Register** EHo reported that the COVID risk had reduced but that the Trust should remain cautious as it entered the winter period. A new emergent pharmacy staffing risk had been identified and an action plan had been developed and was being closely monitored. In response to an apparent difference between the SHMI indicator rating and narrative, AH explained the delay in reporting data and that he would clarify for future reports. There had been two months when the Trust had been outside the expected range and the SHMI report would include the latest data in October. EJ enquired whether there were any concerns arising from the data, noting discussion by the Quality Committee. AH said that the Mortality Report did not demonstrate any evidence for concern and noted that the Medical Examiners' Department was fully staffed and was also reviewing community deaths. In comparison with national audits, DCH performed well. AH explained that it would be expected to see excess deaths in critical care areas and that DCH compared well in this area nationally. The importance of triangulation with other sources of data was noted in providing assurance to the Board as the SHMI provided only one source of data. The Board was informed that the Coding Manager post had been successfully appointed.	**CA** **AH**

	Regarding the MHRA risk, the Board heard that weekly review by the Executive Team continued and that weekly returns continued to be made. No further queries had been raised. Following discussion of the risks the following actions were agreed: • Staffing risk to be strengthened based on current discussion • The Mental Health risk to be reviewed to reflect current discussion and ensure mitigations are appropriate. • Further detail regarding the pharmacy staffing risk to be provided in the next report.	**EHo / MF**
	Resolved: that the Board Assurance Framework and Corporate Risk Register be received and noted.	
BoD22/059	**Maternity Update**	
	Apologies were noted for the late circulation of the report which highlighted a reduction in complaints and the appointment of a Maternity Governance Lead. An external review was planned in order to assure the Trust's response to the Ockenden Reports in the coming weeks. Levels of compliance with training were good although some nationally provided training had been paused due to staffing issues. The Board noted prior discussion by the Quality Committee of the risks associated with neonatal cot provision, which was an issue across the region, and that there had been no subsequent harm events.	
	Resolved: that the Maternity Update be received and noted.	
BoD22/060	**GMC Survey Action Plan**	
	PM joined the meeting for this item and summarised the annual national comparison survey which noted some areas of excellence and the importance of Induction. The Patient Safety Survey results had been received in May 22 and discussions were being had in response. An operating procedure had been implemented within Fortuneswell Ward resulting in significant improvements having been made. Positive improvements had also been made in Urology services. The role of supervision and trainers was noted and feedback was being sought from the Medical Education Group on how this could be further strengthened. The availability of consultant staff made provision of supervision challenging. NJ noted that the Junior Doctors' Forum had been re-established and had discussed issues within the Trauma and Orthopaedic service. An action plan had been subsequently developed. The plan would focus on Foundation training to ensure appropriate supervision. The Junior Doctors' Forum would support doctors in training and encourage engagement going forward.	

	MA thanked PM for his continued commitment to medical training and PM left the meeting.	
	Resolved that: the GMC Survey Plan be approved.	
BoD22/061	**Well Led Review Action Plan Update**	
	The update which outlined the action progress made in response to the Well Led Review in December 2021 was taken as read. Progress had been made in the majority of areas. The Board requested further detail of the progress made in respect to Care Group governance and further detail would be provided within the next update.	**AT**
	Resolved that: the Well Led Review Action Plan Update be noted.	
BoD22/062	**Questions from the Public**	
	KH recounted a story where a friend had received conflicting advice regarding care home support and the implications for her finances and enquired how the Carers' Passport would help to prevent this going forward. EHo advised that the passport would help to ensure that communications were clear and consistent at ward level and would signpost carers to appropriate sources of further help, advice and support. KH reported that she had undertaken a 'meet the public' session recently and that feedback about the Trust had been overwhelmingly positive regarding the care received and attitude of staff, particularly from those that had visited South Walks House. MA thanked KH for the positive comments.	
	CONSENT SECTION	
	The following items were taken without discussion. No questions were previously raised by Board members prior to the meeting.	
BoD22/063	**Annual Reports:** • **Charitable Funds Annual Report and Accounts**	
	New Non-Executive Directors requested further information regarding their Trustee responsibilities and liabilities, noting that the Board of Directors collectively was the Charity Corporate Trustee. An update would be provided to Non-Executive Directors and would be included in the Induction Pack. CA confirmed that she had authority to sign the report and would do so. The Board formally extended its thanks to SP for his leadership and to the Charity team for their continued efforts to generate income for the Charity.	**TH**
	Resolved: that the Charitable Funds Annual Report and Accounts be approved.	

BoD22/064	**Learning from Deaths Quarter 1 Report**	
	Resolved that: the Learning from Deaths Quarter 1 Report be received and noted.	
BoD22/065	**Guardian of Safe Working Report**	
	Resolved that: the Guardian of Safe Working Report be received and noted.	
BoD22/066	**ICB Board Minutes – Part 1**	
	Resolved that: the ICB Board July Minutes Part 1 be noted.	
BoD22/067	**Any Other Business**	
	MA noted that this was the last Board meeting for NL and extended the Board's thanks for her brilliant service to the Trust over a number of years and for her leadership through the extraordinary pandemic period.	
BoD22/068	**Date and Time of Next Meeting**	
	The next Part One (public) Board of Directors' meeting of Dorset County Hospital NHS Foundation Trust will take place at **8.30am** on **Wednesday 30th November 2022.**	

Action Log – Board of Directors Part 1

Presented on: 30th November 2022

Minute	Item	Action	Owner	Timescale	Outcome	Remove? Y/N
Meeting Dated: 28th September 2022						
BoD22/056	**CEO Update**	To share information on the Oxfordshire approach to addressing high numbers of inpatients with No Reason to Reside	**SA**	October 2022	Update not received	
		Further figures were to be provided outlining the Trusts arrangements in support of the Trust's Social Value Pledge to utilise local food producers, reducing food miles and costs.	**CA**	October 2022	Update not received	
BoD22/057	**Performance Scorecard and Board Sub-Committee Escalation Reports**	Further discussion of the workforce challenges and Agency spend to be had at the October Board Development Session.	**TH**	October 2022	Added to Board Development Agenda.	Yes
		NRTR Deep Dive (August FPC to be circulated to Board members.	**TH**	October 2022	Circulated	Yes
BoD22/058	**Board Assurance Framework (BAF) and Corporate Risk Register**	Inflationary cost risk to be added to the Corporate Risk Register	**CA**	October 2022	Update not received	
		To review and clarify SHMI reporting periods in future reports	**AH**	November 2022	Update not received	
	Corporate Risk Register	• Staffing risk to be strengthened based on current discussion	**EHo / MF**	October 2022	• Staffing risk agreed at RAC to be reviewed in Jan 2023	

		• The Mental Health risk to be reviewed to reflect current discussion and ensure mitigations are appropriate. • Further detail regarding the pharmacy staffing risk to be provided in the next report.			– agreed managed risk • MOU now in place • Pharmacy staffing detail in RAC report	
BoD22/061	**Well Led Review Action Plan Update**	An update of progress made on Care Group Governance to be provided in the next report.	**AT**	November 2022	Update not received	
BoD22/063	**Annual Reports: Charitable Funds Annual Report and Accounts**	A summary of responsibilities and liabilities as Corporate Trustees to be provided to new NEDs and included within the NED Induction pack	**TH**	November 2022	Update not received	
Meeting Dated: 25th May 2022						
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	Update not received	
Actions from Committees…(Include Date)						

Meeting Title:	Board of Directors
Date of Meeting:	30 November 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	22/11/2022	Approved

Purpose of the Paper	For information.							
	Note	✓	*Discuss*		*Recommend*		*Approve*	
Summary of Key Issues	This report provides the Board with further information on strategic developments across the NHS and more locally within Dorset. It also includes reflections on how the Trust is performing and the key areas of focus. The key developments nationally are as follows: • The UK COVID-19 Inquiry held its first preliminary hearing on 04 October 2022 for Module 1 – preparedness and resilience, and Module 2 - core political & administrative decision-making took place on 31 October 2022. • On 12 October 2022, NHS Blood and Transplant (NHSBT) issued an amber alert because there is a significant shortage of blood for transfusion across the country. • The Department of Health and Social Care published that the government has announced that over £800 million of funding is to be allocated by the National Institute for Health and Care Research (NIHR). • On 20 October 2022, Liz Truss resigned as UK prime minister after less than two months in office. Rishi Sunak was announced as the new Prime Minister on 25 October 2022. • On 09 November 2022, Royal College of Nursing announced that that nursing staff in the majority of NHS Trusts across the UK have voted to strike. A number of other unions representing NHS employees are also in the process of balloting for strike action. • On 17 November 2022 the Government published the Autumn Statement 2022. The NHS is due to receive an extra £3.3billion in each of the next two years, raising the overall budget by 2% in real terms.							
Action recommended	The Board of Directors is recommended to: 1. **NOTE** the information provided.							

Governance and Compliance Obligations

Legal / Regulatory	Y	Failure to understand the wider strategic and political context, could lead to the Board to make decisions that fail to create a sustainable organisation.
Financial	Y	Failure to address key strategic and operational risks will place the Trust at risk in terms of its financial sustainability.
Impacts Strategic Objectives?	Y	For the Board to operate successfully, it must understand the wider strategic and political context.

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

Chief Executives Report – November 2022

National Perspective

Plan for Patients
On 22 September 2022, the Rt Hon Therese Coffey, Secretary of State for Health and Social Care, published the Government's Plan for Patients. The plan sets out priorities ABCD – ambulances, backlogs, care, and doctors and dentists. The aim of the plan is to highlight common sense changes, delivering tangible benefits for patients. Removing barriers getting in the way of patient care, putting more information at the fingertips of patients, and freeing up the time of clinicians to do what they do best: caring for patients.

Following publication, NHS Providers responded welcoming the short-term focus on winter but highlighted without a long-term workforce plan to recruit and retain staff across all parts of health and care, as well as reform of social care, efforts to improve patients' access to care are going to prove challenging.

COVID Inquiry
On 04 October 2022, the UK COVID-19 Inquiry held its first preliminary hearing for Module 1 – preparedness and resilience. Preliminary hearings are to agree on procedural matters and help the Inquiry and Core Participants prepare for the public hearings where evidence is heard. The next preliminary hearing for Module 2 - core political and administrative decision-making took place on 31 October 2022. The Inquiry has been broken down into several modules involving a gathering of evidence followed by the public hearings. Each module will be heard in sequence, with no order of importance placed on the sequencing.

The Inquiry will analyse the UK's state of readiness for the pandemic and the response to it, determining whether the level of loss suffered was inevitable or whether things could have been done better. Chair, Baroness Heather Hallett has set an ambitious timetable for the Inquiry, determined it will not drag on for decades producing reports when it is too late for them to do any good. Recognising there is a balance to be struck between making timely recommendations and the extent to which every issue is explored.

NHS Blood and Transplant Amber Alert
On 12 October 2022, NHS Blood and Transplant (NHSBT) issued an amber alert because there is a significant shortage of blood for transfusion across the country. This is likely to be the case for at least the next six weeks. Consequently, Trusts are being asked to minimise blood usage (and wastage) wherever possible.

DCH's Emergency Blood Management Group, chaired by Dr David Quick, are closely monitoring blood use across the Trust over the next few weeks and ensuring we reduce usage wherever possible, but stress that no limitations exist for urgent situations with a patient who has active bleeding.

National Institute for Health and Care Research Funding
On 14 October 2022, the Department of Health and Social Care published that the government has announced that over £800 million of funding is to be allocated by the National Institute for Health and Care Research (NIHR). This funding will go to support specialist research facilities bringing together scientists to create an environment where experimental medicine and patient safety research can thrive. This boost to the country's research infrastructure will see further investment in scientific expertise which supports access to innovative technology and novel research projects.

Prime Minister and Cabinet Updates
On 14 October 2022, Liz Truss removed Kwasi Kwarteng as Chancellor of the Exchequer, replacing him with Jeremy Hunt. On 17 October 2022 Jeremy issued budget reversals to all but three of Kwasi Kwarteng's mini budgets.

On 20 October 2022, Liz Truss resigned as UK prime minister. After less than two months in office, she says she is stepping down as Tory leader. On 25 October 2022, Rishi Sunak was announced as the new Prime Minister.

On 26 October 2022, Steve Barclay was appointed as the new Health Secretary, taking over from Therese Coffey.

Industrial Action
On 01 November 2022, Mike Prentice, National Director for Emergency, Planning and Incident Response for NHS England, and Navina Evans, Chief Workforce Officer for NHS England, wrote to NHS Trusts to update on NHS England preparations for potential industrial action in the NHS. This included a Self-Assessment Checklist which has been developed to support Trust preparations and ensuring information on confirmed industrial action, including information on derogations, is shared appropriately across systems.

On 09 November 2022, Royal College of Nursing announced that that nursing staff in the majority of NHS Trusts across the UK have voted to strike. Strikes will now take place at the NHS trusts or health boards that have met the relevant legal requirements. Many of the biggest hospitals will see strike action by RCN members but others narrowly missed the legal turnout thresholds to qualify for action. The RCN will ensure that strike action is carried out legally and safely at all times. Their mandate to organise strikes runs until early May 2023, six months after members finished voting.

UNISON's ballot of NHS staff in England and Wales opened on 27 October 2022 and closes on 25 November 2022, with Northern Ireland strike ballot also opened on 27 October 2022 but closed on 18 November. The British Medical Association (BMA) Junior Doctors Committee has voted to go to a ballot on industrial action in early January 2023 after the government failed to respond to its demands over pay and conditions. A number of other unions representing NHS employees are also in the process of balloting for strike action.

Whilst any industrial action is now not anticipated until next year, NHS Trusts are already planning for strike action to be prepared and to ensure the safe delivery of care and services for patients during any industrial action and to support the wellbeing of their staff.

Autumn Statement 2022 – Budget Outcome
On 17 November 2022 the Government published the Autumn Statement 2022 which highlights that the government's priorities are stability, growth and public services. The NHS is due to receive an extra £3.3billion in each of the next two years, raising the overall budget by 2% in real terms. Social care is due to receive additional funding, and with Council Tax increases, this would increase funding by £7.5billion for the next two years. It was also announced that existing capital commitments, including the New Hospital Programme, will be funded as promised which is great news for Dorset County Hospital's planned new ED and Critical Care build. While any additional funding is welcomed, there is still going to be a gap between allocation and costs, so Trusts are still going to need to focus on maximising productivity and efficiency, both this year and next.

Local Relevance

Operating Framework for NHS England
On 12 October 2022, the Operating Framework for NHS England was published setting out in more detail how NHS England (NHSE) will work with ICSs. The purpose and behaviours of NHS England is outlined including how they will add value, their medium-term priorities, and the accountabilities and responsibilities for the different organisations in the NHS. The framework will inform how NHSE develop as an organisation to become more agile and reduce duplication. Systems are expected to align with the overarching principles of this framework – purpose, areas of value, leadership behaviours and accountabilities, and medium-term priorities and long-term aims. Dorset's system operating framework will be developed taking this into consideration whilst meeting the ambitions of the Integrated Care Strategy and meeting the needs of our local communities.

Operational Resilience
On 18 October 2022, Amanda Pritchard, NHS Chief Executive wrote to system leaders regarding going further on winter resilience plans. In recognition of the challenges systems are already facing ahead of winter, the letter sets out an expansion of previous plans set out in August 2022 to improve operational resilience.

Locally, operational pressures continue across the Dorset system, continuing to declare Operational Pressures Escalation Levels (OPEL) Level 4, since the initial escalation on 30 June 2022. System partners are working together to ensure both our staff and patients are being cared for as best they can and mitigate risks wherever possible.

Several workstreams are underway across the system including a rapid improvement event which ran for two weeks in October with the aim to improve flow resulting in a 30% reduction of no Criteria to Reside (NCTR) across all Trusts. The demand and capacity schemes associated with additional NHS England funding continue to be progressed and monitored. An Urgent and Emergency Care action plan was submitted to NHS England at the end of September and updates will be provided at informal face-to-face fortnightly meetings, with a formal submission monthly basis to NHSE throughout winter.

Dorset and BCP Integrated Care Strategy
The Integrated Care Strategy development, led by the Director of Public Health for Dorset and BCP Councils, Sam Crowe, is well underway. Aligned to NHS Dorset engagement approach the 100 Voices Programme is gathering stories from over 100 people living across Dorset to understand what It means to people to live their best life. They have included a diverse range of people ensuring there is wide representation across geography, age, sex, protected characteristics, deprived communities, minority communities, and disability groups. The publication deadline for the strategy is 19 December 2022.

Once the Integrated Care Strategy has been published, work will begin on the development of system wide enabling plans, including finance, clinical, people, and digital as well as ensuring system partner strategies are reflective of the direction of travel and align to the strategic objectives.

Winter Planning – Exercise Arctic Willow
A national multi-day exercise for ICBs (working with Trusts) called Exercise Arctic Willow is taking place week commencing 14 November 2022 to test preparedness as a System. This is being led by ICB's and will seek to explore the health and social care response to multiple, concurrent operational and winter pressures, and the interdependencies with Local Resilience Forum (LRF) partners in responding to these pressures. This work will be co-ordinated with wider winter planning.

DCH Performance

DCH continued to experience patient flow restrictions. Ambulance handover delays remained at high levels, putting pressure on the ambulance response times. Elective activity was affected throughout the month with some theatre lists cancelled due to high bed occupancy. Cancer performance is being impacted by high referral volumes, which is now resulting in an increased total waiting list size and an increase backlog. 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.

COVID-19 Update – Boosters and Flu Vaccines
Our COVID-19 inpatient numbers are currently stable and we are seeing a small reduction. However, we are aware as we move into Winter the likelihood is that it will rise along with influenza cases. Our work continues to ensure the trust is prepared for this and I would like to thank you for your ongoing support. The weekend vaccination clinics for staff remain well attended and at the end of October 2022, over 600 staff have had their COVID-19 booster and over 760 staff have had their flu booster.

Trusts Annual General Meeting
On 29 September 2022, we held the Annual General Meeting and Annual Members' Meeting for the 2021/22 year. The AGM is always a good opportunity to reflect on all that has been achieved over the year which is incredibly impressive. Attendees also heard about our Orthopaedic Outpatient Assessment Centre in South Walks House and the great work of our Education Team on what we are doing to recruit our future workforce through apprenticeships and other training and education routes.

DCH GEM and Long Service Awards
Dorset County Hospital staff and volunteers receive well-deserved recognition for their hard work and dedication at the Going the Extra Mile (GEM) Awards on 30 September 2022, and the Long Service Awards on 03 October 2022. The awards are presented annually to those who have made an outstanding contribution and to those who have achieved 25 years of service

Clinical Service Accreditation – Anaesthetics
In September 2022, the Trust was contacted by Dr Russell Perkins (Vice President, Royal College of Anaesthetist) to notify us that the Accreditation Committee at the College had awarded our Anaesthetic Department formal Clinical Service Accreditation for the second time. We are one of fewer than 10 departments in the country to get reaccredited which is a great achievement and mark of quality. The visit from the RCOA took place at the end of March this year and was supported by the teams in Theatres, DSU, PAU, Maternity, Endoscopy, Radiology and ED. We are justifiably proud of the whole Anaesthetic team who worked hard to ensure that all of the great work done through the department at DCH was clearly explained and evidenced.

New Hospitals Programme Update
On 30 September 2022, the Outline Business Case for the £90million investment in DCH's new Emergency Department and Critical Care Department building went to the Treasury and Department of Health and Social Care Joint Investment Committee. The case was approved in principle at the committee, with conditions still pending. DCH is the first cohort two Trust to successfully go through this process. The case was reviewed by His Majesty's Treasury (HMT) in October and further queries were raised about system-wide investment and interdependencies. The Trust team have worked with University Hospital Dorset to respond. Ministerial sign off is expected later this month.

A condition of approval of the 'full business case' is DCH signing a partnering agreement with the New Hospitals Programme (NHP). NHP is the national programme of hospital building to meet the governments commitment of delivering 40 'new' hospitals by 2030, of which DCH is one. The partnering agreement is a mechanism by which DCH participate in the national programme for collective advantage. Examples include central procurement and shared learning. Another aspect of the agreement is graduated 'step-in' rights, should the programme run into difficulty. If the programme falls behind schedule or runs over budget the national NHP team have the right to assign a programme manager to the DCH team, set improvement targets and ultimately take on the client role if these mitigating actions are not successful. The Board are asked to note the signing of the partnering agreement.

DCH's Greatest Needs Appeal is also aiming to raise a further £2.5million to enhance the environments we create for both patients and staff.

Targeted Investment Fund – South Walks House
On 03 October 2022, the Trust was successful in its application for a Targeted Investment Fund (TIF) worth £13million. The TIF is a source of external funding and will help make significant steps in improving our planned care activity and waiting times. To do that we will make the temporary Outpatient Assessment Centre in South Walks House a permanent facility and also have plans to create ring-fenced Orthopaedic beds. In addition, we will create a Pathway Home Hub to help patient flow through the hospital and across the system.

Multi-Story Car Park Update
In October the Executive Team agreed to continue to offer free parking for staff on the hospital site until at least the end of this financial year (31 March 2023). We have watched the cost of living further increase over the past few months - further exacerbated by the Government's mini-budget - and have been reviewing ways we are able to support staff. Dorset Council have kindly agreed to refund any remaining months of council annual permits if staff no longer wish to park at the Fairfield or any other council sites whilst staff parking remains free at Dorset County Hospital.

The staff parking portal has been launched with staff now registering their details on the portal so that the barrier system will recognise their number plate and lets them in automatically without needing to take a ticket.

Chemotherapy Outreach Service in Bridport
In October 2022, DCH opened a new Chemotherapy Outreach service based at Bridport Community Hospital, allowing patients in the town and surrounding area to receive chemotherapy and other cancer treatments closer to home. The benefits for patients are huge in terms of not having to travel as far, saving on fuel costs, and receiving treatment in their local area. The new service is part of a longer-term plan to provide more opportunities for patients to receive their cancer treatment closer to where they live, aligned to the ambition of the NHS providing care closer to home.

South West NHSE Regional Insight Visit – Maternity & Neonatal Services
On 10 October 2022, the South West NHSE Regional Insight team visited DCH to review the Maternity and Neonatal services. The visit included local maternity and neonatal system partners who looked at performance data, the experience of staff and parents, as well as governance and leadership to help celebrate the good things and identify opportunities for further improvement. It was a great day of celebrating the amazing transformation and quality improvement work over the last few years. A formal report will follow in about a month's time to help the team on this continuous journey. A comment in the informal feedback on the day reflected on how all the staff they talked to in the units said they were supported and really liked working here.

DCH and DHC Joint Chief Executive & Joint Chair
On 11 October 2022, the advert for the role of joint Chief Executive for the Trusts went live. The teams are now creating a robust process to test the candidates. This will involve a range of stakeholders including non-Executive Directors, Governors, and colleagues from both Trusts as well as patients, carers and representatives from partner organisations. Interviews for the role will take place in early December.

DCH Board Members Updates
On 03 October 2022 Chris Hearn joined DCH in his role of Chief Financial Officer.

On 20 October 2022, we said goodbye to Nicky Lucey who left DCH for her new role as Chief Nursing Officer of the Hampshire and Isle of Wight Integrated Care Board. Nicky worked at DCH for six years. Emma Hoyle, our Deputy Chief Nursing Officer, will be acting up for the next six weeks until Jo Howarth joins us at the end of November.

HSJ Patient Safety Award
On 24 October 2022, at the HSJ Patient Safety Awards our Orthotics Team won the award for Safe Restoration of Elective Care Services. It's great that our colleagues have been recognised nationally for their efforts. Well done to everyone involved.

Nick Johnson
Interim Chief Executive
November 2022

Meeting Title:	November Board Meeting
Date of Meeting:	30 Nov 2022
Document Title:	**Balanced Scorecard**
Responsible Director:	Nick Johnson – Chief Executive Officer
Author:	Philip Davis – Head of Strategy & Corporate Planning

Confidentiality:	No – will form part of part 1 public domain materials.
Publishable under FOI?	No

Prior Discussion		
Job Title or Meeting Title	**Date**	**Recommendations/Comments**
Aug Board	31 Aug 2022	Balanced Scorecard showcased at Board Away Day. Feedback given.
Chief Executive Officer	24 Nov 2022	Approved

Purpose of the Paper	For the Balanced Scorecard to be finally approved and become fabric of Board meetings moving forward – and part of public documents in Part 1.							
	Note	✓	Discuss	✓	Recommend	✓	Approve	✓
Summary of Key Issues	Board members expressed they were struggling to see an at a glance view of how the Trust is performing against key metrics in our guidance for 22/23. Board papers form a document pack often into hundreds of pages, and metrics have to be located across different performance reports or dashboards. A balanced scorecard was requested to overcome the deficiencies above, and following successful implementation at other trusts. SROs were canvassed for the subset of key metrics they would like to be added – noting that it shouldn't contain all framework or constitutional requirements A pilot was taken to the Board away day session, and to EMT – where feedback was collected, specifically: - 100% using SPC charting throughout (following NHSE standard) - PDF version always available - Locked at a specific date each month, and saved for that month - Dates & metrics always tie with other reporting (single version of truth) - A brief narrative be added for each section of the report The final report, encompassing all the feedback above, is presented to the November Board. https://bireports.dchft.nhs.uk/reports/powerbi/DCH%20-%20Trust%20Reports/Executive%20Dashboards/Executive%20Dashboard%20-%20Nov%202022%20Board?rs:embed=true It is proposed that this now become a fixed part of the Board reporting schedule from now on. It should be noted that the above does not supplant or replace anything in the Board reporting, rather it acts as a compliment to what is currently there.							

Action recommended	Board is recommended to: 1. **NOTE** the specific feedback given at Board and EMT has been incorporated into this Balanced Scorecard 2. **Review** and **Comment** on the suitability of the report to form a public domain document, and be part of the Board reporting process moving forwards. 3. **APPROVE** the continuation of Balanced Scorecard in the coming months.

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 – this to become a permanent part of Board packs
Impacts CQC Standards?	Y/N	Y – Should enable easier monitoring and driving of improvement
Impacts Social Value ambitions?	Y/N	N
Equality Impact Assessment?	Y/N	N
Quality Impact Assessment?	Y/N	N

Exec Dashboard Nov 2022 Board

<< VIEW REPORT IN FULL SCREEN >>
(opens in new window)

NHS
Dorset County Hospital
NHS Foundation Trust

Summary of Data

Report Reference
Executive Dashboard (SPC)

Purpose of Report
Provide insight into a broad range of DCH metrics for executive level overview and understand where processes have failed and/or improved through the use of SPC chart tool provided by the national making data count team.

Source of Report
Data sources are primarily from the BI Data Warehouse but also includes information from manual sources as well as system data.

Known Data Quality Issues
Data validation still in progress

Recipients
Executives, Non-Executives, Divisional managers and operational Staff

DCHFT Power BI User Guide
DCHFT BI Gateway User Guide

Business Intelligence Gateway

30 April 2019
Earliest Date

31 October 2022
Latest Date

23 November 2022
Latest Update Date

Report Version 1.0 (Aug-22)
Produced by Dorset County Hospital Business Intelligence Team

Please contact the Team if you have any questions regarding this report
BusinessIntelligence@dchft.nhs.uk

Report Under Development - Data Presented may not yet be validated

pdf version

Making Data Count

Understanding and Interpreting SPC Charts

Cover Page | Executive Summary | Matrix Overview | Performance | Quality & Safety | People | Finance | Appendix A: SPC Basics | Appendix B: SPC Icon Descriptions | Useful Links

Executive Summary

Select an icon to view relating metrics

Variation

Assurance

PEOPLE

Metric Name	Assurance	Variation	Value	Target
Appraisal Rate	F	L	70%	90%
Essential skills Rate	F	H	90%	90%
Shortlist to Hire Ratio (White:ethnic minority + Not Specified)			0.8	
Sickness Rate	?	H	4.28%	3.3%
Turnover Rate	P	H	11.82%	12%

PERFORMANCE

Metric Name	Assurance	Variation	Value	Target
Ambulance Handover Delays Average Time Lost per Day	F	H	24.2	5.09
Cancer (ALL) - 28 day faster diagnosis standard	?		70.54%	75%
Cancer (ALL) - 104 Days Referral to Treatment			22	
Diagnostics - % Patients Waiting Less than 6 Week Diagnostic Test	F	L	67.03%	99%
Elective Recovery - Day Case Activity vs 2019/20	?	H	108.57%	104%
Elective Recovery - Elective Inpatients Activity vs 2019/20	F		60.07%	104%
Elective Recovery - Outpatient Activity vs 2019/20	?		85.19%	104%
Elective Recovery Total Activity vs 2019/20	?		86.77%	104%
Emergency Department - 12 Hour Waits		H	525	
Emergency Department - Overall 4 Hour Performance %	F	L	68.68%	95%
Outpatients - Virtual Activity %	F	H	23.26%	25%
Percent Bed Occupied by No RTR		L	23.21%	
RTT - 52+ week waits	?		1156	1400
RTT - 78+ week waits	F	L	134	180
RTT - Waiting List Size	?	H	18823	17124
Theatres - Theatre Utilisation (TouchTime)	F		69.56%	85%

QUALITY & SAFETY

Metric Name	Assurance	Variation	Value	Target
% EDS available within 24Hrs of discharge	F	H	84.23%	90%
% EDS available within 7 Days of discharge	F	H	92.57%	100%
% Emergency Re-Admissions (16+ & within 30 days)	P	L	7.13%	13.2%
Complaints Total Recieved			107	
FFT Overall Recommend Rate	?	L	91.06%	94%
Incidents - Falls: Fracture/Severe Harm Cases			0	
Incidents - Medication			73	
Incidents - Never Events	F	L	0	0.02
Incidents - Serious, Avoidable	?		0	0
Number of Hospital Onset HealthCare Associated C.Difficile Infections	?		2	3.83
Number of Hospital Onset HealthCare Associated Gram Negative Infections	?		2	5.75
Reportable Hospital Acquired Pressure Ulcers Grade 3			2	
SHMI Value	?	L	1.14	1.13

FINANCE

Metric Name	Assurance	Variation	Value	Target
Total Substantive Workforce Pay Cost		H	15084	
Financial Spend	?		-937	196
CIP			-2412	-239
Capital Expenditure	?		1369	2031
Agency Spend	?	H	1191	917
Agency % of pay costs	F	H	8.1%	5%

Matrix Overview

Dorset County Hospital NHS Foundation Trust

Variance \ Assurance	P	?	F		Total
H		1	5		6
L	1	1	3	1	6
		10	2	6	18
H	1	3	3	4	11
L		1	3		4
				1	1
Total	2	16	16	12	46

The matrix summarises the number of metrics (at Trust level) under each variance and assurance category.

We should be aiming for top left of grid (special cause of improving nature, passing the target).

Items for escalation, based on indicators which are failing target or unstable ('Hit and Miss') and showing special cause for concern are highlighted in yellow.

Hover over the figures within the matrix to view details of the metrics.

To view SPC charts, please refer to 'Performance', 'Quality & Safety', 'People' and Finance' tabs.

For further explanation of the icons and matrix categories, please refer to the 'SPC Icon Descriptions' tab.

Performance

Group: 0 - Total

Metric: All

Hover over metrics to view SPC charts
Number of No Reason to Reside limited data.
Year to Date values under development
Cancer metrics 1 month in arrears due to finalising data 25 workings days after month end.

NHS Dorset County Hospital NHS Foundation Trust

Commentary

Ambulance handover delays: Avg time lost per day has variation of high, with assurance of fail. Compared to all Regional providers, DCH performing well and not considered in need of intervention. Performance against all ambulance handover metrics has improved in reporting month.
Day case activity: Despite DCU being used as overnight escalation, department has consistently delivered >=100% or more of 2019/20 activity levels – improvement SPC supported.
Diagnostic performance, 6-wk standard: % metric is not achieving target, however improvements are in place (67% vs target 99%). Oct saw backlog decrease -621 patients and total waiting list by -2,565 patients, with % perf up 2% from previous month.
ED 12 hr waits, 4hr perf: Huge growth in >12 hr waits, in turn holding back improvements in 4hr perf. ED is an active area of estates development, with improvements in flow and space not yet yielding optimum impact on standards.
NRTR: has reduced to lowest level since Mar-21, because of the internal and system actions coming to fruition – improvement SPC supported.
Waiting list size: Total elective WL size is a special cause of variation, and above trajectory. The trajectory submitted did not account for 30% increase in cancer referrals. The WL profile has changed, with length of wait coming down and long waiters trajectories being met (78kw & 52wk), with WL growth at the front of the pathway.

VariationIcon	Pass	Hit or Miss	Fail	Empty	Total
Improvement		1	2	1	4
Common Cause		4	2	1	7
Concern		1	3	1	5
Neither					
Empty					
Total		6	7	3	16

Metric	Group	Latest Month	Value	Target	Variance to Target	PY - Month Value	YTD Value	Variation	Assurance	Hyperlinks
Ambulance Handover Delays Average Time Lost per Day	0 - Total	Oct-22	24.2	5.09	19.11	18.17				
Cancer (ALL) - 28 day faster diagnosis standard	0 - Total	Oct-22	70.54%	75%	-4.46%	65.22%				
Cancer (ALL) - 104 Days Referral to Treatment	0 - Total	Oct-22	22			19				
Diagnostics - % Patients Waiting Less than 6 Week Diagnostic Test	0 - Total	Oct-22	67.03%	99%	-31.97%	94.87%				
Elective Recovery - Day Case Activity vs 2019/20	0 - Total	Oct-22	108.57%	104%	4.57%	89.72%				
Elective Recovery - Elective Inpatients Activity vs 2019/20	0 - Total	Oct-22	60.07%	104%	-43.93%	60.4%				
Elective Recovery - Outpatient Activity vs 2019/20	0 - Total	Oct-22	85.19%	104%	-18.81%	84.15%				
Elective Recovery Total Activity vs 2019/20	0 - Total	Oct-22	86.77%	104%	-17.23%	84.34%				
Emergency Department - 12 Hour Waits	0 - Total	Oct-22	525			64	2534			https://bireports.dch…
Emergency Department - Overall 4 Hour Performance %	0 - Total	Oct-22	68.68%	95%	-26.32%	72.67%				https://bireports.dch…
Outpatients - Virtual Activity %	0 - Total	Oct-22	23.26%	25%	-1.74%	25.26%				
Percent Bed Occupied by No RTR	0 - Total	Oct-22	23.21%			26.71%				
RTT - 52+ week waits	0 - Total	Oct-22	1156	1400	-244.00	1911	1156			https://bireports.dch…
RTT - 78+ week waits	0 - Total	Oct-22	134	180	-46.00	912	134			https://bireports.dch…
RTT - Waiting List Size	0 - Total	Oct-22	18823	17124	1,699.00	18773	18823			https://bireports.dch…
Theatres - Theatre Utilisation (TouchTime)	0 - Total	Oct-22	69.56%	85%	-15.44%	71.52%				https://bireports.dch…

Quality and Safety

Group: 0 - Total

MetricName: All

Hover over metrics to view SPC charts
Year to Date values under development

Dorset County Hospital NHS Foundation Trust

Commentary
Positive Quality Improvement - No SI's confirmed reportable for October
Positive Quality Improvement - No Never Events reported for 11 consecutive months
Positive Quality Improvement - No Medication Incidents reported for 11 consecutive months
Challenges to Quality Improvement - Maintaining no lapse in care cases under threshold for C-Diff
Challenges to Quality Improvement - Friend and Family Recommendation Rates noted as reflecting national themes
Challenges to Quality Improvement - Fluctuation in data this month for SHMI
Challenges to Quality Improvement - Availability of EDS for GP's remains a challenge despite a slight increase in this metric for October

Assurance	Improvement	Common Cause	Concern	Neither	Empty	Total
Pass	1		1			2
Hit or Miss	2	10	4			16
Fail	8	2	6			16
Empty	1	6	4	1	1	13
Total	**12**	**18**	**15**	**1**	**1**	**47**

SAFE

Metric	Group	Latest Month	Value	Target	Variance to Target	PY - Month Value	YTD Value	Variation	Assurance	Hyperlinks
Incidents - Falls: Fracture/Severe Harm Cases	0 - Total	Oct-22	0			0				
Incidents - Medication	0 - Total	Oct-22	73			48				
Incidents - Never Events	0 - Total	Oct-22	0	0.02	-0.02	0				
Incidents - Serious, Avoidable	0 - Total	Oct-22	0	0	0.00	0				
Number of Hospital Onset HealthCare Associated C.Difficile Infec…	0 - Total	Oct-22	2	3.83	-1.83	3	22			https://bireports.dch…
Number of Hospital Onset HealthCare Associated Gram Negativ…	0 - Total	Oct-22	2	5.75	-3.75	5	24			https://bireports.dch…
Reportable Hospital Acquired Pressure Ulcers Grade 3	0 - Total	Oct-22	2			2	4			https://bireports.dch…

EFFECTIVE

Metric	Group	Latest Month	Value	Target	Variance to Target	PY - Month Value	YTD Value	Variation	Assurance	Hyperlinks
% EDS available within 24Hrs of discharge	0 - Total	Oct-22	84.23%	90%	-5.77%	76.51%				
% EDS available within 7 Days of discharge	0 - Total	Oct-22	92.57%	100%	-7.43%	87.61%				
% Emergency Re-Admissions (16+ & within 30 days)	0 - Total	Sep-22	7.13%	13.2%	-6.07%	8.23%				
SHMI Value	0 - Total	Jun-22	1.14	1.13	0.01	1.2	1.14			https://bireports.dch…

CARING

Metric	Group	Latest Month	Value	Target	Variance to Target	PY - Month Value	YTD Value	Variation	Assurance	Hyperlinks
Complaints Total Recieved	0 - Total	Oct-22	107			103	662			
FFT Overall Recommend Rate	0 - Total	Oct-22	91.06%	94%	-2.94%	91%				

People

Group: 0 - Total

MetricName: All

Hover over metrics to view SPC charts
Missing Metrics - Rolling 12 months shortlist to hire for white: minority ethnic ratio.
Sickness Rate 1 month in arrears.
Year to Date values under development.

Dorset County Hospital NHS Foundation Trust

Commentary

Appraisal Rate: increased from 63% to 71% between Jun & Sep, early indication of improvement not yet meeting SPC criteria. A shorter appraisal form was launched in November to simplify process and encourage completion.

Essential Skills: Although failing on SPC assurance, Compliance has remained within +/- 1% of 90% target for the past 14 months.

Sickness Rate: Some improvement in Sep driven by was in short term absence, although not yet meeting SPC variation criteria. Undulating in 2022 in response to Covid peaks, therefore expected to increase again in October.

Turnover: Turnover remained unchanged in October and after increasing markedly at beginning of the year, and becoming out of SPC control.

Assurance	Improvement	Common Cause	Concern	Neither	Empty	Total
Pass			1			1
Hit or Miss			1			1
Fail	1		2			3
Empty						
Total	**1**		**4**			**5**

Metric	Group	Latest Month	Value	Target	Variance to Target	PY - Month Value	YTD Value	Variation	Assurance	Hyperlinks
Appraisal Rate	0 - Total	Oct-22	70%	90%	-20.00%	72%	70%			
Essential skills Rate	0 - Total	Oct-22	90%	90%	0.00%	89%	90%			
Sickness Rate	0 - Total	Sep-22	4.28%	3.3%	0.98%	4.38%	4.28%			
Turnover Rate	0 - Total	Oct-22	11.82%	12%	-0.18%	8.5%	11.82%			
Vacancy Rate (substantive)	0 - Total	Oct-22	9.63%	5%	4.63%	5.7%				

Finance

Group: 0 - Total

MetricName: All

Hover over metrics to view SPC charts
Missing Metrics - Covid-19 costs and Productivity Metric (region calculation)
Year to Date values under development

Dorset County Hospital NHS Foundation Trust

Commentary

Agency: High cost agency usage remained high in October. Subsequent support & challenge put in place to address cost (£1.2m in Oct) as a Trust priority.
Capital: Capital expenditure behind plan due to slippage against externally funded schemes.
CIP: CIP identification & delivery remains behind plan. Budget lock-ins in place, with sustainable approach to cost savings & productivity in development.
Financial spend: Behind plan, predominantly due to high agency costs, undelivered CIP, and inflationary pressures. See agency and CIP comments.
Total Substantive spend: Substantive workforce spend behind plan due to number of vacancies, however offset by temporary staffing expenditure.

Assurance	Improvement	Common Cause	Concern	Neither	Empty	Total
Pass						
Hit or Miss		2	1			3
Fail						
Empty			1		1	2
Total		**2**	**2**		**1**	**5**

Metric	Group	Latest Month	Value	Target	Variance to Target	PY - Month Value	YTD Value	Variation	Assurance	Hyperlinks
Agency Spend	0 - Total	Oct-22	1191	917	274.00	990	8236			
Capital Expenditure	0 - Total	Oct-22	1369	2031	-662.00	1465	20459			
CIP	0 - Total	Oct-22	-2412	-239	-2,173.00		-2941			
Financial Spend	0 - Total	Oct-22	-937	196	-1,133.00	-623				
Total Substantive Workforce Pay Cost	0 - Total	Oct-22	15084			11378.7				

SPC Basics

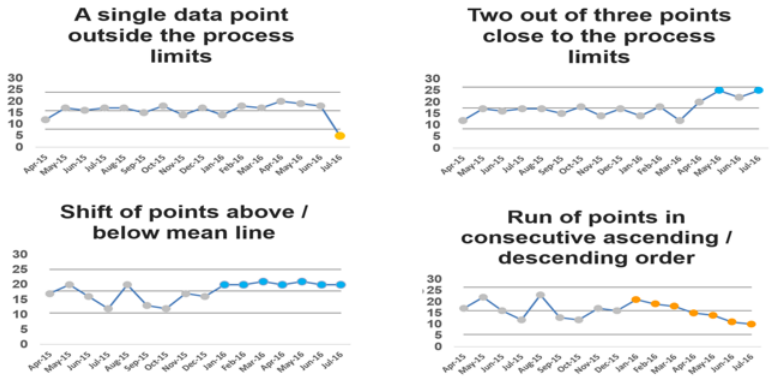
Dorset County Hospital
NHS Foundation Trust

Is Performance Changing?

Statistical process control (SPC) charts help us understand if the performance of a metric is changing significantly.

We use rules (examples seen on the right) to identify significant unusual variation, which is highlighted on the charts.

Once significant variation has been identified we can focus attention on areas that need investigation and action.



What are Summary Icons showing?

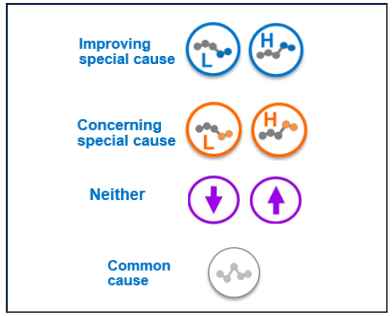
Blue icons indicate significant improvement or low pressure.

Orange icons indicate significant concern or high pressure.

Purple icons indicate direction of change, for metrics where a judgement of improvement or concern is not appropriate.

Grey icons indicate no significant change ('Hit and Miss').

For further details please refer to 'SPC Icon Descriptions' tab.



	Special cause variation where **UP** is neither improvement nor concern.
	Special cause variation where **DOWN** is neither improvement nor concern.
	Special cause or common cause cannot be given as there are an insufficient number of points. Assurance cannot be given as a target has not been provided.

What is a Moving Range Chart showing?

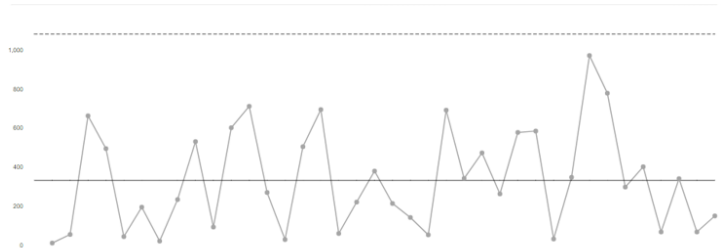
Moving range chart (seen on right) helps to assess the variation in a process by taking the absolute difference between consecutive points.

The chart can determine the data points wherein the special cause variation may be present.

The centre line is the average value of all moving ranges.

The dashed line is the upper process limit and if a point breaches this line, this is where special cause variation may be present.

The moving range chart will display below all SPC visualisations.



SPC Icon Descriptions

Dorset County Hospital NHS Foundation Trust

Variance	Assurance: P	Assurance: ?	Assurance: F	Assurance: ○
H	Special cause of an improving nature where the measure is significantly **HIGHER**. This process is capable and will consistently **PASS** the target.	Special cause of an improving nature where the measure is significantly **HIGHER**. This process will not consistently **HIT OR MISS** the target. This occurs when the target lies between process limits.	Special cause of an improving nature where the measure is significantly **HIGHER**. This process is not capable. It will **FAIL** the target without process redesign.	Special cause of an improving nature where the measure is significantly **HIGHER**. Assurance cannot be given as a target has not been provided.
L	Special cause of an improving nature where the measure is significantly **LOWER**. This process is capable and will consistently **PASS** the target.	Special cause of an improving nature where the measure is significantly **LOWER**. This process will not consistently **HIT OR MISS** the target. This occurs when the target lies between process limits.	Special cause of an improving nature where the measure is significantly **LOWER**. This process is not capable. It will **FAIL** the target without process redesign.	Special cause of an improving nature where the measure is significantly **LOWER**. Assurance cannot be given as a target has not been provided.
~	Common cause variation, no significant change. This process is capable and will consistently **PASS** the target.	Common cause variation, no significant change. This process will not consistently **HIT OR MISS** the target. This occurs when target lies between process limits.	Common cause variation, no significant change. This process is not capable. It will **FAIL** to meet target without process redesign.	Common cause variation, no significant change. Assurance cannot be given as a target has not been provided.
H	Special cause of a concerning nature where the measure is significantly **HIGHER**. The process is capable and will consistently **PASS** the target.	Special cause of a concerning nature where the measure is significantly **HIGHER**. This process will not consistently **HIT OR MISS** the target. This occurs when the target lies between process limits.	Special cause of a concerning nature where the measure is significantly **HIGHER**. This process is not capable. It will **FAIL** the target without process redesign.	Special cause of a concerning nature where the measure is significantly **HIGHER**. Assurance cannot be given as a target has not been provided.
L	Special cause of a concerning nature where the measure is significantly **LOWER**. This process is capable and will consistently **PASS** the target.	Special cause of a concerning nature where the measure is significantly **LOWER**. This process will not consistently **HIT OR MISS** the target. This occurs when the target lies between process limits.	Special cause of a concerning nature where the measure is significantly **LOWER**. This process is not capable. It will **FAIL** the target without process redesign.	Special cause of a concerning nature where the measure is significantly **LOWER**. Assurance cannot be given as a target has not been provided.

Useful Links

Dorset County Hospital NHS Foundation Trust

FutureNHS

If you have a FutureNHS account, you can join the Making Data Count workspace at https://future.nhs.uk/MDC/grouphome.

If you do not have a FutureNHS account, you can self-register on the platform with an @nhs.net / @nhs.uk / @nhs.scot / @phe.gov.uk email address at https://future.nhs.uk.

If you have difficulties joining, send us an email at nhsi.improvementanalyticsteam@nhs.net.

Events

A list of all future sessions to register for through Eventbrite can be found at https://future.nhs.uk/MDC/view?objectId=910865.

There are no events/courses planned for August but these will restart in September. (dates to be announced soon!)

Guides & Cards

Our two interactive PDF guides can be downloaded from https://www.england.nhs.uk/publication/making-data-count.

To request physical copies of our mini guides and/or spuddling cards, fill in the form at https://forms.office.com/r/bhR3dMLYbF.

SPC Surgery

If you have any questions on the national teams tools, training, or anything else SPC related, send the national team an email to nhsi.improvementanalyticsteam@nhs.net. If they do not answer immediately, you can book a virtual meeting slot.

Escalation Report

Executive / Committee: Finance and Performance Committee

Date of Meeting: Wednesday 24th October 2022

Presented by: Stephen Tilton (Chair)

Significant risks / issues for escalation to Committee / Board for action	• The following contracts were approved and recommended to the Board:
	  ○ Angio Room 3
	  ○ Room 5 Replacement radiology Equipment
	• Approval was given to establish additional nursing resource to staff an additional Critical Care bed.
	• Approval was given to make permanent the eight fixed term additional posts within the Recruitment team and to fund an addition four fixed term posts in order to support recruitment activity and reduce Agency expenditure.

Key issues / matters discussed at the Committee	The meeting considered the following items:
	• A rise in the number of cases of COVID in the community
	• The Performance Report noted:
	  ○ Additional insourcing arrangements in the Diagnostic Services
	  ○ A reduction in the follow up backlog
	  ○ Increased number of urgent referrals
	  ○ System working to address the high numbers of patients with No Reason to reside
	  ○ Referral to Treatment targets were in line with plan
	• The Finance Report noted:
	  ○ £1.3m deficit adverse to plan driven by high cost Agency expenditure
	  ○ £1m Cost Improvements still to be identified and the no recurrent nature of schemes to date.
	• Detailed discussion of Agency expenditure by the Finance subgroup and the need to include activities that did not attract income on a future Agenda.
	• Divisional Escalation Reports noted the planed opening of ED 15 at the end of November, alternative models, overseas recruitment and system wide discussions to support unfilled vacancies, and improved Cost Improvement positions.
	• The mandated Premises Assurance Model submission was noted alongside the need for further engagement and work prior to approval of the report recommendations.
	• The EPRR self-assessment was noted.
	• The committee noted the complexities surrounding the Dorset Electronic Patient Record proposal and potential financial implications and funding gap.
	• The Workforce Resourcing and Staffing Increase Update was noted
	• Travel and Sustainability Subgroup Escalation Report.

Decisions made by the Committee	• The following contracts were approved:
	  ○ Angio Room 3
	  ○ Room 5 Replacement radiology Equipment

	• The DCH Subco Ltd contract was reported to have been extended for a period of two years. • Approval was given to progress an additional opportunity to undertake an overseas recruitment exercise. • Approval was given to establish additional nursing resource to staff an additional Critical Care bed. • Approval was given to make permanent the eight fixed term additional posts and to fund an addition four fixed term posts in order to support recruitment activity and reduce Agency expenditure.
Implications for the Corporate Risk Register or the Board Assurance Framework (BAF)	• As per the Board Assurance Framework and Corporate Risk Register
Items / issues for referral to other Committees	• None

INTEGRITY | RESPECT | TEAMWORK | EXCELLENCE

NHS
Dorset County Hospital
NHS Foundation Trust

Escalation Report

Executive / Committee: Finance and Performance Committee

Date of Meeting: Monday 21st November 2022

Presented by: Stephen Tilton (Chair)

Significant risks / issues for escalation to Committee / Board for action	• Approval was given to the Portacabin Funding Bid. • Stroke moved (positively) from C to B through improved access to Therapy service in October.

