Ref: MA/TH

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

You are invited to attend a **public (Part 1) meeting of the Board of Directors** to be held on **25th January 2023** at **8.30 am to 11.30am** at **Board Room, Trust Headquarters, Dorset County Hospital** and via **MS Teams.**

The agenda is as set out below.

Yours sincerely

Mark Addison
Trust Chair

AGENDA

1.	**Patient Story**	Presentation	Jo Howarth	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: Emma Hallett, Anita Thomas	Verbal	Mark Addison	Note	
	b) Conflicts of Interests	Verbal	Mark Addison	Note	
	c) Minutes of the Meeting dated 30th November 2022	Enclosure	Mark Addison	Approve	
	d) Matters Arising: Action Log	Enclosure	Mark Addison	Approve	
3.	**Operational Winter Update**	Verbal	Nick Johnson Adam Savin	Note	9.00-9.15
4.	**CEO Update**	Enclosure	Nick Johnson	Note	9.15-9.35
5.	**Balanced Scorecard**	Enclosure	Nick Johnson	Note	9.35-10.00
6.	**Board Sub-Committee Escalation Reports** (Dec 2022 and Jan 2023) a) Finance and Performance Committee b) People and Culture Committee c) Quality Committee d) Risk and Audit Committee e) Charitable Funds Committee f) System Performance Update	Enclosures	Committee Chairs and Executive Leads	Note	10.00-10.25
Coffee Break 10.25-10.40					
7.	**Board Assurance Framework and Corporate Risk Register**	Enclosure	Paul Lewis Phil Davis Mandy Ford	Approve	10.40-10.55

8.	**Maternity Update** • Continuity of Carer Quarterly Report (January QC)	Enclosure	Jo Howarth Jo Hartley	Note	10.55-11.05
9.	**ICP Strategy Update**	Enclosure	Paul Lewis	Note	11.05-11.15
10.	**Questions from the Public**	Verbal	Mark Addison	Note	11.15-11.20
	CONSENT SECTION				11.20-11.25
	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.				
11.	**ICB Board Minutes Part 1** (Standing Item)	Enclosure	Nick Johnson	Note	-
12.	**Any Other Business** Nil notified	Verbal	Mark Addison		-
13.	**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 29th March 2023 in the Board Room, Trust Headquarters, Dorset County Hospital** and via **MS Teams.**				

Minutes of a public meeting of the Board of Directors of Dorset County NHS Foundation Trust held at 8.30am on 30th November 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
Ruth Gardiner	RG	Interim Chief Information Officer
Emma Hallett	EHa	Interim Chief People Officer
Jo Howarth	JH	Chief Nursing Officer
Emma Hoyle	EHo	Deputy Chief Nurse
Alastair Hutchison	AH	Chief Medical Officer
Nick Johnson	NJ	Interim Chief Executive
Eiri Jones	EJ	Non-Executive Director
Stuart Parsons	SP	Non- Executive Director
Anita Thomas	AT	Chief Operating Officer
Stephen Tilton	ST	Non-Executive Director
David Underwood	DU	Non-Executive Director
Attended via Videoconference:		
Margaret Blankson	MB	Non-Executive Director
Dhammika Perera	DP	Associate Non-Executive Director
In Attendance:		
Judy Crabb		
Phil Davis	PD	Head of Strategy and Corporate Planning
Jo Hartley	JH	Head of Midwifery *(items BoD22/078 and BoD22/079)*
Trevor Hughes	TH	Head of Corporate Governance *(Minutes)*
Paul Lewis	PL	Deputy Director of Strategy, Transformation and Partnerships
Kyle Mitchell	KM	Guardian of Safe Working *(item BoD22/081)*
Simon Pearson	SP	Head of Charity and Social Value *(item BoD22/083)*
Laura Symes	LS	Corporate Business Manager
Jack Welch	JW	Staff member – Staff Story
Andy Willis	AW	Chair, Dorset Healthcare NHS Foundation Trust
Members of the Public Attending via Video Conference:		
Matthew Bryant	MBR	Somerset FT
Judy Crabb	JC	Public Governor
Kathryn Harrison	KH	Public Governor
Apologies:		
None		

BoD22/069	**Staff Story**	
	EH introduced JW Apprentice Library Assistant to discuss his experience as a member of staff with a disability. JW was also Chair of staff disability network 'Without Limits'. JW joined the Trust in September and reasonable adjustments were made in readiness for the interview process. JW outlined his previous employment experiences and his roles and responsibilities which included previously having been a governor at DHC and his work with Mencap. JW's experience of the Trust had been enjoyable to date and he had enjoyed the engagement with various teams to promote access to employment opportunities.	

	JW also worked with the Health Education England Communications Reference Group as an apprenticeship representative to discuss library services. The apprenticeship scheme provided a weekly study day and colleagues had supported assignments and his developing knowledge of healthcare. JW hoped to remain working in the Library as an Assistant and hoped to further develop his career as a professional Librarian. Commenting of his work as Chair of the Without Limits staff network, JW noted a variety of speakers during Disability Awareness month and his role in supporting the developing work to introduce a 'reasonable adjustment passport'. JW also Chaired the Voices Council (Mencap), preparing reports for executive discussion which helped to influenced decision-making. JW reported that the process to join the Trust and been arduous and that the NHS Jobs internet page used to submit his application was difficult to navigate and needed adjustment to widen participation and access with more easy-to-read material. The use of audio and video rather than written applications could also be considered as reasonable adjustments to support applicants do the best they were able. SA commented that as a member of Disabled Directors Network herself. It would be good to make connections with the Without Limits group. SA noted the JW's earlier discussion of the benefits of holding random coffee sessions with a variety of staff in order to increase health literacy, share experiences and promote understanding. She proposed extension of this exercise to include other organisations. JH highlighted the benefits of having an inclusion representative on interview panels for all levels of posts in order to widen participation and advised that she would progress this with the recruitment team. NJ noted the contribution that Library Services made in supporting health literacy, highlighting that the Living Library was a good example of this. In response to a question about what more the Trust could do, JW advised that incremental involvement in recruitment would provide opportunities to deepen knowledge and understanding across the Trust and strengthen an inclusion culture. JW commented that the challenge for the NHS was to innovate and open up decision making to those with a lived experience offer. He noted a general positivity about supporting disability in Dorset and highlighted potential opportunities to improve connections with those with disability in a meaningful way. JW noted his work with the Trust Inclusion Lead and divisions developing more accessible information and communication for the benefit of all and which recognised the differing communications need of individuals.	

	MA thanked JW on behalf of the Board for his eloquent and powerful presentation and for stimulating constructive discussion about further work and proposals in respect to recruitment panel involvement, promoting clarity in the use of language and active listening to feedback from staff networks. MA encouraged JW's further involvement in this work and stated that further updates to the Board on this would be welcome.	
	Resolved that: the Patient Story be heard and noted.	
BoD22/070	**Formalities**	
	The Chair declared the meeting open and quorate and welcomed JH to the meeting as the Interim Chief Nursing Officer and extended the Board's thanks to EHo for her recent support. MA also welcomed CH to his first public meeting. MA noted that this was LS's last day in her current role and thanked her for her support over the previous year. There were no apologies for absence. MA reported that he was saddened to inform the Board of the death of David Tett, Public Governor for the Trust during the previous week. David had been well known in Bridport having been Mayor. He had consistently championed community causes. David lived the role of Governor and had extensive local knowledge and was well networked into the community. David had been exemplary in bringing local population inputs to the Trust. MA also announced the death of Cheryl Fitch, a volunteer with the Trust for some years and whose huge and enthusiastic contribution would be greatly missed. A minute's silence was observed to remember them.	
BoD22/071	**Declarations of Interest**	
	There were no conflicts of interest declared in the business to be transacted on the agenda.	
BoD22/072	**Minutes of the Meeting held on the 26th September 2022**	
	The Minutes of the meeting dated 26th September were approved as an accurate reflection of the meeting.	
	Resolved: that the minutes of the meeting held on 26th September 2022 were approved.	
BoD22/073	**Matters Arising: Action Log**	
	The action log was considered and updates received in the meeting were recorded within the Log 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.	
BoD22/074	**COVID Update**	

	Services during October had been pressured locally with 20-30 COVID positive patients per day requiring additional infection prevention and control management. The number of COVID positive patients in November had reduced to circa 10 patients. Patient flow had been challenged initially with particular pressures experienced in Intensive Care and Paediatric Services. Mutual aid arrangements continued to provide support across the system. There had also been increased in other winter respiratory illnesses (Flu and RSV) and cases of norovirus were emerging across the system.	
	Resolved that the COVID Update be noted.	
BoD22/075	**CEO Update**	
	NJ thanked LS for her significant contribution and support over the preceding year, in particular in construction of this report. NJ highlighted the following key points from the report: • Significant political change since the previous meeting. • A new Secretary of State with a focus on data and performance monitoring prompting greater focus for the Trust on theatre utilisation and agency spend. • Increased funding for the NHS over the next two years, however, the financial position remained tight and efficiency savings would continue to need to be identified and delivered. • The announcement of £500m funding nationally to support patient discharge. • Commencement of the National COVID Inquiry. Involvement was being coordinated by the ICB and it was anticipated that the Trust's direct involvement would be minimal. • Industrial action – the RCN had announced the locations where strike action would be taken. This did not include DCH and no other Dorset locations would be involved. The Royal Devon and Exeter Hospital and Yeovil Hospital would not be involved either. The committee enquired whether individual nurses within DCH were still able to take action and this point would be checked. There was a degree of confidence in managing any industrial action that may occur, although there remained some concern regarding the impact in subsequent days on patient attendances. • No new dates had been published for further action by the RCN at this time. • Unison had balloted staff and the data was being reviewed. • The BMA and Junior Doctors were likely to balloted in the future although there was no clear indication of when this might be. Given the necessary process requirements, it was unlikely that junior doctors would be able to strike before April if they voted to do so. • Robust plans and alternative transport arrangements in the event of potential industrial action by Ambulance staff were being co-ordinated across the system and by the Winter Planning Group. Providers remained concerned about the timeliness of transfers and potential impact of delays and noted the triage arrangements	**EHa**

	in place within the Emergency Department for ambulance arrivals and ambulatory attendances in the department. • The Trust awaited publication of the ICS strategy and this would be discussed further by the Board in December alongside opportunities arising from the joint leadership arrangements with DHC. • The report following the CQC's recent inspection of young people's pathways was awaited. • Winter planning arrangements were in place and had been tested. • The Trust was focused on increasing COVID and Flu staff vaccination coverage. • Progress in reducing the number of people waiting over 104 and 78 weeks for treatment and ambulance transfer times was being maintained • The Trust has been moved into Strategic Oversight Framework Segment 2 by the Regulator as a result of the waiting list improvements, meaning that the Trust no longer required regional performance intervention. • The Anaesthetic service had received national accreditation • There had been a recent HSJ article published highlighted the excellent Orthotic patient safety work within the Trust • The South Walks House Out-patient initiative highlighting improved productivity had been presented nationally via a stand at the NHS Providers national conference. NJ concluded by welcoming CH and JH to the Board. The Board noted also that the Research community was feeling the impact of Brexit as people were no longer able to apply for some funding streams. The Chair noted the significant step from SOF3 to SOF2 and thanks the Executive team for this achievement.	
	Resolved: that the CEO Update be received and noted.	
BoD22/076	**Performance Scorecard and Board Sub-Committee Escalation Reports**	
	NJ summarised development of the scorecard to date and the drivers for further focussed monitoring of the metrics. PD joined the meeting and noted planned further discussion by the Board in December to better understand the scorecard and the data presented. AT recognised improved ambulance handover times but remarked that these were still not where they need to be. She noted the near completion of building works within the Emergency Department, releasing accommodation which was expected to result in further improvements. JH noted the high number of complaints and advised that data quality was under review. The revised report format would be useful in tracking changes and trends in data going forward.	