Key issues / matters discussed at the Committee	The meeting considered the following items:
	• An update on the prevalence of COVID and promotion of the Vaccination Programme
	• The Performance Report noted:
	  ○ High levels of service operational pressures throughout October
	  ○ Positive move from Strategic Oversight Framework segmentation from Segment three to Segment 2.
	  ○ Maintenance of the 78 and 52 week waiting list positions despite service pressures
	  ○ Maintenance of the 31 day cancer standard and increasing numbers of referrals
	• The Finance Report noted:
	  ○ Predicted deficit position by year end and ongoing system discussions to achieve a system-wide break-even position.
	  ○ Further work to identify and deliver the Cost Improvement Programme recurrently and reduce high-cost Agency spend
	  ○ Monitoring of the Capital Plan
	• Detailed discussion by the Finance subgroup pf the Cost Improvement Programme and agency spend reduction plans.
	• Divisional Escalation Reports noted improvement in the Stroke SSNAP from 3 to 2
	• The ED15 Bi-monthly update was noted near completion of the work and planned opening of the facility.
	• Patient Pathway Improvement Programme update was noted.
	• Escalation Reports from:
	  ○ DCH Subco Ltd (including Q2 Performance Report) noting the risk arsing from the size of pharmacy and increased activity.

Decisions made by the Committee	• Approval was given to the Portacabin Funding Bid in principle – further assurances that the best price had been achieved was requested. • No contracts were presented for approval.
Implications for the Corporate Risk Register or the Board Assurance Framework (BAF)	• The Board Assurance Framework discussion noted improvements in the presentation of the report and noted the workforce sustainability risk impact for the three Board committees.

Items / issues for referral to other Committees	• None

Escalation Report

Executive / Committee: People and Culture Committee

Date of Meeting: Thursday 24th October 2022

Presented by: Margaret Blankson

Significant risks / issues for escalation to Board for action	• The Bank and Agency Usage and Expenditure Report is commended to the Board to note. • The Vacancy, Recruitment and Retention report is commended to the Board to note.

Key issues / other matters discussed by the Committee	The meeting considered the following items:
	• People and Performance Report and Dashboard noting:
	  ○ A reduction in sickness absence rates.
	  ○ Appointment to the Freedom to Speak Up Guardian role.
	  ○ 17 overseas recruits commencing employment.
	  ○ Improvements in appraisal rates.
	  ○ Reduced turnover rate.
	• Family and Surgical Services Divisional Report.
	• Bank and Agency Usage and Expenditure Report noting a review of the Incentivised Shift Scheme and system work to align arrangements
	• Workforce Risk Report.
	• Equality, Diversity and Inclusion Plan and further development to more fully reflect the Trust's ambitions.
	• Vacancy, Recruitment and Retention Report.
	• Escalations from Subgroups – nil received.

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

Escalation Report

Executive / Committee: People and Culture Committee

Date of Meeting: Monday 21st November 2022

Presented by: Margaret Blankson

Significant risks / issues for escalation to Board for action	• Annual Review of Whistleblowing arrangements • Guardian of Safe Working Report • Noted the ICB People Committee Minutes.

Key issues / other matters discussed by the Committee	The meeting considered the following items:
	• People and Performance Report and Dashboard noting:
	  ○ A rising number of staff COVID cases during October resulting in absence and a reduction in the number of long-term sickness absences.
	  ○ Launch of the Management Matters Programme
	  ○ Preparation for impending industrial action.
	  ○ Actions underway to support reductions in high-cost agency expenditure including the Incentivised Bank Scheme and increased Bank recruitment activity.
	• Divisional / Departmental Reports:
	  ○ Urgent and Integrated Care Division
	  ○ Informatics and Business Intelligence noting improvements in the staffing position and the appointment of a Coding Manager.
	  ○ Estates and Facilities noting the departure of a number of senior people within the team and the need for succession planning.
	• Appraisal and Talent Management Annual Report noted the launch of a new appraisal approach focussed on staff wellbeing conversations and development and support needs..
	• Education, Training and Development Report noting
	  ○ Procurement of additional Safeguarding level 3 training
	  ○ Additional induction training places to support ongoing recruitment initiatives.
	  ○ The use of recovery funding to support recruitment of additional Medical Education Supervisors
	• Freedom to Speak Up Report noting a reduced number of cases in month and the need to raise awareness amongst staff of the routes available to staff to raise concerns. The new Guardian is due to take up post at the beginning of January 2023.
	• Guardian of Safe Working Report noting actions to support junior doctors in services with high workloads and an increased number of junior doctors employed within the Trust.
	• Annual Review of Whistleblowing Arrangements. No formal disclosures had been received in the previous year.
	• Escalations from Subgroups
	  ○ ED&I Steering Group.

Decisions made by the Committee	• None.
Implications for the Corporate Risk Register or the Board Assurance Framework (BAF)	• The Board Board Assurance Framework noted the need to reflect system wide discussions in workforce risk mitigations and to include a clearer indication of mitigating action timescales.
Items / issues for referral to other Committees	• None.

INTEGRITY | RESPECT | TEAMWORK | EXCELLENCE

NHS
Dorset County Hospital
NHS Foundation Trust

Escalation Report

Committee: Quality Committee

Date of Meeting: 25th October 2022

Presented by: Stephen Tilton / Emma Hoyle

Significant risks / issues for escalation to Board for action	• The incidence of C.Diff and Gram Negative Blood Stream Infections and the actions the Trust is taking to manage this • Detailed feedback from patients is now included in the Quality and Safety Performance Report • The importance of challenge from the Board, following the report into the East Kent Maternity Services • Maternity staffing continues to be a challenge, particularly at night • Patient flow and staff vacancies continues to challenge both divisions, but most notably Urgent and Integrated Care Division • A level of urgency is now required to implement the Quality Improvement strategy across the Trust

Key issues / matters discussed at the Committee	The committee received, discussed and noted the following reports:
	• Quality and Safety Performance Report noting:
	  ○ Reduction in the rate of mixed-sex accommodation, no 'Never Events' in the year to date, and a reduction in formal complaints
	  ○ Challenges include C.Diff and Gram Negative Blood Stream Infections incidence; the Trust remains under trajectory and all cases are thoroughly reviewed
	• Maternity Safety Report noting:
	  ○ Positive Ockenden assurance visit, fully staffed SCBU, and good compliance with training
	  ○ One new claim regarding significant shoulder dystocia. One settled claim regarding psychological trauma.
	• Divisional Exception Reports from
	  ○ Urgent and Integrated Care Division noting the pressures of poor flow and staff vacancies. Positives include improved typing times, stroke business case progressing, and the orthotic team wining the Patient Safety Award at the HSJ awards.
	  ○ Family and Surgical Services Division noting formal accreditation of the anaesthetics team and continued operational pressures.
	• Nutritional Strategy Implementation Update
	• QI Strategy Update
	• Escalation Reports from
	  ○ Infection Prevention and Control Group
	  ○ Clinical Ethics Forum
	  ○ Clinical Practice Group
	  ○ Medicines Committee

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	• Nil

INTEGRITY | RESPECT | TEAMWORK | EXCELLENCE

NHS
Dorset County Hospital
NHS Foundation Trust

Escalation Report

Committee: Quality Committee

Date of Meeting: 22nd November 2022

Presented by: Eiri Jones / Emma Hoyle

Significant risks / issues for escalation to Board for action	• Positive plan for the High Acuity Stroke Unit (HASU) • A focus on the rate of C.Difficile, and Family and Friends responses • Maternity Safety Report discussed with a focus on foetal losses • Assurance provided around the East Kent Maternity Review • Divisional Reports highlighting the restarting of regulatory inspections and the impact of this on services which had only had light reviews in recent years • The SHMI had not fallen as expected; work continues to understand why and to provide assurance to this committee. • Board Assurance Framework • Quality improvement approach to falls prevention. Noted an increase in falls but reduction in falls causing harm • Data from Intensive Care National Audit and Research Centre (ICNARC) highlighting the Trust as an outlier in the number of patients discharged directly from the critical care unit.

Key issues / matters discussed at the Committee	The committee received, discussed and noted the following reports:
	• Quality and Safety Performance Report noting:
	  ○ Positive quality improvements including no never-events or medication incidents for 11 months, and no Serious Incidents in October.
	  ○ Challenges include C.Difficile rates, although these remain under trajectory
	• Maternity Safety Report noting:
	  ○ The service's initial review of the East Kent Maternity Review
	  ○ The ways in which perinatal deaths were monitored
	  ○ The maternity workforce review progress, ahead of formal business planning
	• Review of the Report into East Kent Maternity and Neonatal Services
	• Divisional Exception Reports from
	  ○ Urgent and Integrated Care Division noting improved typing times due to the move to Winscribe and the restart of regulatory inspections.
	  ○ Family and Surgical Services Division noting the trial of orthopaedic day case hip and knee replacement starting 22/11/2022 and that the move to Winscribe had not improved typing times for this division. Work continued to address this.
	• Learning from Deaths Report Q2
	• Transformation Update
	• Board Assurance Framework
	• Falls Quality Improvement Update
	• Escalation Report from
	  ○ Safeguarding Group

	• ICB Quality and Safety Committee Minutes
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	• Nil

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NHS
Dorset County Hospital
NHS Foundation Trust

Escalation Report

Committee: Risk and Audit Committee

Date of Meeting: 22nd November 2022

Presented by: Stuart Parsons

Significant risks / issues for escalation to Board for action	• The Internal Audit EPRR Report provided **moderate assurance** in respect to the Trust's process design and effectiveness • The HFMA Financial Sustainability Audit provided a good level of assurance overall and noted some further actions for completion by January 2023. • The Board Assurance Framework is recommended to the Board. • The internal Audit Equality, Diversity and Inclusion Briefing Report is escalated for information.

Key issues / other matters discussed by the Committee	The committee received and noted the following reports:
	• Internal Audit
	  ○ Progress Report
	  ○ EPRR Report
	  ○ HFMA Financial Sustainability audit
	  ○ Equality, Diversity and Inclusion Briefing Report
	• Review of Effectiveness – Anticrime Report noting confidence in full compliance with standards and further work to review the use Non-Purchase Orders during the COVID response period and commencement of the pre-employment checks review.
	• External Audit Update
	• Subgroup Escalation Reports
	  ○ **Information Governance Group** noted the work in train to ensure compliance with Information Security Standards.
	  ○ **Emergency Resilience Planning Group** noting that regional sign off of the recent submission was awaited.

Decisions made by the Committee	• Refresh of the Standing Financial Instructions was deferred to March 2023.
Implications for the Corporate Risk Register or the Board Assurance Framework (BAF)	• The Board Assurance Framework noting the need to include timescales for mitigating actions. • The full Corporate Risk Register was reviewed
Items / issues for referral to other Committees	• None

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

Confidentiality:	Not confidential
Publishable under FOI?	Yes

Prior Discussion		
Job Title or Meeting Title	**Date**	**Recommendations/Comments**
Interim Chief Executive	16/11/2022	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:** • The most significant issue affecting a wide range of metrics is system flow. "No Criteria to Reside" remains high including in community hospitals. Throughout September 26.6% of occupied acute beds have been used by patients whose needs are better met elsewhere. • Ambulance handover delays continue to challenge the system. • NHS England have allocated £8.2m to Dorset across 8 priority schemes to provide additional bed capacity over the next 6 months. • Progress on reducing long waiters continues however NHS England scrutiny on the next cohort (> 78 weeks) is expected to ramp up further. The number of patients waiting over 104 weeks continue to reduce. **Quality:** • The 7-day case rates of COVID-19 have started to slightly increase over the last few weeks. The number of outbreaks have however remained low in all settings. • The risk identified at UHD with the completion of very old discharge summaries remains outstanding. • Following an audit visit by the Specialist Pharmacy Services at DCH, concerns have been identified with Aseptic Pharmaceutical Preparation. A significant contributor to this issue is the lack of Pharmacy workforce. • Currently 10 nursing homes are rated as an Amber with one home rated Red. • The new national platform for reporting and learning from incidents will replace the existing system after 31 March 2023. All Trusts in Dorset should meet the timescale for switch over as local risk management systems are compliant. **Finance:** • As at August 2022, the ICS is reporting a deficit of £14.0m against breakeven plans submitted to NHS England; £6.5m relating to Dorset ICB and £7.5m relating to NHS providers. • The ICB has reported an overspend of £6.5m against plans as at August 2022 (Month 5), compared to £2.5m at Month 4.							

Action recommended	The Trust Board is recommended to: 1. **Note** the information provided.

Governance and Compliance Obligations

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

Title of Meeting	Board of Directors
Date of Meeting	30 November 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 NHS Dorset Bard meeting held on 03 November 2022.

2.0 Performance

The most significant issue affecting a wide range of metrics is system flow. "No Criteria to Reside" remains high including in community hospitals. This impacts timely access to Emergency Departments with consequences in ambulance handover delays and elective inpatients activity.

Ambulance handover delays continue to challenge the system. For example, in the week commencing 19th September Trusts experienced significant increases in handover delays and hours lost compared to the last reported week of 8th August. Winter funding has provided the opportunity to trial new ways of working with Consultant Connect (a third-party provider which connects clinicians to support easier advice and guidance) to optimise resources.

High Occupancy is driven in the main by delays in discharging patients whose care is best met elsewhere (No Criteria to Reside or NCTR) contributing to lower levels of discharges in comparison to demand for admissions. Throughout September 26.6% of occupied acute beds have been used by patients whose needs are better met elsewhere.

NHS England have allocated £8.2m to Dorset across 8 priority schemes to provide additional bed capacity over the next 6 months – expected outcome 120 additional beds will be achieved across the system. The system is targeting a 30% reduction of NCTR by end of October, equating to about 100 fewer NCTR across the system. This will be kick started over a 2-week period of improving flow from 10 October.

Progress on reducing long waiters continues however NHS England scrutiny on the next cohort (> 78 weeks) is expected to ramp up further. Refreshed plans for the reduction of patients waiting over 78 weeks have been submitted to NHS England with the system planning on delivering zero in line with the national target. There are significant risks associated with delivery of these plans including bed availability for elective care, staffing and theatre availability.

The number of patients waiting over 104 weeks continue to reduce. Currently DCH forecast having 3 patients over 104 weeks by the end of October. UHD forecast they will have 60 patients-42 in orthodontics and 18 across eight other specialties.

In cancer, the Faster Diagnosis Standard and 62-day Performance Standard have stabilised but remain under target. Increases in the volume of 2 week wait referrals (particularly colorectal and gynae) are impacting on the ability to diagnose patients within 28 days. Plans are in place to address this for each of six tumour sites.

There is limited mental health capacity due to availability of workforce in Gateway Service & Core Child and Adolescent Mental Health service (CAMHS). There is agreement to undertake rapid and focused work with partners to transform current CAMHS offer at place level – Bournemouth CAMHS team identified as starting point.

3.0 Quality

The 7-day case rates of COVID-19 have started to slightly increase over the last few weeks. The number of outbreaks have however remained low in all settings. Workforce absence due to COVID-19 is having a low impact on services across our providers at present, after following a small increase in absences been noted. Monitoring is in place should this change

Significant pressure remains with ambulance handover delays. In the latest available data DCH has seen an increase in all delays and is also experiencing increasing extreme delays. UHD has seen a reduction in all delays and in extreme delays at both sites. However, when the full data for September becomes available this is unlikely to still be the case. Despite some progress overall levels of delays remain significantly high. The ambulance handover cell continues and recent successful work by a Bristol hospital to reduce delays will be shared with UHD who are particularly challenged.

The risk identified at UHD with the completion of very old discharge summaries remains outstanding. The timely completion of discharge summaries has improved but remains too early to conclude that progress has been sustained. The work on improving the quality of discharge summaries that are sent had begun. The meetings to monitor progress will continue until sustained progress and improved quality can be evidenced.

Following an audit visit by the Specialist Pharmacy Services at DCH, concerns have been identified with Aseptic Pharmaceutical Preparation. Concerns with aseptic preparation are a national concern. It was known prior to the pandemic that a national review was being undertaken which was likely to suggest one large site for Dorset rather than separate units. Some of the concerns noted have been very historic and a change of inspector has led to a different level of tolerance of issues. A significant contributor to this issue is the lack of Pharmacy workforce. The provider will be working through an action plan to address the noted issues however, full resolution is unlikely to be achieved without a collaborative approach across the county.

Previous issues in August with the launch of ICNET at DHC, which is a clinical surveillance platform, have been resolved and the system has now been successfully launched and interoperability with other clinical systems appears to be working well. Bringing DHCFT inline with other system partners enabling more effective communication and system working in relation to clinical data that supports infection prevention work.

Currently 10 nursing homes are rated as an Amber with one home rated Red. System support is in place form the ICB and local authorities including review of action plans and return visits are planned within appropriate time scales. For the home which was red rated, immediate feedback was given to the home with a visit planned within oneweek to review progress.

A second HealthCare Associated Infection (HCAI) Post Infection Review (PIR) meeting took place with a representation of a key stakeholders including care home representation to discuss a C. difficile serious incident reported in June 2022. There were several learning themes identified particularly around raising awareness of risk factors leading to C. difficile infection and training and communication. As a result, a system wide action plan has been collaboratively developed to implement improvements across Dorset to promote safety of our service users.

In safeguarding, NHS Dorset is participating in a National Review led by the CSPR Safeguarding National Panel to review the quality of services and care to children with complex needs placed in residential care. The pattern of safeguarding is changing, reflecting the national picture, although in the BCP LA area there is a focus on violent crime, Dorset LA area is also now reporting an increase in serious violence with both areas working closely with the Community Safety Partnerships and both Safeguarding Boards. The safeguarding population health management Dashboard being developed is critical to our understanding of contextual safeguarding to enable allPartners to identify trends and align workplans.

The new national platform for reporting and learning from incidents will replace the existing system after 31 March 2023. All Trusts in Dorset should meet the timescale for switch over as local risk management systems are compliant. There are concerns regarding resourcing to support the change in some trusts which will be explored at the Steering group to understand if there is an associated risk for the Dorset system.

4.0 Finance

As at August 2022, the ICS is reporting a deficit of £14.0m against breakeven plans submitted to NHS England; £6.5m relating to Dorset ICB and £7.5m relating to NHS providers. Non-achievement of unidentified CIP targets are the main driver for the two providers in deficit (UHD and Dorset County), with agency expenditure, additional sessions, and energy prices and other inflationary pressures also continuing to impact the monthly position. The system is reporting CIP achievement of £34.7m to date against a target of £43.9m; an underachievement of £9.2m. Of this, £17.9m (52%) has been achieved recurrently.

The ICB has reported an overspend of £6.5m against plans as at August 2022 (Month 5), compared to £2.5m at Month 4. This was an agreed move relating to the Financial Improvement Programme (FIP) residual target held by the ICB on behalf of the system (£15.6m full year). The ICB continues to report a full year forecast of breakeven against plans whilst discussions continue with regional and system colleagues, however there are a number of risks within the position which will need to be managed including; unachieved efficiency targets, above contract activity levels with independent sector providers (ISPs), staffing, prescribing and Personal Health Commissioning (PHC).

The ICB is experiencing increases in No Cheaper Stock Obtainable (NCSO) spend, as well as volume increases beyond planned levels. It is likely that this will cause an overspend against plan but the data received to date is being reviewed alongside forecasting models in order to accurately forecast, given the time lags with prescribing data which is two months in arrears.

Meeting Title:	Board of Directors - Part 1
Date of Meeting:	30 Nov 2022
Document Title:	**Board Assurance Framekwork**
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	10 Nov 2022	BAF discussed and approved to take to RAC & Board: - post meeting Anita Thomas raised whether change to risk score for PL1.3 from 20 to 12 could be reflected ? - Agreed to raise at RAC and FPC
Risk and Audit Committee	22 Nov 2022	

Purpose of the Paper	*Monitor Strategic Risks the Trust faces (delivering the Trust Strategy and achieving the benefits therein) - Approved by Board Dec-21. The BAF is in its 7th round of 2 monthly reviews.*						
	Note	✓	*Discuss*	✓	*Recommend*	✓	*Approve*	✓
Summary of Key Issues	*There are 5 risks scored >20 (Almost certain and with Major consequence): Mitigations have been put in place against these, but as yet these have not driven a reduction in the risk scores.* ***2 of these high risks have Staffing/People at their Core:*** ***- PE1.2*** *Failing to attract & retain staff, more pressure on existing teams* *CPO. People & Culture Committee.* ***- PL1.1*** *Inability to attract & retain clinically skilled clinical staff, will not meet patient demand or required Care Standards or financial objectives.* *CNO. Quality Committee.* *The People Plan (underlying the Trust Strategy) is being worked on by HR teams, and contains various* ***mitigations*** *to counter the above, including:* *- Recruit & Retain Policies/workstreams, International recruitment, Wellbeing support, innovation in workforce plan/train, developing temp staffing function* *Notable* ***gaps in control & actions*** *at this point:* *National workforce shortage situation, progress towards true system working, cost of living crisis & affordability of local housing* *The* ***other 3 high risks*** *are:* ***- PL1.3*** *Failing to meet Performance Standards, not providing High Quality Care* *COO, Finance & Performance Committee.* *Mitigations ongoing: Corporate Planning work for 23/24 and EPMG workstream*						

	- PL1.5 *Emerg & Urgent Care Pathways not meeting population demand, not providing High Quality Care* *COO, Finance & Performance Committee (Perf), Quality Committee (Harm)* *Mitigations ongoing: Redesign of pathways & increased capacity as part of Patient Home hub and ED-15 and NHP program.* *Gaps in Control and Actions: traction in system making progress on reducing NCTR beds within Acutes – Flow cell & winter planning.* ***- PA 2.1*** *Failing to deliver financial breakeven, risk to fiscal sustainability of Trust* *CFO, Finance & Performance Committee.* *Mitigations ongoing: ICS Financial framework & Financial Strategy in place* *Gaps in Control and Actions: Transformational recovery plans system wide still in development.*
Action recommended	The Board is recommended to: 1. **NOTE** the changes this month, made in Red within the BAF, which update on mitigations and progress towards delivering lower risk towards targets. 2. Review and Comment on the mitigations in place at the moment, and consider whether any change to stated risk appetite is appropriate 3. **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: **Nov-22**

Summary Narrative

In total, the Board Assurance Framework includes 35 risks, a number of which have remained in the high risk category 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 result of failing to attract and recruit the right people with the right skills continues to score 20 (Risk PE 1.2)

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

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

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

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

Risk Heatmap

		LIKELIHOOD SCORE				
		1	2	3	4	5
CONSEQUENCE SCORE		Rare	Unlikely	Possible	Likely	Almost certain
5	Catastrophic	5	10 PL2.1	15	20 PE1.2	25
4	Major	4	8 PA1.1, PA3.1, PA3.2	12 PE2.1, PE3.3, PA2.2	16 PE1.1, PL1.2, PL1.10, PL1.11, PL 2.2	20 PL1.1, PL1.5, PL1.3 PA2.1
3	Moderate	3 PL3.1	6 PE3.4, PL1.4, PA1.3, PA2.3	9 PA1.2, PA4.1, PL2.3	12 PA3.3, PL1.6, PL3.2, PL 3.3, PL4.1, PL4.2, PA1.4	15 PE3.2
2	Minor	2 PL1.9	4	6	8	10
1	Negligible	1	2	3 PL3.1	4	5

Key

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

Risk Ref:	Committee	Accountable Executive	Risk Owner	Risk Description/Risk Owner:	Consequence Score	Likelihood Score	Risk Score	Existing Mitigation/ Controls	Assurance/ Evidence	Strength of Control	Strength of Assurance	Target Risk Score	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 Plan • People performance dashboard • People Committee reports • People recovery steering group • Targeted wellbeing support • Wellbeing offer • System & national wellbeing offers	• People Plan • 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	Nov-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 Plan • 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 • Management Matters programme (starting Nov 2022) • Transforming people practices programme • Values based recruitment -HCA workforce	• People Plan • People Dashboard - PCC • PCC reports & workplan • Divisional performance reviews • Recruitment control panel • System workforce plan	Good	Good	15	Nov-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, management matters programme) • 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	Nov -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 Plan • Implementation of just & learning culture principles • Raising concerns policy • Whistleblowing policy • Trust induction • Leadership & management development • FTSUG and champions • Safety walkabouts - In place 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	Nov -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		

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
								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. • ~~Research team established within Urgent & Integrated Care Division~~	• Reports to Quality Committee through the Urgent and Integrated Care division - with annual reporting to Board.	Good	Good	6	Nov-22	
								Gaps in Control and Actions:						

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 (triangulation with PCC)	CNO	CPO - Recruitment and retention and People Strategy	Risk description: If there is a continuing inability to reliably recruit or retain sufficiently skilled clinical staff to meet patient demand, then we will not be able to meet required care standards, so will not meet the strategic ambitions on quality, personalised care and financial objectives.	4	5	20	See People objective • Recruitment and retention policies and work streams • International recruitment • Wellbeing support • Maximise use of opportunities through Health Education England and NHSE/I funding streams • Maximise where able apprenticeships • Workforce planning and innovation with redesign of roles to enable clinicians to practice at the top of their licence • Increased opportunities for supported training places • Stay and thrive programme to aid retention 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	• 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	Good	12	2024	
								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 foreseeable year - Financial pressures hinder options to cover backfill costs of NHSE/HEE opportunities to support workforce bids - Accommodation locally due to the property markets and large numbers of second homes hinder affordable housing options, which impacts upon staff attraction and retention - Cost of living impact on professional roles impacting upon attraction and retention in nursing, AHPs and midwifery - National increase in attribution of students undertaking nursing degree, with a higher issue in the South West of England					
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	• Sub-board committee FPC, QC & PC • Estates master plan and associated business cases • Performance scorecard • External performance monitoring (CQC; OFRG; NHSE/I) • Benchmarking data: clinical networks; GIRFT	Good	Strong	8	2025	
								Gaps in Control and Actions: - Gaps in patient pathways out of hospital for those with complex care needs. ACTION: ICS escalation and collaboration workstreams - Mental health capacity to meet growing demand is impacting on potential delivery of longer term care in the right place and therefore clinical outcomes. Escalated to partners and working with partners.						
PL1.3	FPC	COO	Associate Director of Performance	**Risk description:** If we do not achieve the national performance standards for 2022/23* 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. * Eliminate 104 week waiters (exemption for patient choice) Eliminate 78 wk waiters by March 2023 Maintain Waiting List at 2019/20 size Deliver 62 day backlog to the same size as 19/20 Increase cancer 1st treatments (31 day standard) by 20%	4	5	20	• April 22 - Planning Guidance submissions agreed. Guidance acknowledges this is a multi-year improvement plan. Key steps are outlined in the plan for this coming year. DCH has agreed trajectories for achievement which will be tracked through EPMG and reported up through both Divisional governance and EPMG to FPC/Quality cttees. 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 specialties enrolled in CWT System work (complete), 6 specialties enrolled for System 78wk focus (completed), Theatre program established • Elective Performance Management Group - workstreams aligned to operational planning guidance. Performance Framework - triggers for intervention/support. Target date: completed and reporting through SLG/FPC • Provider assurance framework/Finance and Performance Committee - updated Single Oversight Framework included in FPC/Board reporting	• Division and work stream action plans. External contracting reporting to ICS. Divisional exceptions at FPC Committee • Performance monitoring via weekly PTL meetings, fortnightly EPMG and monthly Divisional Performance Meetings (through to Sub-Board and Board) Weekly meetings with ICS/Region and postive movement noted	Good	Good	12	All monitoring in place. monthly targets to be reviewed at FPC	
								Gaps in Control and Actions: National Elective Recovery Plan sets out a 3 year plan towards achievement of NHS Constitutional Standards. Trajectories agreed for achievement of in year milestones and will be reported via FPC both in the Performance/EPMG report and the						
PL 1.4	FPC	COO	Head of EPRR	**Risk Description:** If we don't have Emergency Preparedness and Resilience Plans then we will not have a defined programme to manage safe services and the triggers for altering those services under change services, therefore the objective of high-quality care that is safe and effective will not be met.	3	2	6	• Emergency Preparedness and Resilience Review Committee (EPRR) reporting, EPRR Framework and review and sign off by CCG and NHSE	• Reporting from EPRR Committee to Risk and Audit Committee and via assigned NED to Board. Yearly self assessment against EPRR core standards ratified by Local Health Resilience Partnership. Internal Audit reports	Good	Good	6	is at target	

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
								Gaps in Control and Actions:						
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 URG & EM care Boards and ICPCS Boards objectives linked to the Boards delivery plan. CEO is the system SRO 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 November 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. October 2022 - first stage of integration i West to begin. Target date: winter 23/24 for full delivery of integrated model • Internal Home First work streams - 7 day discharge services, strengthened front door multi-agency response, PAT. Target date: Key frameworks in place and completed - Patient Flow Program supporting wards to utilise available resources- Target date:Winter Plan- December 22 - March 23 Winter schemes - added Key workers, increased Trusted Assessor support, Tiger (discharge focussed) Team, added hours dedicated to	• Upward reporting and escalation from UECB to SLT and DCH Board. • Ward to Board reporting Home First Board and workstream documentation Home First (DCH) documentation Divisional reporting via Performance Meetings, FPC, Seasonal Surge Plan and reporting IMT Reporting ROI reporting against investment in ED15 model to UECB ED15 Steering Group through to FPC updates	Good	Good	12	Internal mitigations in place for winter 22/23 External mitigations through Home First delivery in 23/24	
								Gaps in Control and Actions: Twice weekly operational meetings in place for the system to map out and agree the deliery of the HF stages of integration. Internal flow cell in place and a refresh of the Patient Flow Program underway - mapped to emerging winter plans. Focus on Pathway 0 patients and front door (ED/Ilchester) multi-agency response to prevent admission Mobilisation Meeting - COO leading on delivery of 3 winter projects for Dorset - Increased TA capacity, increased key worker support, Tiger Teams at Acute sites (discharge MDT at ward level)					
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 • VSCE support front door and discharge response. Pilot in place (completed) Clinical and People Strategies for front door response. Target date:	Home First Board papers UECB papers Divisional reporting to FPC Performance Report - FPC ROI reporting to UECB on investments into patient flow schemes Home First (DCH) Steering group papers.	Requires Improvement	Requires Improvement	9	Internal mitigations in place for winter 22/23 External mitigations through Home First delivery in 23/24	
								Gaps in Control and Actions: System actions currently in development, low level of confidence actions will meet needs. **Please see action detailed above.**						
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	• Reports to SLG and through to Board via Strategy updates	Good	Good	2	Internal transformation plan full delivery by March 23	
								Gaps in Control and Actions:						
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 • The CMO receives a monthly update of number of uncoded SPELLS	• Regular reports to Hospital Mortality group, Quality Committee and Board.	Requires Improvement	Good	8	Ongoing	
								Gaps in Control and Actions:						
PL 1.11	RAC	CIO	CIO	**Risk description:** If we do not deliver robust, accurate and timely coding then data submitted to NHSE and NHS Digital will not be reflective of the care delivered, so workload will be inaccurate and there will be a negative impact on reputation through KPI's such as the Summary Hospital-level Mortality Index.	4	4	16	The coding department is attempting to recruit a new full-time manager (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 19/5/22.	Vacancies versus establishment Coding backlog Improvement in SHMI	Requires Improvement	Requires Improvement	6	?	
								Gaps in Control and Actions:						
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	2	10	• 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 - SEED funding for 2022/23 now agreed	• NHSEI SOC Approval; - NHSEI NHP Deep Dive re. OBC, OBC submitted June 2022	Good	Good	10	Completion of FBC - circa 31/12/2022	
								Gaps in Control and Actions: - Regular reporting to FPC						
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	4	4	16	• Working group to inform SLG decisions • Business case templates and corporate report front-sheets	• Working Group papers • External approval of business cases e.g. NHP	Requires Improvement	Requires Improvement	10	31/03/2023	

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
				populations				**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						
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	• Regular reporting to Strategy and Transformation SLG • Annual reporting on Green Plan to FPC and Board	Good	Good	9	Ongoing	
								Gaps in Control and Actions:						
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	• 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	
								Gaps in Control and Actions:						
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	• 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	
								Gaps in Control and Actions:						
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.	• 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	
								Gaps in Control and Actions:						
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														

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
PL 4.1	Quality Committee	CNO	Alison Male - Patient Engagement Jo Hartley: Maternity voices partners	**Risk description:** If we fail to engage and work with partners and stakeholders to effectively maximise the opportunities to engage and co-design with our communities then services will not be meeting the needs of those that use then.	3	4	12	• Your Voice group of service users- 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 SQG) • 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 Advisor 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 • QI 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	• PEG actions/ notes • Patient feedback • Healthwatch reports • CQC reports • Maternity Voices reports • Complaints including local MPs related to engagement • Local independent groups reports or complaints • Diis Data and Public Health reports • Health Inequalities data	Good	Good	4	Apr-24	
								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.						
PL 4.2	QC	CNO & CMO	CIO - digital and BI Alison Male - 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	• DiiS 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	• 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	
								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						

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	• SLG Meetings • Board and Committees • System Oversight Framework	Good	Good	8		
								Gaps in Control and Actions:						
PA 1.2		CIO	CIO	**Risk description:** If the Trust does not embed population health data within decision-making which highlights health inequalities then the Trust will not know if it is delivering services which meet the needs of its populations	3	3	9	• Dorset Insight and Intelligence Service (DIIS) accessible and available to Trust • DIIS/BI dashboards on key trust metrics provided	• Health Inequalities Programme • Digital Portfolio Board	Requires Improvement	Requires Improvement	6	Mar-23	
								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						
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	• Reporting through SLG	Good	Good	6	Jul-22	
								Gaps in Control and Actions: Many Clinical Leads have never had leadership/management training. ACTION: Appropriate training to commence September 2022 - Julie Doherty.						
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	• 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	
								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.						
Partnership Objective 2: We will ensure best value for the population in all that we do and we will create partnerships with commercial, voluntary and social enterprise organisations to address key challenges in innovative and cost-effective ways														
PA 2.1	FPC	CFO	CFO	**Risk description**: If the Trust fails to deliver sustained financial breakeven and to be self sufficient in cash terms then it could be placed into special measures by the regulator and need to borrow externally to ensure it does not run out of cash	4	5	20	• ICS Financial framework and Financial Strategy. • Current operating plan delivers a breakeven and does not require external financing, but are heavily reliant on non recurrent funding and 2.5% CIP.	• ICS Financial framework and Financial Strategy • Reporting to Board, FPC and BVBCB.	Good	Requires Improvement	12	31/03/2023	
								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.						
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	• Model hospital, GIRFT reviews, Reference costs index, Corporate services benchmarking.	Good	Good	9	31/03/2023	
								Gaps in Control and Actions: CIP programme for 22/23 not fully identified						
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	• Commercial strategy delivery reporting • Your Voice Engagement Group • Social Value strategy oversight	Good	Requires Improvement	6		
								Gaps in Control and Actions:						
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														

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
PA 3.1	FPC	COO	COO	**Risk description:** If the Trust does not optimally 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 dependent on funding stream - 23/24 completion date if funded	• 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	
								Gaps in Control and Actions: ICS The Provider Collaborative has now formed but is in the process of determining its agenda for 22/23.						
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	• Trust Board papers	Good	Good	8		
								Gaps in Control and Actions:						
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.	• Monitoring of clinical strategy via S&T SLG and divisional performance • Business Planning processes	Good	Good	8	?	
								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.						
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.	• Social Value reporting to SLG and Board • SV Dashboard • SV reporting in annual report	Good	Good	6		
								Gaps in Control and Actions:						

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

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

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

Likelihood score (L)

The Likelihood score identifies the likelihood of the consequence occurring.

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

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

Identifying Risks

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

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

Scoring & Grading

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

Consequence score (C)

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

DOMAIN C1: SAFETY, QUALITY & WELFARE					
	1	2	3	4	5
Domain	**Negligible**	**Minor**	**Moderate**	**Major**	**Catastrophic**
Impact on the safety of patients, staff or public (physical/psychological harm)	Minimal injury requiring no/minimal intervention or treatment. No time off work	Minor injury or illness, requiring minor intervention Requiring time off work for >3 days Increase in length of hospital stay by 1-3 days	Moderate injury requiring professional intervention Requiring time off work for 4-14 days Increase in length of hospital stay by 4-15 days RIDDOR/agency reportable incident An event which impacts on a small number of patients	Major injury leading to long-term incapacity/disability Requiring time off work for >14 days Increase in length of hospital stay by >15 days Mismanagement of patient care with long-term effects	Incident leading to death Multiple permanent injuries or irreversible health effects An event which impacts on a large number of patients
Quality /audit	Peripheral element of treatment or service suboptimal	Overall treatment or service suboptimal Single failure to meet internal standards Minor implications for patient safety if unresolved Reduced performance rating if unresolved	Treatment or service has significantly reduced effectiveness Repeated failure to meet internal standards Major patient safety implications if findings are not acted on	Non-compliance with national standards with significant risk to patients if unresolved Low performance rating Critical report	Totally unacceptable level or quality of treatment/service Gross failure of patient safety if findings not acted on Gross failure to meet national standards

DOMAIN C2: IMPACT ON TRUST REPUTATION & PUBLIC IMAGE					
	1	2	3	4	5
Domain	**Negligible**	**Minor**	**Moderate**	**Major**	**Catastrophic**
Adverse publicity/ reputation	Rumours Potential for public concern	Local media coverage – short-term reduction in public confidence Elements of public expectation not being met	Local media coverage – long-term reduction in public confidence	National media coverage with <3 days service well below reasonable public expectation	National media coverage with >3 days service well below reasonable public expectation. MP concerned (questions in the House) Total loss of public confidence
Complaints	Informal complaint/inquiry	Formal complaint (stage 1) Local resolution	Formal complaint (stage 2) complaint Local resolution (with potential to go to independent review)	Multiple complaints/ independent review	Inquest/ombudsman inquiry

DOMAIN C3: PERFORMANCE OF ORGANISATIONAL AIMS & OBJECTIVES					
	1	2	3	4	5
Domain	**Negligible**	**Minor**	**Moderate**	**Major**	**Catastrophic**
Business objectives/ projects	Insignificant cost increase/ schedule slippage	<5 per cent over project budget Schedule slippage	5–10 per cent over project budget Schedule slippage	Non-compliance with national 10–25 per cent over project budget Schedule slippage Key objectives not met	Incident leading >25 per cent over project budget Schedule slippage Key objectives not met
Service/business interruption	Loss/interruption of >1 hour	Loss/interruption of >8 hours	Loss/interruption of >1 day	Loss/interruption of >1 week	Permanent loss of service or facility
Human resources/ organisational development/staffing/ competence	Short-term low staffing level that temporarily reduces service quality (< 1 day)	Low staffing level that reduces the service quality	Late delivery of key objective/ service due to lack of staff Unsafe staffing level or competence (>1 day) Low staff morale Poor staff attendance for mandatory/key training	Uncertain delivery of key objective/service due to lack of staff Unsafe staffing level or competence (>5 days) Loss of key staff Very low staff morale No staff attending mandatory/ key training	Non-delivery of key objective/service due to lack of staff Ongoing unsafe staffing levels or competence Loss of several key staff No staff attending mandatory training /key training on an ongoing basis

DOMAIN C4: COMPLIANCE WITH LEGISLATIVE / REGULATORY FRAMEWORK					
	1	2	3	4	5
Domain	**Negligible**	**Minor**	**Moderate**	**Major**	**Catastrophic**
Statutory duty/ inspections	No or minimal impact or breech of guidance/ statutory duty	Breech of statutory legislation Reduced performance rating if unresolved	Single breech in statutory duty Challenging external recommendations/ improvement notice	Enforcement action Multiple breeches in statutory duty Improvement notices Low performance rating Critical report	Multiple breeches in statutory duty Prosecution Complete systems change required inadequateperformance rating Severely critical report

DOMAIN C5: FINANCIAL IMPACT OF RISK OCCURING					
	1	2	3	4	5
Domain	**Negligible**	**Minor**	**Moderate**	**Major**	**Catastrophic**
Finance including claims	Small loss Risk of claim remote	Loss of 0.1–0.25 per cent of budget Claim less than £10,000	Loss of 0.25–0.5 per cent of budget Claim(s) between £10,000 and £100,000	Uncertain delivery of key objective/Loss of 0.5–1.0 per cent of budget Claim(s) between £100,000 and £1 million Purchasers failing to pay on time	Non-delivery of key objective/ Loss of >1 per cent of budget Failure to meet specification/ slippage Loss of contract / payment by results Claim(s) >£1 million
Environmental impact	Minimal or no impact on the environment	Minor impact on environment	Moderate impact on environment	Major impact on environment	Catastrophic impact on environment

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

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

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

1. Report Details			
Meeting Title:	Board of Directors Part 1		
Date of Meeting:	30 November 2022		
Document Title:	Corporate Risk Register		
Responsible Director:	Emma Hoyle Acting Chief Nursing Officer	Date of Executive Approval	*21.11.2022*
Author:	Mandy Ford, Head of Risk Management and Quality Assurance		
Confidentiality:	*n/a*		
Publishable under FOI?	*No*		
Predetermined Report Format?	*No*		

2. 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	22 Nov 2022	

3. 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 (✓)*	✓
4. 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.							
5. 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							

6. Governance and Compliance Obligations				
Legal / Regulatory Link		**Yes**		*Duty to ensure identified risks are managed*
Impact on CQC Standards		**Yes**		*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.*
Risk Link		**Yes**		*Links and mitigations to the Board Assurance Framework are detailed in the individual risk entries.*
Impact on Social Value		**Yes**		*This will impact on the Trust's ability to provide high quality safe services and the recruitment and retention of staff.*
Trust Strategy Link		**How does this report link to the Trust's Strategic Objectives?**		
Strategic Objectives	People Place	All corporate risk register items are individually linked to the BAF. This is detailed in the appendices		

Partnership			
Dorset Integrated Care System (ICS) Objectives	**Which Dorset ICS Objective does this report link to / support?** *Please summarise how your report contributes to the Dorset ICS key objectives.* *(Please delete as appropriate)*		
Improving population health and healthcare	**Yes**		Effective management and mitigation of the Trusts' operational and strategic risks will support delivery of the ICS objectives.
Tackling unequal outcomes and access	**Yes**		
Enhancing productivity and value for money	**Yes**		
Helping the NHS to support broader social and economic development	**Yes**		
Assessments	**Have these assessments been completed?** *If yes, please include the assessment in the appendix to the report..* *If no, please state the reason in the comment box below.* *(Please delete as appropriate)*		
Equality Impact Assessment (EIA)	**Yes**	**No**	n/a
Quality Impact Assessment (QIA)	**Yes**	**No**	n/a

Audit and Risk Committee
Corporate Risk Register as at 09.11.2022

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

1. Introduction

1.1 This report provides an update from the report presented to the September 2022 Committee meeting and to highlight any new and emerging risks from within the Trust. It should be noted that this report details the Trust position as at 09.11.2022 unless otherwise stated and is reflective of the operational risks.

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

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

- Heat Map (detailed in Appendix 1)
- Corporate Risk Register detail (Appendix 2)
- Details of emerging themes from Divisions (Appendix 3)

1.4 As agreed at the September Committee this month's report is the annual report of all items on the Corporate Risk Register.

2. Top Themes:

2.1 **Covid 19**

- 919 – Covid 19 (Moderate 12 (down from 20))

4.1.1 This risk remains as Moderate.

4.1.2 Clearly the number of positive cases remain variable throughout the hospital as does staff absence. However, the number of patients requiring ITU intervention remain extremely low,

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 in clinical areas, 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 appointed and will be supported by staff from the Divisions.
- Action cards reviewed and revised as required.

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 DCH will achieve zero 104-week waiters at the end of November, apart from patients that are choosing to wait.

4.2.4 DCH has met the trajectory for 78 week waiters month on month since August and is now ahead of plan. DCH will have zero, 78+ week waiters at the end of March 2023.

4.2.5 However, there has been a 29% increase in Cancer referrals which is putting pressure on waits to first seen appointments and is leading to growth in the waiting list. DCH is closed to cancer referrals in the two most at risk areas – Maxillo-Facial and Gastroenterology during the summer. The Gastro service has now re-opened and additional capacity secured. Max-Fax remains closed.

4.2.6 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.

4.2.7 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 13.09.2022)
- 464 – Mortality Indicator (Moderate 12) (update as at 13.09.2022)

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.
- Chief Medical Officer is hopeful a further substantial drop in the SHIMI will occur when the latest coding 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.

4.4 Staffing

Staffing across the Trust remains challenging. 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. Work is ongoing to look at reducing the use of high cost agency, and staff continue to report shortages in staffing across all services. Staffing levels continue to be closely monitored to ensure safe staffing is maintained. No red flag or unsafe shifts have been reported and staffing levels are mitigated by either moving existing staff to other areas, or by using bank staff or agency staff.

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 09 November 2022, the figure stands at 73 patients. (This was reported as 103 at last Committee)

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, or a mental health facility. 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.

5.1.5 This is now also begining to impact on patient safety. As patients are having longer stays there is an increased risk of patients suffering pressure damage, falls, loss to mobility and independence, requiring a greater care package, or they are at risk of getting an infection. It should also be noted that prolonged hospital stays for some patients is affecting staff well-being in some areas, support is being provided to those areas.

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 current year to date position is £4.7m worse than plan for the Trust and delivering the planned year end position will be challenging to recover. This figure was reported as £3.4 m in the September report.

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. The CIP identified level continues to increase and now stands at 82%. (Reported as 72% in September's report)

5.3 1251 – Critical Failings in hospital blood bank (HIGH 15 (previously 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.

5.3.2 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

5.3.3 Mitigations currently in place: (as at 09.11.2022)

- Action plan regularly reviewed
- Rolling recruitment plan in place
- Training plan in place.
- Monthly updates supplied to MHRA
- Electronic blood tracking system purchased.

5.3.4 Update as at 09.11.2022

- The MHRA have reduced the frequency of reporting to bi-monthly. No concerns were expressed in relation to the September and October reports. The next report is due December 2022
- Permanent Histotechnologist (HTL) manager appointed and should be in place by February 2023
- Full complement of staff appointed to Blood Sciences but need training before available to HTL
- Haemonetics BloodTrack system on course for completion 31st July 2023. Paper-based traceability system will end at that time.

5.3.5 Full update is provided within the appendices.

5.4 472: Community Paediatric Long Waits for ASD Patients (Scored as 4 Major x 5 Certain =20 Extreme)

5.4.1 The Service Manager has been trying to put on additional capacity using the funding (75k) the service received.

5.4.2 However, this appears to have been pushed back by finance due to the funding being received late in 21/22 which meant the services did not have time to spend it and subsequently it appears the money was not rolled over to this financial year.

5.4.3 This has been escalated to the Chief Operating Officer and Deputy Director of Finance. The service are hoping to get confirmation of the monies by the end of September 2022 which will allow additional capacity.

5.4.4 There are regular system meetings taking place due to the complexity of addressing the situation across the county.

5.4.5 Update provided by service as at 07.11.2022, current wait times are 18 months. Patient are being booked into be seen 6 weeks in advance of a confirmed clinic date. The triage service is prompt when referred, and patients are being clinically prioritized and sign-posted to other support services whilst waiting to be see. If a patient is deemed to be high risk clinically the patient will be fitted in to a clinic.

5.4.6 Patients and parents are given safety netting advice, and the signposting varies depending on the patient's condition.

5.5 Emerging Risks from Divisions:

5.5.1 Urgent and Integrated Care

5.5.1.1 Pharmacy service

- **1502 Pharmacy Regional Quality Assurance Audit**
  (scored as 4 Major x 5 Certain = Score 20 EXTREME)
  As reported in the previous report, the Pharmacy Aseptic Service received it's audit from Pharmacy Regional Quality Assurance on 1st August. The draft report has been received, and the aseptic service has been rated as high risk to patient safety.

  This is currently a draft report, and the Aseptic Services Manager is responding to the draft. Following this, an Action Plan will be drawn up to address the deficiencies. There are no Critical deficiencies (those that require action within 24 hours), but there are 8 Major deficiency categories (those that require action within 3 months). The current risk is the Trust being able to deliver the actions on the action plan in time. The Trust have fed back our concerns to the auditors challenge until we get Quality Manager in post

  Update (10.11.2022):
- Draft action plan discussed with Aseptic Lead and Chief Pharmacist on 9th November.
- Action plan to go to auditors for agreement
- Intrathecal service still suspended. A meeting took place with relevant staff on 09.11.2022 to agree actions and restart plan
- Pharmacy Quality Manager post is out to recruitment

- **662 Pharmacy Workforce - vacancy rate**
  (scored as 3 Moderate x 5 Certain = 15 (HIGH)
  There remains difficulty in recruiting to the vacant pharmacy roles.
  To mitigate this currently:
  - Relocation expenses and flexible working offered
  - Recruitment plans in place - jobs advertised on NHS jobs
  - Decentralised services withdrawn and continuity plans enacted.
  - Senior Management staff working operationally where possible
  - Senior Part-time staff working additional hours to support operational cover
  - Recruited to 2 8a split posts with Weymouth & Portland PCN
  - Interviewing other split posts with DHC – 2 applicants

- Recruitment & Retention Premium paper to go to Executive meeting w/c 14.11.22

5.5.2 Family Services and Surgical Division

5.5.2.1 There are no new emerging risks from the Division which the Committee are not already sited on or that are already detailed on the Corporate Risk Register.

5.5.3 Trust wide:

5.5.3.1 **1509 Mental Health patients delays in care pathway and services support (this includes Adults and Children and Young People)**
(scored as 4 Major x 5 Certain = 20 EXTREME)
We are experiencing delays in patients that require Mental Health Act assessments or placement in a specialist unit being seen and/or placed.

5.5.3.2 This is leading to patients being held in the ED department for up to 72 hours with no MH support or interventions.

5.5.3.3 NRTR patients awaiting MH beds are also suffering harm from being in the wrong environment, which leads to deteriorating behaviours and staff being affected both physically and psychologically in supporting these patients in an unsuitable environment without specialist mental health nursing support.

5.5.3.4 In order to safely manage these patients and ensure both the individuals safety, the safety of the staff and the other patients on the ward we are having to use security as we have been unable to secure RMN support from either DHUFT or high cost agency.

5.5.3.4 Currently in order to try and mitigate this as far as possible we are:

- Memorandum of understanding regarding escalation processes
- LAEP meetings
- Review of SLA with DHUFT re psychiatric liaison service
- Independent system reviews of individual cases
- Working with provider collaborative
- Escalation to executive level to enable exec to exec conversations within the system
- Legal action

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 10.11.2022
Appendices

- Heat Map (Appendix 1)
- Corporate Risk Register detail (Appendix 2)
- Full Corporate Risk register (Appendix 3)
- Counter Fraud Risk Register (Appendix 4)
- Emergency Planning Risk Register items (Appendix 5)

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	25
	4 Major	4	8	12 (450, 690, 919↓)	16 (474, 1251↓)	20 (472,1221,1252, 1509)
	3 Moderate	3	6 (1513)	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 28.02.23)Workforce Planning & Capacity for Nursing and Allied Health Professional and Health Sciences staff; and 468 (Extreme –next review date 28.02.23) 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:07.11.2022
1252	**Financial Sustainability year 2022/23**	Previous Rating	Extreme
Impact on Strategic Objectives		Lead Executive	Chris Hearn
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. The current year to date position is £4.7m worse than plan for the Trust and delivering the planned year end position will be challenging to recover.		Local Manager	Claire Abraham
Current position As at 07.11.2022(data correct as at 09.11.2022)		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. A programme of work to reduce high cost agency spend is also underway. The CIP identified level continues to increase and now stands at 82%.		Next review date **ACTIONS ONGOING TO MANAGE FINANCES**	30.11.2022

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)	High (15) Consequence: Moderate Likelihood: Certain Reviewed:09.11.2022
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	Graham Smith Andrew Miller Sonia Gamblen
Current position As at 09.11.2022(data correct as at 09.11.2022)		TARGET RATING Target date:	Low (9) Consequence: Moderate Likelihood: Possible 31.03.2023
Mitigation: • Action plan regularly reviewed • Rolling recruitment plan in place • Training plan in place. • Monthly updates supplied to MHRA • Electronic blood tracking system purchased. **Update:** • The MHRA has reduced the frequency of reporting to two-monthly. No concerns expressed to September or October reports. Next report due December. • Divisional meetings still weekly; Executive updates monthly (to coincide with MHRA submission). STAFFING • New 0.5WTE TP support and permanent Band 6 have yet to be advertised. This has been with HR since		Next review date	31.12.2022

September. • No staffing levels below Level 2 reported - supported by Bank staff and overtime • Full complement of staff recruited to Blood Sciences but need training before available to HTL. • Permanent HTL Manager appointed and should be in place Feb 2023 • Band 7 TP on long term absence, to be backfilled by six-month secondment TRAINING • This is all on track in accordance with the plan presented to MHRA QMS • All SOP reviews performed in a timely manner. SOP rewrites prioritised according to risk. First tranche of these are nearing completion. Second group to be disseminated by end of month. • Open NCs down to 16. Four lie with the HTL team (remainder with Path IT), all HTL NCs are within target date. • Audit meeting scheduled for 10.11.22 • Haemonetics BloodTrack system on course for completion 31st July 2023. Paper-based traceability system will end at that time.		

Movement on Risk Register: 	Risk Statement **DATE ADDED TO RISK REGISTER 25.03.2020**	CURRENT RISK RATING (following review and mitigations)	Moderate (12) Consequence: Moderate Likelihood: Likely Reviewed: 13.09.2022
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 13.09.22 (data correct as at 09.11.2022)		TARGET RATING Target date:	Low (9) Consequence: Moderate Likelihood: Possible **Undetermined**
Mitigation: • Regular weekly virtual IMT meeting • 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 within clinical areas, unless they are exempt. • FFP3 lead appointed and will be supported by the Health, Safety and Security manager and staff from the Divisions. **Update:** • Numbers of patients requiring ITU intervention remains low • IPC guidance changed to PPE in clinical areas only, but this continues to be monitored. • PPE is still available • Action cards revised		Next review date **All actions constantly reviewed following national and IPC guidance.**	31.12.2022

Movement on Risk Register: 	Risk Statement Community Paediatric Long Waits for ASD Patients **Date added to Corporate Risk Register 09.06.2021** **Opened by Service 10.09.2018 – reviewed monthly** **Escalated to Division 08.06.2021 request to escalate to Corporate**	CURRENT RISK RATING (Following review and current mitigations)	Extreme (20) Consequence: Major Likelihood: Certain Reviewed: 10.11.2022
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 31.03.2023
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:** Update provided by service as at 07.11.2022, current wait times are 18 months. Patients are being booked into be seen 6 weeks in advance of a confirmed clinic date. The triage service is prompt when referred, and patients are being clinically prioritized and sign-posted to other support services whilst waiting to be see. If a patient is deemed to be high risk clinically the patient will be fitted in to a clinic. Patients and parents are given safety netting advice, and the signposting varies depending on the patient's condition.		Next review date **ACTION RE APPOINTMENT COMPLETED** **OTHER ACTIONS ONGOING TO MANAGE WAITING LIST.**	Update provided 10.11.2022

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: 10.11.2022
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	Adam Savin All speciality leads
Current position As at 10.11.2022 (data correct as at 10.11.2022)		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:** • DCH will achieve zero, 104 week waiters at the end of November, apart from patients choosing to wait • DCH has met the trajectory for 78 week waiters month on month since August and is now ahead of plan. DCH will have zero, 78+ week waiters at the end of March 2023. • 29% increase in Cancer referrals is putting pressure on waits to first seen appointments and growth in the waiting list. DCH closed to cancer referrals in the two most at risk areas – Maxillo-Facial and Gastroenterology during the summer. The Gastro service has re-opened, and additional capacity secured. Max-Fax remains closed. • The Trust has a £6.5 million insourcing plan, which remains on plan.		Next review date	30.11.2022

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: 13.09.2022
474	Review of Co-Tag system and management of issuing/retrieving tags to staff	Previous Rating	Extreme (20)
Impact on Strategic Objectives		Lead Executive	Chris Hearn
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 13.09.2022 (data correct as at 09.11.2022)		TARGET RATING Target date	Very Low (2) Consequence: Negligible Likelihood: Unlikely 31.03.2023
Mitigation: • Estates managing ad-hoc issues as the arise; Communications on management of site security; Site security in place Update: • We are now continuing with the controllers being setting up around the site where we can until the database and cards have been produced and given to all staff. • We are waiting on guidance from facilities on this time scale, in the meantime the engineers are still adding controllers, door equipment, interfaces and locks whilst continuing with configuring the system. • We are currently short of approx. 37 network port allocations due to lack of network switches which still have not arrived.		Next review date	31.12.2022

Movement on Risk Register: 	Risk Statement **Date added to Risk Register 12.07.2019**	CURRENT RISK RATING (Following review and mitigations)	High (15) Consequence: Moderate Likelihood: Certain Reviewed: 13.09.2022
641	Clinical Coding	Previous Rating	Extreme
Impact on Strategic Objectives		Lead Executive	Ruth Gardiner
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 13.09.2022 (data correct as at 13.09.2022)		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**	31.12.2022

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:13.10.2022
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 13.10.2022 (data correct as at 09.11.2022)		TARGET RATING Target date:	Low (9) Consequence: Moderate Likelihood: Possible 31.03.2023
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**	31.12.2022

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**	30.09.2022

Summary of full Corporate Risk Register **Appendix 3**

ID	Title	Risk Statement	Review date	Care Groups	Service of responsibility	Risk level (current)	Previous current risk level	Risk level (Target)	Mitigations/Controls
472	Community Paediatric Long Waits for ASD Patients	There is a vacancy within the community paediatric team, which is causing long waits for patients and an increased workload for the two consultants in post. There has also been a significant increase in referrals to the ASD (Autism Spectrum Disorder) service, alongside ongoing commissioning issues for the service.	07/11/2022	Family Services (B4)	Paediatrics Service	Extreme	High Risk	Moderate Risk	Mitigations currently in place: Maximise capacity by reducing DNAs with significant effect Keeping patients informed and signposting for support and information Holding letters Pan Dorset pathway redesign Additional Clinics being run through September-December. Additional clinics currently running from phase 3 monies.
1221	Tackling the backlog of elective care	Delivery plan for tackling the COVID-19 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.	31/12/2022	All specialities	Central Appointments	Extreme	Extreme	Low Risk	To support elective recovery the government plans to spend more than £8 billion from 2022/23 to 2024/25, supported by a £5.9 billion investment in capital – for new beds, equipment and technology. This is in addition to the £2 billion Elective Recovery Fund and £700 million Targeted Investment Fund (TIF) already made available to systems this year to help drive up and protect elective activity. Under the TIF, the NHS is investing in over 870 schemes across more than 180 hospital trusts to increase capacity through expanding wards, installing modular operating theatres, upgrading outpatient spaces, expanding mobile diagnostics for cancer, upgrading MRI and screening technology, all to tackle cancer and elective waiting lists and reduce waiting times. There will also be investment in technology to improve patient experiences of care and help patients manage their conditions. The funding committed for elective recovery will be spent on delivering additional activity in an innovative way, enabling the NHS to carry out more checks, scans, outpatient appointments, operations and other procedures up to March 2025. A significant part of this will be invested in staff – both in terms of capacity and skills.

ID	Title	Risk Statement	Review date	Care Groups	Service of responsibility	Risk level (current)	Previous current risk level	Risk level (Target)	Mitigations/Controls
1252	Financial Sustainability year 22/23	The final plan for 2022/23, submitted in April, reflects a £17m deficit which threatens the financial sustainability strategic objective.	07/12/2022	Chief Finance Officer	Finance	Extreme	Extreme	Low Risk	Close monitoring of finances and CIP in place.
1509	Mental Health patients delays in care pathway and services support	Delays in patients that require mental health act assessments or placement in a specialist unit being seen and/or placed. This is leading to patients being held in the ED department for up to 72 hours with no MH support or interventions. NRTR patients awaiting MH beds are also suffering harm from being in the wrong environment.	31/12/2022	Partner Agency (SWSFT CCG Community hospitals etc)	Across all specialties	Extreme	Extreme	Low Risk	LAEP meetings Review of SLA with DHUFT re psychiatric liaison service Independent system reviews of individual cases Working with provider collaborative Escalation to executive level to enable exec to exec conversations within the system Legal action
1251	Critical failings in hospital blood bank	Demand for service outstripping capacity and staffing shortfalls leading to the Quality management system not being maintained, resulting in tests not being reported in a timely manner. Blood test results resulting in delays in ED. Staff competencies in using the equipment not maintained. Risk of losing the UCAS accreditation Vacancy for Blood bank Lead	14/07/2022	Pharmacy, Pathology and Medical Physics (A4)	Hospital Transfusion Blood sciences	High Risk	Extreme	Low Risk	mitigations 12.09.2022 Mitigation: • Action plan regularly reviewed • Rolling recruitment plan in place • Training plan in place. • Monthly updates supplied to MHRA • Electronic blood tracking system purchased.

ID	Title	Risk Statement	Review date	Care Groups	Service of responsibility	Risk level (current)	Previous current risk level	Risk level (Target)	Mitigations/Controls
474	Review of Co-Tag system and management of issuing/retrieving tags to staff	The door access system is unstable and due to its age and condition is at the end of its useful life. The Trust is experiencing regular failures of the system causing operational disruption to users and Information Governance concerns.	31/12/2022	Chief Finance Officer	Estates Department	High Risk	Extreme	Very low Risk	The next stage is to bring in Vanderbilt the software specialist ASAP to try and resolve the current issue. Vanderbilt have tried remotely without success. Communication remains ongoing between IT and Vanderbilt. A process will be put in place with HR, to ensure that new starters are allocated cotags in their own name, and only have access to the areas they require with an appropriately signed authority form. A process to be put in place with HR, to ensure that cotags are returned from leavers and tags are deactivated. A message to go out in the communications, reminding staff and managers that if an employee change jobs/leaves/planned long term absence, their cotag should be reviewed/removed. In the next 6 months a list to be sent to all managers enclosing the areas that their staff have access to; they can then sign to state that this is correct and appropriate. The controller which holds all the data is in danger of collapse, if this happens, we will lose all the data held. This will lead to the inability to track who has cotags, and the ability to trace who has gone through a particular door. It will not stop the doors from working. The Information Governance lead has been providing guidance to ensure compliance with current national guidelines.
641	Clinical Coding	Poor clinical coding can result in:- - Failure to optimize legitimate income - lack of adequate information to support resource management and business planning - inaccurate reflection of Trust performance and quality of care (e.g. SHMI)	31/12/2022	Chief Finance Officer	Clinical Coding	High Risk	Extreme	Low Risk	team are in place and training is ongoing.

ID	Title	Risk Statement	Review date	Care Groups	Service of responsibility	Risk level (current)	Previous current risk level	Risk level (Target)	Mitigations/Controls
1513	Exposure to bribery, fraud and corruption committed internally	The Trust is at risk to exposure to risk of fraud, bribery and corruption committed internally by an employee, temporary staff, voluntary workers or externally by individuals, suppliers or a criminal organisation.	31/12/2022	Chief Finance Officer	Finance	Low Risk	Low Risk	Low Risk	Standing Financial Instructions Counter fraud work plan Audits of processes and procedures and access to systems Regular review
690	Malicious attack - Cyber attack on the NHS / Internal ICT failure	Risk Event - Health systems unable to keep essential services running. Cause - Failure of ICT, ICT breached. Impact - significant impact on hospital Trusts ability to provide critical services, and compromisation of patient records/confidentiality, leading to reputational damage.	15/09/2022	Chief Operating Officer	Emergency Planning	Moderate Risk	High Risk	Moderate Risk	* Cyber specialist employed by Trust in ICT * Cyber Policy * Training & Exercise * BC Plans
919	Covid -19	Risk Event – COVID 19 affecting the UK. Cause - When a new subtype of influenza develops the ability to spread rapidly through a global human population with no immunity to it. Impact - Catastrophic impact on all health systems especially acute hospitals being unable to cope with demand, plus mortuary capacity overload.	31/12/2022	Chief Operating Officer	Emergency Planning	Moderate Risk	Extreme	Low Risk	Review of risk, IPC guidance changed to PPE clinical areas only - being monitored. PPE still available IMT weekly Response will be varied depending on circumstances Numbers of patients requiring ITU intervention low
450	Emergency Department Target, Delays to Care & Patient Flow	Inconsistent achievement of the 4-hour standard, caused by crowding, high attendance numbers, insufficient bed/assessment unit capacity, and staffing challenges, leading to external regulator scrutiny, impact on overall performance (linked to PSF package), ambulance handover delays, and patient safety risks.	30/09/2022	Unscheduled Care (A3)	ED - Majors Service	Moderate Risk	High Risk	Moderate Risk	May 2022 - ED15 project addresses several ED space issues however ambulance handover delays still heavily impacted by patients deemed to be medically fit for discharge with no reason to reside.

ID	Title	Risk Statement	Review date	Care Groups	Service of responsibility	Risk level (current)	Previous current risk level	Risk level (Target)	Mitigations/Controls
464	Mortality Indicator	An increased Summary Hospital Mortality Indicator (SHMI) may indicate increased in-patient mortality, and/or a failure to code correctly patients admitted to DCH or a combination of the two.	31/12/2022	Medical Director	Corporate Services	Moderate Risk	Low Risk	Low Risk	The SHMI is not a measure of quality of care. A higher than expected number of deaths should not immediately be interpreted as indicating poor performance and instead should be viewed as a 'smoke alarm' which requires further investigation. The Trust continues to investigate reasons behind the higher than expected SHMI on a regular basis. Processes are overseen by the Learning from Deaths Hospital Mortality Group, which reports to the Quality Committee. Medical Examiners scrutinise all deaths of in-patients at DCH and recommend which cases require further investigation by RCA, SJR or review at an M&M meeting. The Group also reviews audit data gathered both locally and nationally to search for any evidence of unnecessary deaths. Additional monthly information on deaths, care quality and safety is provided by the Dr Foster team.

Counter Fraud Risk Register (all are managed risks) **Appendix 4**

ID	Risk level (current)	Risk level (initial)	Risk level (Target)	Risk Statement	Supporting Information	Due date	Review period	Mitigations/Controls
897	Low Risk	Low Risk	Very low Risk	If robust controls are not maintained there is a risk that an unqualified or inappropriate person will find work with the Trust. As well as a fraud (which could amount to several years of salary overpayments) and reputational risk for the Trust, this could also represent a clinical risk for service users or patients. Fraud leading to financial loss to the Trust in terms of sick pay to the absent member of staff and agency/bank/overtime potentially required to cover sickness absence.	This could have an impact on the Trust in a finance and reputational manner.	31/03/2025	Annual review	Employment checks are in place for all staff, permanent, bank and agency staff.
898	Low Risk	Low Risk	Very low Risk	Potential of collusion between bidders, bribery, splitting orders to avoid tender process, and breaches of Standing Financial Procedures.	Procurement fraud is likely to continue to be a risk for all NHS organisations.	31/03/2025	Annual review	Robust standing financial procedures in place. Robust process in place for waivers if required.
899	Low Risk	Low Risk	Very low Risk	This is a prevalent fraud across all health bodies and other government departments, and incidents are ongoing.	There are a number of variations of this fraud with increasing levels of sophistication. The CFS has received no specific referrals from the Trust. SBS are used - good controls in place.	31/03/2025	Annual review	Robust Standing Financial Instructions in place. Vigilant staff

ID	Risk level (current)	Risk level (initial)	Risk level (Target)	Risk Statement	Supporting Information	Due date	Review period	Mitigations/Controls
900	Low Risk	Low Risk	Low Risk	Ongoing threat to all NHS organisations. Likelihood rated on successful cyber attacks as Trust likely to be regularly targeted.	Likelihood rated on successful cyber attacks as Trust likely to be regularly targeted.	31/03/2025	Annual review	IT department have been externally assessed as compliant with ISO standards. Firewalls and anti-virus software in place and regularly updated across all systems.
902	Low Risk	Low Risk	Very low Risk	Trust requires adequate procedures to be in place in accordance with Bribery Act 2010 requirements and in line with NHS England guidance. Potential risk of a corporate offence - a failure to prevent bribery.	All compensation claims are managed by NHS Resolution and subject to their fraud analysis and investigation where appropriate. Therefore this falls outside the scope of this risk assessment.	31/03/2025	Annual review	Robust Standing Financial Instructions in place
896	Very low Risk	Very low Risk	Very low Risk	Issues regarding false claims for payments being made for hours not worked, or expenses not incurred.	No action required 19/20. The CFS has completed a proactive expenses review in the last two years. Recommendations to improve the control environment have been addressed.	31/03/2025	Quarterly review	No action required 19/20. The CFS has completed a proactive expenses review in the last two years. Recommendations to improve the control environment have been addressed.
901	Very low Risk	Very low Risk	Very low Risk	Failure to manage and monitor petty cash, fuel cards, patient travel claims and losses and compensation, including loss pf patient's property and cash.	Petty Cash is an area vulnerability to abuse in all organisations Corporate Credit Cards are an area which is vulnerable to abuse and or fraud. There have been many instances recorded in both the public and private sector of misuse of company credit cards. CFS has received one referral in the last two years.	31/03/2025	Quarterly review	Robust Standing Financial Instructions in place

Emergency Planning Risk Register (please note the whole process is currently being reviewed) **Appendix 5**

ID	Risk level (current)	Risk level (initial)	Risk level (Target)	Risk Statement	Supporting Information	Due date	Review period	Mitigations/Controls
683	Low Risk	Low Risk	Low Risk	Risk Event - On-call staff not being competent or confident enough to deal with the response to an incident (Business Continuity, Critical Incident or Major Incident). Cause - Lack of training or refresher training. Impact - Reputational to the NHS, potential for inadequate patient safety due to delays and in-effective decision making and command and control. Lack of training/refresher training of on-call managers resulting in inadequate patient safety and ineffective decision making.	Each NHS organisation is responsible for ensuring appropriate leadership during emergencies and other times of pressure. Incidents, emergencies and peaks in demand can occur at any time of day or night, so each organisation must have an appropriate out-of-hours on-call system. A director should always be available to make strategic decisions for the organisation; other staff may also be on-call to provide support. Staff should be appropriately trained noting the National Occupational Standard relevant to their role within the organisational response. Source: NHS England, EPRR Framework 2015 A resilient and dedicated EPRR on call mechanism needs to be in place 24 / 7 to receive notifications relating to business continuity incidents, critical incidents and major incidents. Source: NHS England Core Standards for EPRR v5.0 July 18	30/09/2022	Annual review	* Training & Exercise * On Call Managers / Executive Handbook
684	Low Risk	Low Risk	Very low Risk	Risk Event - Pandemic influenza affecting the UK. Cause - When a new subtype of influenza develops the ability to spread rapidly through a global human population with little or no immunity to it. Impact - Catastrophic impact on all health systems especially acute hospitals being unable to cope with demand, plus mortuary capacity overload.	Dorset LRF Risk Register - 3rd October 2018 Risk Ref: H23 Pandemic Influenza Pandemic influenza is recognised by the Government as the single most disruptive event facing the UK today. As such it remains at the top of the UK Government National Risk Register. The 2009/10 A(H1N1) influenza pandemic has not altered the likelihood of a future pandemic, and the generally mild nature of the 2009/10 event must not be taken as an indicator of the severity of future such events. The NHS England Operating Framework for Managing the Response to Pandemic Influenza (Oct 2013) sets out the roles, responsibilities and functions of NHS England in preparing for and responding to an influenza pandemic. It is intended to complement and support existing plans, policies and arrangements. NHS England is responsible for the command, control, communication, coordination and leadership of the NHS in the event of a major incident or emergency.	30/09/2022	Annual review	* DCH Pandemic Influenza Plan * Training & Exercise * Dorset LRF Managing Excess Deaths Framework * Dorset LRF Pandemic Influenza Response Plan * FFP3 Training Programme (IPC / Risk Dept.)

ID	Risk level (current)	Risk level (initial)	Risk level (Target)	Risk Statement	Supporting Information	Due date	Review period	Mitigations/Controls
687	Low Risk	Low Risk	Low Risk	Risk Event - The ability to effectively respond to a surface flooding event . Cause - Premises of health organisations are compromised due to flooding and/or victims of flooding require medical treatment. Impact - significant or catastrophic impact on acute hospital resources and ability to treat the volume or nature of injuries, and the ability of ambulance service resources to respond effectively.	Flooding across the country in 2007, 2009 and more recently in 2013 and 2014 highlights the various forms of flooding that the UK faces. Rising temperatures, which result in storms carrying more rain, and sea level changes associated with climate change are likely to increase the severity of weather events. The three main types of flooding are from the sea (coastal or tidal), from rivers and streams, and from surface water (caused by excess rainfall before it enters the drainage system). All three forms of flooding could occur during a single storm. The term 'inland flooding' is used to describe all forms of flooding other than coastal. Consequences may include: • casualties and fatalities • damage to property and infrastructure within the affected area, potentially leading to a need for evacuation or temporary housing for those affected • loss of/interruption to supply of essential goods and services and disruption to transport and energy networks • depending on the nature of the incident, contamination and environmental damage	01/09/2022	Annual review	* Estates Department * BC Plans * LRF 'Operation Link' partner * Receive Met Office updates on flooding * Training & Exercise * Dorset LRF Multi-Agency Flood Framework
688	Low Risk	Low Risk	Low Risk	Risk Event – Disruption to health services and staffing to effectively respond to a severe weather incident. Cause - severe weather affecting transportation, and increased demand on health services. Impact - significant impact on hospital resources ability to provide critical services, and the resources to respond effectively.	Dorset LRF Risk Register - 3rd October 2018 Risk Ref: H18 - Cold and Snow Severe weather can take a variety of forms and can cause significant problems and disruption to daily life. Over the coming years we are likely to see rising temperatures and sea levels and an increase in the severity of weather events in the UK. Local impact to Dorset: In rural area possible closure of the "high / ridge" roads across the county due to conditions e.g. A37, Dorchester to Yeovil, if accompanied by drifting. Potential Isolation of communities in the rural areas. Across all of Dorset including the Urban areas, a disruption of working life - closure of schools resulting parents having to stay at home to look after the children, increased risk of injuries due to non- gritting of paths and residential / minor roads. temporary housing for those affected • disruption to travel and logistics, due to deterioration of the road, runway surfaces and vehicle breakdowns • loss of/interruption to supply of essential goods and services and disruption to transport and communications networks • depending on the nature of the severe weather, economic impact and environmental damage.	01/09/2022	Annual review	* Receipt of Met Office weather forecasting updates in place * BC Plans * Cold Weather Plan * Training & Exercise * 4x4 vehicle fleet * Support from Wessex 4x4

ID	Risk level (current)	Risk level (initial)	Risk level (Target)	Risk Statement	Supporting Information	Due date	Review period	Mitigations/Controls
692	Low Risk	Moderate Risk	Low Risk	Risk Event - any issue that affects business continuity without adequate BC plans in place to mitigate or minimise the disruption. Impact - Reputational, financial and operational ability to undertake organisational functions	none.	01/09/2022	Annual review	* BCP Policy review and compliance is being monitored via the Emergency Resilience Planning Group. * BC Training & Exercises * Audits
694	Low Risk	Low Risk	Low Risk	Risk Event - Occurance of terrorism and other malicious attack Cause - terrorism affecting increased demand on health services. Impact - significant impact on hospital Trusts ability to provide critical services,	The UK faces a serious and sustained threat from terrorism both international and relating to Northern Ireland. At the time of publication, the national threat level stands at 'severe' having increased from 'substantial' in August 2014. The threat from Northern Ireland Related Terrorism (NIRT) in Great Britain was reduced from 'substantial' to 'moderate' in October 2012. However, the threat from NIRT in Northern Ireland is currently assessed as 'severe'. 'Severe' means that a terrorist attack is highly likely; 'substantial' that an attack in a strong possibility; and 'moderate' that an attack is possible, but unlikely. Consequences Consequences may include: • casualties and fatalities • damage to property and infrastructure within the affected area, potentially leading to a need for evacuation or temporary housing for those affected • loss of/interruption to supply of essential goods and services and disruption to transport networks • depending on the nature of the incident, contamination and environmental damage.	30/09/2022	Annual review	Major Incident Response Plan

ID	Risk level (current)	Risk level (initial)	Risk level (Target)	Risk Statement	Supporting Information	Due date	Review period	Mitigations/Controls
695	Low Risk	Moderate Risk	Very low Risk	Risk Event - Ability to effectively respond to a mass casualties incident. Cause - major transport incident. Impact - significant impact on hospital Trusts through volume of casualties and the ability of ambulance service resources to respond effectively.	Transport accidents occur across the UK on a daily basis, mainly on roads involving private vehicles, and well-practised plans are in place to deal with these at the local level. This section focuses on those rare major transport accidents which have such a significant impact that they require some form of national response. Thanks to modern safety regimes, large-scale transport accidents are very rare; nevertheless, they cannot be entirely ruled out, as the following examples demonstrate. While accidents do occur much more frequently on the UK's road networks than on other forms of transport, the scale of even the largest such incident would be highly unlikely to warrant a coordinated UK government or devolved administration response. Similarly, continuing improvements to rail safety regimes and infrastructure over recent years have led to a substantial reduction in both the frequency and impact of rail accidents. As with road accidents, it is highly unlikely that an incident of this kind would require a coordinated UK government or devolved administration response. Consequences Consequences may include: • casualties and fatalities • damage to property and infrastructure within the affected area, potentially leading to a need for evacuation or temporary housing for those affected • depending on the nature of the incident, contamination and environmental damage.	01/09/2022	Annual review	* Major Incident Response Plan * Critical Surge and Escalation Plan * Mass Casualty Plan * Training and Exercise Programme * Major Incident Action Cards * Dorset LRF Emergency Contacts Directory * Dorset LRF Managing Excess Deaths Framework
697	Low Risk	Low Risk	Low Risk	Risk Event - Infectious disease outbreak overwhelming local health resources. Cause - High numbers of patients requiring treatment. Impact - Catastrophic impact on all health systems being unable to cope with demand, plus mortuary capacity overload.	Based upon the experience of the outbreak of Severe Acute Respiratory Syndrome (SARS) in 2002 and the Covid-19 outbreak in 2019, the worst case likely impact of such an outbreak originating outside the UK would be cases occurring amongst returning travellers and their families and close contacts, with spread to health care workers within hospital setting. • Short term disruption to local hospital intensive care facilities. • Possible disruption of several weeks to elective procedures. Fatalities & Casualties • Max 200 fatalities across the country and 2,000 casualties based upon fatality rate up to 10%, from global experience of SARS • Expect 10 potential cases and 100 follow up contacts for every single confirmed case of infection as seen in past SARS outbreak	30/09/2022	Annual review	* IPC Department * IPC Policy * Training & Exercise

ID	Risk level (current)	Risk level (initial)	Risk level (Target)	Risk Statement	Supporting Information	Due date	Review period	Mitigations/Controls
699	Low Risk	Low Risk	Low Risk	Risk Event - Ability to provide appropriate health care. Cause - Industrial action by staff or industrial action by non health staff that affects staff attending work or the services we provide. Impact - Significant impact on individual health organisation to respond to business as usual or critical functions.	Industrial action occurs when members of a trade union are involved in a dispute with their employer that cannot be resolved by negotiation. Industrial action takes the form of strike action, a concerted stoppage of work, or action short of a strike, which could be refusing to perform certain duties or cooperate with the employer. Industrial action of varying degrees of intensity and scale can occur in the UK. The UK Government and the devolved administrations work to monitor the frequency and potential impact of industrial action disputes, and promote the mediation services of the Advisory, Conciliation and Arbitration Service (ACAS). Consequences may include: •potential disruption to non-essential services causing widespread inconvenience and difficulties for service users •potential for wider economic impacts.	30/09/2022	Annual review	* HR Department - Workforce Team * Bank staff Office
700	Low Risk	Low Risk	Low Risk	Possible effects on Trust infrastructure ie staff attending work, mail system delivery, supplies, catering and provision of essential equipment. Some Trust vehicles will be supplied with fuel but some suppliers of services may not be given fuel provision (eg specialist bed providers)	Unavailability of fuel (diesel/petrol) across the Dorset area would progressively prevent the flow of vehicles and people creating widespread disruptions to the 'normal' functioning of the community and economy. March 2012 voting in favour of strike action created public fear of a fuel shortage and resulted in panic buying. While the strikes did not materialise the panic buying resulted in an abrupt change in consumer behaviour and quickly led to shortages at filling stations. Stations continued to receive deliveries therefore the main hazard was queuing and public unrest. Many filling stations opted to close for short periods in order to disperse queuing traffic while Dorset Police asked other Filling stations to close to ease congestion. Received national media coverage of the problems in Dorset.	01/09/2022	Annual review	* DCH Fuel Disruption Plan * Transport Department in EFM. * Dorset LRF Fuel Disruption Response Plan
702	Low Risk	Low Risk	Low Risk	Risk Event – Disruption to health services and staffing to effectively respond to a severe weather incident. Cause - severe weather affecting transportation, and increased demand on health services. Impact - significant impact on hospital resources ability to provide critical services, and the resources to respond effectively.	Dorset LRF Risk Register - 3rd October 2018 Risk Ref: H17 - Storms and gales The most significant storms in recent decades were those of 16 October 1987 and 25 January 1990. The first brought down an estimated 15 million trees in the south-east of England. By contrast, the 1990 storm was more extensive and had higher peak wind speeds. The net effect was a much higher death toll but less damage to trees and property.	30/09/2022	Annual review	* BC Plans * Severe Weather Plan * Training & Exercise * Receipt of Met Office updates

ID	Risk level (current)	Risk level (initial)	Risk level (Target)	Risk Statement	Supporting Information	Due date	Review period	Mitigations/Controls
919	Moderate Risk	Extreme	Low Risk	Risk Event – COVID 19 affecting the UK. Cause - When a new subtype of influenza develops the ability to spread rapidly through a global human population with no immunity to it. Impact - Catastrophic impact on all health systems especially acute hospitals being unable to cope with demand, plus mortuary capacity overload.	The risk of severe disease associated with COVID -19 infections for people in the UK is currently considered moderate for the general population and high for older adults and individuals with chronic underlying conditions, based on the probability of community transmission and the impact of the disease. The risk of healthcare system capacity being exceeded in the UK in the coming weeks is considered high. The impact and risk assessment on health system capacity can be mediated by the application of effective infection prevention and control and surge capacity measures. The risk of transmission of COVID -19 in health and social institutions with large vulnerable populations is considered high. The impact of transmission in health and social institutions can be mediated by the application of effective infection prevention and control and surge capacity. Measures taken at this stage should ultimately aim at protecting the most vulnerable population groups from severe illness and fatal outcome by reducing transmission and reinforcing healthcare systems. NHS England is responsible for the command, control, communication, coordination and leadership of the NHS in the event of a major incident or emergency. Necessary measures to mitigate the impact of the pandemic Given the current epidemiology and risk assessment, and the expected developments in the next days to few weeks, the following public health measures to mitigate the impact of the pandemic are necessary countries: • Social distancing measures should be implemented early in order to mitigate the impact of the epidemic and to delay the epidemic peak. This can interrupt human-to-human transmission chains, prevent further spread, reduce the intensity of the epidemic and slow down the increase in cases, while allowing healthcare systems to prepare and cope with an increased influx of patients. Such measures should include: o the immediate isolation of symptomatic persons suspected or confirmed to be infected with COVID-19; o the suspension of mass gatherings, taking into consideration the size of the event, the density of participants and if the event is in a confined indoor environment; o Social distancing measures at workplaces (for example teleworking, suspension of meetings, cancellation of non-essential travel); o Measures in and closure of schools, taking into consideration the uncertainty in the evidence of children in transmitting the disease, need for day care for children, impact on nursing staff, potential to increase transmission to vulnerable grandparents;	31/03/2025	Monthly review	Review of risk, IPC guidance changed to PPE clinical areas only - being monitored. PPE still available IMT weekly Response will be varied depending on circumstances Numbers of patients requiring ITU intervention low

ID	Risk level (current)	Risk level (initial)	Risk level (Target)	Risk Statement	Supporting Information	Due date	Review period	Mitigations/Controls
					o Ensuring the public is aware of the seriousness of COVID-19. A high degree of population understanding, solidarity and discipline is required to apply strict personal hygiene, coughing etiquette, self-monitoring and social distancing measures. Community engagement and acceptance of stringent social distancing measures put in place are key in delaying and reducing further spread. o Prevention and control of COVID-19 in hospitals and long-term care facilities is an immediate priority in order to: (1) slow the demand for specialised healthcare, such as ICU beds; (2) safeguard populations vulnerable to severe outcomes of infection (3); protect healthcare workers that provide care; (4) minimise the export of cases to other healthcare facilities and the community. o Every healthcare facility should initiate training for all staff and those who may be required for healthcare provision during surge capacity. Healthcare institutions should identify additional facilities that can be used for the cohorting of cases with mild symptoms, in the event that surge capacity is exceeded by healthcare facilities. The highest priority for use of respirators (FFP3) are healthcare workers, in particular those performing aerosol-generating procedures, including swabbing. o If resources or capacity are limited, rational approaches should be implemented to prioritise high-yield actions, which include: rational use of confirmatory testing, reducing contact tracing to focus only on high-yield contacts, rational use of PPE and hospitalisation and implementing rational criteria for de-isolation. Testing approaches should prioritise vulnerable populations, protection of social and healthcare institutions, including staff. o All Trust PPE is in accordance with the COVID- 19 Personnel Protective Equipment (PPE) Guidance 17th April 2020. o The Trust provides all staff with the recommended PPE types with a rational for use: o Filtering face piece class 3 (FFP3) respirators o Fluid resistant surgical masks o Eye and face protection o Disposable aprons and gowns o Disposable gloves The Trust currently has sufficient quantities of all PPE as required. Horizon scanning identifies any short comings and these can be fulfilled through mutual aid through escalation to NHS Supplies. In addition daily PPE SitReps are submitted to Dorset CCG. If any PPE item is not going to be available the Trusts Procurement Department will seek alternative supplies locally or nationally. If supplies are provided as an alternative which are not CE marked these item go through a rigorous risk assessment process before being introduced.			

ID	Risk level (current)	Risk level (initial)	Risk level (Target)	Risk Statement	Supporting Information	Due date	Review period	Mitigations/Controls
					Eligible staff have been contacted to receive their Covid 19 vaccination booster to ensure resilience of the workforce. Flu jabs in addition have also been offered.			
698	Moderate Risk	Moderate Risk	Low Risk	Risk Event - any issues that affects business continuity without adequate BC plans in place to mitigate or minimise the disruption. Cause - as above Impact - Significant impact on health systems being unable to cope with the disruption.	NHS organisations and providers of NHS funded care must be able to maintain continuous levels in key services when faced with disruption from identified local risks such as severe weather, fuel or supply shortages or industrial action. All NHS organisations and providers of NHS funded care must contribute to co-ordinated plans for emergency preparation and service resilience through their local health resilience partnerships. NHS England Business Continuity Management Framework (service resilience) (2013):	01/09/2022	Annual review	Regular maintenance of the BCM programme keeps the BC arrangements up to date. This ensures the Trust remains ready to respond to, and manage the impacts from incidents effectively. Maintenance activities include: * Lessons Learned through exercising * Changes to department structures, services and processes. * Changes to the environment in which the Trust operates. * Reviews of Audits * Real incidents where lessons learned can be incorporated.
689	Moderate Risk	Moderate Risk	Low Risk	Risk Event - Health systems unable to keep essential services running. Cause - Failure of utilities. Impact - significant impact on hospital Trusts ability to provide critical services, and the ability of ambulance service resources to respond effectively.	Generator provision at DCH provides full cover in South Wing and Partial Cover in North Wing. Generator functionality testes regularly but currently no 'black-start' testing is undertaken as it is not clear what impact this would have on service provision	01/09/2022	Annual review	* BC Plans * EFM Department Business Management System * Generators on site * Regular Testing of equipment * Training & Exercise * Dorset LRF Loss of Utility Plan - Electricity * Dorset LRF Loss of Utility Plan - Gas

ID	Risk level (current)	Risk level (initial)	Risk level (Target)	Risk Statement	Supporting Information	Due date	Review period	Mitigations/Controls
690	Moderate Risk	Moderate Risk	Moderate Risk	Risk Event - Health systems unable to keep essential services running. Cause - Failure of ICT, ICT breached. Impact - significant impact on hospital Trusts ability to provide critical services, and compromisation of patient records/confidentiality, leading to reputational damage.	Cyber space has become central to our economy and our society. Increasing our reliance on cyber space brings new opportunities but also new threats. While cyber space fosters open markets and open societies, this very openness can also make us more vulnerable to those – criminals, hackers, foreign intelligence services – who want to harm us by compromising or damaging our critical data and systems. A growing number of adversaries are looking to use cyber space to steal, compromise or destroy critical data. The scale of our dependence means that our prosperity, our key infrastructure, our places of work and our homes can all be affected. Vulnerabilities can take time to identify, leaving vast numbers of systems open to exploitation to be used in attacking other systems and networks remotely. Cyber space is already used by terrorists to spread propaganda, radicalise potential supporters, raise funds, communicate and plan. While terrorists can be expected to continue to favour high-profile physical attacks, the possibility that they might also use cyber space to facilitate or to mount attacks against the UK is growing. The threat to the UK from politically motivated activist groups operating in cyber space is real. Attacks orchestrated by hacktivists on public and private sector websites and online services are becoming more common and aim to cause disruption and reputational and financial damage to gain publicity. Consequences may include: • loss/compromise of personal or corporate information • damage to business, the economy and reputation • loss of/interruption to supply of essential goods and services	01/09/2025	Annual review	* Cyber specialist employed by Trust in ICT * Cyber Policy * Training & Exercise * BC Plans

ID	Risk level (current)	Risk level (initial)	Risk level (Target)	Risk Statement	Supporting Information	Due date	Review period	Mitigations/Controls
685	Moderate Risk	Moderate Risk	Moderate Risk	Risk Event: National loss of power. Cause: Severe weather (e.g. very strong winds, lightning and flooding) which damage the distribution network. Impact: Disruption or loss of essential services, particularly transport, food, water, fuel, gas, finance, communications (all types). Casulties if blackouts are prolonged.	Dorset LRF Risk Register - 3rd October 2018 Risk Ref: H41 -Failure of national electricity transmission Instances of electricity failure (also referred to as power loss or blackout) can be caused by a number of things, such as severe weather (e.g. very strong winds, lightning and flooding) which damage the distribution network. Damage to the National Electricity Transmission System is much more rare but could cause significant electricity disruption and, in extreme cases, a widespread loss of power. These failures could be local (e.g. a metropolitan area), regional (e.g. the midlands) or national (e.g. across much of the UK). An electricity failure across entire regions or the UK as a whole has not happened before. Were it to occur, impacts would be very severe, causing widespread disruption to many critical sectors and wider society in general. The National Grid has a recovery process called 'Black Start' to recover the network from a total or partial shutdown. Based on current plans, Black Start recovery could take up to five days with potential for some additional disruption beyond this timescale in the event of significant network damage. Consequences of a national loss of power may include: • fatalities and physical / psychological casualties; • disruption or loss of essential services, particularly transport, food, water, fuel, gas, finance, communications (all types), and education • disruption to business (via lost working hours); and • if blackouts are prolonged, also potential disruption to health care, emergency services and emerging public disorder.	01/09/2022	Annual review	

ID	Risk level (current)	Risk level (initial)	Risk level (Target)	Risk Statement	Supporting Information	Due date	Review period	Mitigations/Controls
686	Moderate Risk	Moderate Risk	Low Risk	Risk Event - The ability of health resources to effectively respond to a CBRNe / HAZMAT incident. Cause - Terrorism related CBRNe incident or hazardous release accident (HAZMAT) with a high number of casualties or type of trauma injuries involved. Impact - significant impact on acute hospital resources and ability to treat the volume or nature of injuries, and the ability of ambulance service resources to respond effectively.	National Risk Register of Civil Emergencies 2020 Edition The UK Government works hard to prevent terrorists from gaining the expertise and materials necessary to deliver attacks employing chemical, biological, radiological or nuclear (CBRN) materials. Such attacks have the potential to cause harm by contaminating people, animals, buildings, outdoor environments, water supplies and food. Their scale and impacts could vary widely depending on the materials involved and the way they are used. Extremists remain interested in CBRN materials, however alternative methods of attack such as employing firearms or conventional explosive devices remain far more likely. Consequences of CBRN attacks could vary heavily depending on methods and materials employed, but may include: • fatalities and physical casualties (including contaminated people); • psychological casualties; • damage to property and infrastructure; • evacuation and shelter of affected individuals; • disruption to critical services, particularly transport but potentially across all sectors; • economic damage, including disruption to business and tourism; and • environmental contamination, including the natural and urban environment, animals, infrastructure, food and water. Potential for mass casualties and restrictions on staff getting to work increase in activity due to casualties, short term, potential for issues of staff getting to work. More likely to have greater impact on DCH due to the size of the Trust 2020 National Risk Register has CBRNe large and medium scale attacks as high. Although we live in a rural location there is still a high chance as a hospital that we could be targeted.	01/09/2022	Annual review	* Maintaining response capabilities with regular training & exercises. * Maintaining equipment including Decontamination Unit - Maintenance contract in place. * 24 x PRPS * Monthly equipment checks in place by DCH ED Team Member. * DCH CBRNe _HAZMAT Plan * DCH Mass Casualty Plan
691	Very low Risk	Very low Risk	Very low Risk	Risk: Staff not attending work due to flights being cancelled Consequence: Unable to provide services.	Space weather refers to the environmental conditions in Earth's magnetosphere, ionosphere and thermosphere due to the Sun and the solar wind that can influence the functioning and reliability of spaceborne and ground-based systems and services or endanger property or human health. Space weather deals with phenomena involving ambient plasma, magnetic fields, radiation, particle flows in space and how these phenomena may influence man-made systems. In addition to the Sun, non-solar sources such as galactic cosmic rays can be considered as space weather since they alter space environment conditions near the Earth.	30/09/2022	Annual review	HR Policy - unable to attend work

ID	Risk level (current)	Risk level (initial)	Risk level (Target)	Risk Statement	Supporting Information	Due date	Review period	Mitigations/Controls
701	Very low Risk	Very low Risk	Very low Risk	Risk Event – Disruption to health services and staffing to effectively respond to a severe weather incident. Cause - severe weather affecting transportation, and increased demand on health services. Impact - significant impact on hospital resources ability to provide critical services, and the resources to respond effectively.	Dorset LRF Risk Register - 3rd October 2018 Risk Ref: H48 - Heat wave Severe weather can take a variety of forms and can cause significant problems and disruption to daily life. Over the coming years we are likely to see rising temperatures and sea levels and an increase in the severity of weather events in the UK. The demographic of Bournemouth, Dorset and Poole is characterised with a high proportion of elderly, who are recognised as one of the most vulnerable groups to the effects of heatwave.The popularity of the area as a tourist destination means there is likely to be an influx of visitors during a heatwave, compounding pressures on the transport network, health and other services. Up to 1,000 fatalities and 5,000 casualties, mainly amongst the elderly. Locally this would translate to less than 10 fatalities and 100 casualties. There is likely to be disruption to power supply, telecommunications links and transport infrastructure during the 2 weeks. The Department of Health has established a 'Heat-Health watch' system, which operates in England from the 1st June to 15th Sept. each year. During this time, the Met Office may forecast severe heat waves, as defined by day and night-time temperatures and duration. While Heat-Health watch is in operation the Public Health England monitors the numbers of calls to 111 and the trends in GP consultations to be reported to the DH daily. The Heat-Health Watch has four levels of alert: Level 1: Awareness - minimum state of vigilance. (in place from 1 June to 15 September and means that people should be aware of what to do if the alert level is raised) Level 2: Forecasts - triggered by forecast of 3 day Heat wave or 80% chance of two consecutive days with temperatures high enough to have significant health effects. Level 3: Heat wave - Triggered as soon as Met Office confirms threshold has been reached in the region. Level 4: Emergency - Reached when effects of the Heat wave are so severe or prolonged that they extend beyond health and social care into power or water shortages, or the integrity of the health and social care systems are compromised.	30/09/2022	Annual review	* DCH Heatwave Plan * Heatwave Plan for England * Trust receives heat-health watch alerts from 1 June to 15 September, based on Met Office forecasts and data * Training & Exercise

Report Front Sheet

1. Report Details			
Meeting Title:	Board of Directors, Part 1		
Date of Meeting:	30 November 2022		
Document Title:	**Review of Report into East Kent Maternity and Neonatal Services**		
Responsible Director:	Emma Hoyle, Acting Chief Nursing Officer	Date of Executive Approval	23/11/22
Author:	Jo Hartley, Director of Midwifery & Neonatal services		
Confidentiality:	No		
Publishable under FOI?	Yes		
Predetermined Report Format?	No		

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

Purpose of the Paper	*Note (✓)*	✓	*Discuss (✓)*	✓	*Recommend (✓)*		*Approve (✓)*	

3. Executive Summary

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

- Data from Power BI provided – ongoing data concerns around first breastfeed – not considered accurate
- Information about pregnancy loss prior to 24 weeks provided
- Staffing challenges remain, notable at night
- East Kent Report - Initial scoping exercise looking for similarities in DCH – historic and current. Awaiting national actions
- Notable improvement in CO monitoring at 36/40. Support for women prior to pregnancy to stop smoking is not provided by maternity services but by LiveWell Dorset. However, the DCH fertility service now conducts CO monitoring on women and their partners
- Two complaints with themes of kindness, sensitive communication and some aspects of clinical care
- Compliance remains good for training. Neonatal study day provided
- Action plan provided for ATAIN
- Some Maternity Incentive Scheme actions now complete and can be signed off by QC and then Board
- Summary of how user feedback is collected with examples from a variety of sources. Also F&F – “You said, we did”

4. Action recommended	The Board is recommended to: 1. **NOTE** the report 2. **RECEIVE** assurance on actions to address any performance issues 3. **AGREE** the key points, risks & concerns to be reported to the Board

5. Governance and Compliance Obligations				
Legal / Regulatory Link		**Yes**		Inability to sustain set standards and maintain safety could lead to a negative reputational impact and inability to improve patient safety, effectiveness and experience.
Impact on CQC Standards		**Yes**		Much of this report aligns to CQC standards for maternity services
Risk Link		**Yes**		Links to Board assurance Framework
Impact on Social Value		**Yes**		
Trust Strategy Link		The quality of our services in providing safe, effective, compassionate, and responsive care links directly with strategic objectives		
Strategic Objectives	People	Credibility of Trust		
	Place	Serving the population of Dorset		
	Partnership	System working to achieve high standards of care		
Dorset Integrated Care System (ICS) Objectives		**Which Dorset ICS Objective does this report link to / support?**		
Improving population health and healthcare		**Yes**		
Tackling unequal outcomes and access		**Yes**		
Enhancing productivity and value for money		**Yes**	**No**	
Helping the NHS to support broader social and economic development		**Yes**	**No**	
Assessments		**Have these assessments been completed?** *If yes, please include the assessment in the appendix to the report..* *If no, please state the reason in the comment box below.* *(Please delete as appropriate)*		
Equality Impact Assessment (EIA)		**Yes**	**No**	
Quality Impact Assessment (QIA)		**Yes**	**No**	

Dorset County Hospital
NHS Foundation Trust

Maternity Quality and Safety report

November 2022 (October activity)

Submitted by Jo Hartley, Director of Midwifery & Neonatal Services

Executive sponsor: Emma Hoyle, Acting CNO

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- Two complaints with themes of kindness, sensitive communication and some aspects of clinical care
- Compliance remains good for training but new doctors have started their rotation so the numbers are lower whilst their training dates are confirmed. Details of neonatal study day provided
- Action plan provided for ATAIN
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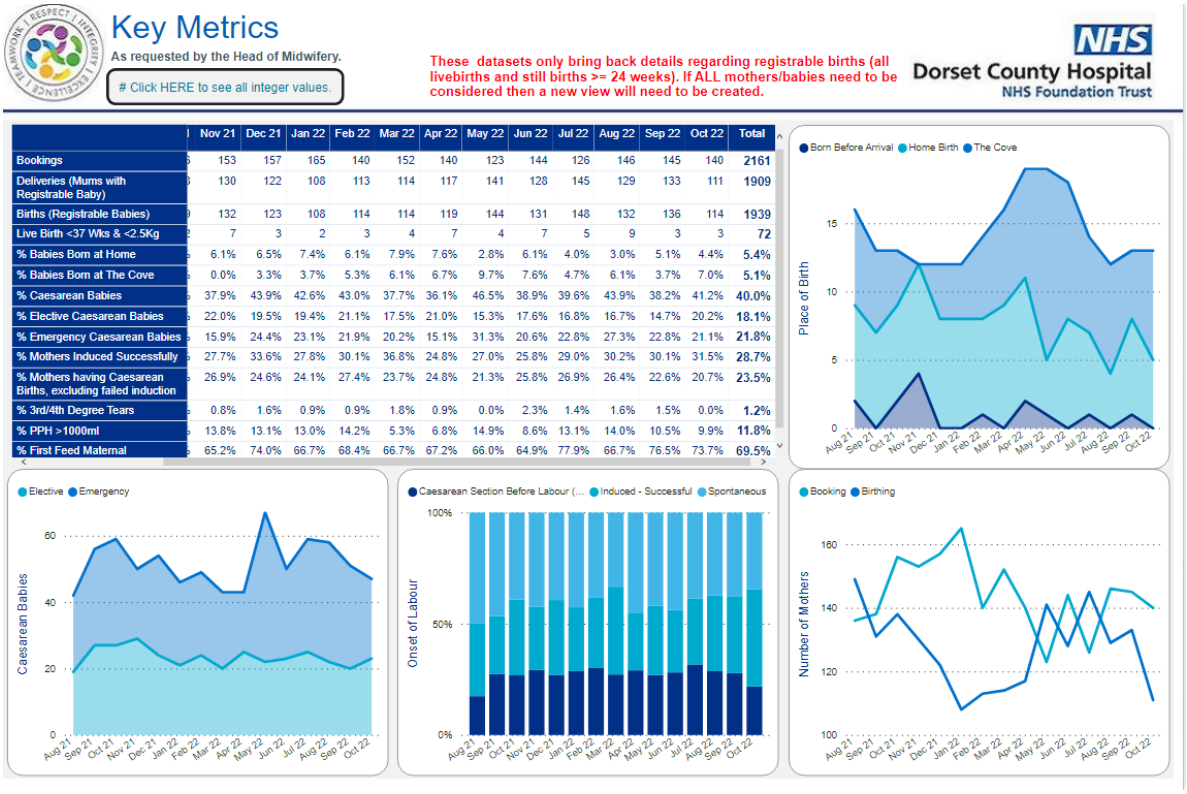
- Summary of how user feedback is collected with examples from a variety of sources. Also F&F – “You said, we did”

Activity

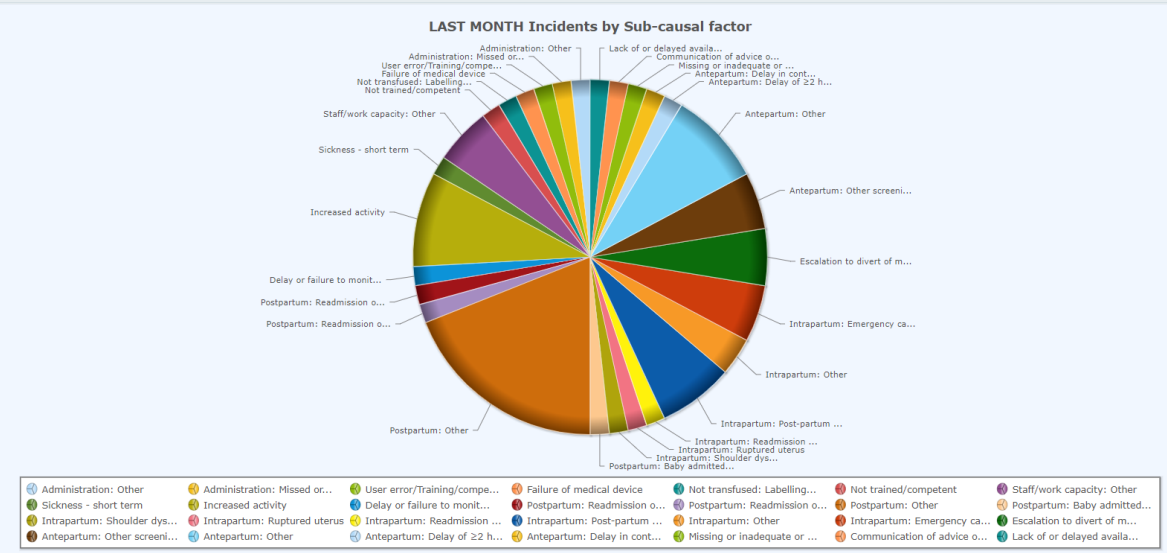


	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Total
Bookings	153	157	165	140	152	140	123	144	126	146	145	140	2161
Deliveries (Mums with Registrable Baby)	130	122	108	113	114	117	141	128	145	129	133	111	1909
Births (Registrable Babies)	132	123	108	114	114	119	144	131	148	132	136	114	1939
Live Birth <37 Wks & <2.5Kg	7	3	2	3	4	7	4	7	5	9	3	3	72
% Babies Born at Home	6.1%	6.5%	7.4%	6.1%	7.9%	7.6%	2.8%	6.1%	4.0%	3.0%	5.1%	4.4%	5.4%
% Babies Born at The Cove	0.0%	3.3%	3.7%	5.3%	6.1%	6.7%	9.7%	7.6%	4.7%	6.1%	3.7%	7.0%	5.1%
% Caesarean Babies	37.9%	43.9%	42.6%	43.0%	37.7%	36.1%	46.5%	38.9%	39.6%	43.9%	38.2%	41.2%	40.0%
% Elective Caesarean Babies	22.0%	19.5%	19.4%	21.1%	17.5%	21.0%	15.3%	17.6%	16.8%	16.7%	14.7%	20.2%	18.1%
% Emergency Caesarean Babies	15.9%	24.4%	23.1%	21.9%	20.2%	15.1%	31.3%	20.6%	22.8%	27.3%	22.8%	21.1%	21.8%
% Mothers Induced Successfully	27.7%	33.6%	27.8%	30.1%	36.8%	24.8%	27.0%	25.8%	29.0%	30.2%	30.1%	31.5%	28.7%
% Mothers having Caesarean Births, excluding failed induction	26.9%	24.6%	24.1%	27.4%	23.7%	24.8%	21.3%	25.8%	26.9%	26.4%	22.6%	20.7%	23.5%
% 3rd/4th Degree Tears	0.8%	1.6%	0.9%	0.9%	1.8%	0.9%	0.0%	2.3%	1.4%	1.6%	1.5%	0.0%	1.2%
% PPH >1000ml	13.8%	13.1%	13.0%	14.2%	5.3%	6.8%	14.9%	8.6%	13.1%	14.0%	10.5%	9.9%	11.8%
% First Feed Maternal	65.2%	74.0%	66.7%	68.4%	66.7%	67.2%	66.0%	64.9%	77.9%	66.7%	76.5%	73.7%	69.5%

Incidents

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

Incidents by sub-causal factor – reporting will improve in accuracy and accessibility as the revised datix trigger list is utilised (as will the quality of the infographic).