	The Board noted a slowly improving appraisal trajectory and that the new appraisal system was expecting to see further improvements in compliance. The pattern of short-term sickness undulated reflecting the number of COVID cases within the community. However, there had been improvements in long term sickness absence. The biannual review of leavers and staff turnover rates was due to be presented to the People and Culture Committee and initial analysis had shown an increase in the number of retirees and a strong emergent theme of staff seeking to establish a good work-life balance. The year-to-date performance against the Cost Improvement Programme and agency spend reductions were noted alongside the plans in place to deliver improvements. The need to monitor capital expenditure given the current funding sources and financial trends was noted. Members of the Board commented that they welcomed the helpful, easy-to-read report format and the ongoing developments. They noted the need to also include supporting narrative on mitigating actions and assurances within the dashboard reports to Committees going forward. Day surgery figures were exceeding the target and reflected the phenomenal team work to maintain performance. Optimal use of the available facilities was helping to protect day surgery care and the Board extended its gratitude to the teams involved, noting that the Trust was the top performing Trust in this area this year. The Board suggested that the Trust should share learning as to how day surgery was being delivered. AH noted the impact of the loss of theatre space in Weymouth. **Escalation Reports** **Finance and Performance Committee** ST advised that there was nothing additional to highlight to the Board that had not been previously discussed. He noted that stroke service had moved from “C” to “B” as a result of improved access. abid to purchase portacabin accommodation had been given approval but that the Committee had sought further due diligence on the price. **People and Culture Committee** MB escalated the following key committee discussions: • Discussion of Agency spend had been underpinned by the Finance Subgroup and there had been a real focus on recruitment which had resulted in positive improvements in appraisal rates in the Estates team. • The Trust continued to experience difficulties accessing the OSC Assessment Centre for internationally recruited nursing staff examinations. • The Equality, Diversity and Inclusion report was deferred to February.	**AT**

	• The Committee had noted the recent Going the Extra Mile and Patient Safety Awards. • There had been a rise in staff COVID cases in November and the committee noted long term sickness absence reductions. • There were issues of single points of failure and succession planning across a number of teams presenting and emerging risk to services. • There had been a reduction in the number of cases reported to the Freedom to Speak Up Guardian and the new Guardian appointment was noted. • Mitigating action timescales were to be included in workforce risk reports going forward. • The Committee heard about the informatics and estates workforce challenges and noted recent improvements. **Quality Committee** EJ reported that the Committee received detailed patients feedback regularly and had noted the national discussion about meaningful consent and planned further review of this by the Committee. The Committee continued tracking challenges from front line to Board and were well sighted on these and on areas of positive performance. Plans were in place for the High Acuity Stroke Unit and the Committee commended the contribution and hard work of staff to reach this point. EJ noted the extent of quality improvement work across the Trust and highlighted the need to consolidate and relaunch the Quality Improvement Strategy in order re-establish the organisational quality culture. The opportunity to incorporate inequalities and sustainability into the mechanism was noted also. SA agreed to circulate some materials. The committee had been assured that work was underway to review the SHMI as the scoring had not reduced as expected as a result of earlier coding difficulties. The Trust continued to compare well in other sources of national data and AH was to undertake a comprehensive review of deaths audit comprising a review of all deaths in month. The Intensive Care National Audit and Research Centre (ICNARC) audit had highlighted higher rates of patients being discharged directly from ITU than other trust which impacted patients and flow. Divisional reports and attendance were good and welcomed by the Committee. Divisional staff were open about the challenges services faced and were able to share good practice. **Risk and Audit Committee** The Internal Audit Report on Business Continuity had provided moderate assurance on the Trust processes and effectiveness but had highlighted the need to ensure further role specific training. The HfMA Financial Sustainability self-assessment undertaken by the Trust had been audited. Further evidence to support the Trust's	**SA**

	scoring was to be provided to auditors. This had been a positive audit and Auditors complimented the Executive team on their engagement and positive responses. BDO had shared an Equality Diversity and Inclusion Report for information of best practice. The Committee noted the high usage non-purchase orders as outlined within the Antifraud Report. The Chief Finance Officer was reviewing the position in order to better understand and control this. **System Performance Update** The update had been taken from ICB public Board papers and provided a picture of the challenges across the system and indicated areas of system focus e.g • No Reason to Reside issues, • availability of workforce within mental health services. • Nursing Homes and impact of availability and impact on patient flow • System working to achieve breakeven. MA summarised that the Equality, Diversity and Inclusion report would be returned to the Board in the spring, that work to assure the SHMI Score continued and that there would be a Quality Improvement refresh / relaunch that linked to and included work to address inequalities.	
	Resolved that: the Performance Scorecard and Sub-Committee Escalation Reports be received and noted.	
BoD22/077	**Board Assurance Framework (BAF) and Corporate Risk Register**	
	PD reminded Board members that the report covered strategic risk. He highlighted five risks that scores 20 or higher and were red RAG rated: • Two risks related to staffing and people. PD recounted discussion at the recent Risk Summit that had noted the national workforce context, the need to reflect this within the BAF and to consider risk appetite. • A decision to reduce the performance standards risk score to 16 as a result of improved performance had been taken by Committee noting planned further review following the winter period. • Emergency care pathways had been discussed at relevant Committees. • Financial breakeven risk. The Board heard that the document was being used as a live document by the committees and that discussion had been triangulated at the Risk Summit. The inclusion of timebound mitigating actions would further strengthen committee and Board oversight and the Board noted planned review of the risk appetite statement within the context of the system's risk appetite.	

	Corporate Risk Register EHo presented the annual report which comprised the complete register. COVID remained a key theme although risks were shifting to recovery. The No Reason to Reside risk remained and the impact on care quality and patient access was expected to increase over the winter period. Work to mitigate the Blood Bank risk had been maintained. There was an emerging risk relating to pharmacy staffing and this was also emerging as a risk across the region also. A number of options including skill mix review and changes to recruitment processes were under consideration by the system and region and the need to identify business continuity arrangements should the position deteriorate were emphasised. Provision of mutual aid would be difficult as all partners were struggling with staffing levels and availability. The work involved preparation of chemotherapy and the Board were advised of the move to increasing use of oral preparations that may help to alleviate pressures. The Quality Committee would maintain oversight of the quality and safety aspects of this risk. The Trust continued to access the Memorandum of Understanding within the system in respect to care of mental health patients and access to tier 4 beds and social care support. A further emerging risk related to the condition of the estate and the impact this had on bed availability was noted. The Board noted that the CoTag risk was longstanding. EHo undertook to further review this and to feedback to the Board.	**EHo**
	Resolved: that the Board Assurance Framework and Corporate Risk Register be received and noted.	
BoD22/078	**Maternity Update**	
	JHa joined the meeting. JHa reminded the Board of prior review of the report by the Quality Committee and sought questions. The Board advised that they found the report useful and that it was assured by the report that action on issues highlighted by the Ockenden Report were being addressed. The 'lived experience' discussion earlier in the meeting had noted communications issues in the maternity service. SA noted that the average reading age nationally was age 10 and that communications needed to reflect this. EJ noted that service visits were in planning. In response to an enquiry about issues that might be of concern in the service. JHa reported that the recent Embrace Report remarked on the services as being satisfactory and specifically neonatal deaths.	

	JHa had reviewed again to ensure there was no further learning that could be extracted. She noted the need to have a clear understanding of events when exceptional incidents happened and remarked on the number of metrics and indicators the service was required to monitor and report against. It was important that the focus on incidents should generate learning because general standards were high and performance was satisfactory. JHa concluded that she remained constantly mindful of behaviours and of the need to address any inappropriate behaviours. There were no immediate concerns in this regard.	
	Resolved: that the Maternity Update be received and noted.	
BoD22/079	**Review of Report into East Kent Maternity and Neonatal Services**	
	The Board sought assurance that the sad and disturbing story at East Kent was not emerging at DCH and remarked that the report was useful. Whilst many actions identified within the report required national action, the Board heard that the Trust was working within the system to identify actions on areas that resonated, and that wide ranging staff engagement had taken place. The Maternity Safety Champion, EJ, would feedback and would review any areas of concern. JHo reported that she had met with Healthwatch and discussed the opportunity to work together with Maternity Voices to undertake a proactive of the culture. Jha advised that she worked closely with the Maternity Voices Representative and that the 15 Steps Review had been completed and that service user feedback was overall positive. However, a recent report discussed by the LMNS had provided less favourable feedback and further work was to be done to understand this and make improvements. AH noted that nationally published reports often highlighted professional relationship breakdown as a common theme. Improved working relationships was an important safeguard to effective team working relationships. He noted that a Governance Lead appointment had been made within the service that would further develop a positive working culture. NJ requested that divisional services also reflect on issues they could take forward and to consider how actions taken could be reported via committees. JHo advised that discussion was planned to promote effective communication, escalation of issues and shared learning on actions taken by both the Trust and the LMNS. MA thanked JHa for the report which provided the Board with assurances that report's findings were being taken forward within the Trust. The point made regarding positive team work and culture would be taken forward by the Executive team ad applied across all service areas.	