Total Number of Incidents for Nov 2021- Oct 2022

Nov	Dec	Jan	Feb	Mar	Apr	May	June	July	Aug	Sep	oct
91	87	64	43	55	70	93	79	76	70	63	74
Number of incidents overdue: 14						Overdue incidents relate to delayed responses from other specialties within the organisation and external such as SWAST and UHD					

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	13 all for maternity – the majority for nightshifts
RF2	Missed medication	2
RF3	Delay in providing or reviewing an epidural in labour	0
RF4	Delay of more than 30 minutes between arrival and admission in ANDAU -	Please see updated SI action re: electronic diary for ANDAU
RF5	Full examination not carried out when presenting in labour	0
RF6	Delay of ≥2 hours between admission for induction of labour & starting process	3 datix submitted but more women would have been affected due to the number of datix submitted for staffing
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

RF6 &7 The delayed activity relates to Induction of labour (IOL). Given the increasing rates of IOL, delays in the procedure will continue. Cases are assessed individually when a delay is anticipated, by the coordinator and the consultant obstetrician and the woman is informed of the delay, with apologies. This pressure is evident throughout the system.

RF4 Staffing continues to be challenging, particularly at night. Whilst we have recruited 10 new midwives who are starting work, we have lost three midwives from our nightcore team. Currently, all staff who are excused from working nights, have been contacted by the DoM to review the arrangement - a number have been excused for health reasons which is unlikely to change but there will be some who start to work a few nights a month. When staffing on nights is poor, we arrange for a doctor to work as an extra - this means that a midwife will not be required to assist in theatre (as usually happens on nights). The maternity manager oncall rota is utilised appropriately by the midwife in charge, with managers attending as required. Ongoing work to update the Escation Policy, based on the Regional Policy.

Incidents of interest not requiring RCA

reference	detail	Further information
DCH77444	significant postpartum hemorrhage (PPH)	**Review and feedback from the safety team** Risk factor for PPH include induction of labour, forceps with episiotomy, prolonged second stage. Baby born in theatre so full team present for management of PPH. Registrar's documentation details management of PPH from perineal trauma; Episiotomy had extended laterally, bleeding ++. Tranexamic acid given while suturing commenced. Haemostatic suture used first to large vessels prior to closure of episiotomy. Episiotomy closed in three layers x2 further haemostatic sutures towards apex on right lateral wall required after closing. Small labial grazes bilaterally also closed with 3-0 vicryl rapide by Obstetric Consultant (called to attend). Haemostasis checked at end with speculum - no pack required. Appropriate management of clinical situation, Obstetric Consultant involved in perineal trauma.
DCH77691	Resuscitation of baby born at home	**Review and feedback from the safety team** Care reviewed by fetal monitoring lead midwife Resuscitation commenced as per guideline and transfer in arranged, saturations recorded within normal range, immediate review of baby on admission and plan in place for observations and blood sugar monitoring and further reviews. Blood gases not taken as baby born at home. Additional training for midwiives to be added to the update day for IA monitoring to ensure we capture any raise in baseline or decelerations

Current SIs, RCAs and HSIB cases (including cases awaiting presentation at the Perinatal Mortiality Review Committee (PMRT)

Incident number & Initials	Description	Date of incident	Progress	Notes	If there are learning & service changes Ockenden recommends 6 months to implement
72942 (PMRT)	Third trimester IUD	4/5/22	Heard at PMRT and Learning from Incident Panel (LIP) RMD to close	Has had follow up appointment with Obstetric Consultant.	Has seen Consultant.
72489	Third trimester 32+1	15/04/22	PMRT & postmortem review completed. Heard at panel and amendments made. V4 saved, just waiting for panel notes to be written up by risk.	Has consultant and bereavement appointment Waiting for risk to close	
72663	Postnatal incident	23/04/22	HSIB report completed and published. Working on implementing recommendations	HSIB report received 14/09/22 Panel 6/10/22 –completed Emergency call bell intermittent fault on risk register Two safety recommendations in progress.	Mar 2023
76500 (SI to be confirmed)	Intraprtum incident	13/09/22	Staff requested for statements RCA/SI paperwork received. In contact with parents with their questions being taken into account	Staff statements completed. Consultant review completed. Waiting for update on Paediatric opinion. Safety team to review documents prior to submitting.	March 2023
73734	Care declined	5/06/22	Low PaPA aspirin process amended Awaiting SOP from USS for changing scan dates Then take back to CIA		Dec 2022
76489 (PMRT)	Intra-uterine death (IUD) second trimester	16/09/22	72 hour report heard at CIA PMRT 27/10/22 (UHD and UHS present as fetal medicine input from UHS) Heard at CIA Needs to be heard at LIP	Care graded as A and A. Difficult to ascertain cause of death as PM declined. For specialist follow up	
73197 (PMRT)	30+5 twin IUD	5/05/22	PMRT completed. RMD writing up panel notes.	Has had postnatal follow up with consultant. Learning identified surrounding communication of how her baby may look after birth. Also, debrief provided for staff involved in her care.	Nov 2022

Closed SIs

HSIB case MI-008713 (DCH72663)

Minute	Action	Owner	Timescale	Outcome/progress
Action 1. Identified by DCH	Resuscitaire not available on Postnatal area. Resuscitaire used in this instance on the midwife led unit resulting in a short delay in setting up area for resuscitation.	Lindsey Burningham	completed	Postnatal resuscitation area available on the postnatal ward. COMPLETED
Action 2. Identified by DCH	Emergency bells not heard consistently in all areas. Risk register ID 1497.	Estates department.	June 2023 (estimated)	This issue is on the Risk Register. Update awaited.
Action 3. Identified by HSIB	The trust to ensure that staff are supported to undertake safety risk assessments when initiating skin to skin contact tin the immediate PN period. .	Matron for Community and PN care (and UNICEF Lead Midwife	Jan 2023	BFI training for all staff underway in which is included risk assessment. Posters being sourced for maternity unit and community areas.
Action 4. Identified by HSIB.	The trust to implement a system to consistently store and send placenta in line with national guidance.	Matron for Antenatal and Intrapartum care and Maternity Safety Team.	Dec 2022	New guidance published along with bright posters and safety pin – currently practice is compliant with placentas labelled (on the bag) until disposal at an appropriate time COMPLETED

Risk Register

ID	Title	Risk Statement	Open	Risk	Risk Level
	lack of capacity within the neonatal network, impacting on in-utero transfer	**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. **Update Oct 2022** – no further incidents. Although risk remains, RG rating down-graded. New Periprem guideline published, including use of the QUIP app that triangulates risk and will reduce the number of inutero transfers required	14/07/2022 Quarterly review	Low	Care group

1227	Provision of the smoking cessation service to pregnant women	All pregnant women 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. **Update Nov 2022** Compliance continues to improve, including the way in which the data is collected around "booking". **Update as requested:** Access for women prior to pregnancy for smoking cessation support is not currently commissioned to be provided by the maternity service. However, recently the Lead Nurse for Fertility has commenced CO monitoring for patients with referral into the cessation service if they are smokers. We are also exploring if we can access referral data as soon as possible, via the digital portal for referrals so that cessation support can be offered at 5-6 weeks of pregnancy (and maybe even earlier).	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 November 2022** Consent to over-recruit to facilitate preceptorship training has been given and one nurse recruited	18/12/2019 Quarterly review	low	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 **Update Oct 2022** Awaiting analysis from the two rooms which failed the test – following mesh being provided to the front of the fans. The rooms with the mesh protection over the fans	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	20/07/2021 Quarterly review	high	division

		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 November 2022.** 13 datix submitted. Poor staffing continues, particularly at night. Whilst we have recruited 10 new midwives who are starting work, there have been changes within the nightcore team. Currently, all staff who are excused from working nights, have been contacted by the DoM to review the arrangement - a number have been excused for health reasons which is unlikely to change but there will be some who start to work a few nights a month. When staffing on nights is poor, we arrange for a doctor to work as an extra - this means that a midwife will not be required to assist in theatre (as usually happens on nights)			

Complaints

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

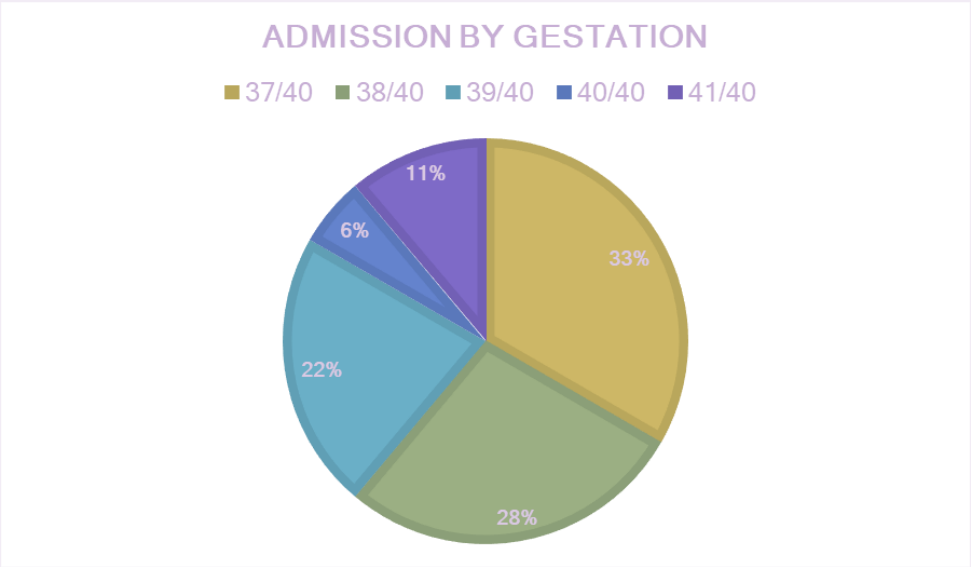
Oct 2022 **P21921** Communication and compassion postnatally	**Update & learning** The matron spoke to the patient and apologized and has also met with the member of staff and helped her reflect on how her actions were experienced by the woman. She was very sorry she had caused any distress. She explained she was concerned about the woman. The Matron explained that there are ways to communicate a concern, in a courteous, sensitive manner following a discussion with the midwife caring for the woman and her baby. **Learning:** treat all patients with respect, taking time to understand their experience, their needs and the agreed plan of care, before commenting or correcting them on any aspects of their
C22069 Care provided to parents postnatally when a baby required neonatal care	The DoM is discussing this with the staff involved. **Learning:** the importance of ensuring that families have the specific care they need, that responds directly to their needs and individual situation – rather than what might be perceived as generic postnatal care. Some practical issues, linked to transport availability which will be difficult to resolve

	unfortunately. Ensuring effective communication between hospitals
Actions from complaint responses	
ensure staff understand the impact of their actions :on a woman when her previous history, or wishes are not respected	Learning from complaints is discussed at every opportunity, including Clinical Governance meetings, Forum, Staff meetings and newsletter. Also, an opportunity for role modelling is used when senior members of the team work clinically. The preceptorship lead midwife has discussed with the newly qualified midwives (NQMs) how best to support them and this has been shared with the senior midwifery team (particularly those who coordinate). She meets with all NQMs for a 1:1 every month and often works with them on the ward, as required. We have recently reminded staff that NQMs must not have a student with them until >6 months into their new post. The practice Educator Team incorporate learning from incidents into their scenarios (where appropriate) and a careful explanation of what is happening, to the woman and her partner, have been incorporated.
Mrs Hartley will discuss your experience anonymously in the Clinical Governance meeting and with her senior midwifery team as an opportunity for reflection and learning	
To provide careful explanations of events taking place during the birth process	
To ensure newly qualified midwives are fully supported when caring for women	
To remind midwives in their newsletter, that the anaesthetist must be asked to review a women if the epidural is not effective within half an hour of it being sited	
The importance of recording women's birthing preferences and discussing with them why it might not be possible to fulfill their request	

ATAIN – avoiding term admissions into neonatal services

learning points and action plan for May 2022 – June 2022

18 infants were admitted to SCBU during this period and separated from their family for the purposes of care. Below are a three charts detailing, Gestation at time of birth, Mode of onset of labour and Indication for admission.


ADMISSION BY GESTATION
37/40
38/40
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41/40
33%
28%
22%
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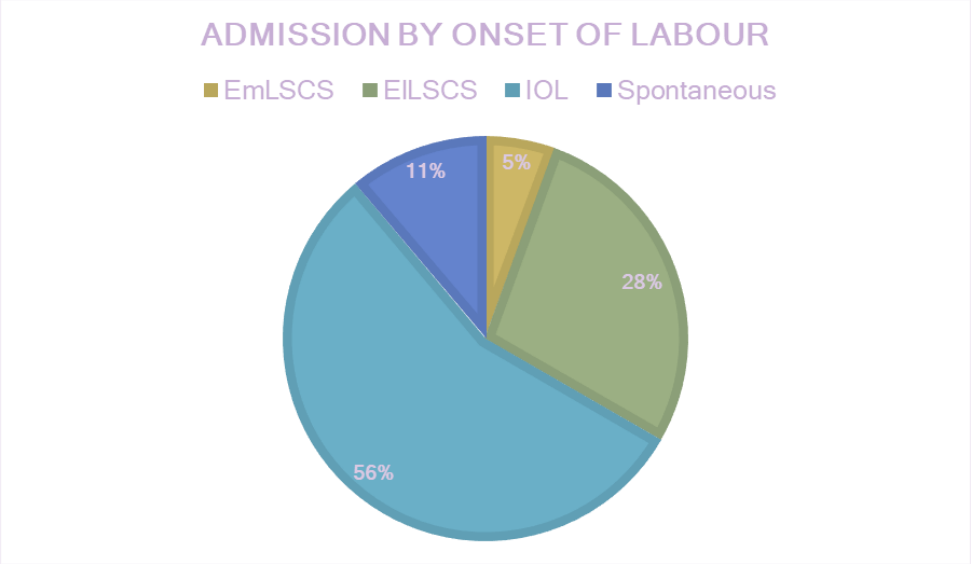
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EmLSCS
ElLSCS
IOL
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5%
28%
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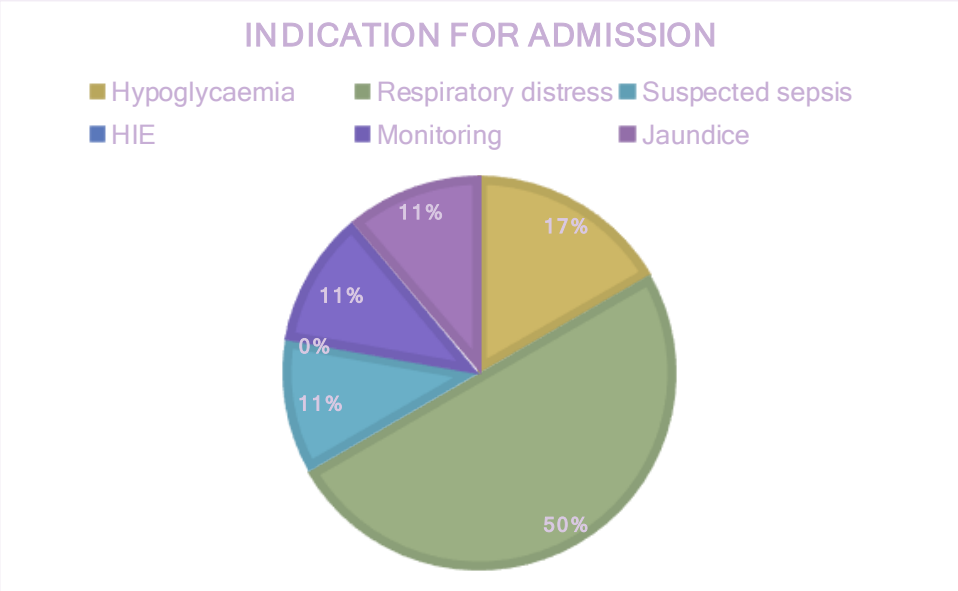


All 18 cases were reviewed by the ANNP and postnatal lead midwife.

Below is the summary of the learning points and actions to be taken after the review of this data.

During this time frame we had 2 infants who required transfer to a tertiary unit, and one infant whose care was reviewed as part of a child death review. This latter case was therefore not reviewed in this data.

Learning point	**action**
Early recognition of a deteriorating patient is essential to ensure timely assessment, care and reduce morbidity	KH to remind all staff of the importance of neonatal observations, charting them correctly on the NEWTT chart and completing the series
If an infant requires observations, it is essential that this series of observations are completed as per the guideline	KH to remind staff that a baby's temperature should be checked FIRST before an other action is undertaken on a baby
Babies undergoing blood glucose monitoring should routinely have a temperature checked, and this should be undertaken before another action is undertaken for the baby	Plans to formalize the transitional care of infants at DCH are ongoing. A meeting planned to move this project on further was unfortunately cancelled, a new date is to be organized
Paediatric staff should ensure some documentation on the maternity BadgerNet system when an infant is transferred over to SCBU. This informs the midwife of the care but more importantly, the parents have a record of where their baby ha gone (this of course does not negate the need to discuss this with the parents face to face)	KH to remind paediatric staff again about the importance of documenting neonatal unit admission both on Neonatal BadgerNet and on Maternity Badgernet

Outstanding actions form last review

Remind staff through the maternity newsletter of the appropriate use of the normothermia guideline, including escalation of care flowcharts

Current Maternity Safety Guidelines and SoPs in Development

Morbidity including M&M meetings

Overview case 1	Overview case 2
Learning and Actions Lack of neonatal cot availability on Trust's agenda and Risk Register and the ODN aware. QUiPP App Toolkit to be utilised by obstetric team.	Learning and Actions Very challenging case for all involved. Placenta not sent to histology. This may have provided some explanation as to the cause of the suspected antenatal insult. Ongoing work by safety team on this subject at present. Aspirin indicated but not documented as being taken. Family supported by Paediatric Team to spend time with baby at a nearby Lake and taking baby for a walk in their pram to make memories.

Training

MATERNITY STAFF COMPLIANCE for MANDATORY TRAINING
Nov 2022
(covering the period up to and including 30th Nov, 2021-17th Nov, 2022)

Training	Staff grade	Percentage of attendance
PROMPT (Practical Obstetric Emergency Procedure Training)	**Obstetric Anaesthetists**	82.6% ****
	Obstetric Consultants	100%
	Doctors (Reg/SHO)	41% *
	Midwives	90% ***
	MSW	68% **
BLS	**Obstetric Anaesthetists**	77.5%
	Obstetric Consultants	75%
	Doctors (Reg/SHO)	88.5%
	Midwives	90%
	MSW	86%

NLS (4 yearly accredited course)	**Senior Midwives/Homebirth Midwives**	96.5%
NLS (yearly update)	**Midwives**	92%
K2 – Fetal monitoring	**Doctors** **Midwives**	88% 96%

*New doctors on rotation, recently joined the Trust will be allocated as a priority over the next 2 sessions)
**MSW to be allocated to PROMPT during the next three months… sickness and cancelled PROMPT session account
*** 7% midwives are out of date due to Sept PROMPT cancellation due to staff shortage
**** 13% more Anaesthetists would have been compliant if PROMPT Sept wasn't cancelled

K2 – reduction in compliance for doctors as new trainees started who haven't completed K2 yet
Attendance at Fetal monitoring sessions

- 4 doctors have attended at least one session
- 94 midwives have attended one or more sessions

Neonatal MDT training day

well attended by 7 Paediatric Consultants and 4 neonatal nurses.

Topics covered

1. Technique for attaching the Neo-Fit ET holder;
2. LISA surfactant administration - focus on technique, use of glidescope for intubation and method of slow administration of surfactant.

3. Application of CFAM monitors - used grapefruits to practice needle insertion/securing and starting the monitor.

4. Review of guidelines/paperwork/Badgernet and process for consistency of medical reviews on SCBU (lively discussions!)

5. M&M meeting online

6. Nursing skills and drills - chest drain insertion

7. Talk from Kath Kopecky (Paediatric Physio) re FINE and neurodevelopment.

A second day is planned before Christmas

Medical cover has been managed effectively with no episodes of consultants acting down and all shifts covered by DCH specialist doctors or trainees. 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 Current position

	Safety Action	Minimum evidential requirement	RAG	Position/Challenges/Concerns
1	Using the perinatal Mortality Review Tool (PMRT) to the required standard to review perinatal deaths	Reporting of cases between 6/5/22-5/12/22		This can now be signed off as completed
2	Submitting the Maternity Services Data Set (MSDS) to the required standard	By Oct 22 – Digital Strategy for maternity aligned with wider Trust Digital Strategy - must be shared with the LMNS and be signed off by the ICB. Trust Boards to assure themselves at least 9 out of 11 Clinical Quality Improvement Metrics (CQIMs) have passed data quality criteria in "*CNST Maternity Incentive Scheme Year 4 Specific Data Quality Criteria"* data file in the **Maternity Services Monthly Statistics publication series** – the national Maternity Services Dashboard will still display the **July data** used for submission. Data for July 2022 will be published and submitted for quality check (QC) during September 2022.		This can now be signed off as completed
3	Following the Avoiding Term Admissions into Neonatal units (ATAIN) programme transitional care (TC) recommendations to minimise separation of mothers & babies	Quarterly report to Safety Champions and Board There is an explicit staffing model Audit trail providing evidence of ongoing audit from year 3 of MIS, of care pathways into transitional care (TC), completed minimum quarterly (point b). If reviews paused, they should recommence using data from quarter 1 of 2022/23 financial year. Audit findings shared with neonatal safety champion quarterly. Audit trail providing evidence and rationale for developing agreed action plan addressing local findings from pathway audit (point b) and ATAIN reviews (point f). Where barriers to full implementation of the policy encountered, agree action plan overseen by Board & neonatal safety champion. Pathway of care into transitional care fully implemented and audited quarterly. Audit findings shared with neonatal safety champion, LMNS, CCG and ICS quality surveillance meeting quarterly. Evidence that term babies transferred or admitted to a neonatal unit are reviewed quarterly and findings shared quarterly with maternity and neonatal safety champions and Board level champion, the LMNS and ICS quality surveillance meeting.		ANNP and MIS lead MW working together to establish criteria for TC at DCH and agree the pathway – since BadgerNet introduction a new way of identifying and coding TC is required. NHSR contacted to ascertain correct criteria/definition of NNU cited in MIS – is this level 2&3 or does it include the level 1 SCBU? Reviews of term babies happen monthly and are reported via the maternity safety report at least bi-monthly – themes and trend are identified, and an action plan formed TBC

				As above.
4	Demonstrating an effective system of clinical workforce planning to the required standard	**Obstetric medical workforce** Board level sign off acknowledging engagement with RCOG workforce document* + action plan to review any non-attendance to clinical situations listed in the document (by exception via RISK). Evidence position with Trust Board, Board level safety champions and LMNS meetings at least once from relaunch of MIS year 4 in May 2022. 1. By 16 June 2022 2. By 29 July 2022 then monitored monthly. **Anaesthetic medical workforce** Rota should be used to evidence compliance with ACSA standard 1.7.2.1. Any six-month period between August 2021 and 5 January 2023 **Neonatal medical workforce** Formally record in Trust Board minutes whether it meets the recommendations of the neonatal medical workforce. If requirements not met, Board should evidence progress against the action plan developed in year 3 of MIS to address deficiencies. Undertake a review in any 6-month period between August 2021 and 5 January 2023 **Neonatal nursing workforce** Neonatal unit meets the service specification for neonatal nursing standards. If requirements not met in both year 3 and 4 of MIS, Trust Board should evidence progress against the action plan developed in year 3 of MIS and include new actions to address deficiencies. If requirements were met in year 3 without the need of developing an action plan to address deficiencies, however they are not met in year 4, Trust Board should develop an action plan in year 4 of MIS to address deficiencies and share with the Royal College of Nursing, LMNS and Neonatal Operational Delivery Network (ODN) Lead. Nursing workforce review undertaken at least once during year 4 reporting period between August 2021 and 5 January 2023.		**Roles and responsibilities of the consultant providing acute care in obstetrics and gynaecology* Currently any incidents of nonattendance by a Cons Obs are Datix reported and investigated accordingly. The document was recently recirculated to the cons body and will be discussed and minuted at the next Cons meeting. Anaesthetic Cons safety champion asked for this No update A review was completed in 2022 and a business case submitted and supported to provide additional funding for the nursing and untrained workforce. The neonatal service is now fully staffed. There is also external funding supporting a practice educator role.
5	Demonstrating an effective system of midwifery workforce planning to the required standard	In line with midwifery staffing recommendations from Ockenden, Trust Boards must provide evidence (documented in Board minutes) of funded establishment being compliant with outcomes of BirthRate+ (BR+) or equivalent calculations. Where Trusts are not compliant with a funded establishment based on BR+ or equivalent		BR+ was completed in early 2021 and was referenced in the LMNS led submission to NHSE for funding in relation to Ockenden. A detailed workforce review is currently underway, and completion is expected in the Autumn.

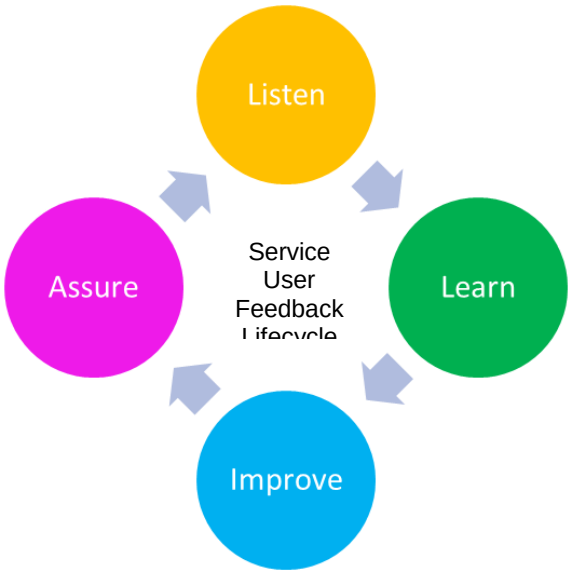
		calculations, Board minutes must show agreed plan, including timescale for achieving appropriate uplift in funded establishment. The plan must include mitigation to cover any shortfalls and be shared with CCG. Reporting between 6 May 22-5 Dec 22		However, the Board continue to support over recruitment of MWs and MSWs
6	Demonstrating **≥** 95% compliance with all five elements of the Saving babies Lives (SBL) care bundle	See SBL update for detail of elements 1-5 The quarterly care bundle survey should be completed until full implementation including data submission requirements		Quarterly care bundle survey completed and submitted in July. Action plan compiled to reflect failing element (CO monitoring) actions.
7	Demonstrating a mechanism for gathering service user feedback and working with the Maternity Voices Partnership (MVP) to co-produce local maternity services	Minutes of MVP meetings demonstrating how service users are listened to and how regular feedback is obtained, actions in place to demonstrate listening has taken place and evidence of service developments resulting from coproduction between service users and staff. Evidence the MVP Chair is invited to attend maternity governance meetings and actions from maternity governance meetings, including complaints' response processes, trends, and themes, are shared with the MVP. 6th May-5th Jan reporting period		This can now be signed off as completed
8	Evidence the training programme includes all six core modules of the core competency framework over the next three years	**A local training plan** in place ensuring all six core modules of the Core competency Framework, are included in training programme over next 3 years. (Trusts only need to focus on the 6 core elements – minus 2 relating to COVID (core modules 7 and 8) 90% compliance of each relevant staffing group attending annual multiprofessional training for; maternity emergencies; intrapartum fetal monitoring and surveillance; immediate resuscitation of the newborn and deterioration of the newborn. (18-month timeframe for reporting)		This can now be signed off as completed
9	Demonstrate robust processes to provide Board assurance on maternity & Neonatal safety and Quality issues	**Perinatal-quality surveillance report** Board level safety champions present a locally agreed dashboard to the Board quarterly, including the number of incidents reported as serious harm, themes identified, and actions being taken to address any issues; staff feedback from frontline champions and walkabouts; minimum staffing in maternity services and training compliance are taking place at Board level no later than **16 June 2022**. NB, the training update should include any modifications made because of the pandemic/current challenges and a rough timeline of how training will be rescheduled later this year if		This can now be signed off as completed

		required. This additional level of training detail will be expected by 16 June 2022. Evidence of bi-monthly engagement sessions (e.g., staff feedback meeting, staff walk around sessions etc.) being undertaken by a member of the Board. Board level safety champions have reviewed the continuity of carer (CoC) action plan in the light of Covid-19. A revised action plan describes how the maternity service will work towards CoC being the default model of care offered to all women by March 2024, prioritising those most likely to experience poor outcomes. Evidence that the Trust claims scorecard is reviewed alongside incident and complaint data and discussed by the maternity, neonatal and Board level safety champions to help target interventions aimed at improving patient safety at least twice in the MIS reporting period at a Trust level quality meeting. This can be a board or directorate level meeting.		
10	Evidence of reporting 100% of qualifying cases to Healthcare Safety Investigation Branch (HSIB) and to NHS Resolution's Early Notification (EN) scheme	100% of all appropriate cases referred to HSIB and NHSR Early Notification scheme (EN) from 1st April 21 until 5th December 22 1. A) Reporting of all qualifying cases to HSIB from 1 April 2021 to 5 December 2022 2. B) Reporting of all qualifying EN cases to NHS Resolution's Early Notification (EN) Scheme from 1 April 2022 until 5 December 2022 C) For all qualifying cases which have occurred during the period 1 April 2021 to 5 December 2022, the Trust Board is assured that: 1. the family have received information on the role of HSIB and NHS Resolution's EN scheme; and 2. there has been compliance, where required, with Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in respect of the duty of candour.		This can now be signed off as completed

Service user feedback

Model of engagement

Our model of engagement is designed to ensure that our people will not only be able to influence decision-making in an informed way, but it also allows for continuous feedback on how views, aspirations and experiences will make a difference. We believe by demonstrating tangible change - 'you said, we listened and learned'- we will secure wide and representative interest. The model ensures we have meaningful service user and staff involvement at every level.



Listen

We use a variety of formal and informal mechanisms to ensure our service users have a voice and can feed back their experience of receiving maternity care at Dorset County Hospital (DCH).

Feedback Mechanism	Provider	Frequency
Friends & Family Test (FFT)	DCH	Monthly
Picker Survey	CQC	Annually
Debrief Service	DCH	Sporadic
Compliments & Complaints	DCH - PALS	Sporadic
Maternity Voices Partnership (MVP) • Social Media • Unit visits – Meeting with families	CCG	 Sporadic Monthly
Bereavement Team • Individual cases • Forget-Me-Not Group	National Bereavement Care Pathway (NBCP)	Sporadic Monthly
The 15 steps for Maternity	NHS	Periodic
Direct Service User Contact • Contemporaneous concerns • Cards/Gifts/Donations • Team meetings	DCH Staff	Sporadic
Incidents & Investigations	HSIB/DCH/Perinatal Mortality Review Tool	Sporadic

Learn

Feedback is collated and shared in differing formats and a variety of forums and routes.

Feedback Mechanism	Format	Forum/Route
FFT	• Spreadsheet • Infographic • Individual comments • Themes &	• Managers – used to collate data • Display board in Unit Shared on MVP Social Media Shared on staff Facebook group • Sent to staff named

	Trends	• Governance forums • Quality & Safety Report
Picker Survey	• Report	• Shared Publicly • Shared within Organisation • Shared with Maternity & Neonatal Teams
Debrief Service	• Summary findings • Themes & Trends	• Email to DOM, Governance Lead & Consultant Obstetrician • Email to staff involved copying in managers • Governance Forums
Consultant led Postnatal Clinic	• Email summary • Letter to woman	• Shared with relevant manager for action • Governance framework • PALS
Compliments & Complaints	• Emails Cards Gifts Letters Verbal	• Governance forums • Shared with team Physically (gifts & cards) Email Maternity Newsletter • Quality & Safety Report
Maternity Voices Partnership • Social Media • Unit visits – Meeting with families	• Email • Report	• Most appropriate avenue • Pertinent areas/staffing groups • Governance Forums
Bereavement Team • Individual cases • Forget-Me-Not Group	• Survey/verbal • Verbal	• Bereavement Team meetings • Governance Forums • PALS
The 15 steps for Maternity	• Toolkit Crib sheet	• Safety Team/Governance Lead
Direct Service User Contact • Contemporaneous concerns • Cards/Gifts/Donations • Team meetings	• Verbal • Miscellaneous • Verbal	• Recorded via email/letter/PALS • Minutes/action tracker
Incidents & Investigations	• Datix • RCAs • Case Reviews • Reports	• Governance Forums Safety Team meeting Maternity Newsletter Team meetings Individuals

Improve

For families' experience to truly influence service provision and decisions, feedback must be collated from touchpoints throughout the childbirth continuum whether reactively through Friends and Family Test (FFT), PALS - complaints/compliments, birth debriefs and investigations or proactively through public and service user involvement work via the Maternity Voices Partnership (MVP); site visits; workshops; focus groups and social media, the press, MP letters, user participation groups or user experience stories. The information collected from these sources comes together in one place to be aggregated and analysed and then triangulated against information from Datix, incidents and nationally collated data.
We also include patient experience garnered via health care professionals such as health visitors and GPs.

The five domains of the family's experience used to theme the information and improvement tactic

Theme	Improvement tactic	Example
Safe high-quality care	Local responsive training and education programme (closing the loop of learning)	Practice development midwives' part of safety team, local cases identified are used to provide contextualized learning opportunities.
Kindness & compassion	Service user story	Bereaved couple highlighted language & terminology used required improvement. Bespoke study day arranged with their input as keynote speakers.
Informed choice & personalisation	Case review & presentation through governance framework/forums – include service user voice	Clinical care reviews presented, and outcomes discussed. Multiprofessional discussion & learning with good practice points highlighted as well as other options and recommendations. Actions identified and tracked at successive meetings. Meetings recorded for wider accessibility.
Access and waiting	Identify barriers	Health equity audit identified disproportionately disadvantaged minority groups. Working party established via LMNS & ICS to address issues associated.
Family friendly	Personalised Care Planning	BadgerNet utilised to provide a framework of pertinent questions to recognise individual family circumstances and identify a suitable, supportive care pathway that meets the family's wishes, beliefs and needs.

Assure

User satisfaction will be monitored, measured, and assurance provided via a variety of formal and informal routes.

Formal	Informal	Example
Picker Survey		Benchmarking & ratings from previous years
CQC Inspection		Caring, effective & Responsive Domains ratings
Ockenden Insight Visit		IEA 2 – listening to women & families. Insight team feedback via CCG
MVP • Focus Groups • Surveys	MVP • Social media • Unit visits	Monitoring of themes & trends
PALS		Compliments & Complaints collation

Theme	Feedback mechanism	Feedback
Safe high-quality care	October FFT	The care and attention given to me has been exceptional and I don't say that lightly. I've found the whole experience scary but wouldn't feel so

	Dorset MVP Survey	positive if it wasn't for such caring, knowledgeable, and truly loving staff from all professions. The staff here are a credit to the NHS, and I seriously will never forget their kindness. I saw many people to mention here but everyone was absolutely wonderful - particularly midwife's Sarah, Emma Lewis, Nat Burdett, Abbi Stevens and Jen Green, Linda Galloway who helped me during labour. --- The only area for improvement could be the communication between the staff dealing with incoming patients and those calling them. I've been in a couple of times at the request of a midwife to deliver a sample and the team haven't been aware of why I was coming in.
		Good: Some midwifes are so caring and respectful in nature... keep their promises while doing their profession. I don't remember all the names because I was in labour after my premature rupture of membrane for more than 24 hours of delivery, when I called to them to inform in the morning, from that time till my hospital discharge time,, my journey is memorable especially for labour unit that how they called to doctor on my request to see my progress and explanation for doing vaginal delivery with forceps and episiotomy and epidural their consequences and risks... Am also in nursing profession from my background and I love that much clearance in explanation... Thank you for everything... only some things.. am not saying that they are wrong, may be in that situation it happens like I felt more that 2 or 3 pricks while taking spinal Epidural and that didn't wait to stop my contractions for 2nd time, No doubt first time they wait. But anyways whole experience is superb, and I will prefer next time to take the same service and sorry for anything if you don't understand because my first language is not English
		My midwife adapted my labour room so that we could recover in private in there after the birth. Every professional coming in to do checks were lovely, supportive and v knowledgeable. I had complications following the birth and rang the postnatal team number a day after returning home. They rang back and supported me and as I deteriorated, they asked me to immediately come back to the postnatal ward for observation and assessment. They provided me with a private room straight away and got my husband a bed as well. The anaesthetist team were so professional and informed me what was happening every step of the way. I had a blood patch done and felt calm and supported throughout. I felt better rapidly afterwards. The care I received was exemplary. The team have been ringing me regularly at home to check on my recovery. Thank you to everyone I encountered at DCH, you have a brilliant maternity unit.
		I had to ask multiple times for pain relief. I had to ask multiple times to be taken off tracing when I knew I was in established labour but no one was there to check. I barely saw a midwife at all throughout my (very quick) labour.
		Staffing levels really affected our labour and I felt very worried and stressed leading to labour. We had our induction pushed or start stopped over five days and during were constantly told mixed messages or not fully given the truth.
		Some parents I spoke to had babies in SCBU, they informed me that they

	MVP representative 'walk the patch' unit visit	have been able to visit whenever they have wanted to, including in the evening. They felt very well informed and up to date with all that was going on. A particular positive comment was a common theme when speaking to the families 'The midwife dealing with us has been absolutely brilliant, as has all of the team'
Kindness & compassion	MVP Facebook page – comments posted underneath the infographic depicting October birth stats	
	----------	----------
	October FFT	Grace Bertie has always been very informative and put my mind at ease. Clemmie has always been friendly and very knowledgeable when I've had to pop in for an additional check. Every member of staff has been friendly and reassuring. ---------- Sharon has been lovely with our antenatal appointments the past couple of times going. Michelle has been so supportive with my anxiety, she's helped with running the Thursday evening classes and my husband and I really appreciate her as she's been so caring, she has taken time out of her day in spare time to talk to me about my anxiety and give advice. When pushing the buzzer for assistance the midwife attended quickly and all have been friendly and helpful
	----------	A first-time mum mentioned that she was having some issues with feeding and after raising this the midwife is arranging to send extra support for her when her baby was due the next feed. She told me she felt supported and encouraged.
	Dorset MVP representative 'walk the patch' unit visit	
Informed choice & personalisation	1. Dorset MVP Survey 2022 2. October FFT	1. Previous emergency c-section, handwriting of surgeon could not be read so it was unclear whether a VBAC or repeat section was recommended for subsequent births. High stress/anxiety led to last min c-section decision 2. Very informative classes. We learnt a lot from the sessions. It was really good getting information based on the hospital we will be going to. 3. Everyone was so friendly and attentive, supportive, and individualised my care. Very differing opinions and advice given regarding breast feeding which was confusing to know what advice to follow. 4. I was supported with the info so in order to make the choice to be induced, which I think was the right choice as the baby's heart rate kept dropping during labour.

		5. Emma Farmer used her experience to get me into different positions (epidural allowing) where the baby was happier, and his heart rate was normal. She listened to me saying I really would like to avoid the C-section if possible and really worked with me to get me there. I was so delighted to have a vaginal birth and that my baby latched straight away and had no problems feeding. My first baby had forceps and it took a while to get breastfeeding established. 6. Staff all very friendly. They treated us all well and with respect during a potentially stressful time. Everything was explained well and without confusion.
Access & waiting	October FFT	I like that reminders are sent via text; appointments were available and good timings. Staff were always friendly and helpful
		Only thing is, we're still awaiting blood test results a day later that were due back within 2-3 hours
		I had planned a home birth. Called when in labour to say no midwives available. Turns out service was cancelled. Midwives aware I was close to labour waters already gone that morning and not informed that homebirths that evening would not happen.
	Dorset MVP survey	My induction took place on a bank holiday Monday, with some complications from the Friday onwards meaning I needed to access the hospital over the bank holiday weekend. Because of this, and the lack of staff, I was denied certain scans and was given no flexibility about my induction date. I also was not fully informed about how long and invasive a process induction was, and how long I was likely to be in. While each individual member of staff I spoke to was lovely, everyone seemed to assume that someone else had kept me informed, and no consideration was given to the fact this was my first pregnancy.
		Quite a few comments to say that Badger Notes had worked well for them, they found them useful and could see blood results and scans.

Friends and Family – you said, we did (as provided to Patient Experience Team)

Feedback	Mood	Theme	We Did
3: My first allocated midwife wasn't good. She got answers wrong from the initial call and keep coming up on the system, and it's very uncomfortable. Don't feel much warmth from the team. No one is on time Was referred to a physio which i didn't realise I was, then she called, late, and was appalling.	Negative	Compassion	Unfortunately, it is very difficult to action this without being able to follow up with the patient. We have a physiotherapist on the ward now regularly so where possible, there is F2F consultation rather than a referral without a first F2F. if it is possible to identify the patient, I am keen to discuss this further

Labour line were great with recognising when things were progressing. Tessa was incredible, with us throughout and explaining everything so well. I particularly noticed how well everyone was with asking for consent before anything and respecting my wishes. Only thing that could be improved is explaining what the discharge process is after birth and how long we should expect to stay in hospital as we didn't realise we needed to ring the bell for anyone to come	Mixed	Communication	I have communicated with the postnatal midwifery team about ensuring women understand the discharge process
2: All the staff were amazing and we felt very cared for throughout labour. The only reason for not choosing very good over good was that on the antenatal ward and postnatally we could sometimes feel a bit neglected due to how busy the ward was and staff needing to prioritise how they spent their time.	Mixed	Regular Checks	This comment relates to staffing, which is still challenging on many shifts, particularly night shifts. We have recruited 10 new midwives and 6 MSWs and three as-and-when midwives. All but 2 substantive midwives have started work now as have all the MSWs. To improve the staffing on nights, all staff with special arrangements (releasing them from night work) are being reviewed with a number of midwives (including the Director of Midwifery) working some regular nights to improve the staffing. Unfortunately, we have 2 LTS within the nightcore team and two midwives changing from nightcore, to a standard working pattern.
2: All the staff were amazing and we felt very cared for by each and every one. The only reason for not choosing very good over good was that we could sometimes feel a bit neglected due to how busy the ward was and staff needing to prioritise how they spent their time. For instance being told that we could go home if a blood test was ok at 6pm but delays with seeing the paediatrician and getting stickers printed meaning we didn't actually leave the hospital until after 9pm.	Mixed	Regular Checks	This comment relates to staffing, which is still challenging on many shifts, particularly night shifts. We have recruited 12 new midwives and 6 MSWs and three as-and-when midwives. All but 2 substantive midwives have started work now as have all the MSWs

Report Front Sheet

1. Report Details			
Meeting Title:	Board of Directors, Part 1		
Date of Meeting:	30 November 2022		
Document Title:	**Review of Report into East Kent Maternity and Neonatal Services**		
Responsible Director:	Emma Hoyle, Acting Chief Nursing Officer	Date of Executive Approval	15/10/22
Author:	Emma Hoyle, Acting Chief Nursing Officer		
Confidentiality:	No		
Publishable under FOI?	Yes		
Predetermined Report Format?	No		

2. Prior Discussion		
Job Title or Meeting Title	**Date**	**Recommendations/Comments**
Quality Committee	22 November 2022	

Purpose of the Paper	*Note (✓)*	✓	*Discuss (✓)*	✓	*Recommend (✓)*		*Approve (✓)*	

3. Executive Summary	• To share with committee members summary of the Independent Investigation into East Kent Maternity Services • Demonstrate actions already effectively implemented by maternity teams at DCHFT following the Ockenden Inquiry • Note Maternity Safety Report will continue to provide assurance to Quality Committee on actions relating to both the Ockenden and East Kent reviews • Divisions to reflect on how recommendations can be applied to all aspects and specialties in clinical care.
4. Action recommended	The Board is recommended to: 1. **NOTE** the report 2. **RECEIVE** assurance on actions to address any performance issues 3. **AGREE** the key points, risks & concerns to be reported to the Board

5. Governance and Compliance Obligations			
Legal / Regulatory Link	**Yes**		Inability to achieve progress or sustain set standards could lead to a negative reputational impact and inability to improve patient safety, effectiveness and experience.
Impact on CQC Standards	**Yes**		As this report incorporates standards outlined by the CQC it is important to note progress or exceptions to these standards.
Risk Link	**Yes**		Links to Board assurance Framework

Impact on Social Value		**Yes**	**No**	
Trust Strategy Link		The quality of our services in providing safe, effective, compassionate, and responsive care links directly with strategic objectives		
Strategic Objectives	People	Credibility of Trust		
	Place	Serving the population of Dorset		
	Partnership	System working to achieve high standards of care		
Dorset Integrated Care System (ICS) Objectives		**Which Dorset ICS Objective does this report link to / support?**		
Improving population health and healthcare		**Yes**		
Tackling unequal outcomes and access		**Yes**	**No**	
Enhancing productivity and value for money		**Yes**	**No**	
Helping the NHS to support broader social and economic development		**Yes**	**No**	
Assessments		**Have these assessments been completed?** *If yes, please include the assessment in the appendix to the report..* *If no, please state the reason in the comment box below.* *(Please delete as appropriate)*		
Equality Impact Assessment (EIA)		**Yes**	**No**	
Quality Impact Assessment (QIA)		**Yes**	**No**	

Independent Investigation into East Kent maternity Services – October 2022

Report Summary

On 19th October 2022 the Independent Investigation into East Kent Maternity Services was published by Dr Bill Kirkup CBE. The investigation was launched by the then Minister of Patient Safety, Nadine Dorries MP, following concerns about the deaths of a number of babies in recent years.

The report revealed that over 11 years there was substandard care, a dangerous culture and a failure by the Trust's management to act on warnings cause to or contributed to:

- The deaths of at least 45 babies
- 12 babies suffering avoidable brain damage
- 23 mothers suffering avoidable injury or, tragically death

Figures showed that had better care been given to nationally recognized standards, the outcome could have been different in 97 of the 202 cases reviewed. It is noted that there were more maternity care failings that were not investigated.

Key Headlines

The report identifies four areas for action:

- Identifying poorly performing units – planned introduction of national safety monitoring to compare outcomes in detail
- Giving care with compassion and kindness – improvements in standards of behaviour
- Teamworking with a common purpose – action to resolve 'dysfunctional' teamwork
- Responding to challenges with purpose – action to force organisations to stop putting 'reputation management' above honesty

This report is the second analysis of NHS maternity services to be published this year. In July 2022 the Ockenden Report into Shrewsbury and Telford NHS Trust found that poor care led to the avoidable deaths of 201 babies. A further inquiry has since begun at Nottingham University Hospitals NHS Trust headed by Donna Ockenden.

DCHFT Recommendations

Our Trust values are Integrity/Respect/Teamwork/Excellence. All of these are interlinked, and you cannot demonstrate one without the other. If there is a break in the chain then the Trust is at risk of poor performance putting patients and staff at risk. Recognising that this report relates to maternity services it is also acknowledged the application of the recommendations across clinical services.

Considering the report and recommendations the following actions are in progress:

- The report has been shared widely amongst clinicians including nurses and AHPs to consider at governance meetings.
- Divisions will incorporate recommendations into their governance framework if not already embedded
- The Trust CQC preparation group will recognise the themes to incorporate into their programme
- Maternity Services will continue to demonstrate actions and report via the monthly Maternity Quality and Safety Report to Quality Committee. As noted in the October 2022 Maternity Report work began immediately on the core recommendations.
- Ensure Trust Board is enquiring and examines the culture at DCHFT. Board needs to seek assurance that the leadership and culture at DCHFT positively support the care and experience provided.

It is of note that the Ockenden Assurance Visit in September 2022 was positive with full sign off of immediate and essential actions agreed. Examples of Maternity engagement/actions Appendix A, B and C). Posters are displayed around the unit for patients and staff to read.

The Executive Summary of the full East Kent report is included with the papers for reference.

Appendix A

Taking Actions on the Ockenden Report

The Ockenden report was published in December 2020 and contained 7 Immediate and Essential Actions (IEAs) to improve safety. These are some of the ways we are implementing these actions.

NHS Dorset County Hospital NHS Foundation Trust

At Dorchester we are proud of the safe, kind, personalised care we provide women and their families but there is always room for improvement. Everyone has their own unique part to play in our ambition.
Contact the Ockenden Lead: Lindsey Burningham with your ideas or for more information - lindsey.burningham@dchft.nhs.uk

Action		Standard required	Our plan	
1	Enhanced Safety	Trusts must work collaboratively ensuring serious incidents are investigated thoroughly and have Board oversight	We keep families front and centre at all times, including when things go wrong. Our focus is on learning and improvement.	Incident investigation

Action		Standard required		Our plan
2	Listening to women and their families	Maternity and neonatal services must ensure women and their families have their voices heard	Dorset MVP	Our MVP (maternity voices partnership) representative talks to our families and we use this feedback to improve the service.

Action		Standard required	Our plan	
3	Staff training & working together	Staff who work together must train together. There must be a consultant led ward round twice daily	Multiprofessional training is rostered for all staff and the education team are actively developing innovative training programmes in response to local incidents.	MDT Training

Action		Standard required		Our plan
4	Managing complex pregnancy	There must be robust pathways in place for managing women with complex pregnancies	Named Consultants	We have a number of Consultants who lead different specialties. Women are referred to the appropriate Consultant who is then the lead for their care.

Action		Standard required	Our plan	
5	Risk assessment throughout pregnancy	Pregnant women must have a risk assessment undertaken and recorded at each contact to include place of birth	Every time a woman is seen, the health professional must review the risks associated with her pregnancy and birth plan and make any necessary changes.	Antenatal care pathways

Action		Standard required		Our plan
6	Monitoring fetal wellbeing	Dedicated leads in fetal monitoring who champion best practice in fetal surveillance	Saving Babies' Lives bundle	Our fetal monitoring leads provide regular interactive online and face to face training. They review cases and use examples for improving practice.

Action		Standard required	Our plan	
7	Informed consent	Women must have access to accurate information to enable informed choice	maternitymattersdorset.nhs.uk has all the information a family need to plan their pregnancy, labour, and birth.	Support & information

INTEGRITY | RESPECT | TEAMWORK | EXCELLENCE

Appendix B

POSTNATAL CARE

FROM THE OCKENDEN INDEPENDANT REVIEW OF MATERNITY SERVICES

NHS
Dorset County Hospital
NHS Foundation Trust

- Women readmitted to the postnatal ward and all unwell postnatal women must have timely consultant review.
- We must ensure consultant review of all postnatal readmissions, and unwell postnatal women, including those requiring care on a non maternity ward.
- The postnatal ward must be adequately staffed at all times. Staffing levels must be appropriate for both the activity and acuity of care required during the day and night, for both mothers and babies.
- Unwell postnatal women must have timely consultant involvement in their care and be seen daily as a minimum.
- Postnatal readmissions must be seen within 14 hours of readmission or urgently if necessary

FOR MORE INFORMATION OR TO RAISE IDEAS CONTACT:

POSTNATAL LEADS

KEELY.VALLANCE@DCHFT.NHS.UK

GEMMA.WESTAWAY@DCHFT.NHS.UK

TARA.POINTER-PUTT@DCHFT.NHS.UK

OCKENDEN LEAD MIDWIFE

LINDSEY.BURNINGHAM@DCHFT.NHS.UK

INTEGRITY RESPECT TEAMWORK EXCELLENCE

Appendix C

Dorset County Hospital NHS Foundation Trust

INTEGRITY | RESPECT | TEAMWORK | EXCELLENCE

Final Ockenden Report

The final Ockenden Report was published in March 2022 - links to the report and key information below. Look out for further details about actions we are taking to ensure compliance with the Immediate and Essential Actions (IEAs) from the first and second report.

Initial Ockenden Report, December 2020 (7 IEAs)

We can evidence compliance for 6 of the 7 immediate and essential actions required to be completed by December 2021. Work is ongoing around the 7th (Place of birth risk assessment at every antenatal contact). We will continue to review each action and monitor compliance through monthly audits.

It is important for everyone working in maternity and neonatal care to be aware of the findings and recommendations of the report so we can learn and improve the care we provide together as a team.
For more information or to raise your ideas please contact Ockenden Lead Midwife Lindsey Burningham lindsey.burningham@dchft.nhs.uk

Ockenden Final Report Ockenden Report

Summary film (Donna Ockenden)

https://youtu.be/mX8H8cRL-jI

The report identifies four key pillars for the successful improvement of all maternity services

1. Safe staffing levels, properly funded
2. Well trained workforce
3. Learning from incidents
4. Listening to families

Snapshot of the 15 immediate & Essential Actions

1. Workforce Planning & Sustainability Includes specific standards for labour ward co-ordinators, HDU care and an emphasis on funding MDT workforce & staff training	**2. Safe Staffing** Focus on clear escalation processes and associated actions. for when staffing falls below minimum level.	**3. Escalation & accountability** Need for clear guidance which supports all staff to escalate clinical concerns. Clear processes ensuring units are staffed by appropriately trained staff at all times	**4. Clinical governance Leadership** Reinforces need for Trust Board oversight of maternity governance. Midwifery & obstetric leadership needed through governance, guidelines & audit	**5. Clinical governance, Incident investigation & complaints** Focus on investigations being meaningful for families and lessons being learnt in a timely manner in practice.
6. Learning from maternal deaths Standards around post-mortems, joint investigations & timely learning in practice	**7. Multiprofessional training** Continues to support MDT training in emergency skills, CTG & human factors	**8. Complex antenatal care** Focus on Maternal Medicine Networks, and care for women with multiple pregnancy, diabetes & hypertension	**9. Preterm birth** Systems & processes to support women at risk of preterm birth. Includes Saving Babies Lives V2	**10. Labour & birth** Includes care outside hospital setting, IOL pathways and centralised CTG monitoring systems
11. Obstetric anaesthesia Includes safe staffing, documentation, information for women & follow-ups. Determining a core dataset that must be recorded during every intervention.	**12. Postnatal care** Safe staffing for postnatal care, timely consultant reviews for women re-admitted or unwell postnatally	**13. Bereavement care** Focus on compassionate, individualised bereavement care available 24/7	**14. Neonatal care** Increasing neonatal critical care cots. Clear pathways of care with advice & support throughout the network	**15. Supporting families** Consideration of mental health & wellbeing of mothers, partners & whole family integral in all aspects of care. Access to specialist psychological support.

Recommendation

The Board is recommended to:

1. **NOTE** the report
2. **RECEIVE** assurance on actions to address any performance issues
3. **AGREE** the key points, risks & concerns to be reported to the Board

Name and Title of Author: Emma Hoyle Acting Deputy Chief Nursing Officer
Date:15/11/2022

next day BRIEFING NHS Providers

Independent Investigation into East Kent Maternity Services

In February 2020, NHS England and NHS Improvement (NHSE/I) commissioned Dr Bill Kirkup to undertake an independent review into maternity and neonatal services at East Kent Hospitals University NHS Foundation Trust. This followed concerns raised about the quality and outcomes of maternity and neonatal care. Dr Kirkup yesterday (19 October 2022) published his report of the investigation, *Reading the signals: Maternity and neonatal services in East Kent – the report of the independent investigation*.

The report is summarised below, along with NHS Providers press statement. We would encourage trust colleagues to read the report in full but if you have any comments about the report or this briefing, please contact Ferelith Gaze, head of policy and public affairs, (ferelith.gaze@nhsproviders.org).

Background

From 2010 onwards, a number of reviews raised concerns about maternity services at East Kent Hospitals University NHS Foundation Trust. In 2020, the inquest into the death of Harry Richford set out various reports and concerns to the coroner. On 13 February 2020, the then health minister, Nadine Dorries, confirmed in Parliament that NHSE/I had commissioned Dr Bill Kirkup CBE to undertake an independent investigation into maternity and neonatal services at the trust. The terms of reference were published on 11 March 2021.

The report

The investigation reviewed 202 cases where the families involved asked to participate and where their care fell within the scope of the investigation. The results of these case reviews draw on evidence from family listening sessions, clinical records and interviews with clinical staff and others. The investigation spans the period from 2009 – when foundation trust status was achieved – to the end of 2020.

The report comprises an open letter followed by:

- Chapter 1, setting out what the investigation found, missed opportunities to put things right, underlying failures that led to harm, and key themes that must be addressed in the response to these failures.
- Chapters 2 to 5, setting out the evidence behind the investigation's findings
- Chapter 6, drawing out the lessons with recommendations both for East Kent and nationwide
- Appendices setting out the terms of reference for the investigation, how it conducted its work and the investigation team

Illustrative cases are presented throughout the report, including but not limited to:

- A mother who was sent home and asked to wait before returning to hospital whose baby was stillborn
- A mother who experienced a traumatic birth and surgical injury, but who was made to feel ignored, marginalised and disparaged followed by a lack of transparency about what had happened and a failure to report and investigate a serious incident. The experience has meant she will never have a second child
- The death of Amber Bennington who died at nine days old following clinical mismanagement of her delivery
- The death of a baby from overwhelming streptococcal infection, whose treatment was delayed following his mother's concerns for one of her twins being dismissed and a trainee seeing no grounds for concern despite signs of an infection
- The death of a baby born with signs of brain damage following a labour known to be high risk, where no formal assessment of the risk to mother and baby of a home birth was made, the trust having advised against delivery in a midwifery-led unit
- A mother who reported reduced fetal movements, and who was sent home without discussion of the risks of delaying being induced. When she attended again to report no fetal movement for six hours, no heartbeat was found
- A baby left with significant brain damage following a delayed emergency caesarean section
- A mother who did not receive the advised preventive treatment to manage her raised risk of venous thromboembolism after an elective caesarean section, and subsequently died
- A mother who chose to follow the VBAC (vaginal birth after caesarean) pathway, but whose request for a caesarean section after experiencing excessive pain and a labour which did not progress, was initially denied. After four hours, her baby was found to have died and her uterus ruptured

In his letter to the secretary of state and the NHS chief executive, Dr Kirkup explains that the primary purpose of the report is to set out the truth for the sake of the families involved so that maternity services in East Kent can begin to meet the standards expected nationally for the sake of those to come. He also notes that events at East Kent were not one-off, isolated, failures and that maternity services have been the subject of more significant policy initiatives than any other service since his 2015 Morecambe Bay investigation report. Without tackling these issues differently, he expects there to be more in the future.

With this in mind, detailed changes to practice and management are not set out in the report. The focus instead is on four areas of action: identifying poorly performing units, giving care with compassion and kindness, teamworking with a common purpose, and responding to challenge with honesty. He also highlights the importance of using meaningful, risk-sensitive outcome measures in maternity services to identify results that are genuine outliers.

Chapter 1: Missed opportunities at East Kent – our Investigation findings

The maternity services in two hospitals, the Queen Elizabeth The Queen Mother Hospital (QEQM) at Margate and the William Harvey Hospital (WHH) in Ashford, between 2009 and 2020 were examined. The investigation found a clear pattern wherein, over this period, those responsible for the services too often provided clinical care that was suboptimal and led to significant harm, failed to listen to the families involved, and acted in ways which made the experience of families unacceptably and distressingly poor, both as care was given and in the aftermath of injuries and deaths.

The investigation found that the individual and collective behaviours of those providing the services were visible to senior managers and the trust board in a series of reports throughout the period and lay at the root of the pattern of recurring harm. At any time during this period, these problems could have been acknowledged and tackled effectively and eight clear separate opportunities were identified when that could have happened. The investigation's assessment of the clinical outcomes found that:

- Had care been given to the nationally recognised standards, the outcome could have been different in 97, or 48%, of the 202 cases assessed by the [investigation team] panel, and the outcome could have been different in 45 of the 65 baby deaths, or 69% of these cases.
- The panel has not been able to detect any discernible improvement in outcomes or suboptimal care, as evidenced by the cases assessed over the period from 2009 to 2020.

These numbers are understood to be minimum estimates of the frequency of harm over the period, and are based on the 202 volunteered cases.

Findings

The report recognises that most mothers and babies are healthy, but where things start to go wrong, problems can rapidly escalate. The investigation identified problems in:

- What happened to women and babies under the care of the maternity units within the two hospitals
- The trust's response, including at trust board level, with a lack of learning and undue assurance taken from the fact that the great majority of births in East Kent ended with no damage to either mother or baby
- The trust's engagement with regulators, including the Care Quality Commission (CQC), and the actions and responses of the regulators, commissioners and the NHS, regionally and nationally

The investigation questions how statistics are used to manage maternity services and believes that it should be possible for:

- individual trusts to monitor and assess whether they have a problem;
- the NHS regionally and nationally to identify trusts whose safety performance makes them outliers; and
- the regulators to differentiate the services provided more quickly and reliably.

What happened to women and babies

The investigation found that no single clinical shortcoming explains the outcomes of the cases examined, and the pattern of repeated poor outcomes should not be attributed to individual clinical error. Shortcomings in physical infrastructure, and workforce and resource shortages, were not found to be causative or sufficient to justify, explain or excuse the experience of the families. The geography, location and demographics of the hospitals were factors but again, should not have been regarded as explaining or justifying the service provided. Instead, the investigation found that the origins of the harm lie in failures of teamworking, professionalism, compassion and listening:

- *Failures of teamworking:* The investigation found gross failures of teamworking across the trust's maternity services, including dysfunctional working between and within professional groups, bullying, lack of mutual trust, and disregard for other points of view.

- *Failures of professionalism:* The investigation found clear and repeated failures, including staff being disrespectful to women. The investigation also found that midwives who were not part of the favoured in-group at WHH were sometimes assigned to the highest-risk mothers and challenged to achieve delivery with no intervention. This report describes this as a downright dangerous practice.

- *Failures of compassion:* The investigation heard many examples of uncompassionate care, including women's questions and concerns being dismissed, dealt with brusquely, ignored or disbelieved. This applied during their care and in the aftermath of injury and death.

- *Failures of listening:* The investigation found that in some cases, failure to listen contributed to an adverse clinical outcome. In others, it was part of a pattern of dismissing what was being said, which contributed significantly to the poor experience of families.

Failures after safety incidents

The investigation found that dysfunctional teamworking and poor behaviour marred the response by staff after safety incidents, including those incidents that led to death or serious damage. The report describes staff who failed to show compassion, denied responsibility or that anything untoward had occurred, and at times blamed mothers for what had happened. Where things went wrong, clinical staff, managers and senior managers often failed to communicate openly with families. Safety investigations, if conducted, were not undertaken in a way, to identify learning. The investigation found that where the nature of the safety incident meant that incidents could not be minimised, a junior obstetrician or midwife was often blamed.

Failure in the trust's response, including at trust board level

The investigation found that problems within teams were known but bullying and divisive behaviours were not effectively addressed.

The investigation also found that the trust board missed opportunities to identify the scale and nature of the problems and put them right. Although action plans were put in place they under-estimated the recurring pattern of failure, often attributing blame to individuals or individual clinical error. Repeated staff turnover exacerbated the tendency to treat problems as a one-off.

The actions of the regulators

The investigation found that the trust was faced with a bewildering array of regulatory and supervisory bodies, but the system as a whole failed to identify the shortcomings early enough and

clearly enough to ensure that real improvement followed. The report adds that it seems the plethora of regulators and others served to deflect the trust into managing those relationships as a priority. Tensions within the roles of regulators and professional bodies were also identified. When regulators did seek to help, these interventions did not secure the necessary improvements.

Missed opportunities

The most significant missed opportunities since 2009 were:

1. In 2010, an internal review report raised significant concerns about midwifery and obstetric management, midwifery staffing and skill mix, and resuscitation of babies showing signs of a shortage of oxygen. Recommendations were made regarding clinical practice, adherence to guidelines and review processes but no evidence was found that these recommendations were followed up.

2. From 2013, the clinical commissioning groups (CCGs) in East Kent raised concerns about the trust, including its maternity services, with NHSE and with the trust. They failed to gain traction with either and approached CQC, which subsequently inspected the trust in 2014.

3. In 2014, CQC rated the trust Inadequate overall, identifying a divide between senior management and frontline staff, governance and assurance processes that did not reflect reality, very poor staff engagement, poor reporting and investigation of safety incidents, and limited use of clinical audit. Maternity services were rated as "Requires Improvement". The report describes the reaction of the trust as defensive saying when action plans were drawn up, they were of poor quality and not effectively followed up.

4. In 2014/15, the new head of midwifery undertook a review, working alongside the trust's HR department, and found considerable evidence of a dysfunctional and frightening work environment. Those individuals identified as central to the issues were set to be relocated or suspended, but following their collective letter of grievance, the trust withdraw support from the review process. The head of midwifery was advised against disclosure by the Royal College of Midwives in the interests of patient safety. No further efforts were made to address the persistent bullying culture.

5. In May 2015, the head of midwifery at the trust noted the similarity of issues and lessons identified within the Morecambe Bay maternity services report and sought to raise similar

issues of concern with the trust leadership. The trust commissioned a report later in 2015 and found that it "was not another Morecambe Bay".

6. In February 2016, a Royal College of Obstetricians and Gynaecologists report made serious criticisms of the maternity services in East Kent.

7. On 9 November 2017, baby Harry Richford died in the neonatal unit at WHH, seven days after he was delivered at QEQM. Many of the same issues cited in previous inspections, reviews and reports appear again in Harry's case, the clinical management of his delivery, the care given to his mother, and the treatment of his family after his death.

8. In 2018, it became evident to the Healthcare Safety Investigation Branch (HSIB) that East Kent maternity services were an outlier because of the rate of occurrence of safety incidents resulting in serious harm. HSIB experienced difficulties in its dealings with the trust, including problems obtaining information, staff attendance at interviews, and support for the process from the trust's senior leadership team. HSIB's concerns increased over the course of 2018 and it sought a meeting with the trust's senior leadership team.

Where accountability lies

The report states that had any of the above opportunities been grasped, there would undoubtedly have been benefits in terms of avoiding death, disability and other harm, and in terms of the mental wellbeing of many families. However, the report authors are also clear that the issues here were systemic throughout the organisation and do not lie at the door of individual clinicians.

The report is clear that a series of failings at board level meant opportunities to identify and rectify failures were missed.

Key areas for action

Recent years have seen investigations including into maternity services in Morecambe Bay in 2015, in Shrewsbury and Telford in 2021/22, the East Kent investigation commissioned in 2020, and latterly Nottingham. To avoid adding multiple, overlapping recommendations which do not lead to sustainable improvement, this investigation identifies a limited number of key themes and recommendations. The investigation is also concerned to avoid the assumption that East Kent will be the last maternity service facing these issues. It therefore identifies four key areas for action that it believes must be addressed by all trusts and nationally.

Key Action Area 1: Monitoring safety performance – finding signals among noise

The report finds that a mechanism is needed to give early warning of problems before they cause significant harm. The aim must be for:

- every trust to have the right mechanism in place to monitor the safety of its maternity and neonatal services, in real time;
- the NHS to monitor the safety performance of every trust; and
- neither the NHS nor trusts to be dependent on families themselves identifying the problems only after significant harm has been done over a period of years.

The mechanism must be nationally standardised and is not optional. It will be based on:

- Better outcome measures that are meaningful, reliable, risk adjusted and timely
- Trends and comparators, both for individual units and for national overview
- Identification of significant signals among random noise, using techniques that account properly for variation while avoiding spurious ranking into "league tables".

Key Action Area 2: Standards of clinical behaviour – technical care is not enough

The investigation found frequent instances of a distressing and harmful lack of professionalism and compassion. Too often, well-founded concerns were dismissed or ignored.

A particular area of concern was the telephone advice given to mothers to stay at home if they were not adjudged to be in established labour. The investigation also found a pattern of poor behaviours by some obstetric consultants, particularly at QEQM. When addressing consultants' behaviour, the report found that the trust's actions were weaker than when dealing with midwives.

The report is concerned not to detract from the importance of employment protection, but at the same time questions the fact that behaviour which seriously threatens patient safety cannot be robustly addressed.

The report finds that there is a pressing need to understand better gross lapses of professionalism, compassion and willingness to listen, including their prevalence, the underlying causes, how they can be changed.

Key Action Area 3: Flawed teamworking – pulling in different directions

The report finds that teamworking in East Kent maternity services was dysfunctional. Many staff described "toxic", "stressful" working environments and poor relationships both within and between

professional groups. The failure of obstetric staff and midwives to trust and, in some cases, respect each other added a further significant threat to patient safety.

No systematic policy in East Kent maternity services was found of inappropriately favouring either unassisted birth or assisted vaginal birth in circumstances where this would place women and babies at risk. However, the way in which "normal birth" was described and set out in material for mothers created an expectation that it was an ideal that staff and women should strive to achieve.

The report authors believe that insufficient attention has been given nationally to the language that is used around "normality" and in the presentation of information among both maternity staff and mothers. The investigation is aware that some recent steps have been taken to improve this, but considers these insufficient to remove the risk of misunderstanding and misinterpretation.

The report found that there is a pressing need to understand the effects of the dynamics of training and education, and how changes made with the best intentions may have unintended consequences. More generally, it believes that it is time to think about a better concept of teamwork for maternity services – one that establishes a common purpose across, as well as within, each professional discipline.

Key Action Area 4: Organisational behaviour – looking good while doing badly

The investigation found that during the period under review, the trust prioritised reputation management to the detriment of being open and straightforward with families, with regulators and with others.

The investigation describes an unhelpful pattern of hiring and firing, initiated by NHSE, at leadership levels, including with regard to the roles of chief executive and chair. It states that while the practice may never have been an explicit policy, it has become institutionalised. The appointments that were made led the trust, and NHSE, to believe that things were changing when in fact the underlying shortcomings remained and created a flawed model based on "heroic leadership".

The report considers the problems of organisational behaviour that place reputation management above honesty and openness are both pervasive and extremely damaging to public confidence in health services. It cites a legal duty of truthfulness placed on public bodies has been proposed as one of the responses to the Hillsborough disaster.

Chapter 2: The Panel's assessment of the clinical care provided

All the cases were graded using the Confidential Enquiry into Stillbirths and Deaths in Infancy (CESDI) scoring system, which defines four levels of suboptimal care based on their relevance to the outcome.[1] The degree of harm in each case was also determined.[2]

The Panel's findings regarding suboptimal care and associated outcomes for all cases mean that:

- Had care been given to nationally recognised standards, the outcome could have been different in 97 of the 202 cases reviewed (48%)
- In 69 of these 97 cases, the outcome would have reasonably been expected to be different
- In 28 of these 97 cases, it might have been different

In relation to baby deaths, the Panel's findings mean that:

- Had care been given to nationally recognised standards, the outcome could have been different in 45 of the 65 cases of baby deaths (69.2%)
- In 33 of these 45 cases, the outcome would have reasonably been expected to be different
- In 12 of these 45 cases, it might have been different

In relation to cases of injury to babies, the Panel's findings mean that:

- Had care been given to nationally recognised standards, the outcome could have been different in 12 of the 17 cases of brain damage (70.6%)
- In 9 of these 12 cases, the outcome would have reasonably been expected to be different
- In three cases, it might have been different

In respect of cases involving maternal injuries and deaths, the Panel's findings mean that:

- Had care been given to nationally recognised standards, the outcome could have been different in 23 of 32 such cases (71.9%)
- In 15 of these 23 cases, the outcome would have reasonably been expected to be different
- In eight cases, it might have been different

[1] Level 0 – No suboptimal care; Level 1 – Suboptimal care, but different management would have made no difference to the outcome; Level 2 – Suboptimal care, in which different management might have made a difference to the outcome; Level 3 – Suboptimal care, in which different management would reasonably be expected to have made a difference to the outcome.

[2] Degrees of harm being: none, minimum, moderate, severe, death.

The Panel found that, in a few cases, there was suboptimal care that did not lead to a poor outcome or which led to an outcome that could have been much worse. These are examples of suboptimal care that went unnoticed, which by chance did not result in a poor outcome. They are described as being "narrow escapes" rather than "near misses".

The Panel also found an overriding tendency of midwives and doctors to disregard the views of women. This is despite the concerns they were raising matching the avoidable factors identified by the investigation.

Chapter 3: The wider experience of the families

Summary

This chapter describes the wider experiences of the families beyond the clinical outcomes and identifies six common themes:

1. Not being listened to or consulted with
2. Encountering a lack of kindness and compassion
3. Being conscious of unprofessional conduct or poor working relationships compromising their care
4. Feeling excluded during and immediately after a serious event
5. Feeling ignored, marginalised or disparaged after a serious event
6. Being forced to live with an incomplete or inaccurate narrative

The Panel found a deep impact on the wellbeing of families that continues to this day, sometimes many years after the birth.

Findings

The Panel undertook family listening sessions where women and their families shared their knowledge, experience and perceptions of the care they received. This was correlated with clinical notes in each case and where necessary, relevant staff were interviewed. Trauma-informed counselling was offered to the families, and in total more than a quarter attended.

The Panel found a number of overarching themes that characterise the experience of the participating families. The behaviours identified are believed to have been detrimental to the quality and safety of the care given to women, and to their overall experience. We would encourage all trusts to read the table of themes and indicative behaviours included within the full report.

Conclusions, including consequences and impact on wellbeing

These families attribute the following consequences to the events they experienced and the actions of clinicians and other trust staff:

- Not knowing if things might have been different; living with "what ifs"
- Feelings of guilt and responsibility for what happened
- Changes in personal beliefs about healthcare
- Mistrust of clinicians, institutions and the wider health system
- Feeling forced into a position where they sought legal advice to find out what had happened
- Loss of personal confidence
- Heightened emotions, including anger, rage and shame
- Self-blame for not raising concerns more forcefully or speaking up enough
- Panic attacks
- Not wanting more children or being frightened at the prospect of having another baby
- Needing to move away from the area or avoid being in proximity to the hospital
- Relationship difficulties, including some that have ended in separation, and difficulties with intimacy.

The report also highlights the additional guilt that many families have come to feel for not speaking up, when they have seen more recent cases come to light.

The Panel found that in addition to failures in clinical care, additional harm was caused by the behaviours and attitudes of those responsible for communicating with and supporting them after the event. It is the Panel's view that aspects of the families' experiences have been so damaging as to have had a profound and lasting effect on their health and wellbeing.

Chapter 4: What we have heard from staff and others

Summary

Alongside listening to families, the investigation has conducted interviews with 112 current and former staff at East Kent Trust and with others whose work brought them into contact with the trust's maternity and neonatal services. This chapter describes what was heard, rather than indicating the Panel's own thinking and conclusions.

Findings

Between October 2021 and June 2022, the Panel met with 90 members of trust staff, including midwives, neonatal nurses, obstetricians, neonatologists, paediatricians and other clinicians, as well as members of the Board, the Executive and other managers. It also interviewed 22 individuals who had been in contact with the trust from the CQC, HSIB, NHSE/I and CCGs.

The Panel's write up focuses on what it heard about the problems and challenges facing the trust. The Panel also notes that it heard about positive aspects, including efforts made to improve the culture and service, the initiatives to support better performance and outcomes, and the commitment of the majority of staff to do their best for their patients. However, the Panel is conscious that some wished to put a positive light on subsequent improvements in services, but this view was not generally borne out by other evidence.

Trust merger

The trust was previously three separate trusts: the Kent and Canterbury Hospital Trust, Thanet Healthcare Trust and South Kent Hospitals Trust. The three merged in 1999 following a local review of services.

The merger is described as having pitched the three original trusts against each other, for example, in reducing the number of maternity units from three to two. It was noted in 2014 by the CQC that the trust still behaved like three separate organisations. As part of its achieving foundation trust status, the then regulator Monitor required fewer management groups, which left senior clinicians feeling they did not have a voice and in 2011 a reorganisation moved a number of unrelated specialties (including women's health) into a single division. This was said to have displaced focus and leadership from maternity services. In 2018, the trust's directorates became clinically-led care groups with the intention of the clinicians delivering services being supported by their managers. The trust was described to the Panel as a "challenged" organisation typical of a cohort of trusts where there were significant performance and operational challenges, but where the underlying problem was really one of culture.

Staff views

Based on its interviews, the Panel describes:

- Poor staff morale
- Lack of staff engagement and leadership
- Staff behaviours that needed addressing including poor relationships between professional groups, difficulty challenging poor behaviour, bullying, racial discrimination and lack of diversity

Organisational issues

Culture of denial and resistance to changes

Many staff, and others, spoke about a culture of denial at the trust and a resistance to change.

Culture of blame and handling complaints

The Panel heard from a number of people about a "blame culture" when things went wrong. When a learning opportunity was identified, it felt like a punishment. When things went wrong, there was no opportunity to debrief; the response was reactive rather than proactive.

External factors or problems as the staff saw them

The issues cited as external factors or problems were:

- Facilities and infrastructure which were not fit for use
- Geography which made maintaining staffing levels and service quality a challenge
- Staffing shortages and difficulties in recruiting
- Leadership which, at a board level, struggled with the size, complexity and diversity of the trust, and where there was toxic culture and unhealthy tension between managers and clinicians, who had different priorities
- Changes at board and senior management level where there were prolonged periods of instability with regular senior staff turnover
- Clinical leadership with difficulty attracting clinical leaders as well as resistance by clinicians to being led, and a lack of a midwifery voice at board level
- Financial Special Measures which had a significant adverse impact on the transformation and improvement agenda and on innovation
- Governance which suffered from a disconnect between ward and board and poor information flows, and a lack of robust structures and processes
- Response to the Royal College of Obstetricians and Gynaecologists report which didn't see an organisational approach to tackling the problems identified
- Risk management was disjointed, under-utilised and under-resourced, as well as lacking ownership and leadership, and suffering the impact of wider cultural issues

The Panel also sets out the trust's relationships with involved bodies:

- Regulators and commissioners were numerous and created the potential for confusion in their roles, with relationships between the trust and these bodies also challenging

- Clinical Commissioning Groups in the area did things differently, making it hard to respond, and from the CCG perspective relationships were very challenging
- Care Quality Commission and the trust had significantly different views about the trust's performance, and had a very difficult relationship
- Healthcare Safety Investigation Branch saw the trust was an outlier in its referral rate and struggled to get the engagement and support of the trust's leadership team
- Nursing and Midwifery Council whose involvement varied according to the referrals received, and noted these are not always indicative of the degree of problems faced
- General Medical Council which had not received feedback on issues within the maternity services at the trust
- Local Supervising Authority which audited the trust between 2012 and 2016, and identified a number of issues including in relation to adherence to standards, learning from incidents, governance and transparency
- NHS England/NHS Improvement which became concerned about the trust in 2019 following concerns were raised by HSIB and which then undertook extensive scrutiny of and involvement with the trust
- Improvement initiatives and programmes began to have an impact from 2018, initially with the BESTT programme, but the multiplicity of recommendations and ongoing prevalence of issues was also notable

Chapter 5: How the trust acted and the engagement of regulators

Summary

This chapter gives an account of how the trust considered maternity and neonatal services and engaged with regulators and others. This chapter sets out how the trust conducted itself as reflected in its own documents and is not an expression of the investigation's findings.

Findings

The first indication of awareness of concerns about maternity services within the trust came at the Board meeting on 24 September 2010, where the Medical Director gave an overview of a recent SUI within maternity. Over subsequent years, reviews were undertaken by the trust and external bodies, and concerns were raised by a number of individuals and organisations. Changes were made to the configuration of its maternity units and plans developed, but concerns continued that these were not being embedded and that cultural issues persisted.

The chapter expands on the findings of the reviews and further concerns mentioned earlier in this briefing, namely those by the trust, by Monitor, the CQC, following the Morecambe Bay investigation and RCOG. It also sets out the interactions between the trust, regulators and HSIB, as well as board oversight of maternity services over the period of the investigation.

Harry Richford

This chapter also sets out in detail the circumstances surrounding the birth and death of Harry Richford in November 2017, the subsequent investigation and its considerable flaws, and the findings of the coroner. The coroner's report identified the following failures in Harry's care:

- Harry was hyperstimulated by an excessive use of Syntocinon over a period of approximately ten hours.
- The CTG reading became pathological by 2am and Harry should have been delivered within 30 minutes, not 92 minutes later.
- The delivery itself was a difficult one. It should have been carried out by the consultant who should have attended considerably earlier than [they] did.
- The locum on duty that night was relatively inexperienced. [They] were not properly assessed, if at all and should not have been put in the position of being in charge unsupervised.
- There was a failure to secure an airway and achieve effective ventilation during the resuscitation attempts after birth leading to a prolonged period of postnatal hypoxia. The resuscitation afforded to Harry Richford failed to be of an appropriate standard.
- There was a failure in not requesting consultant [paediatrician] support earlier enough during the resuscitation attempts.
- There was a failure to keep proper account of the time elapsing during the resuscitation attempts with the result that control was lost.

The coroner also issued a regulation 28 report – a report requiring action to prevent future deaths. This detailed 19 concerns identified during the inquest and the coroner's recommendations as to how they could be addressed to prevent future deaths. The recommendations included:

- Action to ensure proper review and assessment of locums and a reminder that it is the supervising consultant's responsibility to ensure the locum under their supervision is competent and experienced
- A review of trust processes to ensure clarity around the actions required in the event of an obstetric concern or emergency developing
- A review of procedures to ensure staff understand the circumstances where consultant attendance is required

- Training and learning, including simulation training, covering neonatal resuscitation
- Cross-site paediatric working between QEQM and WHH
- Addressing confusion among staff regarding the guidelines and policies that apply to them, by reviewing staff awareness of governing clinical and operational guidance
- An audit of the quality of record keeping and documentation, as the record keeping on the obstetric unit was substantially substandard
- A review of trust policies to ensure that the outcomes of independent reports are shared with trust staff so that important learning takes place to prevent any future deaths.

Harry's death was not raised in any detail with the trust board until late 2019, months before the inquest began and almost two years after Harry died. The report finds that it was only in the aftermath of the coroner's findings and the regulation 28 report that the trust took meaningful action in response to the failings identified in the Richford case. The trust established a Learning and Review Committee (LRC) with separate workstreams to look at the myriad issues, as well as previous investigations such as the RCOG report, the Richford Root Cause Analysis and the HSIB report. The LRC reported to the board on its implementation of recommendations and actions, and all actions were completed by June 2020, when the LRC became the Maternity Improvement Committee.

Over the course of 2020, the board made assurances to the public of its commitment to listening to patients and their families, that the trust was making significant changes to its maternity services, and that it was working with the national bodies to make the necessary improvements.

Chapter 6: Areas for action

The investigation has not sought to identify multiple detailed recommendations. It takes those recommendations and the resulting policy initiatives as a given. Instead, it identifies four broad areas for action, based on its findings but with much wider applicability.

Key Action Area 1: Monitoring safe performance – finding signals among noise

The problem	The future
• A dearth of useful information on the outcome of maternity services • How information and data are used, and the false assurances that are drawn	• Effective monitoring of outcomes, with benefits including identification of scope to improve effectiveness and address safety problems, and early identification of warning signs / outliers

	• Requirement 1: generation of measures that are meaningful; risk adjustable; available; and timely • Requirement 2: the use of sound, statistically based approaches to detecting the signal among the noise, and presenting this graphically to show not only the level of variation but also the significant trends and outliers • The approach must be national, and it must be mandatory

Recommendation 1

- The prompt establishment of a Task Force with appropriate membership to drive the introduction of valid maternity and neonatal outcome measures capable of differentiating signals among noise to display significant trends and outliers, for mandatory national use.

Key Action Area 2: Standards of clinical behaviour – technical care is not enough

The problem	The future
• Failure to listen directly affects patient safety because vital information is ignored • If role models themselves display poor behaviours, the potential is there for a negative cycle of declining standards • Patterns of unprofessional behaviour, lack of compassion and failure to listen are normalised and difficult to correct	• Compassionate care lies at the heart of clinical practice for all healthcare staff. If some are able to lose sight of that, then it needs to be re-established and re-emphasised • Professional behaviour and compassionate care must be embedded as part of continuous professional development, at all levels • Reasonable and proportionate sanctions are required for employers and professional regulators so that poor behaviour can be addressed before it becomes embedded and intractable • The importance of listening to patients must be re-established as a vital part of clinical practice

Recommendation 2

- Those responsible for undergraduate, postgraduate and continuing clinical education be commissioned to report on how compassionate care can best be embedded into practice and sustained through lifelong learning.
- Relevant bodies, including Royal Colleges, professional regulators and employers, be commissioned to report on how the oversight and direction of clinicians can be improved, with nationally agreed standards of professional behaviour and appropriate sanctions for non-compliance.

Key Action Area 3: Flawed teamworking – pulling in different directions

The problem	The future
• In almost every failed maternity service to date, flawed teamworking has been a significant finding, often at the heart of the problems • The divergence of objectives of different groups • Poor morale among obstetric trainees is a common feature	• A stronger basis for teamworking in maternity and neonatal services, based on an integrated service and workforce with common goals, and a shared understanding of the individual and unique contribution of each team member in achieving them • National guidance on of different care pathways must be the same for all staff involved, and not suggest that there are different objectives for obstetricians and midwives • Teams who train together work better together – there are opportunities at every stage of training to increase understanding of others' roles and responsibilities, and to become used to working with other disciplines and the contributions they make • Re-evaluation of the changed patterns of working and training for junior doctors, and in particular how the unintended consequences of fragmentation of work and lack of support can be avoided or mitigated

Recommendation 3

- Relevant bodies, including the Royal College of Obstetricians and Gynaecologists, the Royal College of Midwives and the Royal College of Paediatrics and Child Health, be charged with

reporting on how teamworking in maternity and neonatal care can be improved, with particular reference to establishing common purpose, objectives and training from the outset.

- Relevant bodies, including Health Education England, Royal Colleges and employers, be commissioned to report on the employment and training of junior doctors to improve support, teamworking and development.

Key Action Area 4: Organisational behaviour – looking good while doing badly

The problem	The future
• The default response of almost every organisation subject to public scrutiny or criticism is to think first of managing its reputation. This can lead to denial, deflection, concealment and aggressive responses to challenge, rather than learning, improvement and compassion • Pursuit of decisive action in the face of difficulties, with changes to leadership being one of the few levers available to NHSE – this halts steps towards recovery and creates an incentive to be less frank about emerging problems	• The balance of incentives for organisations needs to be changed. The need for openness, honesty, disclosure and learning must outweigh any perceived benefit of denial, deflection and concealment • Legislation to oblige public bodies and officials to make all of their dealings, with families and with official bodies, honest and open • A review of the regulatory approach to failing organisations by NHSE to identify alternatives to the "heroic leadership" model, including the provision of support to trusts in difficulties and incentives for organisations to ask for help rather than conceal problems

Recommendation 4

- The Government reconsider bringing forward a bill placing a duty on public bodies not to deny, deflect and conceal information from families and other bodies.
- Trusts be required to review their approach to reputation management and to ensuring there is proper representation of maternity care on their boards.
- NHSE reconsider its approach to poorly performing trusts, with particular reference to leadership.

East Kent Hospitals University NHS Foundation Trust

The report states that the new leadership of the trust are already aware that there are deep-seated and longstanding problems of organisational culture in their maternity units. They will know what assistance they can commission from external bodies, including NHSE, and must receive full support. They must work in partnership with families who wish to contribute, and report publicly on their

approach and its progress. We expect that staff will want to give their full engagement and cooperation, having seen the harm that resulted from previous behaviour that had become normalised.

In making its recommendations, the report is clear that the first step in the process of restoration is for all those concerned to accept the reality of what has happened. The damage caused to families is incalculable, and their courage in coming forward to ensure this came to light is exemplary, but it should not have been necessary. This must be acknowledged without further delay. Only then can the trust embark on trying to make amends.

Recommendation 5

- The Trust accept the reality of these findings; acknowledge in full the unnecessary harm that has been caused; and embark on a restorative process addressing the problems identified, in partnership with families, publicly and with external input.

Press statement

NHS Providers responds to report on East Kent maternity services

Responding to the report of the independent investigation led by Dr Bill Kirkup into maternity and neonatal services in East Kent, NHS Providers' interim chief executive, Saffron Cordery, said:

"Dr Kirkup's findings are harrowing. It is clear in the cases investigated here that women, their babies and families did not receive the safe, compassionate care they should have done.

"As Dr Kirkup notes, there have been many other recent investigations and reports into maternity services, and the parallels in each are clear.

"This sensitive, insightful report seeks a different approach to avoiding any more families facing the same devastating failures of care. Dr Kirkup's focus on behaviours as the driving factor is the right one, and we welcome his insistence on the need for honesty, openness and compassion throughout the NHS.

"We welcome too his recognition of maternity and neonatal services as being delivered as part of a wider system. Where failures are collective, reflection and improvement must also be collective.

"Some of the problems identified are more common in maternity and neonatal services, some exist in the NHS more widely particularly with regard to the need to invest in and staff the workforce appropriately. From NHS wards and boardrooms to national regulators and the government, there must be an absolute commitment to developing a safety culture throughout the NHS.

"Across the country and across its services, the NHS delivers high quality care every day and night. But as this report makes clear, this is not an experience shared consistently by everyone. It is essential that we both build on the good care within the NHS and learn from the experiences of those in this report and its predecessors.

"There must be openness and support throughout the system to listen to where there is the potential for harm, and commitment to continually learning from mistakes and building on strengths."

Annex: Terms of reference

In February 2020, Dr Bill Kirkup was appointed by NHSE/I to chair the independent investigation into the management, delivery and outcomes of care provided by the maternity and neonatal services at East Kent University Hospitals NHS Foundation Trust during the period since 2009 (when the Trust came into being) drawing upon the methodology followed in the Morecambe Bay investigation. This was confirmed in parliament. The minister at the time, Nadine Dorries, also announced that the Chief Midwifery Officer, Jacqueline Dunkley-Bent, had sent an independent clinical support team to the Trust to provide assurances that all possible measures were being taken.

The investigation considered four issues in particular:

1. What happened at the time, in individual cases, independently assessed by the investigation.
2. In any medical setting, as elsewhere, from time to time, things do go wrong. How, in the individual cases, did the trust respond and seek to learn lessons?
3. How did the trust respond to signals that there were problems with maternity services more generally, including in external reports?
4. The trust's engagement with regulators including the CQC. How did the trust engage with the bodies involved and seek to apply the relevant messages? And what were the actions and responses of the regulators and commissioners?

The investigation considered those cases where there was:

1. A preventable or avoidable death;

2. Concern that the death may have been preventable or avoidable;
3. A damaging outcome for the baby or mother;
4. Reason to believe that the circumstances shed light on how maternity services were provided or managed or how the Trust responded when things went wrong.

The investigation was tasked with providing an independent assessment of what happened with East Kent Maternity and Neonatal Services and identifying lessons and conclusions. This was to include:

a. Determining the systems and processes adopted by the trust to monitor compliance and deliver quality improvement within the maternity and neonatal care pathway.
b. Evaluating the trust's approach to risk management and implementing lessons learnt.
c. Assessing the governance arrangements to oversee the delivery of these services from ward to board.

In doing so, the investigation committed to focusing on the experience of the families affected, providing them with an opportunity to be heard and to shape the key lines of enquiry. It also focused on the actions, systems and processes of the trust (with reference to clinical standards for maternity and neonatal care during the period). It would also consider the relevant processes, actions and the responses of regulators, commissioners and the wider system.

The investigation would then draw conclusions as to the adequacy of the actions taken at the time by the trust and the wider system. Taking account of improvements and changes made, the investigation aimed to provide lessons helpful to East Kent and nationally in order to improve maternity services across the country. It committed to agreeing with NHSE/I steps to help ensure that the lessons identified are understood and acted upon.

The full terms of reference, including the protocols and methodology used by the investigation, are set out in the report and on its website: https://iiekms.org.uk/terms-of-reference/.

Meeting Title:	November Board Meeting
Date of Meeting:	30 Nov 2022
Document Title:	**Update to Board – Trust Strategy Update**
Responsible Director:	Paul Lewis – Deputy Director Strategy, Transformation & Partnerships
Author:	Philip Davis – Head of Strategy & Corporate Planning

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**
May Board	24 May 2022	Last update to Board on Trust Strategy (updates are 6monthly)

Purpose of the Paper	*Review progress of DCH delivering on the Trust Strategy approved by Board and Published Dec-21.*							
	Note	✓	*Discuss*	✓	*Recommend*	✓	*Approve*	✓
Summary of Key Issues	*2022 has seen the Trust move from a Trust Strategy Document (Vision and Objectives) to a Strategic Delivery Plan.* *All the components of the Strategic Delivery Plan have been put in place (* or are very close to being finalized), specifically:* *- Strategic Priorities agreed* *- Trust wide Change Agenda* *- Annual Planning Cycle* *- Strategy Dashboard ** *- Strategic Risks (BAF)* *- Delivery of Projects & Benefits* ***Strategic Priorities**: Agreed by Execs in Jul, these are i) Patient Flow, ii) Elective Recovery and iii) Fiscal Sustainability. Resources have been aligned to transformation activities in these areas.* ***Trust wide Change Agenda**: pulls from across Digital, Finance, Access and Transformation & Improvement teams – a single view of Trust wide change.* *The target future state for Trust is defined on key metrics.* *6 Change Programmes and target Outcomes, and 34 Projects & target outcomes underneath are mapped to strategic Priorities.* ***Annual Planning Cycle**: Business Planning process is joined up across Divisions/CGs and Corporate Functions, and founded in the Trust Strategy* ***Strategy Dashboard**: Monthly Reports update on progress in delivery of Projects and target benefits, as well as responsibilities, deliverables and risks.* ***Strategic Risks**: discussed in the BAF documents, scored, clear owners and*							

	mitigations/actions, and raised in Board Committees. ***Delivery of Projects & benefits**: progress feeds up through Strategy Dashboard for monitoring. Resource allocation and interdependencies noted.* *The Trust Strategy was written with 11 discrete Objectives, organized under the People/Place/Partnership theme. Examples of transformation activities ongoing have been described under each objective.* *Next steps are to ensure that all work on Strategy Delivery at DCH can be accurately mapped the ICS Strategy expected in Dec-22, and we can demonstrate DCH is integrated with the ICS strategy and working with partners at a strategic level. Additionally there is work to do, to ensure that the Strategy Dashboard becomes fabric of how DCH SLG and Board monitor delivery of the Trust Strategy. Lastly, the outlook beyond 18months needs monitoring, to ensure that we are planning for major system wide changes that are expected in the mid term (such as the system wide EMR plans and Sustainability/Social Value Agenda)*
Action recommended	Board is recommended to: 1. **NOTE** the progress that has been made towards a Trust Strategic Delivery Plan. 2. **Review** and **Comment** on the Trust wide change Agenda and Strategy Dashboard, And the proposed next steps 3. **APPROVE** the continuation of Strategy delivery in the manner and direction currently ongoing, and described in this report.