	Resolved that: the Review of Report into East Kent Maternity and Neonatal Services be received and noted.	
BoD22/080	**Strategy Update**	
	PL outlined the consolidated presentation of the strategy and progress within the report which was being presented for the Board to note. The document was dynamic and had considered the system context and noted the annual planning cycle. PD reported the aim to develop a strategy dashboard that would show delivery against the strategic objectives and reminded that the BAF would support management of the strategic risks. PD noted the planned discussion by the Board in December which aimed to refresh the Trust's priorities in the ICB context and which would also informed by the joint working and collaboration with DHC. EJ enquired about the level of staff understanding in respect of the trust-wide change programme. Staff understanding was mixed and PD noted the need to further embed transformation and improvement methodologies and to explain to staff how these strands of work needed to integrate. Addressing inequalities and promoting sustainability were cross cutting themes that also ought not to be lost as part of the strategy refresh. The agreement of action milestones and clear oversight of responsibility for delivery were also noted. It was suggested that JW's involvement in the development of a Communication Strategy would help to develop that clarity RG noted the key themes and highlighted the need for clarity on the programmes of work that impacted staff. The dashboard would support this and staff being able to identify where they were able to engage. Further discussion would be had at the December Board Development session. RG left the meeting MA summarised by restating the importance of appropriate communications and engagement and identification of the key messages, connection with Equality, Diversity and Inclusion, population health, and team work. MA noted the need to include milestones and links to the broader road map and the need for clarity about accountability.	
	Resolved that: the Strategy Update be noted.	
BoD22/081	**Guardian of Safe Working Report**	
	KM joined the meeting for this item. KM reminded the Board that it was a privilege that the care system afforded doctors with contractual protection and highlighted the	

	increase in the number junior doctors within the Trust from 145 to 190+ over recent years. The report provided assurance that the Trust was compliant with the junior doctor contract and assured that scrutiny was maintained within challenging areas. In particular, Trauma and Orthopaedics and Gastroenterology which comprised small teams leading to greater feelings of isolation and impacting on the education and overall experience. Recruitment activity was underway in order to support the Gastroenterology Consultant Medical team which was down to three from six and the shortage was reflected nationally. Alternative staffing models were under consideration. Immediate safety concerns were not being reported from the service. AH noted that the report covered the change over of junior doctors in August – this group being most affected by the pandemic. The Junior Doctors Forum meeting the previous day reflected that this group were generally more confident and that issues raised had been responded to directly by the divisions. The only concern raised was that doctors were being discouraged from reporting their concerns and this would be monitored closely going forward. NJ congratulated KM on his work to encourage junior doctor engagement and reporting of their concerns. He commented that the principles of safe working could be applied to other disciplines.	
	Resolved that: the Guardian of Safe Working Report be received and noted.	
BoD22/082	**Well Led Action Plan Update**	
	NJ explained that an Executive review had been undertaken to refresh the baseline and that the Action Plan had been updated. NJ sought questions on the updated plan and requested that Non-Executive colleagues maintained discussion of the document. Further review references to meetings with partners would be undertaken following the appointment of the joint Chair and CEO. MA requested that he Front sheet Noted highlighted of issues for Board's attention of areas of good governance going forward.	
	Resolved that: the Well Led Action Plan Update be received and noted.	
BoD22/083	**Social Value Bi-annual Report**	
	SP attended the meeting for this item and introduced himself to the new Board members. In presentation of the bi-annual report SP noted the recent implementation of new software that reflected the social value programme objectives. The aim was that this software would generate metrics for inclusion in future reports.	

	The social value impact assessment and policy were moving forward. The Social Value Programme Group met regularly to monitor progress on delivery of the plan and SP noted that the Trust was working towards the 'living wage' accreditation. SP reported that the Trust had received a document from NHS England outlining its carbon foot print baseline that would support carbon reduction going forward. Social value considerations were being included in major capital projects on site and reports on this would be provided going forward. The opportunity to 'grow' qualified trades people as part of these projects providing qualifications if not long term employment within the Trust were noted. SP reported that the Scholarship Programme for Year 13 school leavers had resulted in a number of participants being recruited into the Trust. He also noted work to further develop and promote health literacy cards. The Trust was a member of the UK Health Anchors Network across the UK and local Dorset network meetings were to resume in the near future. SA commended the report and noted the opportunities to directly link social value to the Trust Strategy review process. The need to ensure staff were appropriately trained to complete social value impact assessments was widely supported by the Board and further consideration would need to be given to consolidating the impact assessment process within the Trust. The connections Governors' had with their communities was acknowledged and their contribution to assessing the Trust's progress against the social value plan and delivery of the Trust's pledge would be welcomed as this work progressed. NJ noted the contribution of software tool in developing the report going forward and reiterated the aim to report how the Trust was meeting its social value pledges across the various executive portfolios going forward. MA summarised discussion and noted the need for social value to be fully connected to the Trust Strategy. He welcomed greater clarity on the various Impact Assessment processes and reasserted the crucial role of Governors in supporting community engagement and feedback. MA concluded on the need to develop embedding social value into the daily business of the Trust.	
	Resolved that: the Social Value Bi-annual Report be received and noted.	
BoD22/084	**Trust Green Spaces**	
	MA reminded Board members about the site visit with Prime to look at the new critical care facilities and Helipad following the meeting. MA presented a number of slides of the Trust's green spaces. He	

	emphasised the need to ensure the continuation of the high standards of green outlooks and areas in the furthering development of the site. He restated the well researched positive impact on health that these had for staff, patients and visitors. The Board noted that the new Sustainability Manager had a background in biodiversity and would be able to take this agenda forward.	
	Resolved that: the Trust Green Spaces Slides and discussed be noted.	
BoD22/085	**Questions from the Public**	
	KH restated the importance of green spaces in hospital. KH reported that she had conducted a further coffee morning and community engagement exercise in Bridport and enquired how best this could be fed back to the Trust. There had been excellent feedback on the quality of the nursing staff. However, the attitude of some medical staff needed to be improved, as people had reported that they had felt that they were not listened to. MA thanked for the helpful feedback and advised that any formal complaints could be properly investigated within the Trust. Governors were encouraged to reiterate the message that care would not be affected and patients would be supported to make a complaint. JHo and EHo would meet with KH to seek further feedback.	**JHo, EHo**
	CONSENT SECTION	
	The following items were taken without discussion. No questions were previously raised by Board members prior to the meeting.	
BoD22/086	**Learning from Deaths Q2 Report**	
	Resolved: that the Charitable Funds Annual Report and Learning from Deaths Q2 Report be approved.	
BoD22/087	**Communication Team Activity Report**	
	The Board acknowledged the considerable amount of work being undertaken in a small team and noted that the team would have a specific role going forward within national Patient Safety Framework.	
	Resolved that: the Communications Team Activity Report be received and noted.	
BoD22/088	**ICB Board Minutes – Part 1**	
	Resolved that: the ICB Board July Minutes Part 1 be noted.	
BoD22/089	**Any Other Business**	
	No other business was raised or notified.	

BoD22/090	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 23rd January 2023. Venue to be confirmed.**

Action Log – Board of Directors Part 1

Presented on: 23rd January 2023

Minute	Item	Action	Owner	Timescale	Outcome	Remove? Y/N
Meeting Dated: 30th November 2022						
BoD22/075	**CEO Update**	Check to be made as to whether individual nurses at DCH were able to take strike action when DCH had not been identified by the RCN as a location taking action.	**EHa**	December 2022	Update not received	
BoD22/076	**Performance Scorecard and Board Sub-Committee Escalation Reports**	To share Day Surgery practice and management arrangements with partners	**AT**	December 2022	Complete shared at COO meeting 16.12.22 and offered to SRG 20.12.22	**Yes**
		SA to circulate some materials on incorporating inequalities and sustainability into Quality Improvement work.	**SA**	December 2022	Update not received	
BoD22/077	**Board Assurance Framework (BAF) and Corporate Risk Register**	Review the long standing CoTag risk and provide feedback	**EHo**	December 2022	Update not received	
BoD22/085	**Questions from the Public**	JHo and EH to meet with KH to seek further feedback, following concerns raised about the attitude of some medical staff.	**JHo, EHo**	January 2023	Update not received	
Actions from Committees…(Include Date)						

Report Front Sheet

1. Report Details			
Meeting Title:	Board of Directors		
Date of Meeting:	Wednesday 25th January 2023		
Document Title:	CEO report		
Responsible Director:	Nick Johnson, Interim CEO	Date of Executive Approval	13-01-2023
Author:	Jonquil Williams, Corporate Business Manager to CEO		
Confidentiality:	If Confidential please state rationale:		
Publishable under FOI?	Yes		
Predetermined Report Format?	No		

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

3. Purpose of the Paper								
	Note (✓)	X	Discuss (✓)		Recommend (✓)		Approve (✓)	

4. Key Issues

Key points to note:

National

1. 8th November the third Covid-19 Public Enquiry opened. NHSE will be working with the Inquiry to establish how it will work with NHS organisations.
2. In November the Hewitt Review was announced in the Chancellors Autumn Statement Speech. ToR were published in December outlining how it will consider oversight and governance.

Local

3. 19th December ICB submitted the first Integrated Care Strategy which was signed off by the ICP
4. SWAST has appointed a new Chair, Stephen Otter.

DCH

5. DCH has seen a lot of pressure on discharge and flow over the winter months which has not been helped with high numbers of No Criteria to Reside Patients
6. Industrial Action has taken place over December and January with both SWAST and RCN taking action. Planning is in place for future strike action this year from other Union members.
7. 16th December the ED15 refurbishment was completed and has opened.
8. 23rd December the Joint Forward Plan was published. Timeframe has been provided for ICB and partner trust to work towards.
9. Outline planning permission has been approved for NHP. Outpatient centre has temporarily moved to Vespasian House.

5. Action recommended	Note: CEO Report

6. Governance and Compliance Obligations				
Legal / Regulatory Link		**Yes**	**No**	If yes, please summarise the legal/regulatory compliance requirement. (Please delete as appropriate)
Impact on CQC Standards		**Yes**	**No**	If yes, please summarise the impact on CQC standards. (Please delete as appropriate)
Risk Link		**Yes**	**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**	**No**	If yes, please summarise how your report contributes to the Trust's Social Value Pledge
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			
	Place			
	Partnership			
Dorset Integrated Care System (ICS) goals		**Which Dorset ICS goals 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)		**Yes**	**No**	
Quality Impact Assessment (QIA)		**Yes**	**No**	

CEO Report

National Relevance
COVID-19 Public Inquiry

On Tuesday 08 November 2022, the UK COVID-19 Public Inquiry opened its third investigation which examines the impact of the COVID-19 pandemic on healthcare in the UK. Issues it will look at include capacity across primary, secondary, and tertiary healthcare sectors, people's experience of healthcare and healthcare-related inequalities. The Inquiry has already held initial procedural hearings for Module One (preparedness) and Module Two (core political decision-making). These have set out how the Inquiry will conduct its investigations. NHS England is working with the Inquiry to understand how it intends to work with NHS organisations.

The Hewitt Review

In November, a planned review of local NHS care by former health secretary Patricia Hewitt was announced in the Chancellor's autumn statement speech. The Terms of Reference were published in early December outlining how it will consider how the oversight and governance of Integrated Care Systems (ICSs) can best enable them to succeed, balancing greater autonomy and robust accountability with a particular focus on real time data shared digitally with the Department of Health and Social Care, and on the availability and use of data across the health and care system for transparency and improvement. In December, Patricia Miller joined an oversight group of ICB CEO colleagues from across the country who will be responsible for drafting the recommendations with Patricia Hewitt.

2023/24 Priorities and Operational Guidance and Joint Forward Plan

On 23rd December NHS England published the 2023/24 priorities and operational planning guidance. The document sets out the priorities for the next financial year including recovering core services, improving productivity and renewing focus on delivering the long term plan. The key priorities identified are:

1. Recovering our core services and productivity
2. Delivering the key NHS Long Term Plan ambitions
3. Transforming the NHS for the future

NHSE has also published its guidance for integrated care boards (ICBs) and their partner trusts and foundation trusts on the development of five-year joint forward plans (JFPs).It covers specific statutory requirements that the plans must meet, such as setting out how an ICB and its partner trusts will meet the health needs of its population. It sets out three principles describing the nature and function of the JFP: alignment with the wider system partnership's ambitions; supporting subsidiarity by addressing local strategies and priorities as well as the wider NHS commitments; and being delivery-focused, including specific objectives, trajectories and milestones.

ICBs and their partner trusts have a duty to prepare a first JFP before the beginning of 2023/24. However for this first year of the process, NHSE has said it expects systems to produce a version

by 31 March, but consultation on further versions can continue beyond that date, in time for a final plan by 30 June.