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*

INTEGRITY | RESPECT | TEAMWORK | EXCELLENCE

NHS
Dorset County Hospital
NHS Foundation Trust

Strategy Update

November Board

Paul Lewis / Phil Davis

Outstanding care for people in ways which matter to them

Contents

Trust Strategy - Bringing it together

How the strategy and supporting components now fit together

Strategy Priorities
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Delivery progress

Annual Planning Cycle
Business Planning grounded in Strategic change

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BAF – Assurance with SRO ownership & Governance

Trust wide Change Agenda
Mapping all Projects to target future state

Delivery
Project portfolio/plan (interdependencies)
Benefits delivery

Outstanding care for people in ways which matter to them

Progress on Trust Strategy in 2022

Concept to delivery

Trust Strategy

↓

Strategic Delivery Plan

Dec 2021	**Trust Strategy** approved at Board and formally published
Feb/Mar 2022	**Clinical, People and Digital Plans** agreed, distributed to teams for guidance
Apr 2022	**BAF** established and extended to Board Committees
May 2022	**Strategic Services Review** first draft of Productivity trends analysis
Jul 2022	**Strategic Priorities** of Trust Agreed - Elective recovery, Patient Flow, Fiscal sustainability
Aug 2022	**Close working Digital and TIO** established One change portfolio, interdependencies identified
Sep 2022	**Business Planning process** kicked off, grounded in Trust Strategic Priorities
Oct 2022	Trust-wide **Change Programmes** captured & mapped to Trust Strategic Priorities - Current vs target Future state of hospital defined - 6 **Change Programmes**, and target outcomes defined - 34 **Projects** and target outputs defined
Nov/Dec 2022	**Strategy Dashboard**, capturing all Trust wide change projects and **delivery status** - Assurance on what we are delivering, where & why, monthly highlight reports - Captures KPIs, Responsibility, timelines, deliverables, risks and escalation
Dec 2022	**ICS Strategy** to be published, ensure we can directly link in our change programs

Outstanding care for people in ways which matter to them

Trust-wide Change Programmes

Apr-24 timeframe (18 months)

★ TIO team supporting
★ Digital projects

Dorset County Hospital NHS Foundation Trust

Strategy Update

Patient Pathway Improvement (PPIP)

Pathway Home Hub	★	- Lower NCTR, avoidable NEL, LOS
24 Ring fenced beds	★	- EL cancellations down, EL Activity up
South Walks House	★	- More productive OP Assessment
EM Zone	★	- Higher SDEC as % NEL
Virtual Wards	★	- Inpatient App, Home monitoring
Service Redesign		- Single Dorset OMF, Rheum, Orthodon - Stroke & Audiology service Develop
Agyle in Phase 2	★	- Self check-in, Streaming/redirection - Book/referral, ECDSv4, SDEC/EM Zone
Agyle – full IP functionality	★	- Agyle Task Mgmt and Handover - Data accessibility & efficiency

Theatres Efficiency

Theatre Staffing		- Fill LT vacancies - Less Theatre downtime
Smart Booking		- 85% Utilisation
Increasing Capacity		- Higher EL activity, productivity
Digital in EL Pathways	★	- eConsent, ePreassessment - My Endo

OP Transformation

Virtual OP	★	- Larger % telephone/online OPA
Advice & Guidance		- Fewer avoidable OPAs
PIFU	★	- Lower FU:FA, Fewer avoidable FUs - More discharges to surveillance
Digitally enable OP	★	- eForms incl eOutcomes Form - ePrescribing in OP - MyPreOp ePresassessment - eRS and Advice & Guidance in DPR - mediSIGHT Ophthalmology - Medefer Gastro WL review
Digital Documentation + Speech Recognition	★	- eClinic Letters - eBooking / other clinical edocs

Sustainable Workforce

Attract & Retain		- Fill LT vacancies, some over-recruit - Scheme of cash/non cash benefits - Childcare, food & drink, training etc - Incentives, accreditation fees etc
Safe Staffing		- Increase substantive staff selectively
High Cost Agency Reduction	★	- Grow Bank, higher bank fill rate - Process & Gov, control off framework - Data/Insight, Automation, dashboards ★
Medical Staffing		- Review Rota, rebuild in eRoster ? - System partnerships to fill, build clinic - Locum usage, supplemental payments

CIP/FIP

CIP Delivery	★	- Deliver 2.5% across Div/Corp Functions
Commercial Income		- Grow PP, Retail, other Inc Streams - £2.37m incl in 23/24
Strategic Services Review		- Turnaround of under-performing CGs
FIP Workstreams		- Reverse out C19 spending - Agency spend reduction to 19/20 level - EL recovery, productivity restored
ICS Procurement		- Economies of scale - system tendering
CSR/Social Value		- Carbon footprint reduction - Reduce energy consumption/renewable - Demonstrable SV in locality

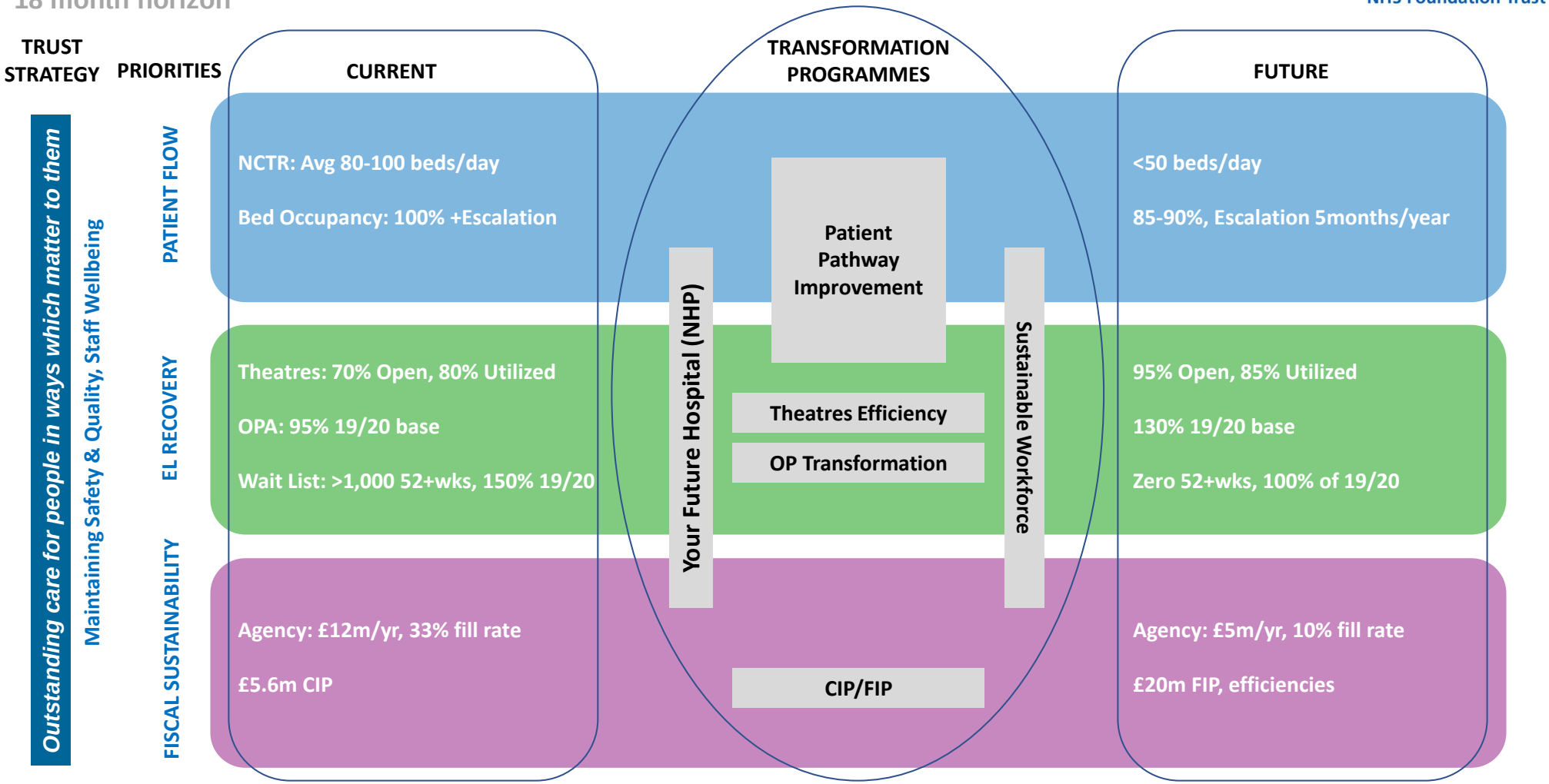
Your Future Hospital (NHP & Strategic Estates)

SWH Development		- SWH kitted out, OP team moved - Medical OP repurposed
ED 15	★	- New layout/capacity online & staffed
Car Park		- In full use by staff/patients
NHP – ICU/ED		- Additional Emergency capacity online
Key Worker Housing		- Fill LT vacancies - Attract & retain, esp junior staff
West Annex Decant		- Demolition and repurposing site
Main entrance		- Plan to redevelop front door

Our Strategic Priorities, Transformation Programmes and Target Outcomes

18 month horizon

Dorset County Hospital NHS Foundation Trust



Transformation & Improvement Office supporting the Strategy

Support and delivery

Theme	Objective	Progress on Strategy Delivery
People	1. We will look after and **invest in staff**, developing our workforce, creating collaborative and MDT's to support outstanding care and equity of outcomes	- **Workforce now defined as a Change Programme** and aligned to Trust 3 Strategic Priorities, with 4 underlying projects at different stages
	2. We will create an **environment where everyone feels they belong**, they matter, and their voice is heard	- **BAF** continues to highlight Strategic Risk posed by workforce, as well as mitigations being worked on including Management matters, staff surveys, training etc
	3. Improve **safety and quality of care** by creating a culture of openness, innovation and learning	- **QI/QSIR** training roll out has continued at pace in 2022 - Further development of the **temp staffing team** ongoing (move to SWH) - **High Cost Agency Project**: 3 project mgrs. joined from ICS to assist, detailed delivery plan now in place, workstreams reporting progress against plan to EMT/SLG
Place	4. We will deliver **safe, effective and high-quality personalised care** for every patient focussing on what matters to every individual	- **Patient Pathway Hub** (part of PPIP), delivery plan developed, aimed at avoiding overnight admissions in frailty patients, and providing service GPs can refer into for rapid response (avoiding ED front door/wait, or deterioration leading to NCTR)
	5. We will build **sustainable infrastructure** to meet changing needs of the population	- **ED-15 project** closes Nov/Dec, increasing ED capacity and improved patient flow - **24 Ring Fenced Orthopaedic beds** project, has developed initial delivery plan for Ridgeway ward works, more advanced planning in progress
	6. We will utilise **digital technology** to better integrate with our partners and meet the needs of patients	- **Agyle 2.0** roll out and expanded functionality in EM patients in planning - **Digital summit** and planning work ongoing for **systemwide EMR options** moving forward, extensive working with System partners
	7. 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	- **Place workstream** at ICS level: DCH engaged with dedicated TIO resource allocated – redesigning services & listening to patients needs, working with VCSO

Outstanding care for people in ways which matter to them

Transformation & Improvement Office supporting the Strategy

Support and delivery

Theme	Objective	Progress on Strategy Delivery
Partnership	8. We will contribute to a strong, effective **Integrated Care System**, focussed on meeting the **needs of the population**	- TIO team following the **Inequalities/PHM strategy** as it gets closer to being articulated within final ICS Strategy (planned by YE) - TIO working with **Transition Service**, to use data to better understand our demand from Children & Young People, and design better pathways and service provision from DCH and DCH into community
	9. 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	- **CIP** new schemes being actively investigated and delivery of current schemes being supported by TIO team, eg. in Pathology, Pharmacy & transport) - **Business Planning** round kicked off, grounded in Trust and ICS Strategy
	10. 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	- **Joint CEO/Chair work** ongoing to define strategic value/benefits, TIO actively supporting
	11. Through **partnership working** we will contribute to helping improve the **economic, social and environmental** wellbeing of local communities	- Commercial & Estates teams took initial proposal to EMT regarding **energy efficiency** options, formal business case in development to take to EMT/SLG in Jan - Commercial took initial proposal to EMT regarding **Staff Childcare**, modelling options and cost/impact/benefits for Trust, to take back to EMT/SLG in Jan

Looking Ahead

Next steps

- **Review Trust strategy Q4/Q1**
  - Strategy Dashboard Dec 22
  - Retest objectives and Strategic Priorities
  - Review Clinical & People Plans for relevance and robustness

- **Integration with ICS Strategy**
  - Ensure DCH Change Project portfolio has clear link to ICS Strategy and the wider ICB plan, Place Plans, JSNA, JHWS Dorset Council
  - Regular interface with System Strategy peers
  - Joint Strategic working cross system

- **Outlook beyond 18months**
  - Planning around major changes expected and interdependencies
  - System wide Electronic Patient Record and clinical applications refresh
  - Greater Provider collaboration
  - Population Health & Health Inequalities
  - Sustainability Agenda and Social Value

Outstanding care for people in ways which matter to them

Report Front Sheet

1. Report Details			
Meeting Title:	Board of Directors, Part 1		
Date of Meeting:	30 November 2022		
Document Title:	**Quarterly Guardian Report of Safe Working report: Doctors in Training (July 2022 – Sept 2022)**		
Responsible Director:	Alastair Hutchinson, Chief Medical Officer	Date of Executive Approval	11 November 2022
Author:	Kyle Mitchell, Guardian of Safe Working		
Confidentiality:	No		
Publishable under FOI?	Yes		
Predetermined Report Format?	Yes		

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

3. Purpose of the Paper	The production of a quarterly Guardian of Safe Working (GoSW) report to the Board is a requirement of the 2016 Junior Doctor Contract. The report is also shared with the Local Negotiating Committee for Medical and Dental staff.							
	Note (✓)	✓	*Discuss (✓)*		*Recommend (✓)*		*Approve (✓)*	✓
4. Executive Summary	A summary of key issues relating to safe working hours and rota gaps for Junior Doctors in training for quarter 2 (2022/2023)							
5. Action recommended	The Board is asked to: 1. **NOTE and APPROVE** the GoSW paper.							

6. Governance and Compliance Obligations				
Legal / Regulatory Link		**Yes**		National contract
Impact on CQC Standards			**No**	
Risk Link		**Yes**		Adhering to requirements of the Junior Doctor Contract 2016
Impact on Social Value			**No**	
Trust Strategy Link		**How does this report link to the Trust's Strategic Objectives?** *Please summarise how your report will impact one (or multiple) of the Trust's Strategic Objectives (positive or negative impact). Please include a summary of key measurable benefits or key performance indicators (KPIs) which demonstrate the impact.*		
Strategic Objectives	People	The guardian of safe working ensures that issues of compliance with safe working hours are addressed by the doctor and the employer or host organisation as appropriate. It provides assurance to the board of the employing organisation that doctors' working hours are safe.		
	Place			

Partnership			
Dorset Integrated Care System (ICS) Objectives	**Which Dorset ICS Objective does this report link to / support?** *Please summarise how your report contributes to the Dorset ICS key objectives.* *(Please delete as appropriate)*		
Improving population health and healthcare		**No**	
Tackling unequal outcomes and access		**No**	
Enhancing productivity and value for money		**No**	
Helping the NHS to support broader social and economic development		**No**	
Assessments	**Have these assessments been completed?** *If yes, please include the assessment in the appendix to the report..* *If no, please state the reason in the comment box below.* *(Please delete as appropriate)*		
Equality Impact Assessment (EIA)		**No**	
Quality Impact Assessment (QIA)		**No**	

Title of Meeting	**Board of Directors, Part 1**
Date of Meeting	**30 November 2022**
Report Title	**Quarterly Guardian Report of Safe Working report: Doctors in Training (July 2022 – Sept 2022)**
Author	**Mr Kyle Mitchell, Guardian of Safe Working (GoSW)**

1. Executive summary

- Exception Reports continue to be submitted at a rate consistent with pre-pandemic practice.
- Junior Doctor and Educational Supervisor engagement remains consistently excellent.
- On eight occasions in this quarter, Exception Reports were escalated as being of Immediate Safety Concerns and there was prompt escalation and engagement from divisional leadership. The Guardian of Safe Working has highlighted to divisional leadership the clinical workloads within Trauma & Orthopaedic Surgery (T&O), and in Gastroenterology, as representing a potential risk to safe working for Junior Doctors.

2. Introduction

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

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

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

3. High level data

Number of training post (total):	195	(188 Q1)
Number of doctors in training post (total):	174.5	(163.4 Q1)
Annual average vacancy rate among this staff group:	13.4	(18.6 Q1)

Exception reports in order of number raised

Exception reports by department				
Specialty	No. exceptions carried over from last report	**No. exceptions raised**	No. exceptions closed	No. exceptions outstanding
Gastroenterology	0	**24 (1 ISC)**	24	0
T&O	0	**13 (5 ISC)**	13	0
Geriatric medicine	1	**13 (1 ISC)**	13	1
Urology	0	**4**	3	1
General Medicine	1	**3**	4	0
Cardiology	0	**2**	1	1
General Surgery	0	**2**	2	0
Obs & Gynae	0	**2**	2	0
Respiratory Medicine	0	**2**	2	0
Emergency Dept.	0	**1**	0	1
ENT	0	**1 (1 ISC)**	1	0
Medical Oncology	0	**1**	1	0
Renal Medicine	0	**1**	1	0
Acute Medicine	2	**0**	2	0
Total	4	**69**	69	4

Exception reports by grade				
Grade	No. exceptions carried over from last report	No. exceptions raised	No. exceptions closed	No. exceptions outstanding
FY1	2	49	50	1
FY2	0	6	4	2
CT1	0	8	8	0
CT3	0	1	0	1
ST1	2	3	5	0
ST3	0	2	2	0
Total	4	69	69	4

4. Work schedule reviews

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

Exception Reports taken to Level 1 Work Schedule Review

Specialty	F1
Geriatric Medicine	2

Rota	Total
2022 F1 Medical 03/08/22 – 06/12/22	2

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

5. Immediate Safety Concerns.

Eight Exception Reports were highlighted as being of Immediate Safety Concern (ISC). All were promptly escalated and scrutinized, and, where appropriate, there was active involvement of both Divisional Manager & Director.

"Sporadic" ISCs in ENT and Geriatric Medicine were both caused by absence of senior staff. Subsequent discussion/ reflection with trainees and supervisors has included consideration of management algorithms to mitigate risk in these uncommon but inevitable scenarios.

More "systemic" ISCs in T&O and Gastroenterology were promptly escalated to divisional leadership and contribute to a dataset highlighting the current strain in these areas. The Guardian is aware of ongoing efforts in both areas to improve the junior medical staffing model.

6. Vacancies

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

7. Fines

There were no fines levied during this period.

8. Other issues arising

An evolving response to Covid-19 pandemic has allowed a relaunch of the Junior Doctors Forum. The first forum with refreshments and a face-to-face format was held 20th Sept 2022 and was well attended by Junior Doctors and representatives of the Executive. Updated Terms of Reference have been submitted to the Local Negotiating Committee and future dates for alternate-month JDFs have been proposed subject to confirmation.

9. Summary

An element of flexibility has always been part of how all doctors, including those in training, work. The 2016 Contract formalises arrangements to recognise, record and remunerate this. The Guardian recognizes the Trust's efforts to ensure compliance with these contractual arrangements. As a result of the Trust's engagement with this process, specific

areas (T&O and Gastroenterology) have been highlighted as being at risk of compromising compliance with safe working components of the 2016 Junior Doctors Contract.

10. Recommendation

The Guardian asks the committee to note this report; to consider it to provide an assurance of compliance with the safeguarding aspects of the 2016 Junior Doctors Contract provided there is ongoing scrutiny of Junior Doctor staffing level and support within T&O and Gastroenterology; and to approve its submission to the Trust Board.

APPENDICES

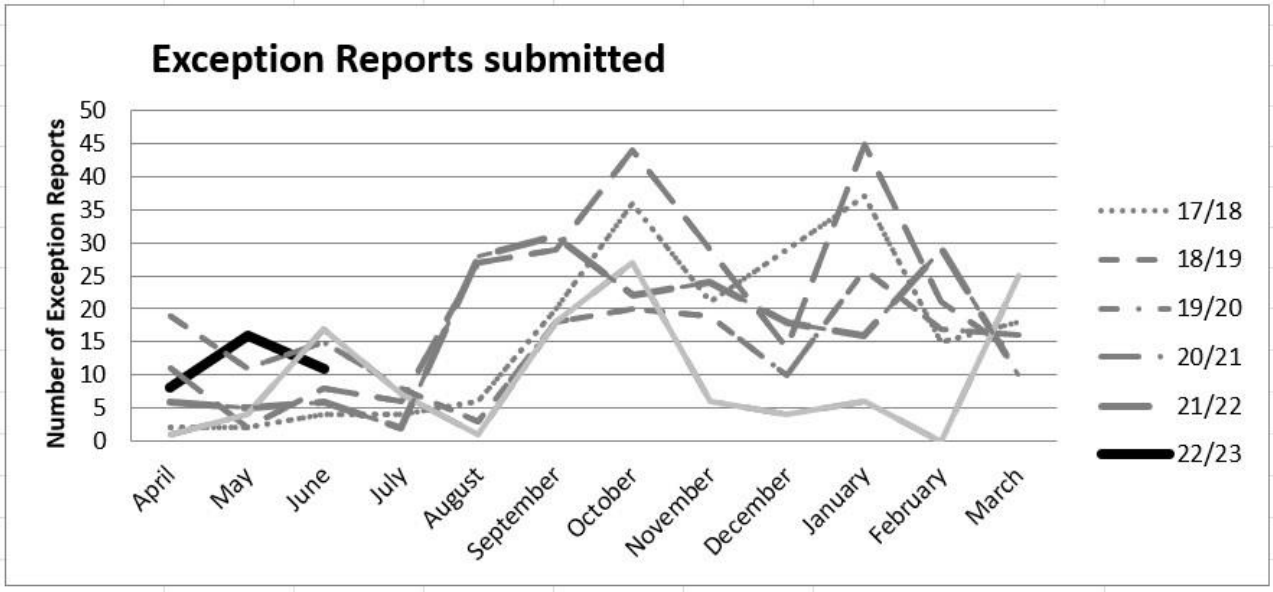
QUARTERLY GUARDIAN REPORT ON SAFE WORKING HOURS: DOCTORS IN TRAINING

JULY 2022 – SEPTEMBER 2022

Appendix 1 – Trainee Vacancies within the Trust

Department	Grade	Rotation Dates	July 22	Aug 22	Sept 22	Average Q2
Paediatrics	ST3	Sept	0	0	0.2	0.1
Paediatrics	ST4+	Sept	0.4	0.4	0.08	0.3
O&G	ST1	Oct	0	0	0	0.0
O&G	ST3+	Oct	0	0	0	0.0
ED	ST3+	Sept and Feb	1	1	1	1.0
Surgery	CT1	Aug	0	0	0	0.0
Surgery	CT2	Aug	1	0	0	0.3
Surgery	ST3+	Oct	1	1	1	1.0
Orthopaedics	ST3+	Sept	1	1	1	1.0
Anaesthetics	CT1/2	Aug	1.2	1	1	1.1
Anaesthetics	ST3+	Aug and Feb	0.4	0.4	0.4	0.4
Medicine	CT1/2	Aug	3.8	3.4	3.4	3.5
Medicine COE	ST3+	March	0.4	0.4	0.4	0.4
Medicine Diab/Endo	ST3+	Aug	1	1	1	1.0
Medicine Gastro	ST3+	Sept	1	1	0	0.7
Medicine Resp	ST3+	Aug	0	0	0	0.0
Medicine Cardio	ST3+	Feb	0	0	0	0.0
Medicine Renal	ST3+	Aug	1	1	1	1.0
Haematology	ST3+	Sept	0	0	0	0.0
Med/Surg	FY1	Aug	1	0	0	0.3
Med/Surg	FY2	Aug	0	0	0	0.0
GPVTS	ST1	Aug & Feb	2	0.4	0.4	0.9
GPVTS	ST2	Aug & Feb	0.4	0.4	0.4	0.4
GPVTS	ST3	Aug & Feb	0	0	0	0.0
Orthodontics	ST3+	March	0	0	0	0.0
Total			16.6	12.4	11.28	13.43

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



Report Front Sheet

1. Report Details			
Meeting Title:	**Board of Directors**		
Date of Meeting:	**30th November 2022**		
Document Title:	**Well Led Review Action Plan Update**		
Responsible Director:	**Nick Johnson, Interim Chief Executive**	Date of Executive Approval	23/11/2022
Author:	**Trevor Hughes, Head of Corporate Governance**		
Confidentiality:	Not Confidential		
Publishable under FOI?	Yes		
Predetermined Report Format?	No		

2. 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.

3. 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 (✓)*	
4. 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. This month's the review focussed on ensuring that the following areas were addressed: • Actions addressed the recommendation. • Timescales are specific for each action. • Clarifying singe executive and management leads. • A review and update of RAG ratings. • Alignment of the evidence to the recommendation. The Updated Action Plan is attached.							

5. Action recommended	The Board of Directors is invited to note the updated actions.

6. Governance and Compliance Obligations				
Legal / Regulatory Link		**Yes**		Foundation Trusts are required to commission an independent external review of their Well Led arrangements every three years.
Impact on CQC Standards		**Yes**		Foundation Trusts are required to commission an independent external review of their Well Led arrangements every three years.
Risk Link			**No**	*f yes, please state the link to Board Assurance Framework and Corporate Risk Register risks (incl. reference number). Provide a statement on the mitigated risk position. (Please delete as appropriate)*
Impact on Social Value		**Yes**		Ensuring that the Trust is Well Led is a fundamental requirement to ensuring delivery of the Trust's social value ambitions.
Trust Strategy Link		**How does this report link to the Trust's Strategic Objectives?** *Please summarise how your report will impact one (or multiple) of the Trust's Strategic Objectives (positive or negative impact). Please include a summary of key measurable benefits or key performance indicators (KPIs) which demonstrate the impact.*		
Strategic Objectives	People	Ensuring that the Trust is Well Led is a fundamental requirement to ensuring delivery of the Trust Strategy.		
	Place			
	Partnership			
Dorset Integrated Care System (ICS) goals		**Which Dorset ICS goal does this report link to / support?** *Please summarise how your report contributes to the Dorset ICS key goals.* *(Please delete as appropriate)*		
Improving population health and healthcare		**Yes**	**No**	*If yes - please state how your report contributes to improving population health and health care*
Tackling unequal outcomes and access		**Yes**	**No**	*If yes - please state how your report contributes to tackling unequal outcomes and access*
Enhancing productivity and value for money		**Yes**	**No**	*If yes - please state how your report contributes to enhancing productivity and value for money*
Helping the NHS to support broader social and economic development		**Yes**	**No**	*If yes - please state how your report contributes to supporting broader social and economic development*
Assessments		**Have these assessments been completed?** *If yes, please include the assessment in the appendix to the report..* *If no, please state the reason in the comment box below.* *(Please delete as appropriate)*		
Equality Impact Assessment (EIA)			**No**	
Quality Impact Assessment (QIA)			**No**	

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~~ February 2023 – in line with planning timetable	**Medium**	1. Promote opportunities for greater NED scrutiny and challenge on the financial and deficit positions		~~Paul Goddard~~ Chris Hearn	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. A formal subgroup has been formed to undertake deeper dives on financial hot topics, with CEO and CFO Financial scrutiny meetings continue to be held with all Divisional and Corporate Budget leads.
			November 2022		2. Regular reports to FPC on CIP trajectory delivery and the underlying deficit position going forward into 2022/23	Complete	~~Paul Goddard~~ Chris Hearn	Claire Abraham		Finance Reports to FPC include CIP progress and monitoring for onward escalation to Board. Underlying deficit position is routinely reported to FPC.
			February 2023 – in line with planning timetable		3. Develop a medium term financially sustainable strategy of which DCH will be a part		~~Paul Goddard~~ Chris Hearn	Paul Goddard		DCH is playing into the wider Dorset ICS medium term financial plan. The sharing of underlying financial forecasts and assumptions, to inform the production of the medium-term financial plan, will take place in early September. This is being coordinated by the ICB CFO and involves all CFO's and deputies within the system. The preliminary outputs of this work will be shared with the FPC and Board.

No.	Area	Recommendation	Timescale	Priority	Action	Action Progress Status	Responsible Executive	Management Lead	Assurance	Evidence
			November 2022		4. Enhanced financial monitoring in place, sub-group of FPC	Complete	~~Paul Goddard~~ Chris Hearn	~~Paul Goddard~~ Chris Hearn		Sub group in place to enhance financial monitoring. Executive budget/CIP meetings in place.
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~~ Emma Hallett	Trevor Hughes		Revised NED recruitment process agreed with Governors. Flexible induction programme to meet individual needs in place.
			March 2022 (To repeat exercise for new Board members)		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~~ Emma Hallett	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. Exercise to be repeated in Q4 for the benefit of the Board members who have joined since April 2022
Responsible Committee:		Board								
3	**System Working**	In order to accelerate progress in the Integrated Care System towards clinical and financial sustainability, DCH should consider	Ongoing now	**Medium**	1. Develop the DCH Strategy narrative and promote discussion and sharing of financial and other plans via various system mechanisms.		Paul Lewis	Phil Davis		Awaiting ICS Strategy, Expected December 2022. DCH Strategy aligned to the 4 aims of the ICS and is published on the external DCH website. (Complete)

No.	Area	Recommendation	Timescale	Priority	Action	Action Progress Status	Responsible Executive	Management Lead	Assurance	Evidence
		how it communicates with system partners. This should include:								Weekly CEO calls and Senior Leadership Team meetings in place.
		• Ensuring System Partners have a good understanding of DCH's challenges and plans to tackle these	Ongoing now		2. At ICB and other system CLINICAL meetings communicate the DCH position, challenges and opportunities		Jo Howarth			DCH are now working much more closely with UHD, NHS Dorset and Dorset HealthCare in the development of GIRFT, especially thought the High Volume Low Complexity (HVLC) workstreams where the Trusts have identified Clinical Leads to promote more joint working and sharing of key data to make progress against action plans. System working on Nursing / workforce faculty workstream including agency reduction project
			February 2023 – in line with planning timetable		3. At ICB and other system FINANCE meetings communicate the DCH position, challenges and opportunities		Chris Hearn	Claire Abraham	Routine involvements from CFO and Deputy CFO at system meetings	ICB meeting and discussing financial sustainability at Strategic level. Strategic Discussions at ICS level on Agency – moving towards for single Tariff and agreed process, eliminating Off framework. System capital conversation ongoing on a routine basis to understand challenges.
			Ongoing now		4. At ICB and other system OPERATIONAL meetings communicate the DCH position, challenges and opportunities		Anita Thomas			Closer working through GIRFT HVLC workstreams. Presentations weekly and monthly cycle on DCH position, requirements, mutual aid and offers. Participation in clinical networks - MSK Board, Eye Care Board, One Dorset Orthodontics/Rheumatology/OMF and Urology. Active participation in system pressures escalation meetings and system solution

No.	Area	Recommendation	Timescale	Priority	Action	Action Progress Status	Responsible Executive	Management Lead	Assurance	Evidence
										finding reviews e.g. winter planning and mobilisation.
			Ongoing now		5. At ICB and other system DIGITAL meetings communicate the DCH position, challenges and opportunities		Ruth Gardiner		Active involvement/contribution in ICB digital and transformation related meetings, initiatives	DCH Digital leads including CIO, Head of Systems and Head of Infrastructure play leading roles across all major ICB Digital initiatives. Active current discussions, contribution and leadership of some workstreams around single Dorset EPR and how a single Digital Service for Dorset could be provisioned as key examples. Other regular meetings have active DCH representation including weekly Dorset CIO meetings, Dorset Informatics Group, Dorset Care Record etc.
			Ongoing now		6. At ICB and other system LEADERSHIP meetings communicate the DCH position, challenges and opportunities		Nick Johnson			Weekly CEO calls and Senior Leadership Team meetings in place
			Ongoing now		7. At ICB and other system WORKFORCE meetings communicate the DCH position, challenges and opportunities		Emma Hallett			Acting CPO attending monthly Dorset CPO Meeting and Dorset People and Culture Steering Group (both chaired by ICS CPO)
			Ongoing now		8. At ICB and other system STRATEGY & TRANSFORMATION meetings		Paul Lewis	Phil Davis		DCH Strategic Priorities have been agreed at Executive level. (Complete) (Underlying Projects and Target Outcomes) – have been shared with UHD and ICS.

No.	Area	Recommendation	Timescale	Priority	Action	Action Progress Status	Responsible Executive	Management Lead	Assurance	Evidence
					communicate the DCH position, challenges and opportunities					Attendance by Head of Strategy at ICS Planning meeting. (Complete) Meeting with UHD Director of Transformation & Improvement planned Nov 22
			Ongoing now		9. Invite ICS colleagues to EMT & Board		Nick Johnson	Laura Symes		Exec to Exec with DHC Oct 22 and Nov 22 UHD attended EMT Nov 22
		• Ensuring DCH is communicating in a way that is impactful - consider who is giving the messages and in what forum.	December 2022	**Medium**	10. Stakeholder Messaging Strategy to be developed.		Nick Johnson	Phil Davis		A map of key stakeholders system wide in Strategy has been pulled together, with details of who has relationships with these people, and what meetings they are at.
			Ongoing now		11. Develop regular key messages for sharing INTERNALLY		Nick Johnson	Paul Lewis		New Corporate Planning Cycle developed and taken to EMT & SLG (Complete) This includes engagement sessions for DM/CG leads as they move into business planning for FY23/24 (Complete) Development of Strategic Services Review, extensive discussions with Divisional and CG Managers (and Theatres Manager) ongoing, to compliment their own planning.(ongoing) Strategy & Transformation monthly update, has been developed – simple bulleted email and cross cutting themes, for CEO/Chair and other Execs. This will help inform DCH board with latest position/messages, and help them in communications with system. (First edition Complete)

No.	Area	Recommendation	Timescale	Priority	Action	Action Progress Status	Responsible Executive	Management Lead	Assurance	Evidence
										DCH Strategic Services Reviewing refreshed for M6 - key messaging will be used in comms to specialties and Corp Functions (Ongoing)
			December 22		12. Develop regular key messages for sharing EXTERNALLY		Nick Johnson	Paul Lewis		Work with CEO, EMT and SLG to develop key messages (Ongoing)
			Ongoing now		13. Agree with Trust Board key messages & positives relating to ICS/ICB		Nick Johnson	Phil Davis		BAF updated and improved, in 7th iteration –all Board committees review relevant risks. (Complete) Balanced Scorecard now part of Board reporting, simple impactful metrics +SPC pointing to our performance – help monitor improvement (fully live in Board November 2022). Strategy Dashboard, worked up after EMT feedback, pending completion in December 22. Will sit alongside BAF and be key tool in demonstrating delivery plan and progress for Trust Strategy. Board Development Session covered NHS Operating Framework and developing ICP strategy and impact on the Trust. (Complete),
		• Training to service managers and clinicians on system working, including the leadership skills and capabilities required to		**Medium**	14. Linked to People Plan – development and roll out of the Management Matters Programme for all staff stepping into management post – bands 6 and above.	Complete	~~Dawn Harvey~~ Emma Hallett	Julie Barber		**Management Matters** – focus groups completed, and programme designed. Cohort 1 of the programme commences in November 2022.

No.	Area	Recommendation	Timescale	Priority	Action	Action Progress Status	Responsible Executive	Management Lead	Assurance	Evidence
		deliver successful cross-system projects								
			Next session March 2023		15. Leadership engagement events twice a year		Emma Hallett	Julie Barber		Bi-annual Leadership Summits agreed, first one held on 5th September. Agenda and covered: (1) Strategic oversight, ICS, DHC & collaborative working. (2) Operational Finance & Performance, financial challenges/thinking & working differently (3) How we do Assurance at DCH – difference between reassurance & assurance, environment more focused on finance & performance. Session was well attended and well received.
			January 23		16. Provide system QI & project skills training		Paul Lewis	Head TIO		The Quality Improvement Lite (QI Lite) training package was developed using QI expertise within DCH and has been rolled out to partners, alongside Project Management Lite (PM Lite). (Complete) (QSIR) programme continues to run with input from across the system, with more plans to work together in 2023/24.
		•	January 23		17. Engage staff with Place Based Partnership, case study and promote cross-system projects		Paul Lewis	Head TIO		Engagement event in planning (for Jan-23), for targeted DCH Clinical and service leads, with ICS representatives invited – on what Place and Provider collaborations mean – and helping them identify cross system working benefits in their areas (and champions within DCH) (Ongoing) Maintain West Dorset Place meetings

No.	Area	Recommendation	Timescale	Priority	Action	Action Progress Status	Responsible Executive	Management Lead	Assurance	Evidence
										Maintain West Dorset Clinical Collaborative working
		• As part of the strategy review and trust priority process, consider ways to communicate the outputs with internal & external stakeholders.	Jan – May 23	**Medium**	18. INTERNAL Communication & stakeholder engagement plan		Paul Lewis	Phil Davis		6 monthly Strategy update to Board (planned December 22). Strategy engagement sessions with Divisions as part of business planning (complete). Strategy engagement session planned with Corporate functions (planned for Jan-23) SLG, Sub-committees and Board received regular strategy and priorities updates. Re-publish on Intranet site _+ comms when appropriate
			Jan – May 24		19. EXTERNAL Communication & stakeholder engagement plan		Paul Lewis	Phil Davis		Engage with ICB, UHD, DHC and Primary Care West Dorset Clinical Collaborative ICS Strategy leads Publish on Internet site (Planned)
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. People Plan. Review of recruitment, appraisals, performance management, policies and procedures.		Emma Hallett			Revised Appraisal process launched in November 2022. Review of provider recruitment services being undertaken in conjunction with ICS during Q4. The DCH People Plan will be updated in early 2023, to re-test if is still valid and to check it is aligned to the ICB People Strategy. Workforce (and People Plan) has been elevated in the strategic priorities for the trust – in particular Attract & Retain and Agency Reduction.

No.	Area	Recommendation	Timescale	Priority	Action	Action Progress Status	Responsible Executive	Management Lead	Assurance	Evidence
			January 23		2. Clinical plan alignment to strategy		Alastair Hutchison	Phil Davis		Clinical Plan aligned to the DCH Strategy and any new business cases are expected to be aligned (monitored through Strategy and Transformation SLG) (Ongoing Business Planning feeding into this). Clinical Plan will be updated in early 2023, to re-test it is still valid. Annual refreshing of Clinical Plan will support alignment to the Trust Strategy and ambition is for this to be complementary to the Business Planning process.
					3. Digital plan alignment to strategy		Ruth Gardiner			Digital Strategy, programmes and projects are fully aligned with Strategic objectives. Large scale strategic programmes have digital enablers embedded within the programmes and projects associated with strategy delivery. New requirements for digital assets are evaluated against Trust strategic objectives.
			January 23		4. Ongoing strategy monitoring		Paul Lewis	Phil Davis		Business planning for FY23/24 - is grounded in Trust Strategy/Strategic Priorities, and structures cross talk between Digital/Workforce/Finance and CGs and Corp functions – for refreshed and joined up plans and informed staff. (Ongoing) The Corporate Planning Cycle is aligned to Strategic Priorities and Strategy Dashboard giving assurance of Project Output Delivery. This will be wrapped back up into performance against Clinical Plan and People Plan. (Ongoing)
Responsible Committee:		Quality Committee – Clinical Plan Finance and Performance Committee – Digital Plan People and Culture Committee – People Plan								

No.	Area	Recommendation	Timescale	Priority	Action	Action Progress Status	Responsible Executive	Management Lead	Assurance	Evidence
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.	Ongoing now	**Medium**	1. Develop and implement Care Group level Performance Dashboards in support of quarterly reporting requirements. Strategic Change and Leadership / Improvement Capability.		Anita Thomas	Phil Davis		CGs receive monthly Financial, Activity & Workforce Performance Dashboards – via Finance & Workforce Business Partners and BI team. Custom productivity and Strategic Services views have been supplied at YE21/22 and for M6 22/23. All above has SPC applied. Balanced Scorecard Dashboard at Board, and drillable down to CGs/Corp functions – now part of fabric of Board packs/reporting. (Complete). Dashboard suite and support from BI teams is especially advanced in critical performance areas eg. Agency reduction and EL recovery (ongoing)
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.	December 2022	**Medium**	1. See 5 above re Performance Management Framework.		Anita Thomas	Divisional Managers		Care Groups to demonstrate the measures of performance that they are using. This forms part of the Corporate Governance CG Audit November 2022
			December 2022		2. Identify Care Group clinical leaders to lead Care Group meetings.		Anita Thomas	Divisional Managers		Family and Surgical Services have leadership in place per care group Urgent and Integrated Care are completing a review to align matron to a Care Group and then the leadership roles are identified for the Division – presentation to SLG planned (November 22)
			December 2022		3. Implement a programme of divisional and care groups leadership development –		Anita Thomas	OD Team		Included in the Care Group audit November 2022 – Care Groups to demonstrate and evidence leadership development that is in place. Management Matters launches in November 2022

No.	Area	Recommendation	Timescale	Priority	Action	Action Progress Status	Responsible Executive	Management Lead	Assurance	Evidence
					consider Myers Briggs or 4OD.					
			December 2022		4. Implement a minimum of monthly 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		Divisions have completed internal audit of CG governance. Corporate Governance Audit in progress November 2022. U&IC Division awarded SoF 2 following consistent performance in Q1 and Q2 22/23 including upward reporting from Care Group against the framework.
			December 2022		5. Standard Agendas for Care Group meetings to be re-established.		Anita Thomas	Divisional Managers		Corporate Governance Audit in progress November 2022.
					6. Care Group action plans outlining how the above will be delivered to be developed.	Complete	Anita Thomas	Divisional Managers		Clear systems, process and infrastructure in place at care group level. Divisional teams have reviewed
			December 2022		7. Audit divisional and Care Group meetings to ensure these are happening, are quorate and are covering score card domain subjects		Anita Thomas	Corporate Governance Team		Quarterly meetings recommenced. Audit tool refined and agreed with COO and underway to evidence. U&I C Division given Segment 2 following review of Q1 and Q2 submissions. Corporate Governance Audit in progress November 2022.
Responsible Committee:		Divisional Performance Reviews with Executives – see also section 5								
7	**Leadership Visibility**	Implement a more structured	September 2022	**Low**	1. Re-energise the Executive	Complete	~~Dawn Harvey~~			Executive, Wellbeing, NED and Safety walk arounds continue.

No.	Area	Recommendation	Timescale	Priority	Action	Action Progress Status	Responsible Executive	Management Lead	Assurance	Evidence
		approach to Board visibility across the organisation for example through periodic Executive briefings			Walkabouts Programme and Staff Wellbeing visits		Emma Hallett			A central record of these is now maintained by the CEO office to ensure all areas of the Trust are covered. Weekly CEO communications to all staff continues
					2. Recommence NED Safety Visits Programme to site in May 2022 in line with national guidance which were paused in line with national guidance.	Complete	~~Nicky Lucey~~ Emma Hoyle	Kerry Little	Updates as per evidence summaries and minutes of committees/board etc	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.	Complete	~~Dawn Harvey~~ Emma Hallett	Susie Palmer		Team briefing has been reviewed and re-launched in October 2022 as a hybrid meeting in response to feedback from attendees. The number of slides and speakers have 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	Complete – in terms of groups and networks re-established since covid	~~Nicky Lucey~~ Emma Hoyle	Ali Male	Patient experience group minutes and reports to QC, safeguarding minutes (reference Learning disabilities and MCA)	Patient Experience Group notes and partnership with Healthwatch Dorset, independent providers (such as charities) and Patient and Public engagement groups. Dorset Abilities co-design work on ED build and accessible information People First Dorset collaboration on Learning Disabilities and Autism (see Safeguarding Group notes and annual report) Young Volunteers work with Dorset Council and Healthwatch Dorset to help with transition work stream

No.	Area	Recommendation	Timescale	Priority	Action	Action Progress Status	Responsible Executive	Management Lead	Assurance	Evidence
										Dorset Parent and Carer council supporting transition for young people into adult services. Live action and performance reported via Patient Experience Group and reported to Quality Committee
					2. Maternity Voices Partners (part of the LMNS Transformation Programme in place	Complete	~~Nicky Lucey~~ Emma Hoyle	Jo Hartley	Part of LMNS governance and nots/programme tracker. Reports into QC	MVP now recruited and active in the LMNS and linked to specific Trust Maternity Service. Recent MVP visit to the maternity service was very positive with detailed feedback from service users provided. Co-production of patient information ongoing. Live action reported to Quality 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	Complete	Alastair Hutchison	Stuart Coalwood & Andy Miller		Email available on request
					2. Divisional teams to present outline plan to June Quality Committee	Complete	Alastair Hutchison	Stuart Coalwood & Andy Miller		See minutes of June and subsequent meeting. Clinical Audit Reports are well established.
Responsible Committee:		Quality Committee.								

Report Front Sheet

1. Report Details			
Meeting Title:	DCHFT Board		
Date of Meeting:	30 November 2022		
Document Title:	DCH Social Value Programme Report (6 month)		
Responsible Director:	Emma Hallett, Acting Chief People Officer	Date of Executive Approval	21/11/2022
Author:	Simon Pearson, Head of Charity & Social Value		
Confidentiality:	No		
Publishable under FOI?	Yes		
Predetermined Report Format?	No		

2. Prior Discussion		
Job Title or Meeting Title	**Date**	**Recommendations/Comments**
Social Value Programme Group	17.11.22	Social Value Action Plan review
Senior Leadership Group	23.11.22	Noted/Recommended to Board

3. Purpose of the Paper	Progress report for DCH Social Value programme (6 month)							
	Note (✓)	✓	*Discuss (✓)*		*Recommend (✓)*		*Approve (✓)*	
4. Executive Summary	This paper highlights the progress and key developments for the DCH Social Value programme. Key elements in the report include: • DCH Social Value Action Plan review (6 month) • IMPACT Social Value reporting platform • Embedding Social Value across DCH • Estate capital projects – social value delivery • Health Anchors Learning Network • Dorset ICS: Dorset Anchors Network update							
5. Action recommended	DCHFT Board is recommended to: 1. **NOTE** the progress of the DCH Social Value programme.							

6. Governance and Compliance Obligations			
Legal / Regulatory Link		**No**	*If yes, please summarise the legal/regulatory compliance requirement. (Please delete as appropriate)*
Impact on CQC Standards		**No**	*If yes, please summarise the impact on CQC standards. (Please delete as appropriate)*
Risk Link		**No**	*f yes, please state the link to Board Assurance Framework and Corporate Risk Register risks (incl. reference number). Provide a statement on the mitigated risk position. (Please delete as appropriate)*
Impact on Social Value	**Yes**		Supports Social Value Pledge as reports on delivery of DCH Social Value programme
Trust Strategy Link	**How does this report link to the Trust's Strategic Objectives?** *Please summarise how your report will impact one (or multiple) of the Trust's Strategic Objectives (positive or negative impact). Please include a summary of key measurable benefits or key performance indicators (KPIs) which demonstrate the impact.*		

Strategic Objectives	People	Social value commitments to local employment; good employer and EDI.		
	Place	Social value contributes to the social and economic health of our local communities.		
	Partnership	Social value pledge aims to work with Dorset anchors across the ICS system.		
Dorset Integrated Care System (ICS) Objectives		**Which Dorset ICS Objective does this report link to / support?** *Please summarise how your report contributes to the Dorset ICS key objectives.* *(Please delete as appropriate)*		
Improving population health and healthcare		**Yes**		Addressing social determinants of health.
Tackling unequal outcomes and access		**Yes**		Addressing social determinants of health.
Enhancing productivity and value for money		**Yes**		Local investment and employment.
Helping the NHS to support broader social and economic development		**Yes**		Social value contributes to the social and economic health of our local communities, through provision of local employment and local investment in Dorset economy.
Assessments		**Have these assessments been completed?** *If yes, please include the assessment in the appendix to the report..* *If no, please state the reason in the comment box below.* *(Please delete as appropriate)*		
Equality Impact Assessment (EIA)		**Yes**	**No**	N/A
Quality Impact Assessment (QIA)		**Yes**	**No**	N/A

DCH Social Value Programme: Progress Report (6 month) Nov 2022

Our Social Value Pledge
Dorset County Hospital Foundation Trust, as an anchor institution, commits to maximise the positive social value impact we have on our local communities, contributing to improving the economic, social and environmental well-being of the local population. Through our approach to delivering social value as an Acute Trust, we aim to reduce avoidable inequalities and improve health and wellbeing across our community. Our Social Value Pledge is available here: https://www.dchft.nhs.uk/about-us/social-value/

This report presents a six-month progress update in implementing our Social Value programme.

- **DCHFT Social Value Action Plan:** our operational plan comprises key workstreams which reflect our social value commitments and objectives. The Social Value Programme Group are currently carrying out a six-month review and update of the plan.

- **Social Value Evaluation/Reporting:**

  IMPACT Social Value Reporting: this online platform has been implemented. The Social Value Programme Group are currently populating the platform with key DCH social value projects, activities and goals from the Social Value Action Plan – expected completion Jan 2023. IMPACT will provide DCH social value reporting data and information for future reports to SLG and Board once completed.

- **Embedding Social Value across DCH:**

  Strategic: Social Value Programme Group continue work on embedding social value in the Trust's strategic planning process, integrating social value into business planning and operational activities. DCH Social Value attends SLG Working Group to ensure social value considerations represented in Trust business cases.

  Social Value Impact Assessment (SVIA): is now included in the Trust policies checklist approval form, requiring consideration of the social value impact of new and reviewed policies. Please see the SVIA form here: http://sharepointapps/clinguide/CG%20docs1/2055-Social-value-assessment-FORM.doc.

  Board Assurance Framework: Work in progress to incorporate social value in the Board Assurance Framework to monitor delivery of social value programme.

- **NHS Trust Carbon Footprint Estimates:** NHSE's first published estimate of individual trusts' contribution to the NHS Carbon Footprint Plus, consistent with the emissions data used to establish the emissions reduction trajectory set out in the Delivering a Net Zero NHS report. The document, received by DCH on 16.11.22,

provides an estimate of DCH's contribution to the NHS Carbon Footprint Plus for the period 2019/20. NHSE advise this footprint data should be used for baselining, identifying emissions hotspots, and understanding NHS organisations' contributions to the national emissions set out in the Delivering a Net Zero NHS report. Consideration now required about DCH's approach to using this data in line with the Trust's Green Plan carbon reduction objectives.

- **Estate Capital Projects:** DCH Social Value lead has met with Head of Social Value for Tilbury Douglas who will be building the new Emergency Department and Critical Care Unit. Tilbury Douglas will produce a social value plan to measure and report on the social return on investment delivered by this major capital project. Next meeting planned for December 2022.

- **Scholarship Programme:** this programme ran at DCH in September and provides an excellent example of social value in action. The programme was targeted at Year 13 school leavers and consisted of a cohort of 15 young people over a 2-week period. 11 of those15 have subsequently interviewed and joined DCH as HCA's.

- **Health Literacy:** information 'postcards' have now been developed, working with DCH Librarian and others, to explain social value and health inequalities terminology and objectives. Plans in progress to communicate these with staff teams and across the hospital.

- **Health Anchors Learning Network (HALN):** DCH is a member of the Health Anchors Learning Network (HALN), led by the Health Foundation and NHSE, to learn and develop best practice for the NHS's role as anchor institutions contributing to the social, economic and environmental well-being of the communities it serves. DCH Social Value lead attends HALN meetings. Information about HALN including resources and events is available here: https://haln.org.uk/

- **Dorset ICS – Dorset Anchors Network (DAN):** DCH Social Value lead met with Dorset Anchors Network lead on 18.11.22 to discuss plans for moving the network forward. DAN lead is developing an Our Dorset Anchor Institutions Maturity Matrix to test with DAN members, which would capture baseline information relating to four key anchor institutions impact themes – Employment/Procurement/Estate/Environment. Plans to introduce this approach through the network in early 2023.