Surge in Flu patients

Responding to 6th January [i]winter situation report from NHS England, which shows flu cases in hospital have jumped up by 47% and ambulance handover delays have increased, Miriam Deakin, interim deputy chief executive and director of policy and strategy at NHS Providers said: "With seasonal pressures at their peak, we're seeing a deeply worrying surge in beds occupied by flu patients. Along with ongoing COVID-19 infections, more people are requiring medical care at a time when the number of beds and staff is falling far short of what's needed. Bed occupancy remains unacceptably high, and we're still seeing a high number of patients stay in hospital when they're medically fit to leave. This is putting a massive strain on the entire health and care system. The 44% increase in ambulance handovers delayed by 30 minutes or more is also extremely concerning. Staff across ambulance, acute, mental health and community services are anxious that strikes will further disrupt an already challenging situation. Trust leaders are doing all they can to deliver safe, high-quality care for patients, but they cannot weather the storm alone.

Local Relevance

Industrial Action

On 15 December 2022, the NHS saw nurses strike for the first time since its inception. Although Dorset did not participate in December's strikes due to careful consideration from the Royal College of Nursing (RCN) given the cost-of-living crisis. The first SWAST strike took place on 21st December 2022 and although this was a challenging day we have taken some important lessons learnt to support for upcoming and future Industrial Actions.

Additional Industrial action days in January for both SWAST and RCN on 11th January, and 18th and 19th January respectively. Further RCN Strikes are currently planned for February alongside strikes in other sectors.

Getting in Right First Time (GIRFT) Visit

On 05 December 2022, Professor Tim Briggs, the newly appointed National Director for Clinical Improvement and Elective Recovery and lead for GIRFT, visited the Dorset system. It was an opportunity to hear the clinical teams outline the progress they have made at a specialty level and being clear about challenges and how they are dealing with them. We were able to showcase how our clinical teams across Dorset County Hospital and University Hospitals Dorset are working together with a shared purpose.

Invasive Group A Streptococcus

November and December saw high level of demand, across England, due to concerns over Group A Streptococcus (GAS), although numbers of invasive GAS infections have remained low. Locally, general practice received an overwhelming number of enquiries with some practices receiving over 200 phone calls in a single day. Consequently, this had a knock-on effect on their ability to undertake routine and other urgent work.

Integrated Care Strategy

On 19 December 2022, ICB submitted the first version of the Dorset Integrated Care Strategy to NHS England South West which was signed off by the Integrated Care Partnership on 09 December 2022. It grounded in the views of our local communities. In the New Year there will be some further staff engagement to make sure the right priorities have been identified.

SWAST Chair

Stephen Otter has been appointed the new Chair for SWAST. Previously, Stephen was a non-executive director at Taunton and Somerset NHS Foundation Trust, is set to start in his new position this month.

DCH Performance

ED has been incredibly busy over the last couple of months with waiting times increasing at critical points, bed space within wards over subscribed which is not helped with the increasing number of NCTR patients, this resulted in a critical incident being declared on 29th December which was stepped down on 30th December. Flow has been difficult at times however the DCH team has worked well to discharge patients where possible and even more crucially during times of extreme measure such as during the Industrial Actions.

High cost agency use

The Trust's financial position continues to be challenging, reflecting the operational pressures seen recently across the Trust. After eight months of the financial year, we are £6.5 million behind plan. One of the driving pressures to this position is our reliance on high cost agency as a result of high demand and NCTR patients, with £9.4million spent so far this financial year. A significant reduction in high cost agency usage must be achieved, with a target reduction of £1.5million set by the end of the financial year. Since November, we spent £0.208 million less with the highest cost off-framework agencies which is a fantastic achievement and must continue.

ED Refurbishment

Week commencing 16th December we marked the completion of our Emergency Department refurbishment, where we have increased the capacity of resuscitation, majors and Same Day Emergency Care. We invited patient representatives from People First Dorset and Dorset Abilities, who have supported us throughout the project by giving their feedback, to look around the department and meet some of the project team. We also welcomed representatives for NHS England and our contractor Willmott Dixon. It has not been easy refurbishing a live department during a pandemic, and we are incredibly grateful to staff for continuing to provide outstanding care to patients under very challenging circumstances, particularly those working in Radiology and the Emergency Department. This project was a real Team DCH effort and involved teams from all over the Trust. A big thank you to everyone who played a part in this. This scheme provides better facilities in the short-term and paves the way for the new Emergency Department and Critical Care Unit that we are planning to build over the next few years. [ii]Read more in our press release about the scheme.

CQC Maternity National Review

Dorset County Hospital's Maternity Service continues to provide high standards of care, according to the latest national survey results.

The DCH Maternity Service was the only service in the country to be noted as "much better than expected," across the experience of labour and birth and care on the ward after the birth. Being the one maternity service in England to achieve this sets DCH apart. How women, birthing people and families rate their experience of the service is the most valuable gauge of the quality of the service and therefore the most meaningful endorsement.

The national 2022 Maternity Survey, published by the Care Quality Commission (CQC), summarises the experiences of women who gave birth during January and February 2022. The survey asked women about their experiences of care across the entire pregnancy pathway, from antenatal care, labour and birth, and postnatal care. Over 100 responses were received for Dorset County Hospital. As well as delivering individual hospital reports, the CQC publishes a report which focuses on variation in results for care during labour and birth.

Dorset County Hospital received high scores in all areas, including:

- treating people with respect and dignity
- having trust and confidence in staff
- being involved in decisions about patient care

Most improved areas included:

- patients seeing a midwife as much as they wanted after birth
- midwives and doctors being aware of medical history
- patients being given enough information about feeding their baby

CQC Children's and Young People's Pathway Inspection

Following an unannounced inspection in August the CQC provided a draft report on the 12th January 2023. The draft report will be reviewed by the DCH team for factual accuracy errors and returned to CQC prior to publication. The Action Plan which was developed immediately after the inspection will be updated accordingly.

Planning Permission NHP

Outline plans to develop the Dorset County Hospital (DCH) site have been approved by Dorset Council. The Trust's Your Future Hospital programme sets out plans to expand facilities on the site in Dorchester and help meet increasing demand. These include building a new Emergency Department (ED) and Critical Care Unit on the site of the former Damers First School, which is included as part of the Government's New Hospital Programme that will see 40 new hospitals built by 2030. The outline plans also take into account the Trust's longer-term aspirations to improve the hospital's main entrance, provide integrated care and offer key worker housing for staff.

Southwalks House update

Work is underway to turn two floors of South Walks House into clinical space – including outpatient clinics, a day case room for local anaesthetic procedures, X-ray, ultrasound scan and dexa scan facilities. As you will be aware, we had been running an Outpatient Assessment Centre out of one floor of South Walks House. This was initially set up as a temporary measure to tackle waiting lists. The centre has been a great success and in March we signed a 20-year lease with Dorset Council to use three additional floors of the building on a long-term basis. We wanted to do this to help address our most pressing challenges around patient flow and long waiting times. We received funding from NHSI of more than £14.4m to turn the temporary centre space into a more permanent facility, as well as provide diagnostic services at South Walks House and create ringfenced beds on the main hospital site. Construction work at South Walks House has begun and the Outpatient Assessment Centre has temporarily moved to the ground floor of [iii]Vespasian House in Dorchester while work is carried out. The aim is that clinical services will start operating from South Walks House again later this year.

Joint CEO and Chair update

Matthew Bryant will be starting in his new position on 6th March, he will follow an initial induction month shadowing both myself and Dawn Dawson, Acting CEO of Dorset Healthcare, and will then take the reins from 1st April from which point he will be the Accountable Officer for both organisations.

The recruitment of Chair is due to commence shortly and the interviews are scheduled for end March. An extension of Mark Addisons' tenure will be requested to cover the period between March and when the new chair takes their position.

Celebrating success

Congratulations to the Emergency Department team for a successful scoop at this year's Wessex Emergency Medicine and Excellence Awards. We are very proud of our winners - Leah Hughes, ACP of the year, and Rachel Wharton, Consultant Educationalist of the Year.
Well done also to everyone who was nominated - Kess Akowheri (junior doctor of the year), Luhaib Alomari (junior doctor of the year), Zoe Bianco (middle grade of the year), Huw Evans (middle grade of the year), Qui (nursing and allied HCP of the year), Veanna Santos (nursing and allied HCP of the year), Akhila Varghese (nursing and allied HCP of the year), Matt Cape (nursing and allied HCP of the year), Tim (nursing and allied HCP of the year), Andrew Brett (consultant educationalist of the year), Rob Torok (consultant educationalist of the year), Tamsin Ribbons (consultant educationalist of the year), Emergency Department – educational environment of the year.

DCH had the largest number of nominations from all the hospital trusts – a true credit to our fantastic team we have so many people worthy of mentioning. Congratulations to all for your continuous dedication, enthusiasm and support for our patients and each other.

Ward accreditation

In November both Ilchester and the stroke wards were recipients of silver awards. 2 Gold (Purbeck and Ridgeway) and 2 Silver awards (Critical Care and Kingfisher) for the Division.

Great work and congratulations to the hard work of the teams on those wards.

[i] https://www.england.nhs.uk/statistics/statistical-work-areas/uec-sitrep/urgent-and-emergency-care-daily-situation-reports-2022-23/#utm_campaign=1183057_Winter%20situation%20report%20statement&utm_medium=email&utm_source=NHS%20Confederation&dm_i=6OI9,PCUP,4WZ9VK,351EG,1

[ii] https://www.dchft.nhs.uk/about-us/latest-news/hospital-marks-completion-of-emergency-department-refurbishment/

[iii] https://www.dchft.nhs.uk/patients-and-visitors/information-for-outpatients/vespasian-house/

Report Front Sheet

1. Report Details			
Meeting Title:	*Board of Directors*		
Date of Meeting:	*Wednesday 25th January 2023*		
Document Title:	*Balance Scorecard*		
Responsible Director:	*Nick Johnson, Interim CEO & Phil Davis Head of Strategy and Corporate planning*	Date of Executive Approval	*18-01-2023*
Author:	*Jonquil Williams, Corporate Business Support Manager to CEO*		
Confidentiality:	*If Confidential please state rationale:*		
Publishable under FOI?	*Yes/No*		
Predetermined Report Format?	*Has the format of the report been set in order to meet a regulatory or statutory requirement? i.e., to satisfy the reporting requirements following a national inquiry / been determined by NHSE/I / CQC?* *Yes / No? if yes please state.*		

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

3. Purpose of the Paper								
	Note (✓)	*x*	*Discuss (✓)*		*Recommend (✓)*		*Approve (✓)*	
4. Key Issues	*Performance* 1. *Ambulance handovers worse than planned but DCH better than other 24/7 Eds in S-West* 2. *DCH declared critical incident for flow after Christmas – due to poor discharge profile* *Quality and Safety* 1. *Fluctuation in data for this month SHMI* 2. *Mixed sex accommodation breached continue to be monitored* *People* 1. *Increase in vacancy rate* 2. *Overall sickness decreased in month* *Finance* 1. *Agency Spend still above internal plan however increase improvement on previous months* 2. *YTD capital spend £23m vs planned £30m*							
5. Action recommended								

6. Governance and Compliance Obligations				
Legal / Regulatory Link		**Yes**	**No**	*If yes, please summarise the legal/regulatory compliance requirement. (Please delete as appropriate)*
Impact on CQC Standards		**Yes**	**No**	*If yes, please summarise the impact on CQC standards. (Please delete as appropriate)*
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Strategic Objectives	People			
	Place			
	Partnership			
Dorset Integrated Care System (ICS) goals		**Which Dorset ICS goals 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)		**Yes**	**No**	
Quality Impact Assessment (QIA)		**Yes**	**No**	

Balanced Scorecard

1. Executive Summary

2. Performance

a) Ambulance handovers whilst worse than planned, were better than other 24/7 EDs in S-West against challenging demand
b) Cancer wait times, long wait reductions, theatre utilisation and PIFU all improved in Dec, but longer period of improvement required before SPC Assurance
c) DCH declared critical incident for flow in days after Christmas, due to poor discharge profile during period
d) Inpatient EL activity continues to be adversely affected by intensity of EM care pathway and high proportion of NRTR patients
e) Significant rise in winter infections impacted EM flow in Dec, driving worse 4hr perf
f) Surrounding hospitals at critical incident levels pre-Christmas, altering ambulance activity to DCH and driving lower handover times

3. Quality and Safety

a) Availability of EDS for GP's remains a challenge with a slight decrease in Dec
b) Challenges to Quality Improvement:
   a. Fluctuation in data this month for SHMI
   b. Maintaining no lapse in care cases under threshold for C-Diff
   c. Mixed Sex Accommodation breaches continue to be closely monitored, increase in incidents for Dec
   d) Positive QI: No Never Events or Serious Harm Medication Incidents reported for 13 consecutive months, no Serious Incidents confirmed in Dec

4. People

a) 0.9% increase in vacancy rate, caused by adjustment to establishment. 29 WTEs added to establishment in Dec, majority being Nursing (14) and HCSW (11) roles.
b) Appraisal rate reduced 1% in month, the first reduction since May-22. Op pressures impacting on opportunities for appraisals to be undertaken, but shorter appraisal form introduced to assist.
c) Overall sickness % decreased in month, with a marginal decrease in both long and short-term absences.

5. Finance

a) Agency Spend still above internal plan & NHSE ceiling, however seeing improvement on previous months. Proportion of off-framework also reducing.
b) CIP - £5.6m identified against £5.7m annual target. £3.3m delivered YTD, with further progress required to deliver identified schemes by YE.
c) YTD capital spend £23m vs a plan of £30m, primarily delays on NHP and other externally funded items

Exec Dashboard Jan 2023 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

31 December 2018
Earliest Date

31 December 2022
Latest Date

09 January 2023
Earliest Jan 2023 board Date

pdf version

Making Data Count

Understanding and Interpreting SPC Charts

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

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	71%	90%
Essential skills Rate	F	H	90%	90%
Sickness Rate	?	H	4.62%	3.3%
Turnover Rate	P	H	11.87%	12%
Vacancy Rate (substantive)	F	H	10.36%	5%

QUALITY & SAFETY

Metric Name	Assurance	Variation	Value	Target
% EDS available within 24Hrs of discharge	F	H	81.01%	90%
% EDS available within 7 Days of discharge	F	H	91.49%	100%
% Emergency Re-Admissions (16+ & within 30 days) 1 month in arrears	P	L	5.82%	13.2%
Complaints Total Recieved			97	
FFT Overall Recommend Rate	?	L	86.59%	94%
Incidents - Falls: Fracture/Severe Harm Cases			0	
Incidents - Medication			59	
Incidents - Never Events	F	L	0	0.02
Incidents - Serious, Avoidable	?		0	0
Number of Hospital Onset HealthCare Associated C.Difficile Infections	?		3	3.83
Number of Hospital Onset HealthCare Associated Gram Negative Infections	?		2	5.75
Reportable Hospital Acquired Pressure Ulcers Grade 3			0	
SHMI Value	?	L	1.14	1.13

PERFORMANCE

Metric Name	Assurance	Variation	Value	Target
Ambulance Handover Delays Average Time Lost per Day	F	H	42.92	1.55
Cancer (ALL) - 28 day faster diagnosis standard	?	H	78.55%	75%
Cancer (ALL) - 104 Days Referral to Treatment			20	
Diagnostics - % Patients Waiting Less than 6 Week Diagnostic Test	F	L	67.87%	99%
Elective Recovery - Day Case Activity vs 2019/20	?	H	106.38%	104%
Elective Recovery - Elective Inpatients Activity vs 2019/20	F		81.59%	104%
Elective Recovery - Outpatient Activity vs 2019/20	?		92.24%	104%
Elective Recovery Total Activity vs 2019/20	?		92.69%	104%
Emergency Department - 12 Hour Waits		H	598	
Emergency Department - Overall 4 Hour Performance %	F	L	70.83%	95%
Outpatients - Virtual Activity %	F	H	22.66%	25%
Percent Bed Occupied by No RTR		L	22.49%	
RTT - 52+ week waits	?		1218	1300
RTT - 78+ week waits	F	L	99	100
RTT - Waiting List Size	?	H	19484	16974
Theatres - Theatre Utilisation (TouchTime)	F	L	62.96%	85%

FINANCE

Metric Name	Assurance	Variation	Value	Target
Total Substantive Workforce Pay Cost		H	19152	
Financial Spend			-226	
CIP			1221	
Capital Expenditure	?		1258	2136
Agency Spend		L	-599	
Agency % of pay costs	F	H	8%	5%

Matrix Overview

Dorset County Hospital NHS Foundation Trust

Assurance

Variance	P	?	F		Total
H		2	5		7
L	1	1	3	2	7
		8	1	7	16
H	1	2	3	4	10
L		1	4		5
				1	1
Total	2	14	16	14	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

Dorset County Hospital NHS Foundation Trust

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.

Commentary
Ambulance handovers whilst worse than planned, were better than other 24/7 EDs in S-West against challenging demand
Cancer wait times, long wait reductions, theatre utilisation and PIFU all improved in Dec, but longer period of improvement required before SPC Assurance
DCH declared critical incident for flow in days after Christmas, due to poor discharge profile during period
Inpatient EL activity continues to be adversely affected by intensity of EM care pathway and high proportion of NRTR patients
Significant rise in winter infections impacted EM flow in Dec, driving worse 4hr perf
Surrounding hospitals at critical incident levels pre-Christmas, altering ambulance activity to DCH and driving lower handover times

VariationIcon	Pass	Hit or Miss	Fail	Empty	Total
Empty					
Neither					
Concern		1	4	1	6
Common Cause		3	1	1	5
Improvement		2	2	1	5
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	Dec-22	42.92	1.55	41.36	12.81				
Cancer (ALL) - 28 day faster diagnosis standard	0 - Total	Dec-22	78.55%	75%	3.55%	67.1%				
Cancer (ALL) - 104 Days Referral to Treatment	0 - Total	Dec-22	20			29				
Diagnostics - % Patients Waiting Less than 6 Week Diagnostic Test	0 - Total	Dec-22	67.87%	99%	-31.13%	91.18%				
Elective Recovery - Day Case Activity vs 2019/20	0 - Total	Dec-22	106.38%	104%	2.38%	88.07%				
Elective Recovery - Elective Inpatients Activity vs 2019/20	0 - Total	Dec-22	81.59%	104%	-22.41%	101%				
Elective Recovery - Outpatient Activity vs 2019/20	0 - Total	Dec-22	92.24%	104%	-11.76%	97.33%				
Elective Recovery Total Activity vs 2019/20	0 - Total	Dec-22	92.69%	104%	-11.31%	96.57%				
Emergency Department - 12 Hour Waits	0 - Total	Dec-22	598			47	3440			https://bireports.dch…
Emergency Department - Overall 4 Hour Performance %	0 - Total	Dec-22	70.83%	95%	-24.17%	71.95%				https://bireports.dch…
Outpatients - Virtual Activity %	0 - Total	Dec-22	22.66%	25%	-2.34%	23.99%				
Percent Bed Occupied by No RTR	0 - Total	Dec-22	22.49%			28.34%				
RTT - 52+ week waits	0 - Total	Dec-22	1218	1300	-82.00	1703	1218			https://bireports.dch…
RTT - 78+ week waits	0 - Total	Dec-22	99	100	-1.00	606	99			https://bireports.dch…
RTT - Waiting List Size	0 - Total	Dec-22	19484	16974	2,510.00	17024	19484			https://bireports.dch…
Theatres - Theatre Utilisation (TouchTime)	0 - Total	Dec-22	62.96%	85%	-22.04%	70.98%				https://bireports.dch…

Quality and Safety

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

Group: 0 - Total

MetricName: All

NHS Dorset County Hospital NHS Foundation Trust

Commentary
Availability of EDS for GP's remains a challenge with a slight decrease in Dec
Challenges to Quality Improvement:
Fluctuation in data this month for SHMI
Maintaining no lapse in care cases under threshold for C-Diff
Mixed Sex Accommodation breaches continue to be closely monitored, increase in incidents for Dec
Positive QI: No Never Events or Serious Harm Medication Incidents reported for 13 consecutive months, no Serious Incidents confirmed in Dec

Assurance	Improvement	Common Cause	Concern	Neither	Empty	Total
Pass	1		1			2
Hit or Miss	3	8	3			14
Fail	8	1	7			16
Empty	2	7	4	1	1	15
Total	14	16	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	Dec-22	0			0				
Incidents - Medication	0 - Total	Dec-22	59			52				
Incidents - Never Events	0 - Total	Dec-22	0	0.02	-0.02	0				
Incidents - Serious, Avoidable	0 - Total	Dec-22	0	0	0.00	1				
Number of Hospital Onset HealthCare Associated C.Difficile Infections	0 - Total	Dec-22	3	3.83	-0.83	6	29			https://birepo…
Number of Hospital Onset HealthCare Associated Gram Negative Infections	0 - Total	Dec-22	2	5.75	-3.75	5	27			https://birepo…
Reportable Hospital Acquired Pressure Ulcers Grade 3	0 - Total	Dec-22	0			0	10			https://birepo…

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	Dec-22	81.01%	90%	-8.99%	77.91%				
% EDS available within 7 Days of discharge	0 - Total	Dec-22	91.49%	100%	-8.51%	88.23%				
% Emergency Re-Admissions (16+ & within 30 days) 1 month in arrears	0 - Total	Nov-22	5.82%	13.2%	-7.38%	6.59%				
SHMI Value	0 - Total	Jul-22	1.14	1.13	0.01	1.15	1.14			https://bireports.…

CARING

Metric	Group	Latest Month	Value	Target	Variance to Target	PY - Month Value	YTD Value	Variation	Assurance	Hyperlinks
Complaints Total Recieved	0 - Total	Dec-22	97			70	897			
FFT Overall Recommend Rate	0 - Total	Dec-22	86.59%	94%	-7.41%	92%				

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
0.9% increase in vacancy rate, caused by adjustment to establishment. 29 WTEs added to establishment in Dec, majority being Nursing (14) and HCSW (11) roles.
Appraisal rate reduced 1% in month, the first reduction since May-22. Op pressures impacting on opportunities for appraisals to be undertaken, but shorter appraisal form introduced to assist.
Overall sickness % decreased in month, with a marginal decrease in both long and short-term absences.