Simon Pearson MCIOF
Head of Charity & Social Value

Meeting Title:	**Board of Directors**
Date of Meeting:	30th November 2022
Document Title:	**Mortality Report: Learning from deaths Qtr 2 2022-23**
Responsible Director:	Prof. Alastair Hutchison, Medical Director
Author:	Prof. Alastair Hutchison, Medical Director

Confidentiality:	Public
Publishable under FOI?	Yes

Prior Discussion		
Job Title or Meeting Title	**Date**	**Recommendations/Comments**
Hospital Mortality Group	16th November 2022	None specific
Quality Committee	22nd November 2022	

Purpose of the Paper	To inform the Board of Directors of the learning that has occurred as a result of deaths being reported, investigated and appropriate findings disseminated throughout the Trust.
Summary of Key Issues	The latest published SHMI data for DCH was above the 'Expected Range' for the rolling 12 months to March, April, May & June 2022 (page 5), possibly influenced by a fall in the depth of coding. No other local or national indicators suggest excess unexpected deaths are occurring at DCH. Structured Judgement Reviews are used to examine the care of a significant sample of people who died whilst in-patients (around 20%), and to learn from any good practice or lapses in care identified. The DCH Medical Examiners review every death, speak to immediate relatives and highlight any obvious causes for concern.
Action recommended	The Board of Directors is recommended to: 1. **NOTE** the report 2. **APPROVE** the report for publication on the DCH internet website

Governance and Compliance Obligations

Legal / Regulatory	Y	Learning from the care provided to patients who die is a key part of clinical governance and quality improvement work (CQC 2016). Publication on a quarterly basis is a regulatory requirement.
Financial	Y	Failure to learn from deaths could have financial implications in terms of the Trust's claim management and CNST status.
Impacts Strategic Objectives?	Y	Learning from the care provided to patients who die is a key part of clinical governance and quality improvement work (CQC 2016). Ensuring that an elevated SHMI is not a result of lapses in care requires regular scrutiny of various data and careful explanation to staff and the public. An elevated SHMI can have a negative impact on the Trust's reputation both locally and nationally.
Risk?	Y	• Reputational risk due to higher than expected SHMI • Poor data quality can result in poor engagement from clinicians, impairing the Trust's ability to undertake quality improvement • Clinical coding data quality is improving, but previously adversely affected the Trust's ability to assess quality of care • Clinical safety issues may be under-reported or unnoticed if data quality is poor • Other mortality data sources (primarily from national audits) are regularly checked for any evidence of unexpected deaths.
Decision to be made?	N	
Impacts CQC Standards?	Y	An elevated SHMI will raise concerns with NHS E&I and the CQC. The previous reduction in SHMI and improvements in coding are acknowledged, but Covid-19 and elective tariff incentivisation targets have adversely influenced coding and therefore recent SHMI figures are inaccurate.
Impacts Social Value ambitions?	N	
Equality Impact Assessment?	N	
Quality Impact Assessment?	N	

CONTENTS

1.0 DIVISIONAL LEARNING FROM DEATHS REPORTS

Each Division is asked to submit a quarterly report outlining the number of in-patient deaths, the number subjected to SJR, and the outcomes in terms of assessment and learning. See appendix 1 and 2 for full reports (not published).

1.1 Family Services and Surgical Division Report - Quarter 2 Report

Structured Judgement Review Results: The Family Services & Surgical Division had 60 deaths in quarter 2 that require SJR's to be completed. Across the Division 42 SJRs have been completed in quarter 2 however 34 of these SJRs were completed for deaths reported in previous months.

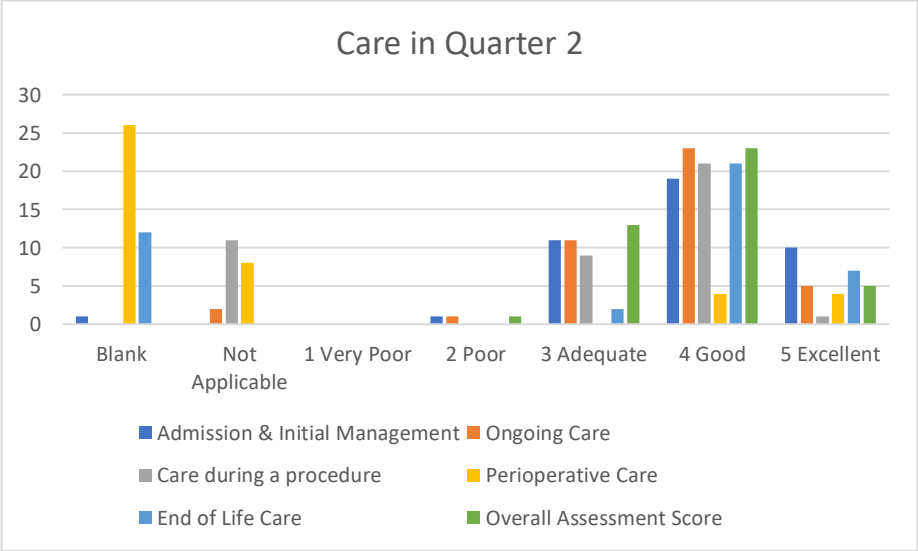
SJR Backlog (incomplete >2 months): Current number of outstanding SJR's for the Division is 48 (on 11/10/22)

Oct 21	Nov 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	July 22	Aug 22
3	2	4	5	2	4	2	5	5	16

The availability of the notes for these patients has been re-checked to ensure Clinical staff can complete this work. It has been identified that 23 sets of patient records are only available on DPR and so these SJR's will be unable to be completed.

Feedback from SJR's completed in quarter 2:

Phase Score	Admission & Initial Management	Ongoing Care	Care during a procedure	Perioperative Care	End of Life Care	Overall Assessment Score
Blank	1			26	12	
Not Applicable		2	11	8		
1 Very Poor						
2 Poor	1	1				1
3 Adequate	11	11	9		2	13
4 Good	19	23	21	4	21	23
5 Excellent	10	5	1	4	7	5



Overall Quality of Patient Records:

Blank	Score 1 Very poor	Score 2 Poor	Score 3 Adequate	Score 4 Good	Score 5 Excellent
3		3	8	24	4

Avoidability of Death Judgement Scores:

Score 1 Definitely avoidable	Score 2 Strong evidence of avoidability	Score 3 Probably avoidable (more than 50:50)	Score 4 Possibly avoidable but not very likely (less than 50:50)	Score 5 Slight evidence of avoidability	Score 6 Definitely not avoidable
0	0	0	2	2	38

Learning from the Division:

In the previous quarter we noted a new Quality Manager who set the following workplan:

- Track completed SJRs with open actions DATIX to ensure actions are completed in line with recommendations. This is working well with SJRs closed off promptly and the mortality spreadsheet up to date.
- Capture SJRs that are not fully completed on DATIX due to missing scores. Any missing data is being challenged with the person responsible for the SJR so they can be promptly rectified, more work required to improve the reporting.
- Support the clinicians to manage the backlog by ensuring notes are available for outstanding SJRs. Medical notes have been requested for all the outstanding SJRs from the various departments. It has been noted that 23 patients identified for an SJR only have scanned notes on DPR which makes performing an SJR difficult.

Action Recommendations:

No Action required	Consideration for RCA	Further Learning required	Other Action	Referred to Trust Group / Committee	Blank / not recorded	For coroners review
32	1	1	5	1	1	1

Dates of 2022 M+M meetings:

Specialty	July	August	September	October	November	December
Anaesthetics	8th July 2022	5th August 2022	2nd and 30th September 2022	28th October 2022	25th November 2022	23rd December 2022
Gastroenterology	6th July 2022	3RD August 2022	7th September 2022	5th October 2022	2nd November 2022	7th December 2022
Breast Surgery	Hosted by YDH – Checking on future dates					
General Surgery + Colorectal	8th July 2022	5th August 2022	2nd and 30th September 2022	28th October 2022	25th November 2022	23rd December 2022
Head, Neck & Specialist	15/07/2022	12th August 2022	6th September 2022			
Orthopaedics						
Maternity Safety Report	15th July 2022	18TH August 2022	16th September 2022			
Perinatal	27th July 2022	24th August 2022	21st September 2022	19th October 2022	23rd November 2022	TBC
Paediatrics	6th July 2022	3rd August 2022	7th September 2022	5th October 2022		
Urology						
ENT	15th July 2022	26TH August 2022	23rd September 2022	TBC	TBC	TBC

Report completed by: Richard Jee – Divisional Mortality Lead
Michelle Purdue – Interim Quality Manager

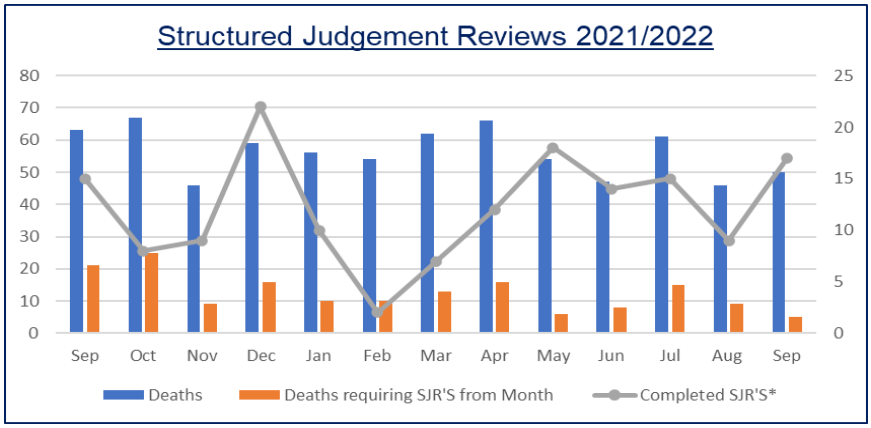
1.2 Division of Urgent & Integrated Care – Quarter 2 Report

Structured Judgement Reviews: In quarter 2 there were 157 deaths, 29 SJRs requested from these deaths and 41 were completed in total (completed SJRs not necessarily from this quarter).

	Apr-22	May	June	July	Aug	Sep	Total YTD
Deaths	66	54	47	61	46	50	324
Deaths requiring SJR'S from Month	16	6	8	15	9	5	59
Completed SJR'S*	12	18	14	15	9	17	85

Total outstanding SJR's (not including nosocomial's) = **15 (27)**
Outstanding SJR's >2 months (prior to 14/08/2022) = **8 (15)**

21 Nosocomial deaths (not included in above figures) will be reviewed by James Metcalf and a summary report will be written for HMG (9 reviewed so far on 13/06/22), 12 still to review). – JM Still pending review of final 12.



'Phase of care' score from 39 completed SJR's in Quarter 2:

Phase Score	Admission & Initial Management	Ongoing Care	Care during a procedure	Perioperative Care	EoL Care	Overall Assessment Score
N/A or Blank	0	1	26	41	7	1*
1 Very Poor	0	0	0	0	0	0
2 Poor	0	2	0	0	1	0
3 Adequate	8	6	6	0	4	12
4 Good	28	29	8	0	25	25
5 Excellent	5	3	1	0	4	3

*Returned to clinician who completed for overall assessment score to be added – 14/10/22

Overall quality of patient record

Blank	Score 1 Very Poor	Score 2 Poor	Score 3 Adequate	Score 4 Good	Score 5 Excellent
1	0	1	20	16	3

Avoidability of Death Judgement Score

Score 1 Definitely avoidable	**Score 2** Strong evidence of avoidability	**Score 3** Probably avoidable (> 50:50)	**Score 4** Possibly avoidable but not very likely (<50:50)	**Score 5** Slight evidence of avoidability	**Score 6** Definitely not avoidable
0	0	0	1	1	39

Dates of 2022 M+M meetings:

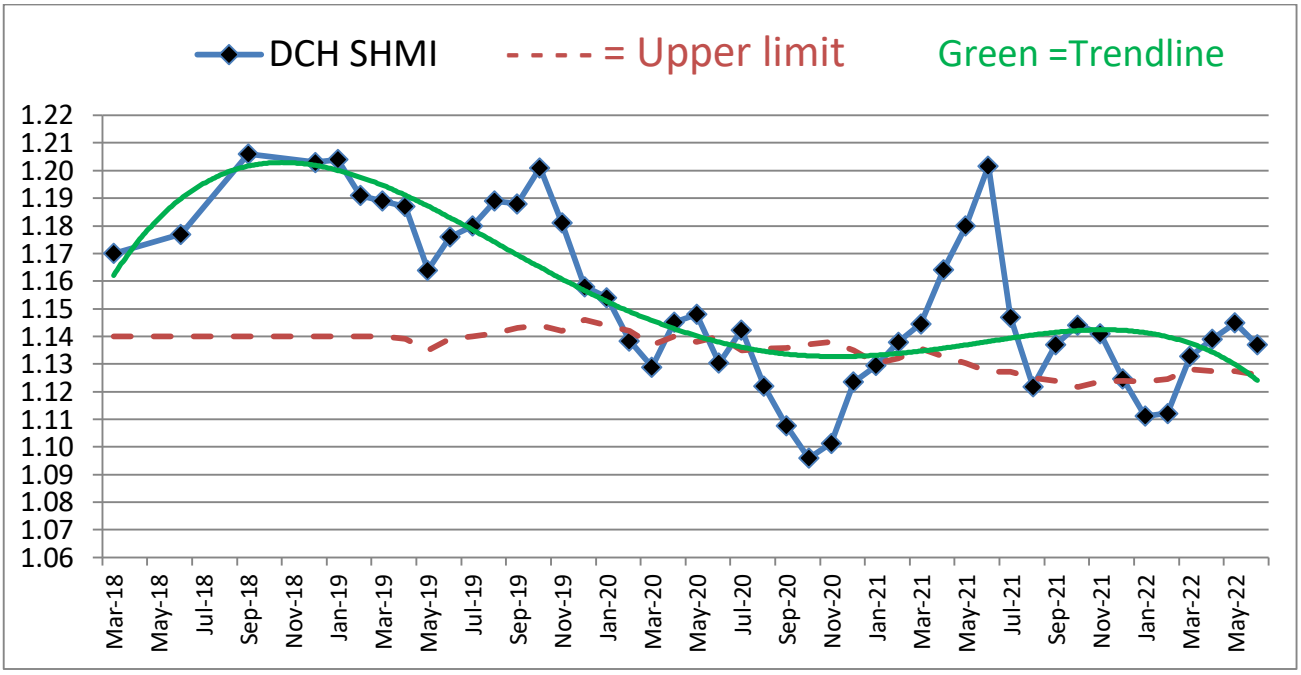
Specialty	Contact	April	May	June	July	Aug	Sep	Oct	Nov	Dec
Cardiology	Helen Dell E Boston-Griffiths	12/04/22	24/05/22	29/06/22	05/07/22		27/09/22		08/11/22	20/12/22
Renal	Kathleen O'Neill	04/2022	x	29/06/22	27/07/22	x				
Vascular	James Metcalfe	Weekly at DCH Monthly at Network Mtg's in Bournemouth 14/07/22 and 16/09/22								
Diabetes	Mo-Lee Wong		15/6/22	x	17/08/22Rearranged	28/09/22	19/10/22 Rearranged	30/11/22	15/6/22	
Oncology	Abi Orchard		20/05/22	17/06/22						
Haematology	Sarah Attfield Jill McCormick	X	X	X	X	X	X	X	07/11/22	05/12/22
ED & AM	Andy Brett James Ewer			16/06/22		18/08/22				
Respiratory (1/4 M+M)	Marianne Docherty	26/04/22	24/05/22	28/06/22	26/07/22	23/08/22	27/09/22			
EC & Stroke	James Richards Harold Proschel	X	13/05/22	X	X	10/08/22	X	21/10/22	11/11/22	X

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

2.0 NATIONAL MORTALITY METRICS AND CODING ISSUES

2.1 Summary Hospital-level Mortality Indicator (SHMI)

SHMI is published by NHS Digital for a 12 month rolling period, and 5 months in arrears. It takes into account all diagnostic groups, in-hospital deaths, and deaths occurring within 30 days of discharge. The SHMI for the rolling years from October 2020 to June 2021 showed a clear reversal of the previous trend to improvement, then stabilised around a SHMI of 1.11 (within the 'Expected Range'). However, the most recently published data for March to June 2022 has risen outside the 'Expected Range' we know that our data continues to be adversely influenced by difficulties in the Coding Department. Revised data was submitted for the end of year HES submission in mid May is included in the calculations for May and June 2022. However the depth of coding in this data appears to have been relatively poor – see section 2.4 below. A new Senior Coder has been appointed following the departure of Sue Eve-Jones, and is due to start work before the end of November. The latest published SHMI (rolling year to June 2022) is shown below:



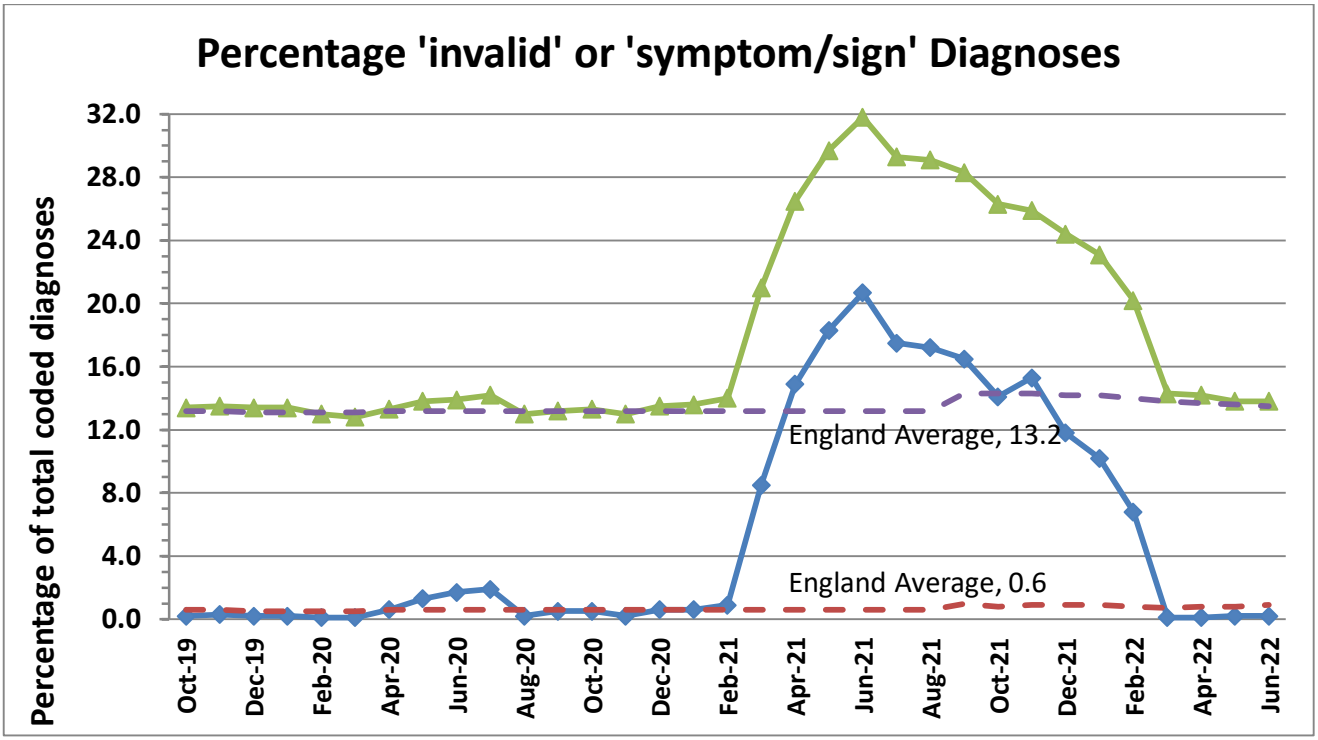
SHMI is calculated by comparing the number of observed (actual) deaths in a rolling 12 month period to the expected deaths (predicted from coding of all admissions). From October 2019 onwards there had been a steady trend of improvement in DCH's SHMI as a result of investment in the coding department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

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

DCH has recently had a very high but now normalised number of spells with a primary diagnosis which is a symptom or sign – for example either no entry at all (uncoded), or 'chest pain' rather than 'myocardial infarction' – at 31.8% for June 2021 but improving progressively since then to a latest figure of 13.8% for June 2022. The England average is around 13.5%.

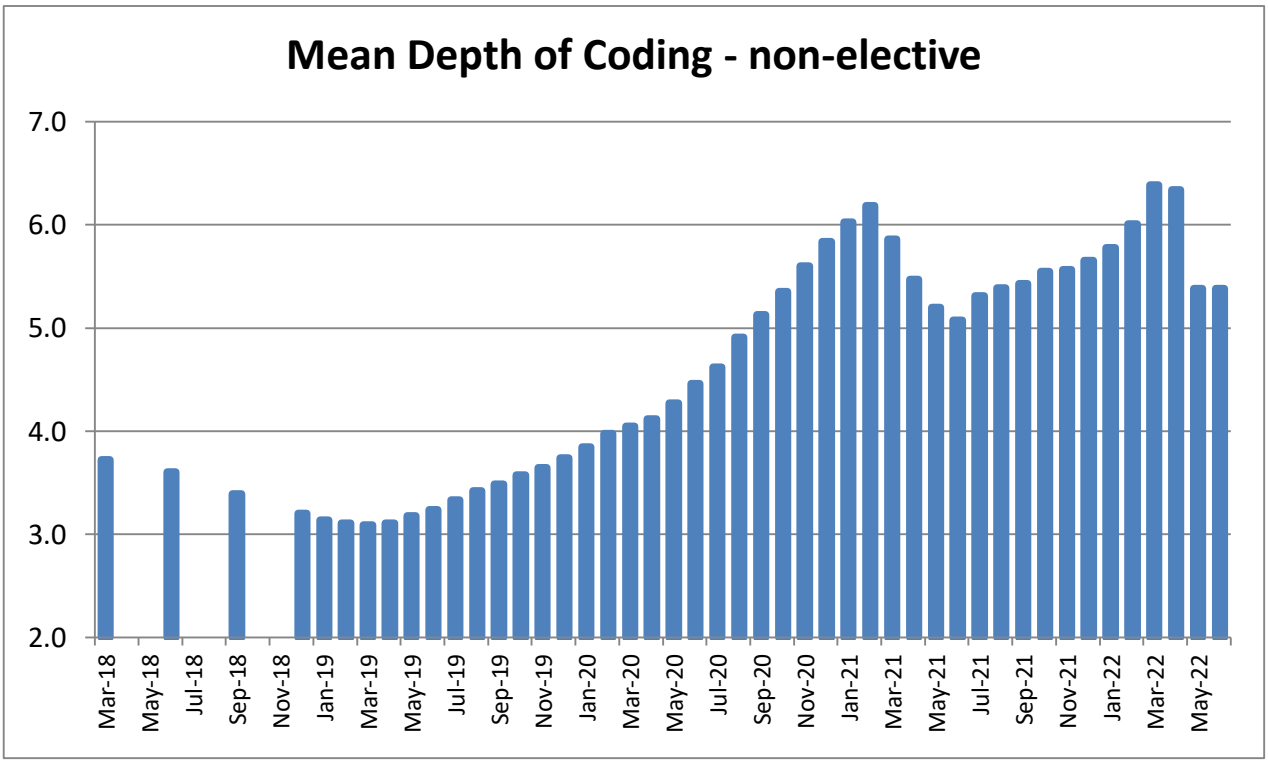
2.3 Percentage of provider spells with an invalid primary diagnosis code: NHS Digital states "*This indicator presents the percentage of finished provider spells with an invalid primary diagnosis code (identified as those spells where the primary diagnosis is given by the ICD-10 code R69X). A high percentage of provider spells with an invalid primary diagnosis code compared to other trusts may indicate a data quality problem*."

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



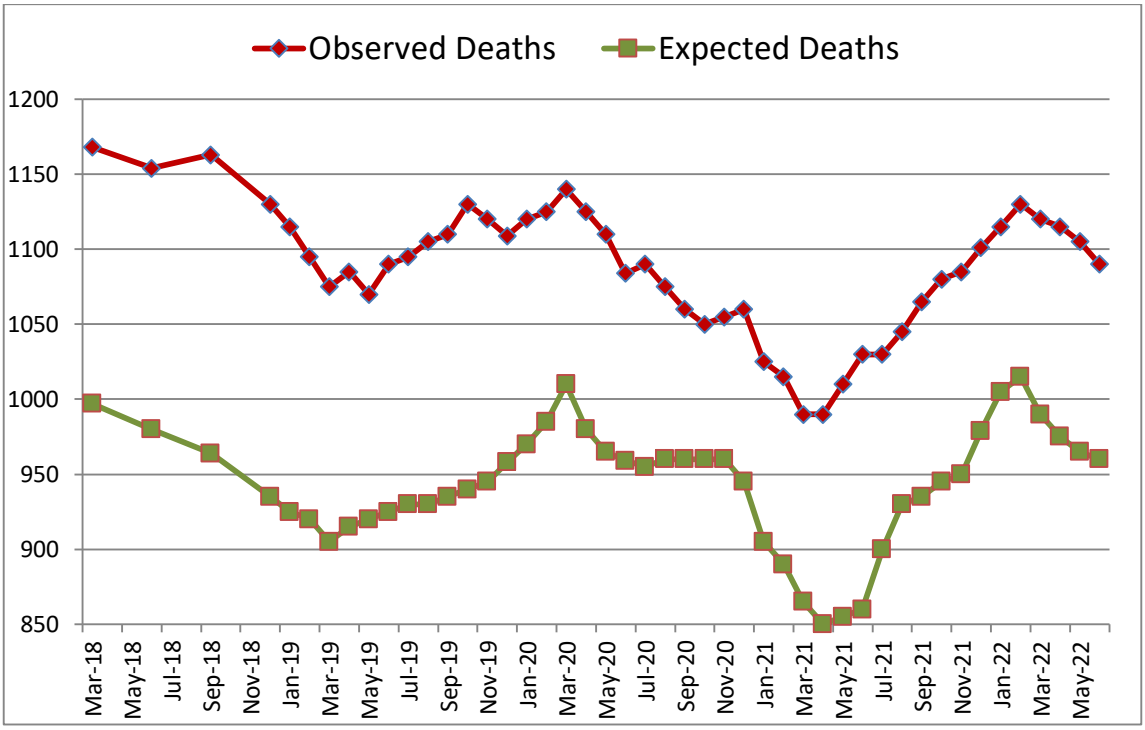
2.4 Depth of coding: NHS Digital states "*As well as information on the main condition the patient is in hospital for (the primary diagnosis), the SHMI data contain up to 19 secondary diagnosis codes for other conditions the patient is suffering from. This information is used to calculate the expected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

DCH's depth of coding had been improving steadily up to March 2022 (see graph below), but the two most recently reported months which include the corrected M14 data show a significant decrease. It suggests that the coding department concentrated on primary diagnoses alone rather than depth of coding as they corrected the backlog of uncoded data. This may partially explain the recent reduction in 'Expected Deaths' and consequent rise in SHMI.

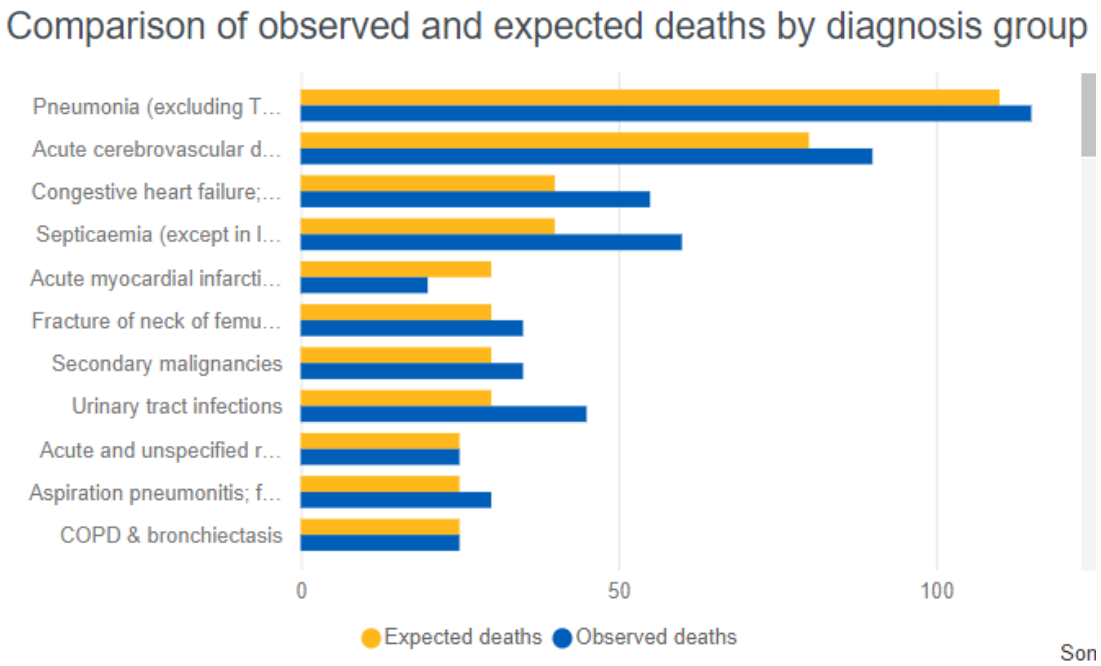


2.5 Expected Deaths (based on diagnoses across all admissions per rolling 12 months):

The chart below shows observed and expected deaths over the past 3+ years (rolling years from March 18 to June 22), and whilst both observed (actual) and expected deaths have increased (as total number of in-patients increases post covid-19), the expected deaths have decreased over the 4 months to June 22, possibly as a result of the focus on recovery of the coding backlog. Prof. Hutchison has arranged to meet the new Coding Manager as soon as she arrives on site to discuss this data in detail.



2.6 Comparison by 'Diagnostic Group Description'



Several diagnosis groups have higher observed numbers of deaths than Expected although only one of these is statistically significant – Septicaemia. These groups are being investigated further where appropriate – the total number of cases differs significantly between grooups, so for example the data contains 620 cases of 'pneumonia' versus only 60 cases of 'aspiration pneumonitis'.

2.7 Communication with NHS Digital:

We continue to engage with NHS Digital who have suggested investigating **the SHMI Extract Service** which will enable us to examine the data we have submitted previously:

Good morning Alastair,

Apologies for the late response, I have been on annual leave.

I have looked at the HES extracts used for last month publication and the M14 data was used.

Are you aware of the SHMI Extract Service? I think it might be helpful for the investigation. Each month, when we publish the SHMI we also publish the corresponding record level data for each trust to access via a secure e-file transfer service (SEFT). Two people per trust are granted access to this. This allows trusts to reconcile any differences and to provide assurance with the data. I can see that Anthony Saunders currently has access for Dorset Country Hospital NHS Foundation Trust. If you would like to apply for access yourself, let me know and I can send over the details of how to apply. Once we receive your details it doesn't take long to create an account.

I look forward to hearing from you.

Best wishes,

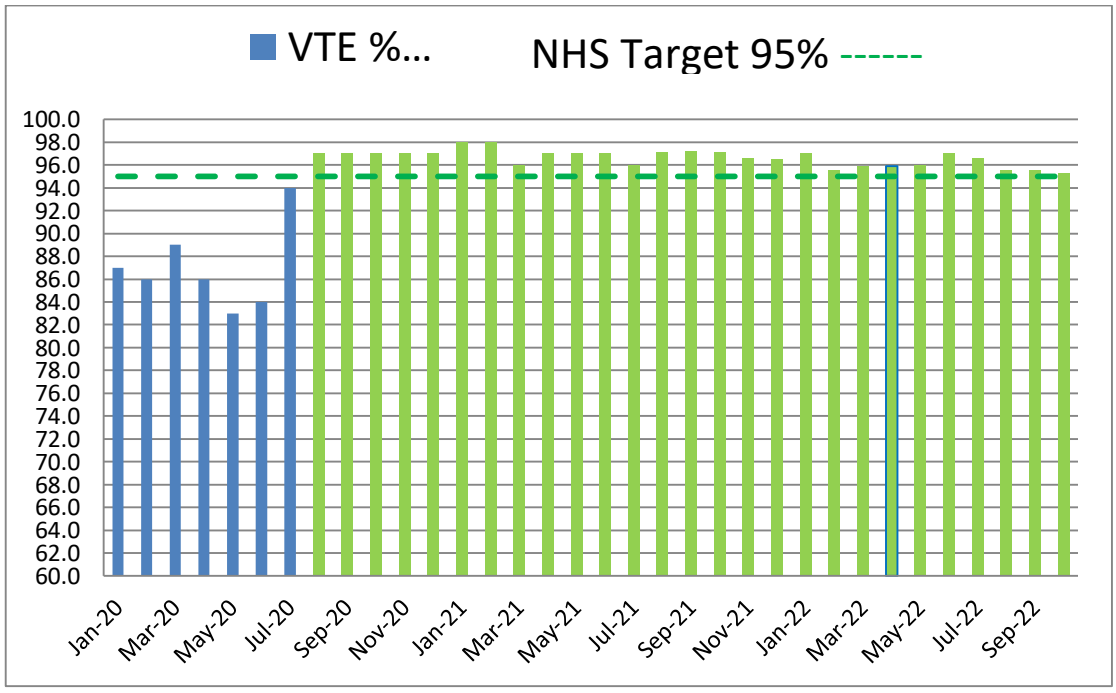
Emily Davison
Higher Information Analyst
Pronouns: she/her
On behalf of
Population Health, Clinical Audit, and Specialist Care
clinical.indicators@nhs.net

3.0 OTHER NATIONAL AUDITS/INDICATORS OF CARE

The DCH Learning from Deaths Mortality Group regularly examines any other data which might indicate changes in standards of care and it continued to meet on a monthly basis throughout the COVID-19 crisis. The following sections report data available from various national bodies which report on Trusts' individual performance. However much of this data has also been interrupted by covid-19 and has not yet caught up again.

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

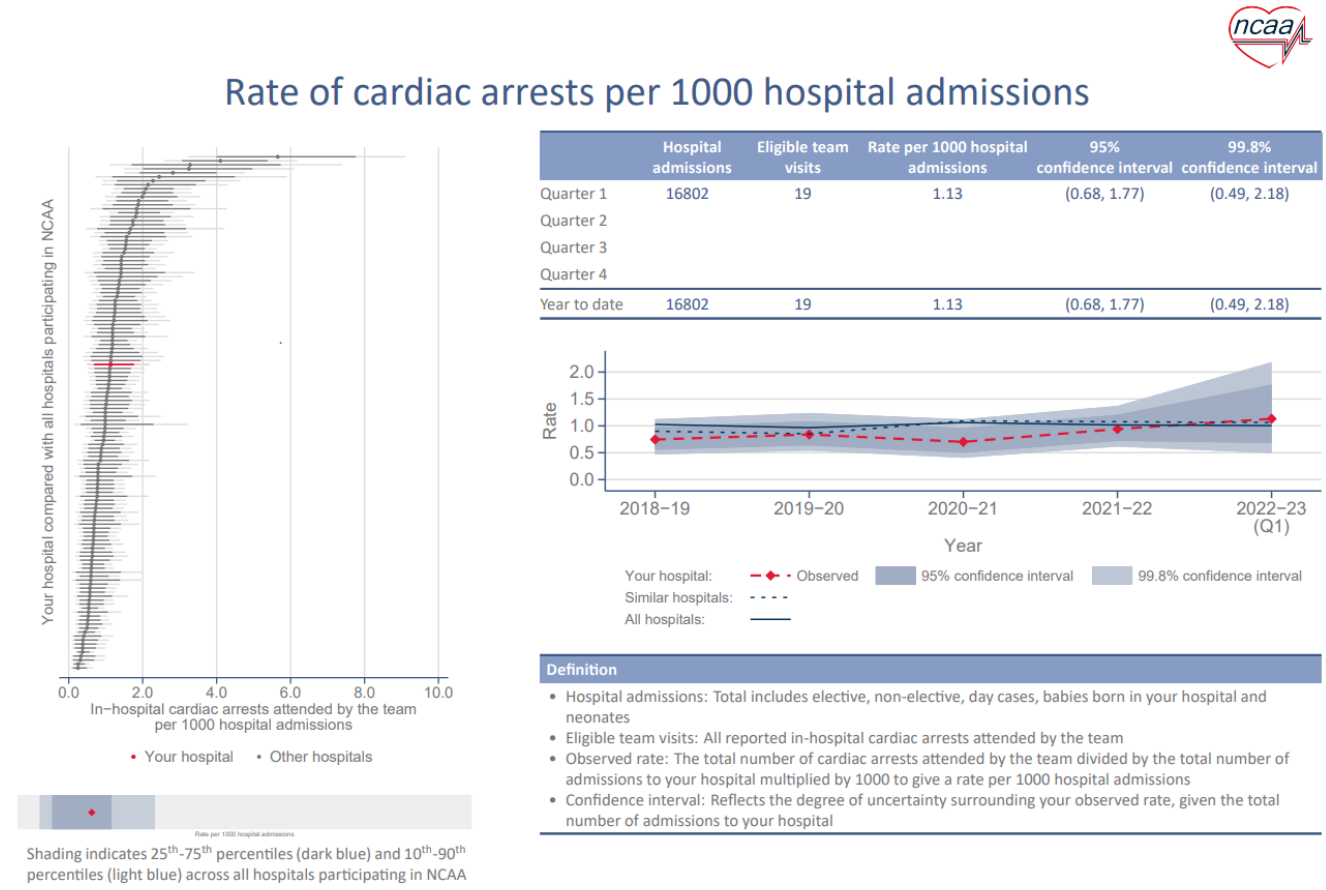
DCH VTE risk assessment recording reached 97% in August 2020 with the introduction of a more accurate reporting system, and after a process of data cleansing which removed a number of duplicate reports in Surgery it is clear that the Trust is now achieving the required standard. Dr Aruna Arjunan has taken over as chair of the VTE Group and is auditing compliance with the VTE prophylaxis policy which has been recently revised.



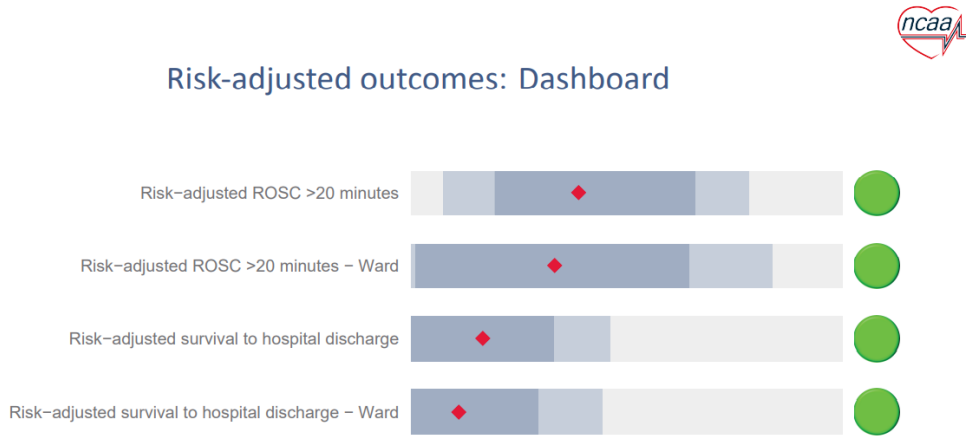
3.1 NCAA Cardiac Arrest data

The national Cardiac Arrest audit for DCH including data from April 2022 to June 2022 was published on 23/8/2022. A total of 19 cardiac arrest calls were recorded for this first quarter of the year.

The graph below represents the number of in-hospital cardiac arrests attended by the team per 1,000 admissions for all adult, acute care hospitals in the NCA Audit. DCH is indicated in red, and lower on the chart is better. The table to the right gives more detail by quarter year, and the graph below it summarises the past 5 years.



The graph below shows two outcome measures:
a) Return of Spontaneous Circulation (a measure of resuscitation effectiveness) and
b) Survival to Discharge.
These and all other measures in the report get a 'green' indicator for the most recently reported Quarter 1 (2022/23).



3.2 National Adult Community Acquired Pneumonia Audit latest data – last published Nov 2019 (see below), and not undertaken for either 2019/20 or 2020/21. It has been announced that data collection will restart in Spring 2022 for publication in Summer next year.

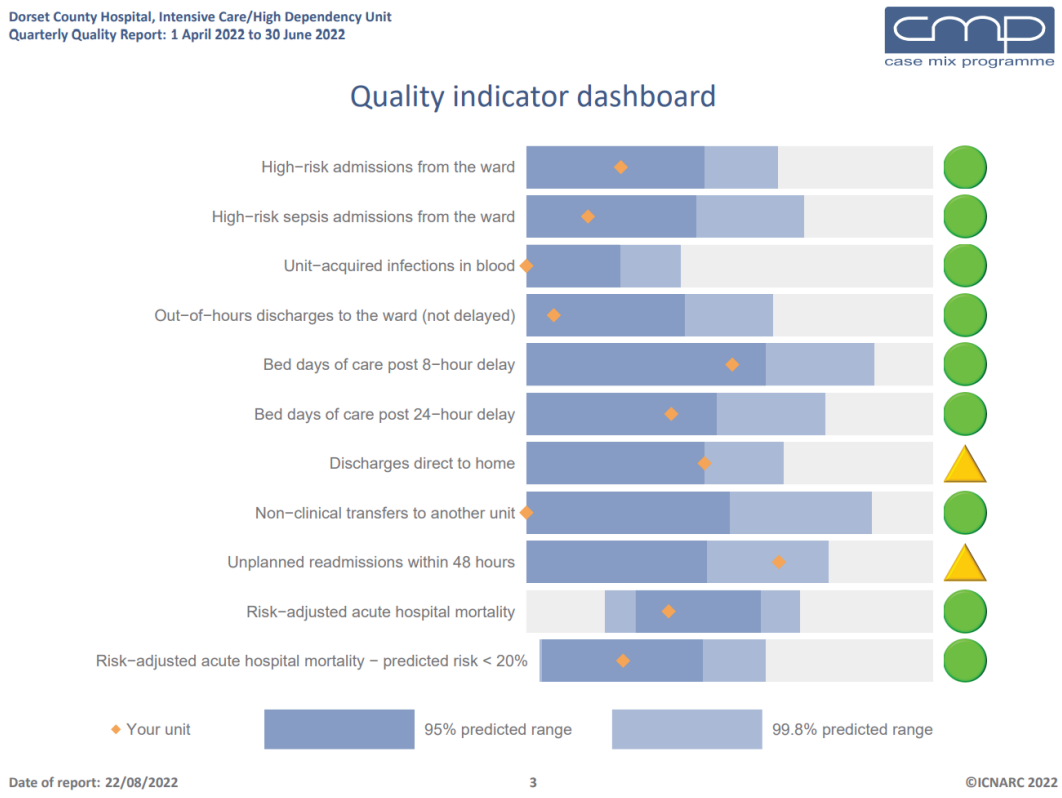
Results Summary		Dorset County Hospital	National results
Patient Characteristics and Diagnosis		**n = 88**	**n = 10174**
Gender	Male Female	43% 57%	48% 52%
Age	Median (IQR)	78 (61-84)	75 (61-85)
Cohort Severity (CURB65 score)	0-1 2 3-5	42% 31% 27%	47% 29% 24%
Inpatient mortality	Proportion deceased	7%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

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

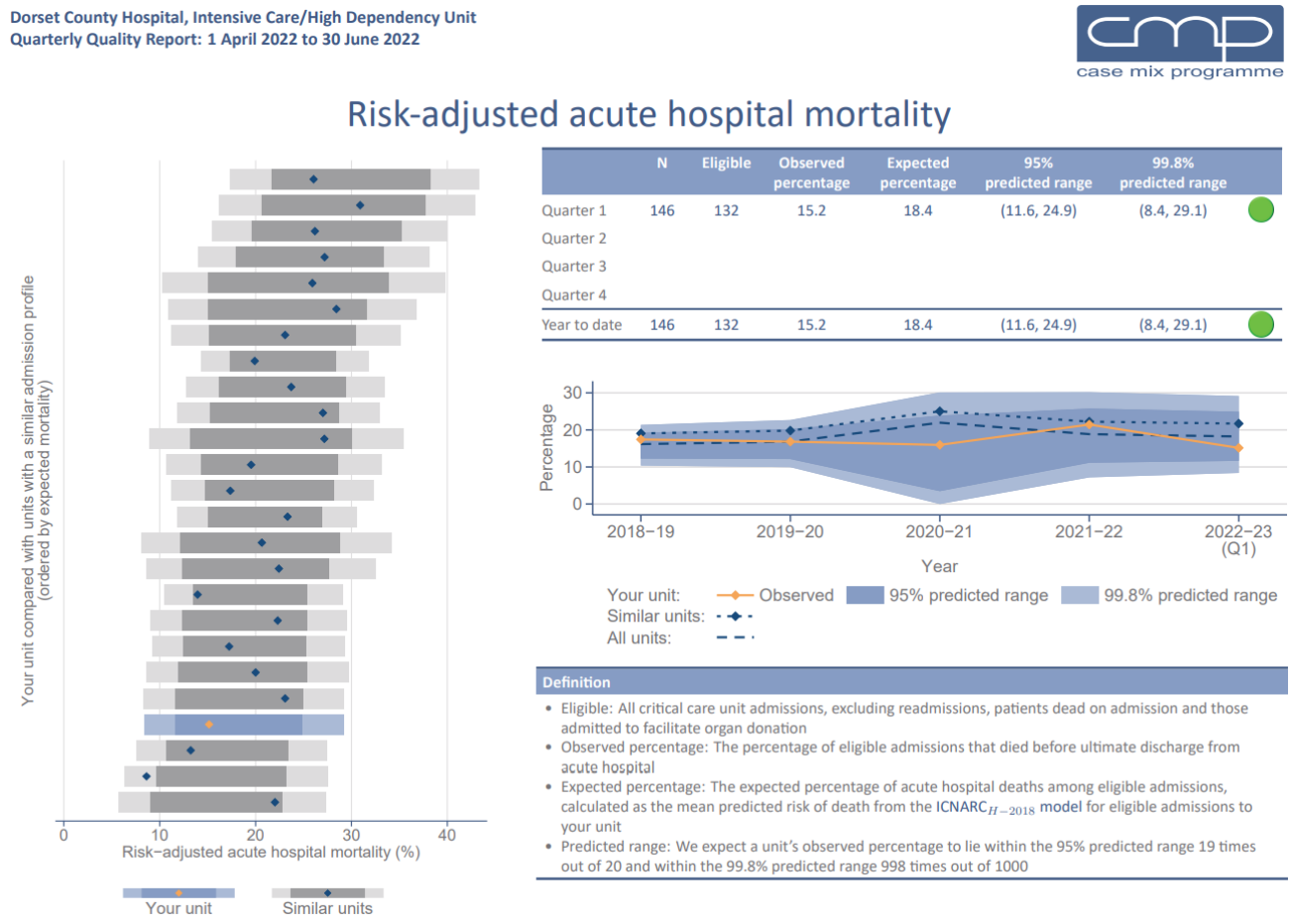
3.3 ICNARC Intensive Care survival latest data for Aril to June 2022; published 22 August 2022; n = 146 patients.

The amber indicators in the chart below indicate delays in being able to discharge patients from ICU, with some delays being long enough that the patient was discharged direct to home. This is an indicator of DCH bed pressures.

Unplanned readmissions (4% versus expected 1%) will be audited to provide a detailed analysis.



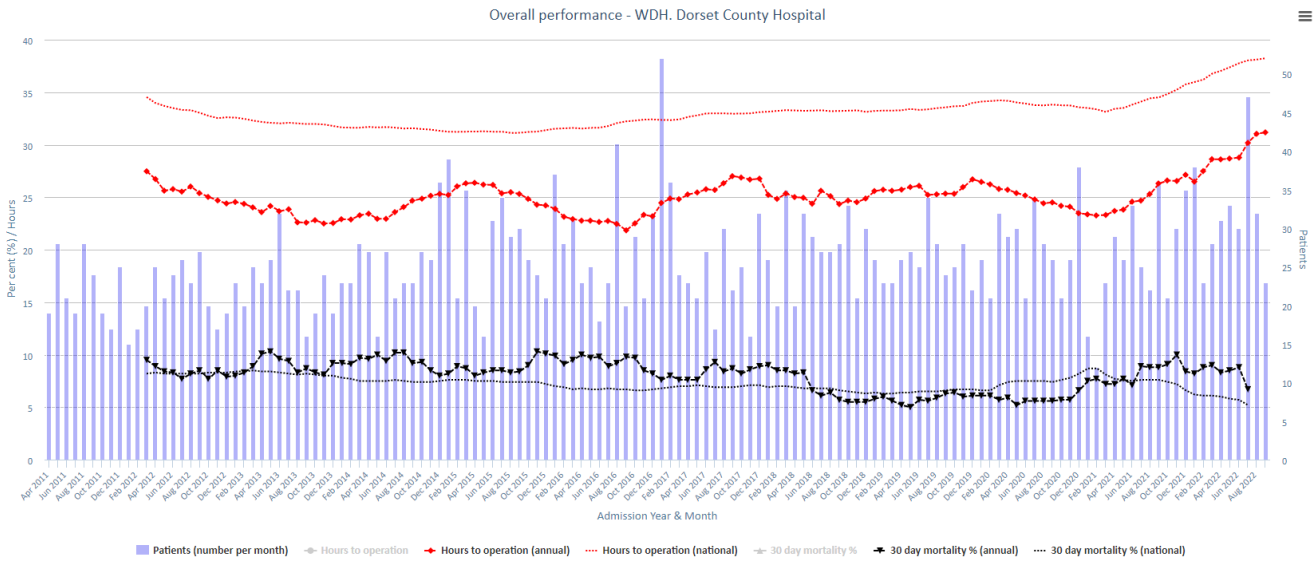
The charts below show the “risk adjusted acute hospital mortality” following admission to the DCH Critical Care Unit, Q1 2022/23. They compare observed and expected death rates in a similar fashion to SHMI.



These results are within the expected range and have improved again compared to the last quarter.

3.5 National Hip Fracture database to April 2021.

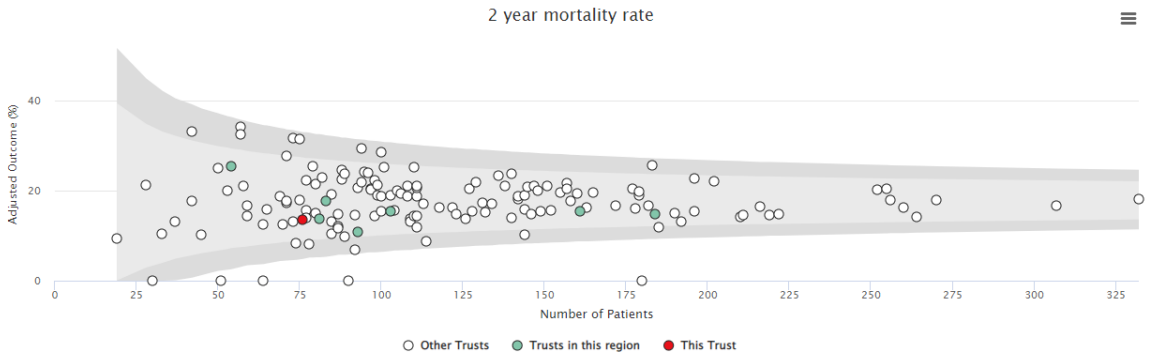
Mortality data had been delayed by contract negotiations with NHS Digital, but is now up to date and shows that the DCH crude mortality is now above the national average. The data has been flagged to the Orthopaedic Department and they are reviewing it.