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	Dec-22	71%	90%	-19.00%	69%	71%			
Essential skills Rate	0 - Total	Dec-22	90%	90%	0.00%	90%	90%			
Sickness Rate	0 - Total	Nov-22	4.62%	3.3%	1.32%	4.79%	4.62%			
Turnover Rate	0 - Total	Dec-22	11.87%	12%	-0.13%	8.69%	11.87%			
Vacancy Rate (substantive)	0 - Total	Dec-22	10.36%	5%	5.36%	6.3%				

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

NHS Dorset County Hospital NHS Foundation Trust

Commentary

Agency Spend still above internal plan & NHSE ceiling, however seeing improvement on previous months. Proportion of off-framework also reducing.

CIP - £5.6m identified against £5.7m annual target. £3.3m delivered YTD, with further progress required to deliver identified schemes by YE.

YTD capital spend £23m vs a plan of £30m, primarily delays on NHP and other externally funded items.

Assurance	Improvement	Common Cause	Concern	Neither	Empty	Total
Pass						
Hit or Miss		1				1
Fail			1			1
Empty	1	1	1		1	4
Total	**1**	**2**	**2**		**1**	**6**

Metric	Group	Latest Month	Value	Target	Variance to Target	PY - Month Value	YTD Value	Variation	Assurance	Hyperlinks
Agency % of pay costs	0 - Total	Dec-22	8%	5%	3.00%	8%				
Agency Spend	0 - Total	Dec-22	-599			826	8769			
Capital Expenditure	0 - Total	Dec-22	1258	2136	-878.00	4325	23046			
CIP	0 - Total	Dec-22	1221				-855			
Financial Spend	0 - Total	Dec-22	-226			143				
Total Substantive Workforce Pay Cost	0 - Total	Dec-22	19152			11692.12				

SPC Basics

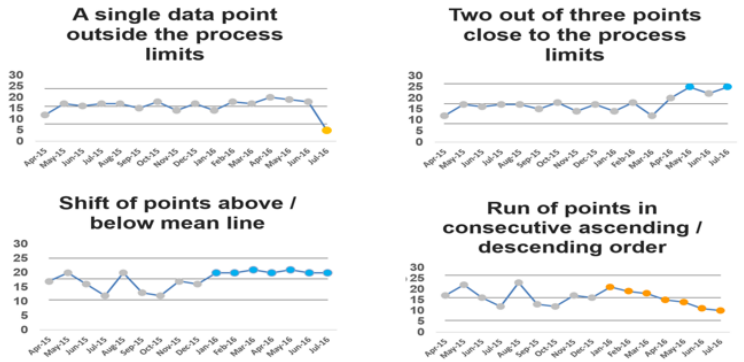
Dorset County Hospital
NHS Foundation Trust

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?

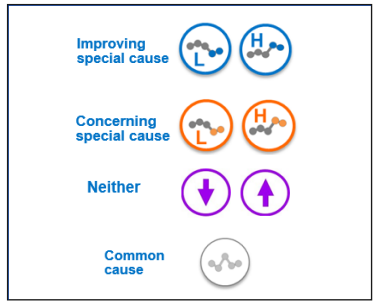
Blue icons indicate significant improvement or low pressure.

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?

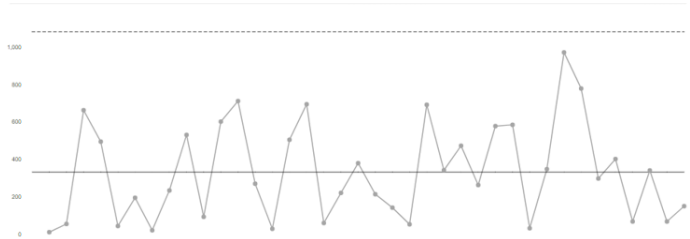
Moving range chart (seen on right) helps to assess the variation in a process by taking the absolute difference between consecutive points.

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.

INTEGRITY | RESPECT | TEAMWORK | EXCELLENCE

NHS
Dorset County Hospital
NHS Foundation Trust

Escalation Report

Executive / Committee: Finance and Performance Committee

Date of Meeting: Monday 19th December 2022

Presented by: Stephen Tilton (Chair)

Significant risks / issues for escalation to Committee / Board for action	• Approval was given to the CT Scanner Weymouth procurement • Expenditure as part of the New Hospitals Programme was approved

Key issues / matters discussed at the Committee	The meeting considered the following items:
	• An update on the winter pressures across the system noting increases in respiratory infections and the planned industrial action
	• The Performance Report noted:
	  ○ Improved performance in November relating to ambulance handovers and ability to undertake elective recovery activities
	  ○ Ahead of planned trajectory for reducing long waits for treatment
	  ○ The impact of increased respiratory infections on the Emergency Department and on staff absence.
	  ○ Additional demands on the Trust arising from requests for system partners to provide mutual aid.
	• The Finance Report noted:
	  ○ Actions being taken to reduce high-cost agency expenditure and the imperative to deliver the identified Cost Improvement Schemes.
	• Detailed discussion by the Finance subgroup of the Cost Improvement Programme and agency spend reduction plans.
	• Divisional Escalation Reports
	• Planned expenditure on enabling works at South Walks House
	• The Estates Master Plan update
	• Patient Pathway Improvement Programme update was noted.
	• There were no subgroup Escalation Reports

Decisions made by the Committee	• Approval, in line with delegated authority from the Board, was given to the CT Scanner Weymouth • Expenditure as part of the New Hospitals Programme was approved in line with delegated authority from the Board.
Implications for the Corporate Risk Register or the Board Assurance Framework (BAF)	• Nil new.
Items / issues for referral to other Committees	• None

INTEGRITY | RESPECT | TEAMWORK | EXCELLENCE

NHS
Dorset County Hospital
NHS Foundation Trust

Escalation Report

Executive / Committee: Finance and Performance Committee

Date of Meeting: Monday 16th January 2023

Presented by: Stephen Tilton (Chair)

Significant risks / issues for escalation to Committee / Board for action	• The Community Diagnostic Centre procurement is recommended to the Board for approval. Delegated authority to the Chief Finance Officer and Chief Operating Officer is requested to progress the subsequent contracting arrangements with the Trust. • Fortuneswell Pharmacy Expansion Option – the full development option is recommended to the Board for approval.

Key issues / matters discussed at the Committee	The meeting considered the following items:
	• An update on service and winter pressures across the system noting current industrial action by ambulance workers and nurses.
	• The Performance Report noted:
	  ○ High numbers of respiratory infection cases impacting patient flow.
	  ○ Comparatively good Ambulance handover performance
	  ○ Reductions in Agency Expenditure
	  ○ Positive cancer waiting time performance – one of two trusts regionally RAG rated green for the proportion of the waiting list over 62 days, meeting the 31 day and 28 day diagnosis
	  ○ Reductions in the104, 78 and 52 week waiting lists despite pressure on beds
	  ○ Improved Patient Initiated Follow Up performance and on track to deliver the 5% target by the end of March.
	• The Finance subgroup did not meet in January.
	• Divisional Escalation Reports were stood down due to service pressures
	• The ICP Strategy
	• Operational Plan and Business Planning Update
	• ICB Finance Committee Minutes

Decisions made by the Committee	• Community Diagnostic Centre Procurement is recommended to the Board. • Fortuneswell Expansion Options is recommended to the Board.
Implications for the Corporate Risk Register or the Board Assurance Framework (BAF)	• Nil new.
Items / issues for referral to other Committees	• None

Escalation Report

Executive / Committee: People and Culture Committee

Date of Meeting: Monday 19th December 2022

Presented by: Eiri Jones (Vice Chair)

Significant risks / issues for escalation to Board for action	• There had been a marked positive shift in the agency expenditure pattern in month

Key issues / other matters discussed by the Committee	The meeting considered the following items:
	• People and Performance Report and Dashboard noting:
	  ○ 30% staff attrition rate within pharmacy
	  ○ A low staff survey response
	  ○ Apparently low staff vaccination rates
	  ○ Low essential skills and mandatory training compliance rates
	• Divisional / Departmental Reports:
	  ○ Family and Surgical Services Division
	• Agency Report and Dashboard and move to SPC reporting
	• Biannual Leavers and Retention Report noting
	  ○ Proportionally higher numbers of leavers within the Allied Health Professional and the Professional and Technical staff groups
	  ○ Good retention rates for overseas recruits.
	• Apprenticeships and Widening Participation Biannual Report noting a number of successful schemes
	• Financial Wellbeing and Cost of Living Support for Staff Report and strong commitment from the Board
	• Ward Accreditation and Learning from Excellence Report
	• There were no escalations from subgroups

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

INTEGRITY | RESPECT | TEAMWORK | EXCELLENCE

NHS
Dorset County Hospital
NHS Foundation Trust

Escalation Report

Executive / Committee: People and Culture Committee

Date of Meeting: Monday 16th January 2023

Presented by: Stuart Parsons (Chair)

Significant risks / issues for escalation to Board for action	• Twice daily review of shifts and staffing levels. • Focus on advanced rostering in respect of the Agency Reduction Programme – having a positive impact on fill rates and appropriate staffing levels.

Key issues / other matters discussed by the Committee	Divisional representation at the meeting was stood down due to service operational pressures and preparations for planned industrial action.
	The meeting considered the following items:
	• People and Performance Report and Dashboard noting:
	  ○ Reduced staff sickness absence although this was expected to increase in December.
	  ○ Reduced appraisal compliance rates in December.
	  ○ A reduction in Agency expenditure in month.
	  ○ Plans in place for expected industrial action.
	  ○ Low staff COVID and Flu vaccination rates reflecting the national picture.
	  ○ Monitoring of staff working hours where these exceed the Working Time Directive.
	  ○ Twice daily safe staffing reviews.
	• ICB People Committee Minutes

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

INTEGRITY | RESPECT | TEAMWORK | EXCELLENCE

NHS
Dorset County Hospital
NHS Foundation Trust

Escalation Report

Committee: Quality Committee

Date of Meeting: 20th December 2022

Presented by: Eiri Jones / Jo Howarth

Significant risks / issues for escalation to Board for action	• The CQC's withdrawal of the warning letter regarding the care of children and young people with mental health needs • Evidence of good practice, stability and focus on harms despite the significant challenges at present • Concerns regarding electronic discharge summaries (EDS) to GPs, discharges directly from critical care, and continuing concerns from patients regarding waiting times • Three maternity reports, including the MMBRACE report and Self-Assessment Tool • Approval of the Nutritional Strategy • Increased and proactive focus on infections and winter viruses, most notably Covid-19, flu and RSV

Key issues / matters discussed at the Committee	The committee received, discussed and noted the following reports:
	• Quality and Safety Performance Report noting a picture of stability:
	  ○ No serious incidents and no never-events reported. No serious medication incidents.
	  ○ Challenges continue to be the rate of C.Difficile in Dorset and EDS. Achieving Outstanding CQC preparation group stood down for December due to operational pressures. Renewed focus to begin in the new year.
	• Maternity Safety Report, Maternity Self-Assessment, and 2020 MMRBACE report noting:
	  ○ Improvements in staffing, although challenges remain particularly overnight, challenges following changes to the Maternity Incentive Scheme requirements, positive feedback from the Cranberry continuity team.
	  ○ 2020 MMBRACE data showing overall rates within normal range of similar sized Trusts, with appropriate assurances provided regarding the neonatal death rates >5% greater than similar sized Trusts.
	• Divisional Exception Reports from
	  ○ Urgent and Integrated Care Division noting solutions to the CPAP service challenges, income generating trials for the Research Team, and challenges around flow of stroke patients.
	  ○ Family and Surgical Services Division noting challenges around EDS, roll out of the orthopaedic day case programme, and the Trust as an outlier for discharging direct from critical care.
	• Nutritional Strategy
	• Escalation Reports from
	  ○ Infection Prevention and Control Group
	  ○ Patient Experience Group

Decisions made by the Committee	• Approval of the Nutritional Strategy
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: 17th January 2023

Presented by: Eiri Jones / Jo Howarth

Significant risks / issues for escalation to Board for action	• Continued good focus on safety and falls prevention despite the operational pressures. • Ward clerk shortages impacting in general and on timely Electronic Discharge Summaries (EDS). • SHMI continues to be above the expected range; a number of workstreams being undertaken to understand the root cause of this. • The committee supported the integrity and transparency of the maternity team in declaring that they were compliant with 8 out of 10 standards in the Maternity Incentive Scheme. • CQC report has been received and is being reviewed for accuracy.

Key issues / matters discussed at the Committee	The committee received, discussed and noted the following reports:
	• Quality and Safety Performance Report noting:
	  ○ Operational pressures were high in December, but at the time of the committee there were no areas of escalation open in the hospital.
	  ○ Maintained safety position with no never-events, serious incidents, or serious medication incidents in December.
	  ○ Challenges include an increase in mixed sex accommodation, timeliness of EDS, and fluctuating SHMI.
	• Maternity Safety Report and Maternity Incentive Scheme (MIS) noting:
	  ○ Positive results on the CQC national survey, with thanks given to the whole maternity team.
	  ○ Increased complexity of the MIS standards. The Trust was compliant with 8 out of 10 of the standards and the committee supported this position. The 2 standards not met were around the audit of transitional care, and CO monitoring at 36 weeks.
	• Board Assurance Framework focus on current strategic risks due to increased pressures
	• 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

INTEGRITY | RESPECT | TEAMWORK | EXCELLENCE

NHS
Dorset County Hospital
NHS Foundation Trust

Escalation Report

Committee: Risk and Audit Committee

Date of Meeting: 17th January 2023

Presented by: Stuart Parsons

Significant risks / issues for escalation to Board for action	• Internal and External Audit Procurement recommending:
	  ○ The appointment of BDO as the Trust's Internal Auditors to the Board of Directors for approval for a period of three years with the option to extend for two, one-year periods.
	  ○ The appointment of KPMG as the Trust's External Auditors to the Council of Governors for approval for a period of three years with the option to extend for two, one-year periods.

Key issues / other matters discussed by the Committee	Attendance by external colleagues was stood down due to service operational pressures and to enable preparations for planned industrial action. The committee received and noted the following: • Antibribery and Counter Fraud Policy noting no material changes. • The ICB Risk and Audit Committee Minutes were noted

Decisions made by the Committee	The Committee approved:
	  ○ The Antibribery and Counter Fraud Policy
	And recommends:
	  ○ the appointment of BDO as the Trust's Internal Auditors for a three-year with the option to extend for two, one-year periods to the Board of Directors for approval.
	  ○ The appointment of KPMG as the Trust's External Auditors for a three-year with the option to extend for two, one-year periods to the Council of Governors for approval.

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

INTEGRITY | RESPECT | TEAMWORK | EXCELLENCE

NHS
Dorset County Hospital
NHS Foundation Trust

Escalation Report

Executive / Committee: Charitable Funds Committee

Date of Meeting: 22 November 2022

Presented by: Dave Underwood

Significant risks / issues for escalation to Committee / Board for action	• **Dorset County Hospital Charity finances** impacted by pandemic and economic situation, as per UK charity sector. DCH Charity Financial Review (Q2 22/23) held by Charity Strategy Group (Oct 2022) and report submitted to Charitable Funds Committee 22.11.22. Next review Q3 22/23 (Jan 2023). • **Dementia Appeal/Purbeck Room** The DCHC Dementia Appeal (2015/16; £80K raised) funded work on Purbeck Ward to create a bespoke room for dementia patients to use as part of their care and recovery. During the pandemic this space was requisitioned to be used for inpatient beds. This use has continued and Purbeck staff would like it returned to its intended use for dementia patients which was charity funded. **Action:** Board asked to consider this issue and the request to reinstate the room on Purbeck Ward to the purpose intended and funded by the charitable appeal.
Key issues / matters discussed at the Committee	**DCHC Financial review (Q2 22/23)** held by DCHC Strategy Group 27.10.22 • **DCH Charity Financial Review (Q2)** The Reserves position at the end of Sept 2022 (M6) showed a surplus of £16k above the target of £200k. Pending Legacy and grant income expected will provide a forecast reserves surplus of £196k. • **DCH Charity Risk Register review (Q2 22/23)** Current risk ratings maintained due to impact of pandemic and economic situation on charity performance. CFC reviewed the DCHC Risk Register on 22.11.22. **DCHC Charitable Funds Committee (22.11.22)** • **DCH Charity Finance/Income 22/23** reports (M6 Sep 2022) received. • **DCHC Reserves Policy** reserves level £200K to be reviewed and policy updated if required.

	• **New Policies** draft DCHC Grants Policy and Ethical statement reviewed by CFC. To be finalised for approval. • **DCHC Policies Review (3-year)** review to commence of all DCHC policies. • **Dementia Appeal/Purbeck Room** The DCHC Dementia Appeal (2015/16; £80K raised) funded work on Purbeck Ward to create a bespoke room for dementia patients to use as part of their care and recovery. During the pandemic this space was requisitioned to be used for inpatient beds. This use has continued and Purbeck staff would like it returned to its intended use for dementia patients which was charity funded. Board asked to consider this issue and the request to reinstate the room on Purbeck Ward to the purpose intended and funded by the charitable appeal.
Decisions made by the Committee	• Nil
Implications for the Corporate Risk Register or the Board Assurance Framework (BAF)	• Nil
Items / issues for referral to other Committees	• Nil

Report Front Sheet

1. Report Details			
Meeting Title:	Board of Directors		
Date of Meeting:	Wednesday 25th January		
Document Title:	Dorset System Performance		
Responsible Director:	Nick Johnson, CEO	Date of Executive Approval	13th Jan 2023
Author:	Jonquil Williams, Business Manager		
Confidentiality:	If Confidential please state rationale: No		
Publishable under FOI?	**Yes**/No		
Predetermined Report Format?	Has the format of the report been set in order to meet a regulatory or statutory requirement? i.e., to satisfy the reporting requirements following a national inquiry / been determined by NHSE/I / CQC? Yes / No? if yes please state.		

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

3. Purpose of the Paper	What is the paper about? Why is the paper is being presented and what you are asking the Board / committee to do?							
	Note (✓)		Discuss (✓)		Recommend (✓)		Approve (✓)	
4. Key Issues	The information in this report was pulled from the ICB System Performance report. Headline points: Maternity 1. Workforce pressures and safe staffing levels are identified as one of the top concerns for the Maternity Units at both University Hospitals Dorset (UHD) and Dorset County Hospital (DCH). The impacts on care include delayed inductions of labour, transfer of women or babies out of area and the inability to facilitate some booked homebirths Elective 1. In comparison to UHD we consistently hit target of our >104 Week waits. 2. Area of concern – Diagnostic Recovery – both total diagnostic waiting list and % waiting over 6 weeks is showing as concerning variation. UHD are in a better position however Dorset are in line with DCH 3. Cancer recovery – area of concern – 62 day backlog and 104 days back stop both showing as concerning variation. This is mirrored across the system. Urgent and Emergency care 1. Trend across the system showing concerning variation 12 hour breaches ED, NCTR patient number and length of stay >21 days. 2. Average hours lost to ambulance handover delays across the system is a failed target however DCH showing a slightly better variance than the rest of the system Finance The year to date position is an overall deficit of £7.3 million against a planned deficit of £0.8 million, being £6.5 million away from plan at M8.							

5. Action recommended	N/A

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		**No**		If yes, please summarise how your report contributes to the Trust's Social Value Pledge
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			
	Place			
	Partnership			
Dorset Integrated Care System (ICS) goals		**Which Dorset ICS goals 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		**No**		If yes - please state how your report contributes to improving population health and health care
Tackling unequal outcomes and access		**No**		If yes - please state how your report contributes to tackling unequal outcomes and access
Enhancing productivity and value for money		**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		**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)		**Yes**	**No**	
Quality Impact Assessment (QIA)		**Yes**	**No**	

System Performance

1. Quality

1.1 **Maternity Services**
Workforce pressures and safe staffing levels are identified as one of the top concerns for the Maternity Units at both University Hospitals Dorset (UHD) and Dorset County Hospital (DCH). The impacts on care include delayed inductions of labour, transfer of women or babies out of area and the inability to facilitate some booked homebirths. There are also clinical and safety risks associated with delayed inductions of labour. Using local protocols, the Units are working together to divert women to the next closest hospital when needed. The Local Maternity & Neonatal System (LMNS) is reviewing the Ockenden workforce requirements as set out in the final report and assessing the impact of additional national funding which is yet to be confirmed and allocated to Dorset. Active recruitment of midwifery students has been successful with new starters joining the Maternity Units in September

1.2 **Site Visit Dorset County Hospital**
A therapy focused discharge quality assurance visit was undertaken. Whilst this demonstrated some very positive practice, several areas of concern were found. This included a lack of strategic Allied Health Professional (AHP) leadership within the organisation which is out of alignment with the other main providers in Dorset and nationally. Concerns were also found with the equipment provider and store which can create delays to discharges for even basic equipment e.g., a wheeled zimmer frame. This has been escalated to the responsible commissioner for action. Another area of concern identified was that discharge paperwork cannot be submitted until the patient is deemed ready for discharge. For patients with early identified levels of discharge complexity, this further adds to delays. This has been escalated to the System Flow Director who is going to review the process with health and social care agencies. A similar visit is planned to UHD.

2. Performance Report (Appendices a-c)

2.1 **Key performance issues: Elective Care**
Progress on reducing long waiters continues with individual trust plans in place for areas of highest risk but operational pressures remain. However, total waiting list size is higher than plan across the system. There is an improved 104 week wait position, with DCH (Dorset County Hospital) forecasting zero by December 2022 and UHD (University Hospitals Dorset) zero by January 2023. Both trusts have used an adapted form of the “Somerset Tool” to retest their demand against capacity to meet the 78-week target. For DCH this has resulted in no change to its forecast which remains zero by the end of March 23. However, for UHD this has produced a forecast more in line with the profile the trust suggested in early October.

2.2 **Key performance issues: Diagnostics**
Activity recovery is generally good driving a strong performance on the proportion of patients waiting less than six weeks and the number waiting less than twenty-six weeks. Plans are in place at modality level to improve areas of challenged performance including those submitted to the national Community Diagnostics team for their review

and decision following regional approval given on the 28 October.