The latest national average annualised mortality for hip fracture is 5.2%, with DCH's annualised mortality at 6.7% to August 2022. 'Hours to operation' remains significantly better than the national average for Q2 (31.2 vs 38.3 hours) but there has been a steady rise across the country post covid..

3.6 National Bowel Cancer Annual audit

No new data has been published for the year 2019/20 since the Q3 report. The graph below shows the latest available 2 year survival data for patients admitted in financial year 2019/20, compared to all other NHS Trusts, with other Wessex Trusts in green.



Trust	Number	Adjusted	Observed
Dorset County Hospital NHS Foundation Trust	76	13.5%	15.9%
Other trusts within the region: Wessex			
Hampshire Hospitals NHS Foundation Trust - Basingstoke and North Hampshire Hospital	83	17.7%	14.2%
Hampshire Hospitals NHS Foundation Trust - Royal Hampshire County Hospital	81	13.7%	11.6%
Isle of Wight NHS Trust	54	25.5%	20.8%
Portsmouth Hospitals NHS Trust	184	14.7%	11.6%
University Hospital Southampton NHS Foundation Trust	161	15.4%	14.9%
Poole Hospital NHS Foundation Trust	93	10.8%	13.8%

3.7 Getting it Right First Time; reviews in Qtr 2

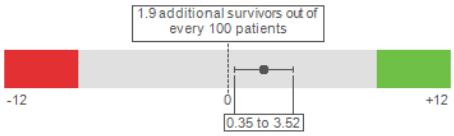
GIRFT are now responsible for recovery of waiting lists in 6 High Volume Low Complexity (HVLC) specialties – ophthalmology, ENT, gynaecology, general surgery, urology and orthopaedics. However, this has no direct bearing on Learning from Deaths.

3.8 Trauma Audit and Research Network

DCH is a designated Trauma Unit (TU) providing care for most injured patients, and has an active, effective trauma Quality Improvement programme. It submits data on a regular basis to TARN which then enables comparison with other TUs. No new data has been published since the previous Q3 Learning from Deaths report. The data below is therefore unchanged and reports up to December 2021 only. No explanation is currently available for this.

Rate of Survival at this Hospital

Between January 1st 2019 and December 31st 2021



Rate of Survival Breakdown at this Hospital

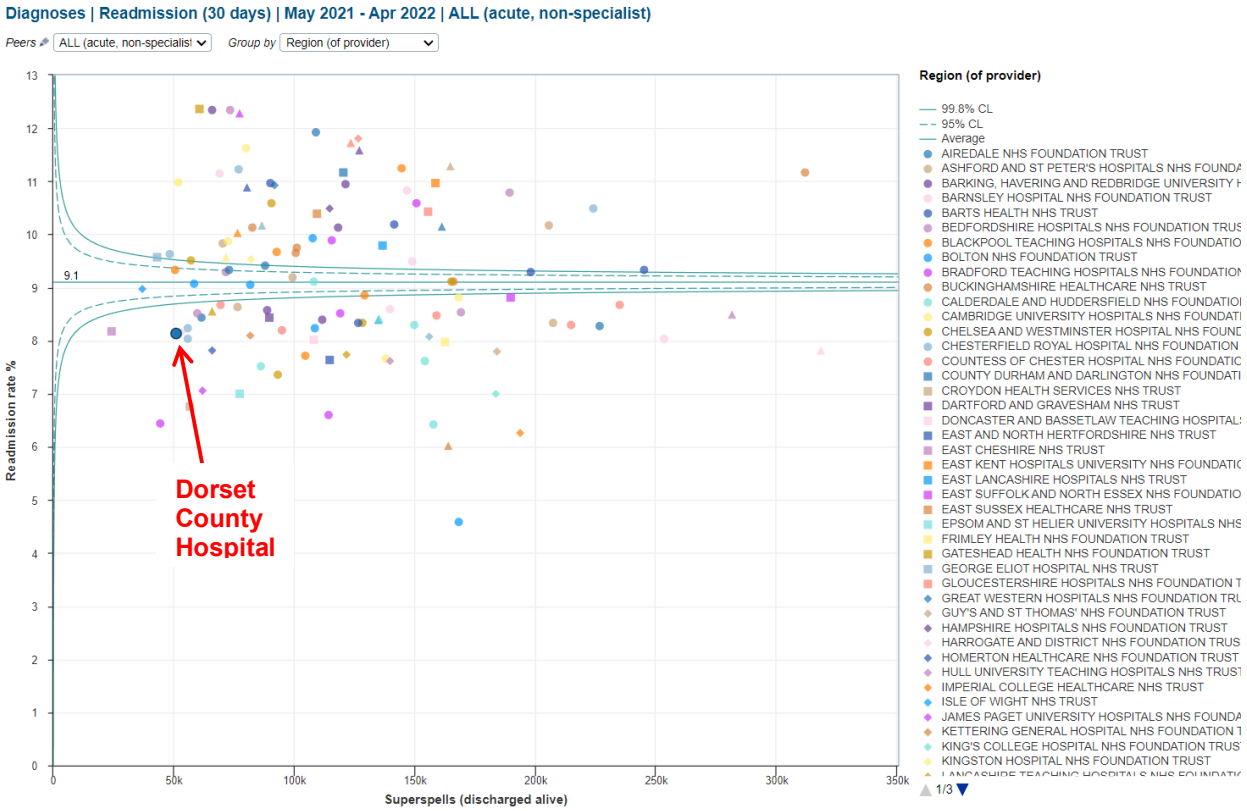
Survival band %	Number in group	Expected survivors	Actual survivors	Difference*	Adjusted difference**
95 - 100	518	508	514	1.1	0.8
90 - 95	190	176	177	0.4	0.1
80 - 90	112	95	102	5.4	0.5
65 - 80	46	34	33	-2.2	-0.1
45 - 65	15	8	14	34.3	0.8
25 - 45	4	1	2	10.4	0.2
0 - 25	4	0	0	-12.9	-0.2
Total	**889**	**825**	**842**	**1.9**	**1.9**

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

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

The first column categorises patients by percentage likelihood of survival, followed by the total number of patients seen at DCH, the calculated likely number of survivors and then the actual number of survivors. In this data there were 17 more survivors than expected.

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



A readmission to hospital within 30 days suggests either inadequate initial treatment or a poorly planned discharge process. However, DCH's readmission rate continues to be significantly lower than the average of other acute Trusts.

3.10 Dr Foster Safety Dashboard

This dashboard has been temporarily withdrawn by Dr. Foster but will apparently be reinstated later this year.

4.0 QUALITY IMPROVEMENT ARISING FROM SJRs

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

a) Poor quality of some admission clerking notes, particularly in surgery - the hospital clerking proforma has been revised, and the continuation note paper has had reminder watermarks added to remind staff to date, time, print name/GMC no. The introduction of the 'AGYLE' electronic patient record software occurred in the Emergency Dept. at the end of Q4 and, as this is rolled out across the Trust, it will be fully auditable and replace written records. This will solve many of the legibility and quality issues that exist with written records. UHD are now considering adopting AGYLE for their A&E department, creating a single software system across the Dorset Acute Trusts and based at DCH.

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

c) With an elevated SHMI and in the absence of any obvious flags from SJRs, an audit of 50 consecutive deaths is being undertaken to re-examine the accuracy and quality of the SJR scrutiny.

5.0 MORBIDITY and MORTALITY MEETINGS

Morbidity and mortality meetings are continuing across the Trust, with minutes collated by Divisional Quality Managers. Dates of these meetings are reported in sections 1.1 and 1.2 above.

6.0 LEARNING FROM CORONER'S INQUESTS Q2

DCH has been notified of 16 new Coroner's inquests being opened in the period July 2022 – September 2022.

10 inquests were held during Quarter 2. 5 inquests were heard as Documentary hearings, not requiring DCH attendance. 5 required the clinician to attend Court in person. 0 required attendance remotely from the DCH 'virtual courtroom' (in THQ) using Microsoft Teams.

We currently have 61 open Inquests. The Coroner has reviewed all outstanding cases to decide whether any can be heard as documentary hearings. 0 pre-inquest review was listed during this period.

We continue to work with the Coroner's office, and will continue to support staff at these hearings. The coroner requested that from May 2022 witnesses should attend the court room at the Town Hall, Bournemouth in person. Authority is now required, if we wish the clinician to attend remotely.

7.0 LEARNING FROM CLAIMS Q2

Legal claims are dealt with by NHS Resolution, who also produce a scorecard of each Trust's claims pattern and costs. GIRFT is also requesting us to examine our pattern of claims for the past 5 years to see what learning can be gleaned – this is currently in process with a deadline of early December.

Claims pattern this Quarter:

New potential claims	18
Disclosed patient records	11
Formal claims	10 clinical negligence, 0 employee claim
Settled claims	2 clinical negligence, 0 employee claim
Closed - no damages	1 clinical negligence, 0 employee claim

8.0 SUMMARY

SHMI has not improved as expected despite the backlog of uncoded notes having been cleared, and updated HES data for 2021/22 submitted to NHS Digital by the deadline of 19th May 2022. Although this was not going to change previously published figures which remain on record, it is surprising that there is no perceptible impact on the two latest SHMI values. This requires close scrutiny and our intention is to undertake an audit of approximately 50 deaths to look for any evidence of 'avoidability' or poor care, as well as closer examination of diagnostic groups that are indicating higher observed than expected deaths.

No other metrics of in-patient care suggest that excess mortality is occurring at DCH and much of the national data suggests better than average mortality, although National Hip Fracture mortality is less good than it was.

The newly appointed Senior Coder starts work on 21st November 2022 and her input will be invaluable.

Nevertheless the Hospital Mortality Group remains vigilant and will continue to scrutinise and interrogate all available data to confirm or refute this statement on a month by month basis. At the same time internal processes around the completion and recording of SJRs, M&M meetings and Learning from Deaths are now well embedded and working effectively within the Divisional and Care Group Teams.

Report Front Sheet

1. Report Details			
Meeting Title:	Board of Directors		
Date of Meeting:	30 November 2022		
Document Title:	Communications Activity Report		
Responsible Director:	Paul Lewis, Deputy Director of Strategy, Transformation and Partnerships	Date of Executive Approval	1 November 2022
Author:	Susie Palmer, Head of Communications Melissa Craven, Communication and Engagement Manager		
Confidentiality:	No		
Publishable under FOI?	Yes		
Predetermined Report Format?	No		

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

3. Purpose of the Paper	This report gives an overview of communications activity for the Trust.							
	Note (✓)	✓	*Discuss (✓)*		*Recommend (✓)*		*Approve (✓)*	
4. Executive Summary	Included in the report is information about key campaigns, initiatives and events, and analytics for our social media channels and public website. There is also a summary of news releases issued and media coverage.							
5. Action recommended	The Board is recommended to: 1. **NOTE** the report							

6. Governance and Compliance Obligations			
Legal / Regulatory Link		**No**	*If yes, please summarise the legal/regulatory compliance requirement. (Please delete as appropriate)*
Impact on CQC Standards		**No**	*If yes, please summarise the impact on CQC standards. (Please delete as appropriate)*
Risk Link		**No**	*f yes, please state the link to Board Assurance Framework and Corporate Risk Register risks (incl. reference number). Provide a statement on the mitigated risk position. (Please delete as appropriate)*
Impact on Social Value	**Yes**		**Our comms activities highlight the Trust's contribution to Social Value**

Trust Strategy Link		**How does this report link to the Trust's Strategic Objectives?** *Please summarise how your report will impact one (or multiple) of the Trust's Strategic Objectives (positive or negative impact). Please include a summary of key measurable benefits or key performance indicators (KPIs) which demonstrate the impact.*
Strategic Objectives	People	A significant amount of our comms resource goes into keeping staff well informed and supporting recruitment and retention initiatives
	Place	Supporting the comms and engagement for the site development
	Partnership	The comms team works closely with system comms leads to coordinate key messages

Dorset Integrated Care System (ICS) Objectives	**Which Dorset ICS Objective does this report link to / support?** *Please summarise how your report contributes to the Dorset ICS key objectives.* *(Please delete as appropriate)*		
Improving population health and healthcare	**Yes**		Health/NHS services awareness campaigns
Tackling unequal outcomes and access		**No**	
Enhancing productivity and value for money	**Yes**		The comms team strives to achieve value for money when there is a requirement to use external suppliers. We also generate income from advertising.
Helping the NHS to support broader social and economic development		**No**	
Assessments	**Have these assessments been completed?** *If yes, please include the assessment in the appendix to the report..* *If no, please state the reason in the comment box below.* *(Please delete as appropriate)*		
Equality Impact Assessment (EIA)		**No**	n/a
Quality Impact Assessment (QIA)		**No**	n/a

Communications Activity Report

Quarters 1 and 2: April 2022 – September 2022

1. Introduction

This regular report gives an overview of communications activity for the Trust. It is not an exhaustive account of what the communications team has been involved with but covers key areas of our work and a summary of activity.

This period has seen another six months of juggling priorities and limited resources but the comms team have managed to introduce new initiatives and support colleagues throughout the Trust.

One member of the three-person comms team is now on maternity leave and has not been replaced to make a CIP saving. This will of course increase pressure on the team to maintain a comprehensive comms service, so we will have to focus on the highest priorities during the coming year.

Further consideration will be given to creating a new staff engagement role to support the crucial work to improve staff engagement and retention.

2. Key Campaigns, Initiatives and Events

Team Brief Format Changes

We reviewed the monthly Team Brief meeting for heads of departments and refreshed the format in response to a survey of attendees to improve the flow of information and feedback within the organisation.

Respondents favoured a 'hybrid' meeting with the opportunity to attend in person as well as remotely via Teams, and any member of staff is now welcome to attend. Unfortunately, due to COVID-19 rates, we have not been able to hold a meeting in person yet, but we hope to introduce this new format by the end of the year.

As part of the changes, we are now highlighting the recipients of our Hospital Heroes certificates at each Team Brief to recognise the staff receiving them and raise the profile of the awards scheme. Recipients will be invited to attend in person when the hybrid meetings begin so that they can receive their certificates in front of an audience.

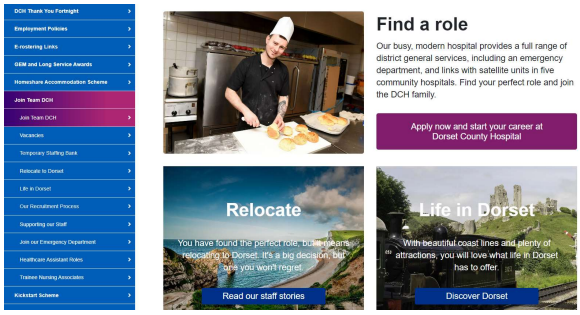
The number of slides for each Team Brief has been reduced to focus on key messages and attendees are encouraged to feed back and ask questions.

Recruitment Marketing

The comms team continue to support the recruitment and workforce teams to enhance and develop the way we promote vacancies, especially hard to recruit to posts.

Our online recruitment information has been transferred from the outdated microsite to a new dedicated section on our Trust website.

The content has been refreshed and new pages have been created to highlight key job roles, such as healthcare assistants and Emergency Department vacancies.



Since the new pages went live in July, the new landing page is one of our most visited pages (often top five) and, to date, has been viewed more than 5,500 times, with our vacancies receiving more than 20,000 views.

We are working with the recruitment, workforce and education teams to produce a video and clips for our ongoing healthcare assistant campaign, which can be used on our website and social channels, as well as presentations and recruitment events. The videos are aimed at highlighting DCH's unique offering around support and career development. If the video project proves successful, we will look to expand to other key roles.

We have started to make use of paid-for advertising on our social media channels to increase the reach of key vacancies and target specific audiences. We used Facebook and Eventbrite to promote healthcare assistant recruitment events, allowing us to track the number of people interested and registering for the event. The most recent event saw the team successfully recruit more than 20 people.

We are also actively encouraging staff to make more use of professional groups and contacts they are part of on social media to spread awareness of job opportunities.

System Comms
We have continued to work closely with system comms leads to create content and coordinate key messages. Key campaigns have included encouraging families to support timely discharge and promoting the appropriate use of local NHS services to help ease pressure on emergency departments.

A programme of coordinated comms is being planned between comms leads to reach the many and varied audiences across all partner platforms and increase the reach for key messages.

We supported widespread internal and external comms for the launch of Our Dorset Integrated Care System and Board to explain what the changes are and how it will affect the way we work in the future, and the potential benefits for our patients.

Strategy Work
Alongside comms around the launch of the ICS, we have been spreading awareness of our Trust Strategy and supporting plans, including the People Plan and the Clinical Plan.

We have developed a visual identity for all the related documents to illustrate how these plans link together.

Collaboration Comms
We have coordinated with our comms colleagues at Dorset HealthCare to keep staff and stakeholders updated on the collaboration discussions and appointments of a joint Chair and joint CEO. A dedicated intranet page has been created to publish each update as well as answers to frequently asked questions.

We are working with Dorset HealthCare comms team on content for recruitment materials so both Trusts are represented appropriately.

Thank You Fortnight
We supported HR colleagues to run Thank You Fortnight – an opportunity for us to thank staff for their contribution and to reflect on all that Team DCH has achieved.

All staff received a Love2Shop voucher as a small gesture of appreciation and other initiatives were offered, including free hot drinks, free meals for children, daily prize draws, visits from an ice cream van and taster sessions for staff in yoga and mindfulness.

We received a lot of valuable feedback from staff about what worked well and what could be improved, which will be fed into plans for next year.

The Going the Extra Mile (GEM) and Long Service Awards were held during Thank You Fortnight – held as separate events this year. This worked well as it meant more people could attend each event and each was more focussed on the groups of staff we were celebrating.

Feedback was positive from those who attended both events and we will be building on this for planning next year's events. We are keen to include as many staff as possible in celebratory events and the plans for next year will reflect this.

Staff App Relaunch
We successfully launched a new, more simple download method for our Staff App, which required staff to delete their current version and download a new version from the Apple Store or Google Play. This offered a good opportunity to refresh the content of the app and ensure that app users are current staff members.

Current users clearly value the app as they downloaded the new version promptly, and we have picked up new users as well. At the time of writing this report, we have 2,377 users, which represents a high percentage of our staff. The app is promoted at staff induction so we add to our download numbers each month.

Feedback tells us that staff without regular access to a Trust device particularly value being able to access their email, newsletters and rosters so easily on their phones. Users also appreciate receiving push notifications directing them to important updates. This function has proved valuable when we have experienced issues with internal digital systems.

Staff Flu and COVID-19 Vaccination Campaign
At the time of writing this report, we had just launched the staff flu and COVID vaccination programme. We are taking a different approach this year by combining both flu and COVID vaccinations at each session rather than running separate campaigns.

Our comms materials support this national focus on getting 'doubly protected' this year and we will update on how successful this has been in our next Communications Activity Report.

Design Work
The comms team continues to provide a design service for simple materials we can design in-house. Examples for this period include:

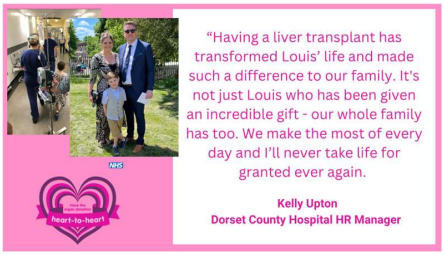
Face mask guidance posters and signs
Radiology Uniform poster
Heatwave poster
Staff awards certificates
Coffee voucher for staff
ED15 posters

We continue to work with external designers and printers for any design work needing a more professional look and feel.

Organ Donation Week
This campaign was an excellent example of our push to generate content which is appropriate for each of our social media channels, including videos, infographics and interviews.


'Be an organ donor and transform lives'

The objective was to encourage people to talk about their wishes and we told the stories of staff who had seen first-hand the difference organ donation can make.



One video was viewed more than 2,000 times online and we also received coverage through local radio, TV and the press. The clips can also be viewed on our You Tube channel.

Your Future Hospital Projects
In May we submitted outline planning permission for our site masterplan. We publicised this, as well as updating staff, governors, MPs and other stakeholder groups.

Here are updates on specific projects connected to Your Future Hospital:

Site Signage
We developed new directional signs for across the DCH site externally as part of the multi-storey car park project. Patient and staff feedback was incorporated into the sign design, colours, wording and wayfinding approach.

The new signs have been well received, with feedback that they are clearer, brighter, more professional and far easier to use for navigation.

Old signage has been removed throughout the site and overall there are now far fewer signs in place, which makes the site look cleaner and aids navigation further.
The wayfinding inside hospital buildings now needs to be improved with a similar design and this will be explored as part of future site development. In the meantime, the wall maps will be updated to reflect the design of the external signs, and department moves.

Car Parking
The comms team have played a key role in managing the opening of the hospital's multi-storey car park and the new charging system. This hasn't been without its challenges with several technical issues to overcome with the barrier and parking portal systems.

Regular, clear comms has ensured that staff and the public have been kept up to date with developments and we have responded swiftly to queries and concerns.

The multi-storey is now open for use by staff, with surface parking largely dedicated to patients and visitors, and parking issues have eased across the site.

There has been a lot of interest locally about when the multi-storey will be opened to the public and what has caused the delay. We have been responding to local media enquiries and keeping local reporters informed, and media coverage has been largely positive.

South Walks House
The comms team are closely involved in the work to move more teams to South Walks House – both in terms of teams leaving the West Annex and plans to create new clinical facilities in the building.

We have supported the strategic estates team with internal comms for the teams that are moving from West Annex, including a briefing document for managers.

We are currently working on internal and external messages about the Targeted Investment Funding bid, plans to improve South Walks House and what this means for the existing Outpatient Assessment Centre.

Emergency Department Expansion (ED15)
We continue to support with communications for the ED15 project – including staff messages about the phases of work, staff engagement and sharing progress of the scheme on social media.

We publicised the opening of a new Outpatients Therapies Centre in Charlton Down, which forms part of the scheme. We are planning to do a follow-up case study to see how this has impacted on waiting times.

The project is almost complete and we are supporting the team with a celebration event planned for December.

New Hospital Programme (NHP)
Over the summer we publicised our partnership with Tilbury Douglas – the main contractor for the NHP scheme. This was picked up by national trade press.

We led a recruitment drive for additional patient volunteer representatives to join the scheme. We have now secured a patient rep for the Emergency Department scheme, so both Critical Care and the Emergency Department have regular patient representation, and we have others interested in joining focus groups.

We helped prepare presentations to the NHP team to help secure approval to move to Full Business Case, and we have supported the DCH Charity team with the first stage of their Emergency Department and Critical Care Appeal.

We continue to update key stakeholders on our major projects and provide targeted information for specific groups – an example being an easy read version of the masterplan.

3. Social Media

The statistics below demonstrate how many people we are reaching each quarter through each channel. Also included is a small selection of the most popular posts for each month.

Please note in September 2022, there was a ban on social media posting for the period of mourning following the death of Her Majesty the Queen which has impacted our engagement figures.

Facebook Analytics – www.facebook.com/DCHFT

The organic reach of FB posts (how many people see your post without paid advertising) is cut after reaching 10,000 followers. This means the number of engaged users will dramatically decrease (as demonstrated in the table below). The comms team will therefore be exploring further options, such as paid-for advertising and utilising other community pages, to further the success of the Trust's page and ensure key messages and updates are seen widely.

	Q3 2021	Q4 2021/22	Q1 2022	Q2 2022
Engaged users	77,031	92,587	95,826	100,586
Number of posts	106	82	137	130
Number of followers	11,767	12,067	11,816	12,184

Facebook Highlights for April 2022

Dorset County Hospital NHS Foundation Trust
Mon 4/25/2022 8:25 am PDT

The artwork panels are being installed on our new multi-storey car park. These will feature images of famous Dorset landmarks that were voted for by the local community. This...

Total Engagements	**3,294**
Reactions	296
Comments	120
Shares	19
Post Link Clicks	132
Other Post Clicks	2,727

Dorset County Hospital NHS Foundation Trust
Thu 4/14/2022 10:00 am PDT

Congratulations to our amazing catering team who have achieved 5 Stars in their Food Hygiene Rating inspection. An impressive achievement to be awarded the top score of 'Very...

Total Engagements	**1,352**
Reactions	559
Comments	53
Shares	13
Post Link Clicks	—
Other Post Clicks	727

Dorset County Hospital NHS Foundation Trust
Mon 4/4/2022 2:00 am PDT

Meet our Inpatient Pain Service team! The expanding team are developing the service in a number of new and innovative ways, including a new rib fracture pathway that will...

Total Engagements	**1,044**
Reactions	271
Comments	20
Shares	9
Post Link Clicks	96
Other Post Clicks	648

Facebook Highlights for May 2022

Dorset County Hospital NHS Foundation Trust
Wed 5/4/2022 8:15 am PDT

Another phase of our Emergency Department refurbishment is complete, with a new resus and majors area now live. Thank you to patients and staff for bearing with us while work is...

Total Engagements	**3,226**
Reactions	810
Comments	42
Shares	38
Post Link Clicks	50
Other Post Clicks	2,286

Dorset County Hospital NHS Foundation Trust
Thu 5/5/2022 5:00 am PDT

Meet Midwife Anna She has delivered babies in war zones, in a tropical storm by the light of a headtorch and has been responsible for the female health of 30,000 Rohingya refuge...

Total Engagements	**2,318**
Reactions	879
Comments	72
Shares	24
Post Link Clicks	52
Other Post Clicks	1,291

Dorset County Hospital NHS Foundation Trust
Tue 5/31/2022 3:03 am PDT

An image of Portland Bill can now be seen on our new multi-storey car park. Look out for Durdle Door and Corfe Castle, which will feature on the other sides. These Dorset landmark...

Total Engagements	**1,303**
Reactions	372
Comments	25
Shares	18
Post Link Clicks	56
Other Post Clicks	832

Facebook Highlights for June 2022

Dorset County Hospital NHS Foundation Trust
Fri 6/3/2022 4:00 am PDT

Did you know Her Majesty the Queen officially opened Dorset County Hospital on 8 May 1998? We are so thrilled to be celebrating her #PlatinumJubilee this weekend!

Total Engagements	**1,862**
Reactions	395
Comments	12
Shares	22
Post Link Clicks	—
Other Post Clicks	1,433

Dorset County Hospital NHS Foundation Trust
Thu 6/9/2022 8:25 am PDT

Today we have been celebrating #BiomedicalScienceDay2022. Thank you to the teams in our #biomedical departments who work tirelessly behind the scenes to help...

Total Engagements	**1,476**
Reactions	364
Comments	21
Shares	22
Post Link Clicks	—
Other Post Clicks	1,069

Dorset County Hospital NHS Foundation Trust
Tue 6/28/2022 7:00 am PDT

We are absolutely delighted that our Volunteer Guide Wendy (who recently celebrated her 90th birthday) has been shortlisted for the Hero of the Year Award in the Dorset Hero...

Total Engagements	**1,125**
Reactions	728
Comments	38
Shares	12
Post Link Clicks	—
Other Post Clicks	347

Facebook Highlights for July 2022

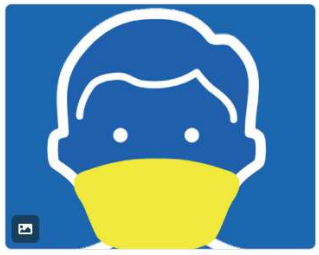
Dorset County Hospital NHS Foundation Trust
Fri 7/29/2022 1:47 am PDT

Team DCH delivered 131 babies last month. On our busiest days we welcomed eight newborns into the world each day. The lightest weighed just 1lb 4oz and the heaviest...

Total Engagements	**2,290**
Reactions	854
Comments	35
Shares	20
Post Link Clicks	—
Other Post Clicks	1,381

Dorset County Hospital NHS Foundation Trust
Fri 7/1/2022 4:24 am PDT

IMPORTANT INFORMATION REGARDING FACE MASK GUIDANCE AT DORSET COUNTY HOSPITAL Due to rising numbers of COVID cases in the local community, we have...



Total Engagements	**1,373**
Reactions	213
Comments	26
Shares	185
Post Link Clicks	19
Other Post Clicks	930

Dorset County Hospital NHS Foundation Trust
Wed 7/13/2022 3:00 am PDT

A MASSIVE congratulations to our Lead IBD Nurse Abby Oglesby who recently received IBD STARS' Rising Stars of 2022 Award! Since being in post, Abby has introduced many...

Total Engagements	**741**
Reactions	304
Comments	42
Shares	6
Post Link Clicks	—
Other Post Clicks	389

Facebook Highlights for August 2022

Dorset County Hospital NHS Foundation Trust
Tue 8/30/2022 7:00 am PDT

📢 Parking news! We will be testing out our new multi-storey car park (MSCP) with vehicles from Thursday, 1 September to relieve parking pressures on the hospital site. Hospital staff...

Total Engagements	**3,442**
Reactions	251
Comments	114
Shares	72
Post Link Clicks	36
Other Post Clicks	2,969

Dorset County Hospital NHS Foundation Trust
Tue 8/2/2022 8:40 am PDT

Huge thanks to Nigel and Dan from Townsend Engineering in Bridport for 'sharpening' our pencils today! The 30-foot Blue and Red Crayons sculpture by Peter Logan (known locally as...

Total Engagements	**1,519**
Reactions	489
Comments	35
Shares	15
Post Link Clicks	—
Other Post Clicks	980

Dorset County Hospital NHS Foundation Trust
Mon 8/15/2022 4:02 am PDT

Head over to Dorset Maternity Voices and give them a follow for a wealth of information about local maternity services 👇

Total Engagements	**1,201**
Reactions	79
Comments	23
Shares	9
Post Link Clicks	—
Other Post Clicks	1,090

Facebook Highlights for September 2022

Dorset County Hospital NHS Foundation Trust
Tue 9/20/2022 8:35 am PDT

🎓Congratulations to these students on becoming qualified midwives! They've spent the past three years carrying out placements alongside our maternity staff whilst studying at...

Total Engagements	**3,667**
Reactions	687
Comments	62
Shares	8
Post Link Clicks	—
Other Post Clicks	2,910

Dorset County Hospital NHS Foundation Trust
Mon 9/26/2022 9:45 am PDT

We kickstarted our Thank You Fortnight to recognise the amazing contribution of all our staff with an ice-cream van supplying a delicious range of treats. #ThankYouTeamDCH

Total Engagements	**3,505**
Reactions	294
Comments	27
Shares	13
Post Link Clicks	5
Other Post Clicks	3,166

Dorset County Hospital NHS Foundation Trust
Fri 9/30/2022 2:43 pm PDT

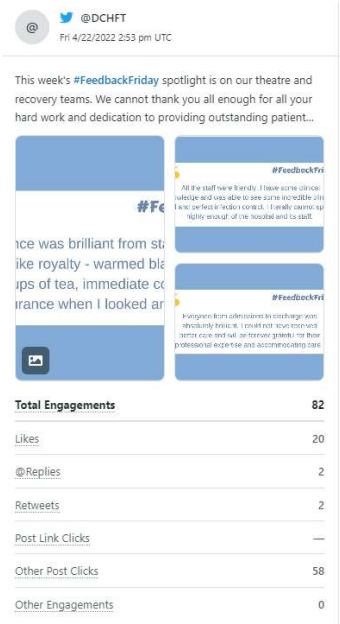
We had a fantastic night celebrating staff and volunteers who go the extra mile at our #GEMAwards2022. Look out for a round-up next week! #ThankYouTeamDCH 🤗

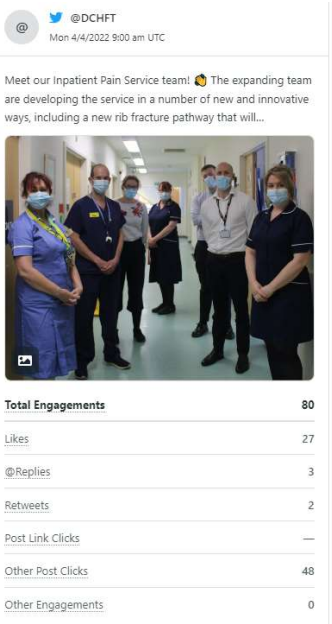
Total Engagements	**2,559**
Reactions	311
Comments	21
Shares	3
Post Link Clicks	1
Other Post Clicks	2,223

Twitter Analytics - @DCHFT www.twitter.com/DCHFT

	Q3 2021	Q4 2021	Q1 2022	Q2 2022
Tweets	148	162	219	188
Tweet impressions (how many times our tweets were seen)	260,453	240,273	178,024	152,724
Engagement (likes, replies, clicks, retweets)	8,987	8,322	6,105	5,532
Number of followers	6,216	6,456	6,663	6,800

Twitter Highlights for April 2022





Twitter Highlights for May 2022

@DCHFT
Wed 5/4/2022 3:15 pm UTC

Another phase of our Emergency Department refurbishment is complete, with a new resus and majors area now live. Thank you to patients and staff for bearing with us while work is...

Total Engagements	201
Likes	57
@Replies	1
Retweets	13
Post Link Clicks	12
Other Post Clicks	118
Other Engagements	0

@DCHFT
Tue 5/31/2022 10:03 am UTC

An image of Portland Bill can now be seen on our new multi-storey car park. Look out for Durdle Door and Corfe Castle, which will feature on the other sides. These Dorset landmark...

Total Engagements	118
Likes	30
@Replies	1
Retweets	4
Post Link Clicks	10
Other Post Clicks	73
Other Engagements	0

@DCHFT
Tue 5/24/2022 12:00 pm UTC

We are looking for people completing year 13 this year to join a three-week training program to become a healthcare support worker. If you are interested in starting your healthcare career, you can find out more and register for our webinar below.
https://t.co/SHibBTuVHz #TeamDCH

Total Engagements	109
Likes	20
@Replies	2
Retweets	15
Post Link Clicks	14
Other Post Clicks	58
Other Engagements	0

Twitter Highlights for June 2022

@DCHFT
Tue 6/28/2022 1:45 pm UTC

We are absolutely delighted that our Volunteer Guide Wendy has been shortlisted for the Hero of the Year Award in the Dorset Hero Awards 2022. 🍌 Wendy is our longest serving...

Total Engagements	99
Likes	44
@Replies	1
Retweets	5
Post Link Clicks	1
Other Post Clicks	48
Other Engagements	0

@DCHFT
Sun 6/26/2022 10:00 am UTC

A group of our consultants, known as the 'Dorchester Divas', who took on the 100km Jurassic Challenge last year have regrouped and will be heading to Yorkshire to compete in...

Total Engagements	88
Likes	19
@Replies	0
Retweets	1
Post Link Clicks	13
Other Post Clicks	55
Other Engagements	0

@DCHFT
Wed 6/1/2022 10:00 am UTC

It's #VolunteersWeek! 🍌 Kickstarting our celebrations is @DCHFT_CNO Nicky Lucey. The last few years have really highlighted the vital role volunteers play and this week we...

Total Engagements	86
Likes	29
@Replies	0
Retweets	6
Post Link Clicks	—
Other Post Clicks	51
Other Engagements	0

Twitter Highlights for July 2022

@DCHFT
Fri 7/1/2022 11:31 am UTC

Due to rising numbers of COVID cases in the local community, we have reintroduced the mandatory wearing of face coverings for all visitors in all areas. Please enter the hospital...

Total Engagements	**169**
Likes	30
@Replies	3
Retweets	29
Post Link Clicks	11
Other Post Clicks	96
Other Engagements	0

@DCHFT
Sat 7/30/2022 8:42 am UTC

If you have an injury that is not life-threatening, you can get help from a Minor Injuries Unit (MIU) rather than going to our Emergency Department. This will allow us to concentrate on...

Total Engagements	**97**
Likes	20
@Replies	1
Retweets	18
Post Link Clicks	14
Other Post Clicks	44
Other Engagements	0

@DCHFT
Tue 7/5/2022 1:30 pm UTC

We were proud to be recognised today as part of NHS, Social Care and Frontline Workers' Day. Fantastic to have representatives from #TeamDCH, including staff from ED, ou...

Total Engagements	**85**
Likes	19
@Replies	0
Retweets	5
Post Link Clicks	—
Other Post Clicks	61
Other Engagements	0

Twitter Highlights for August 2022

@DCHFT
Wed 2/2/2022 5:09 pm UTC

Today Carrie Ward retires as Ward Leader for Lulworth Ward. We are incredibly sad to see her go and will miss her dearly (especially her fancy dress)! She has been an incredible asset...

Total Engagements	**287**
Likes	90
Comments	11
Shares	1
Post Link Clicks	2
Other Post Clicks	183
Other Engagements	0

@DCHFT
Fri 2/11/2022 6:30 pm UTC

Our amazing Maternity Unit has been recognised as one of the best in the country in the latest national survey results. Read more about why their service is rated so highly here...

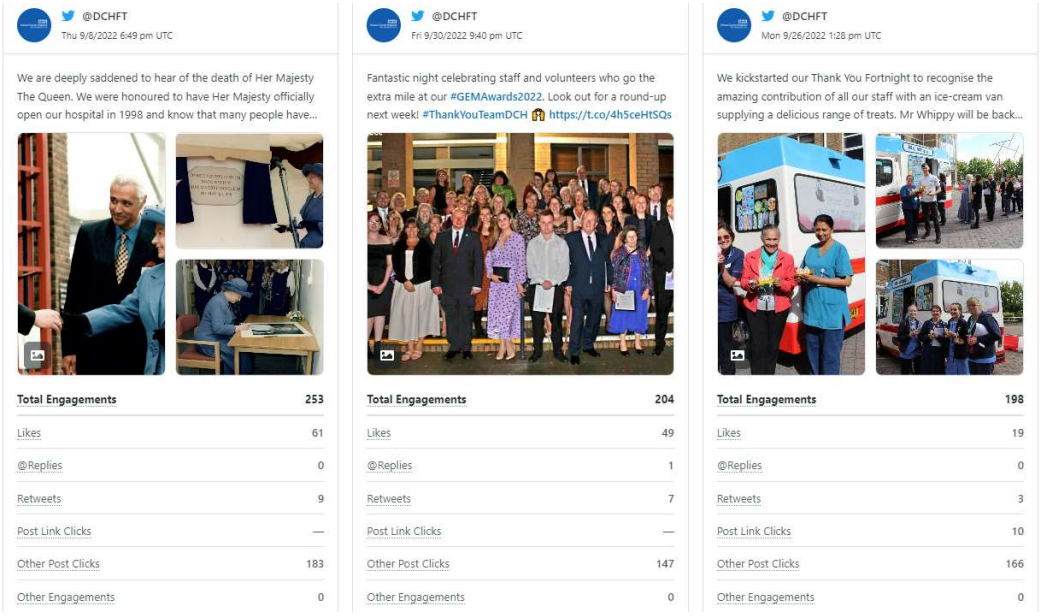
Total Engagements	**201**
Likes	60
Comments	3
Shares	12
Post Link Clicks	22
Other Post Clicks	104
Other Engagements	0

@DCHFT
Mon 2/28/2022 8:42 am UTC

We have exciting plans to expand our clinical facilities and redevelop our site over the next five years, including building a new Emergency Department, Critical Care Unit, main...

Total Engagements	**157**
Likes	34
Comments	1
Shares	16
Post Link Clicks	46
Other Post Clicks	60
Other Engagements	0

Twitter Highlights for September 2022

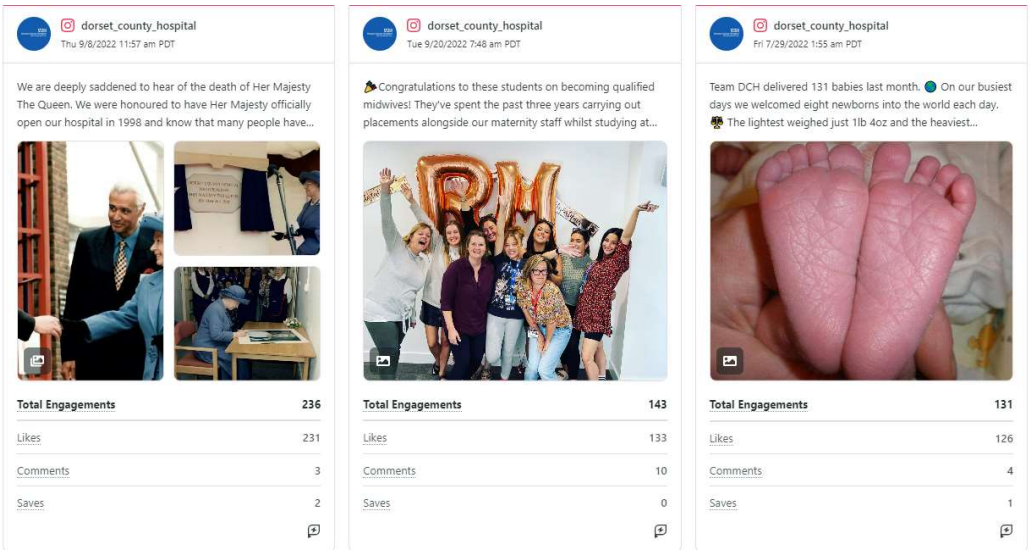


Instagram Analytics - www.instagram.com/dorset_county_hospital/

	Q3 2021	Q4 2021/22	Q1 2022	Q2 2022
Total impressions	33,228	16,391	28,896	52,008
Average impressions (number of times the post was shown) per day	361	182	318	565
Average daily reach per profile (unique views)	255	122	231	390
Number of followers	2,521	2,573	2,619	2,673

Instagram Highlights – April to June 2022

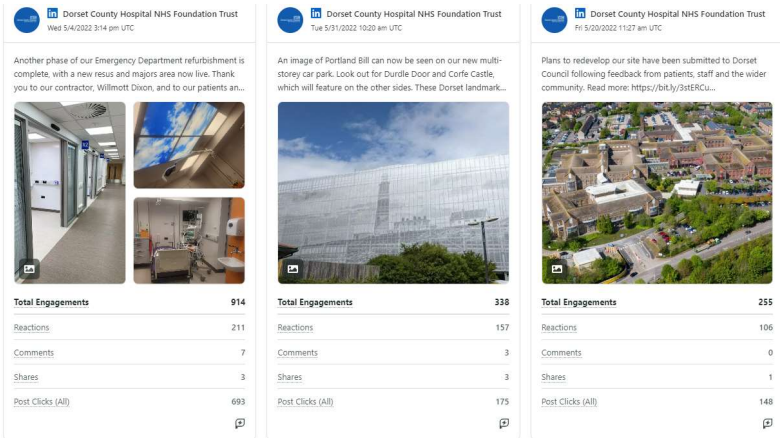
Instagram Highlights – July to September 2022



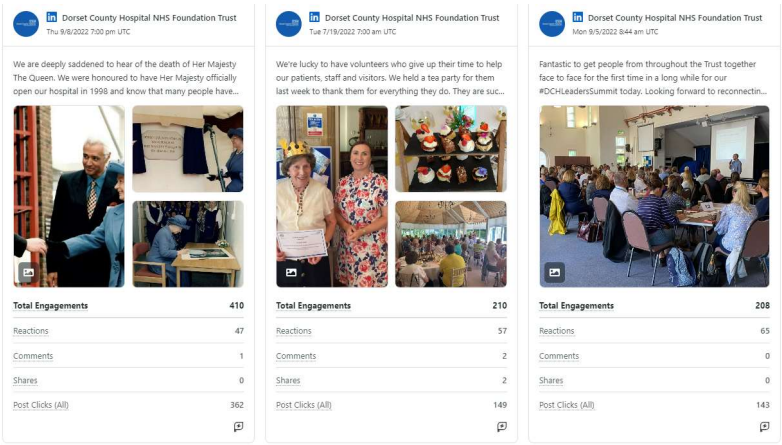
LinkedIn Analytics - www.linkedin.com/company/dorset-county-hospital-foundation-trust

	Q3 2021	Q4 2021/22	Q1 2022	Q2 2022
Total impressions (number of views)	26,356	40,951	48,993	33,207
Total engagements (clicks, likes, replies and shares)	1,911	3,014	3,424	2,272
Organic followers gained	228	381	380	314
Number of followers	2,991	3,364	3,720	4,000

LinkedIn Highlights – April to June 2022



LinkedIn Highlights – July to September 2022



4. Public Website

The analytics below show general usage of the website and the most visited pages:

Website Analytics – www.dchft.nhs.uk

	Q3 2021	Q4 2021/22	Q1 2022	Q2 2022
Sessions	96,376	66,390	52,999	108,218
Page Views	167,336	118,098	88,365	175,213
Users	72,155	49,577	40,405	88,275
Average Session Duration	00:00:53	00:00:54	00:00:51	00:00:40

**We saw a significant drop in visits to the website due to an issue with Google search. This was resolved in September 2022 and, as you can see, we are starting to see an increase in visitors again.

Most Popular Webpages (April 2022 to September 2022)

Page	Page Views	Average Time on Page
https://www.dchft.nhs.uk/	39,961	00:00:48
http://www.dchft.nhs.uk/working-for-us/join-team-dch/vacancies/	16,903	00:00:41
http://www.dchft.nhs.uk/working-for-us/e-rostering-links/	11,505	00:00:35
http://www.dchft.nhs.uk/patients-and-visitors/a-z-of-services/	8,049	00:01:09
http://www.dchft.nhs.uk/patients-and-visitors/visiting-guidance/	5,358	00:00:42
http://www.dchft.nhs.uk/working-for-us/join-team-dch/	4.359	00:00:58
http://www.dchft.nhs.uk/patients-and-visitors/getting-here/	3,933	00:00:57
http://www.dchft.nhs.uk/patients-and-visitors/	3,786	00:01:00
http://www.dchft.nhs.uk/working-for-us/	3,328	00:00:41

5. News Releases

A round-up of the news releases issued by the communications team with links to the full releases on our website. While news releases and media relations are still an important part of our comms approach, we are increasingly prioritising using our own channels to reach our audiences directly:

Patients praise levels of care at Dorset County Hospital - 29 September 2022
Patients have praised the level of care experienced at Dorset County Hospital.

DCH staff encouraging families to have a 'heart-to-heart' about organ donation - 23 September 2022
Staff from Dorset County Hospital are encouraging people to talk to their families about organ donation after experiencing first-hand the difference it can make.

New Chemotherapy Outreach Service at Bridport Hospital - 22 September 2022
Dorset County Hospital (DCH) has opened a new Chemotherapy Outreach Service in Bridport. The service, based at Bridport Community Hospital, will allow patients in the town and surrounding area to receive chemotherapy and other cancer treatments closer to home.

Update on appointments scheduled for Her Majesty the Queen's state funeral on 19 September - 12 September 2022
We are finalising arrangements for Monday (19 September), following the announcement that the Queen's state funeral will be a bank holiday.

Dorset County Hospital pays to tribute to Her Majesty The Queen - 8 September 2022
We are very sorry to hear the news about the death of Her Majesty The Queen. Our Chairman, Mark Addison, has paid tribute.

NHS trusts agree to appoint a joint Chief Executive and joint Chair - 8 September 2022
Dorset HealthCare and Dorset County Hospital have agreed to appoint both a joint Chief Executive and a joint Chair to lead the two organisations. The two Trust Boards believe that a joint leadership model will improve the delivery of care to local communities by simplifying decision-making, increasing integration and improving quality.

Dorset County Hospital looking for patient representatives to help develop its services - 28 July 2022
Dorset County Hospital (DCH) is looking for volunteers to help shape and improve services by acting as patient representatives on key projects – including patient safety and its site development plans.

Hospital volunteers treated to an afternoon tea party - 18 July 2022
Volunteers from Dorset County Hospital (DCH) were treated to a summer tea party as a thank you for their hard work.

Tilbury Douglas selected to build new Emergency Department and Critical Care Unit - 27 June 2022
Dorset County Hospital (DCH) has selected Tilbury Douglas, a leading UK building, infrastructure, engineering and fit-out business, as its main contractor to design and build a brand-new Emergency Department and Critical Care Unit.

Dorset County Hospital's Cygnet Homebirth Team celebrate seventh anniversary - 20 June 2022
Dorset County Hospital's Cygnet Homebirth Team is celebrating seven years of success.

Dorset County Hospital submits plans to develop its site - 22 May 2022
Plans to redevelop the Dorset County Hospital (DCH) site have been submitted to Dorset Council following feedback from patients, staff and the wider community.

Dorset NHS Trusts collaborate to create a landmark sustainability programme in bid to go net zero - 11 May 2022
Five NHS organisations across Dorset have joined forces to produce a sustainability programme in a combined effort to engage their staff with a range of sustainability activities supporting the Trust Green Plans.

Essential roadworks at hospital site entrance on Williams Avenue - 11 May 2022
Please be aware that from Monday (16 May) we will be carrying out some essential works at the entrance to our hospital site from Williams Avenue.

Outpatient therapies offered from new Charlton Down base - 22 April 2022
Dorset County Hospital has opened a new Outpatients Therapies Centre in Charlton Down

7. Media Coverage

Each of our news releases generated positive local media coverage. Further coverage was prompted by events, national statistical reports, announcements and public meetings. The charts below show the balance of positive, negative and neutral stories, and the table shows each quarter.

	Q3 2021	Q4 2021/22	Q1 2022	Q2 2022
Media stories	161	125	79	77
Positive	86	55	54	57
Negative	0	0	8	5
Neutral	75	70	17	15

April 2022 to September 2022 - Coverage to note included:

- Dorset County Hospital staff survey results released following tough two years
- Family's concerns about Nikki Grahame's care for anorexia
- Overwhelming positive feedback for Dorset County Hospital ED
- DCH opens new Outpatient Therapies Centre in Charlton Down
- Art designs installed at Dorset County Hospital's car park
- Doctor accused of assaulting colleague
- NHS Trusts in Dorset launch green programme
- Plans submitted to redevelop Dorset County Hospital
- Cygnet Homebirth Team celebrate 7th anniversary
- Dorset County Hospital recruiting new healthcare assistants
- Tilbury Douglas appointed to build new Emergency Department and Critical Care Unit

in Dorset

- NHS staff parking charges to be reintroduced at DCH
- Hospital volunteers treated to an afternoon tea party
- Dorset County Hospital looking for volunteer patient representatives
- Outpatient clinic shortlisted for three patient experience awards
- Dorset County Hospital staff to test new multi-storey car park ahead of its opening
- First look at Dorset County Hospital's new multi-storey car park
- NHS spent over £700,000 in taxpayer cash on 'virtue-signalling' staff magazines
- 'Outstanding' trust to share CEO and chair
- DCH staff encouraging families to have a 'heart-to-heart' about organ donation
- New chemotherapy service for Bridport
- Dorset County Hospital car park still not open for public use

Media Coverage - April 2022 to September 2022
145 Stories