2.3 **Key performance issues: Cancer**
The percentage of patients waiting less than 62 days for a first definitive cancer treatment has stabilised but remains under target. This is caused by a significant increase in referrals. Plans are in place (such as the development of the "FIT (Faecal Immunochemical Test) less than 10" pathway and the automation of MDT (multidisciplinary team) processes) to support improvements. Full compliance is anticipated for all relevant tumour sites by March 2023.

Neither trust currently meets the target for 75% of patients to receive a diagnosis or all clear in 28 days. A cancer recovery plan is in place supported by the Wessex Cancer Alliance. Improvement examples include Colorectal e-triage (live UHD, go live DCH in Jan), gynaecology peri-menopausal bleeding clinic in a Community Diagnostic Centre (go live Q4) and upper GI review of Northern Cancer Alliance model to improve resilience. Compliance with this target is anticipated by March 23 however is reliant on some funding sources which have not yet been confirmed.

2.4 **Key performance issues – Urgent and Emergency Care**

The number of patients with "No Criteria to Reside" has reduced. From mid-November, the daily SPC chart demonstrates that there has been a sustained decrease. Further work is underway to sustain the reduction through the development of an integrated P1 offer (P1 patients need a small amount of care to go home), the streamlining of MDT decision making processes, and the development of a Discharge to Assess programme as well as efforts to improve communication with patients and families. The level of challenge and the constraints affecting the system mean that it is not currently possible to say by when the situation will have improved.

Category 2 ambulance response times have not been compliant with the target of 18 minutes since May 2021 with an October mean at fifty minutes. Actions to improve this include three priority workstreams: transfer of lower acuity incidents to the Dorset CAS (Clinical Assessment Service) from 23rd November, increased access to the summary care record via smartcards and simplified pathways into Same Day Emergency Care (SDEC) for low-risk chest pain, low risk abdominal pain and paediatrics.

More recent performance on mean 999 call answering times (58 seconds) have moved below the mean of one minute and six seconds but remain significantly above the target of ten seconds. Actions to address this centre on recruitment and associated training and induction. Compliance is anticipated from March 2023.

3. Finance (appendix d)

Dorset County Hospital NHS Foundation Trust (DCHFT) has delivered a deficit position for the month of November 2022 of £0.5million against a planned surplus of £0.2 million after technical adjustments. The year to date position is an overall deficit of £7.3 million against a planned deficit of £0.8 million, being £6.5 million away from plan at M8.

The adverse year to date position against plan is predominantly a result of undelivered efficiencies (£1.5 million), pressures incurred using high cost agency expenditure (£2 million) largely due to additional cover for nursing and medical vacancies, ongoing sickness, heightened challenging patient acuity and supporting safe staffing levels. Additional medical sessions within Urology, ED,Gastroenterology, Anaesthetics and Dermatology are also contributing to the adverse position (£1.1 million).

Non pay is over plan largely due to activity driven increases in consumables and high cost drugs, with further increased inflationary pressures associated with utilities, rates and catering provisions which represent the remainder of the variance to plan.

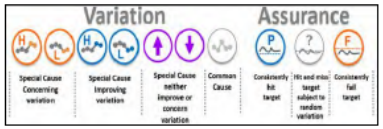
Due to accounting standard IFRS16 Leases coming into effect this financial year, the capital position now includes this updated lease reporting. The year to date capital spend is £21.9 million against a plan of £27.6 million. Within the year-to-date position, the impact of the IFRS16 Lease addition for the Multi-Storey Car Park totals £14.7 million. The cash position as at November 2022 is £16.3 million and is in line with plan.

Appendix a

1.0 Service Delivery Scorecard – Elective Performance

NHS Dorset

Elective Care Recovery	Latest Period	Target	UHD				DCH				Dorset				South West	
			Plan	Actual	Variance	Assurance	Plan	Actual	Variance	Assurance	Plan	Actual	Variance	Assurance	Actual	Rank
Elective Recovery - Total Waiting List																
Total Waiting List Size	Oct 22	-	68,952	70,918	-	-	17,314	18823	-	-	86,266	89,741	-	-	-	-
>104 Week waits	Oct 22	0 Jun 22	62	63	-	F	6	6	-	P	68	69	-	F	-	5
>78 Week Waits	Oct 22	0 Mar 23	571	513	-	?	180	134	-	?	751	647	-	?	-	4
>52 Week Waits	Oct 22	0 Mar 25	3,875	3,468	-	P	1,400	1,156	-	P	4,669	4,624	-	P	-	3
Elective Recovery Productivity/Transformation																
Total Ouptatient - Virtual (%)	Sep 22	25.0%	29.4%	20.0%	L	?	18.0%	24.2%	~	?	25.6%	21.4%	L	?	20.2%	5
Patient Initiative Follow ups % (PIFU)	Sep 22	5.0%	-	2.0%	~	F	-	1.0%	~	F	-	1.9%	~	F	4.10%	5
Advice & Guidance % of 1st Outpatient	Aug 22	16.0	-	-	-	-	-	-	-	-	-	9.8	~	F	27.5	7
Diagnostic Recovery																
Total Diagnostic Waiting List	Oct 22	-	-	11,431	~		-	5,793	H		-	17,224	H	-	-	-
% waiting over 6 weeks	Oct 22	25% Regional 1% National	-	16%	~	P	-	33%	H	?	-	22%	H	P	37%	2
Number waiting over 26 weeks	Oct 22	0	-	62	-	-	-	8	-	-	-	70	-	-	-	-
Cancer Recovery																
Faster Diagnosis Standard (FDS) 28 days	Sep 22	75%	-	65%	L	?	-	65%	~	?	-	65%	~	?	-	-
Number of patients waiting <62 days to 1st definitive treatment	Sep 22	85%	-	71%	~	F	-	68%	~	?	-	69%	~	F	65%	2
62 day backlog	Oct 22	<220	-	288	H	-	-	108	H	-	-	393	H	-	-	-
Number of patients waiting <31 days to treatment	Sep 22	96%	-	97%	~	?	-	96%	~	?	-	96%	~	?	93%	1
Cancer two week wait	Sep 22	93%	-	-	-	-	-	47%	~	F	-	-	-	-	-	-
104 days back stop	Oct 22	-	-	54	~	-	-	28	H	-	-	78	H	-	-	-



1.1 Exception Report - Elective Recovery – Exception Report – Waiting List >104 Weeks-
1.2 Exception Report - Elective Recovery – Exception Report – Waiting List >78 Weeks
1.3 Elective Recovery – Exception Report – Waiting List >52 Weeks
1.4 Exception Report - Elective Recovery – Exception Report – Diagnostic >6 week performance

1.5 Elective Recovery – Exception Report – Number of patients waiting <62 days to 1st definitive treatment
1.6 Elective Recovery – Exception Report - Number of patients waiting <62 days to 1st definitive treatment
1.7 Elective Recovery – Exception Report – 104 days back stop

INTEGRITY | RESPECT | TEAMWORK | EXCELLENCE

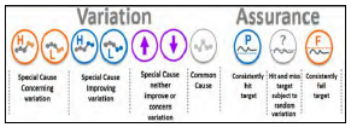
NHS
Dorset County Hospital
NHS Foundation Trust

Appendix b

2.0 Service Delivery Scorecard – Elective Activity Recovery

NHS Dorset

Elective Recovery	Latest Period (4 week rolling average)	Target	UHD			DCH			Dorset			SW Region
			19/20	Actual	% Act	19/20	Actual	% Act	19/20	Actual	% Act	% Act
Elective Activity												
Elective Day Case Spells	06 Nov 22	104.00%	1690	1584	93.7%	497	565	113.7%	2187	2149	98.3%	93.6%
Elective Ordinary Spells	06 Nov 22	100.00%	257	231	89.9%	70	46	65.7%	327	277	84.7%	81.1%
Outpatient attendances - First Attendance	06 Nov 22	104.00%	3994	4533	113.5%	946	996	105.3%	4940	5529	111.9%	98.8%
Outpatient attendances - Follow up Attendance	06 Nov 22	75.00%	5747	4717	82.1%	1982	1767	89.2%	7729	6483	83.9%	93.0%
Diagnostic Activity												
Imaging: Diagnostic Recovery %	06 Nov 22	120%	3399	3603	106.0%	1320	1490	112.9%	4719	5092	107.9%	-
Physiological Measurement: Diagnostic Recovery %	06 Nov 22	120%	442	573	129.6%	178	148	83.1%	620	720	116.1%	-
Endoscopy: Diagnostic Recovery %	06 Nov 22	120%	1088	2041	187.6%	693	772	111.4%	1728	2813	162.8%	140.2%



2.1 Report - Elective Activity – YTD
2.2 Report – Diagnostic Activity – YTD

INTEGRITY | RESPECT | TEAMWORK | EXCELLENCE

NHS
Dorset County Hospital
NHS Foundation Trust

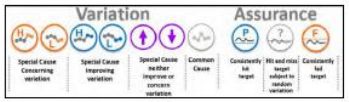
Appendix c

NHS
Dorset

3.0 Service Delivery Scorecard – Urgent & Emergency Care

Urgent & Emergency Care Scorecard	Latest Period	Target	UHD			DCH			Dorset			South West	
			Actual	Variance	Assurance	Actual	Variance	Assurance	Actual	Variance	Assurance	Actual	Rank
Urgent Care Access													
Non-Elective Admissions v 19/20 actual - Month	Oct 22	4,949 (19/20)	2,744 (3,375 - 19/20)	-	-	1,189 (1,914 - 19/20)	-	-	3,933	-	-	Avg - 7,073	4
A&E attendances V 19/20 actual - Month	Oct 22	17,751 (19/20)	12,674 (13,973 - 19/20)	-	-	4,445 (4,780 - 19/20)	-	-	17,139	-	-	Avg - 24,613	3
12 hour breaches ED	Oct 22	-	282			34			316			3,906	3
No criteria to reside (NCTR) number of patients	Oct 22	-	141			79			115			-	-
No criteria to reside % of beds occupied - Daily	05 Dec 22	-	25%		-	23%		-	24%		-	23.9%	6
Length of Stay >21 days number of patients (average)	Oct 22	-	78			51			69			-	-
Adult general and acute type 1 bed occupancy	Oct 22	<92%	95.3%		-	99.0%		-	96.5%		-	96.9%	2

Urgent & Emergency Care Scorecard	Latest Period	Target	UHD			DCH			Dorset			SWAST	
			Actual	Variance	Assurance	Actual	Variance	Assurance	Actual	Variance	Assurance	Actual	Rank
Urgent Care Compliance													
Mean 999 Call answering times	Oct 22	00:00:10	-	-	-	-	-	-	00:00:58			00:00:58	-
Category 1 Ambulance Response Times	Oct 22	7	-	-	-	-	-	-	9.8			11.2	-
Category 2 Ambulance Response Times	Oct 22	18	-	-	-	-	-	-	49.7			72.2	-
111 Call abandonment	Sep 22	<=3%	-	-	-	-	-	-	7%			-8.60%	3
Average Hours Lost to ambulance handover delays per day	Oct 22	-	1.3			0.5			1.2			1.2	-
Total Hours lost to ambulance handover delays (month)	Oct 22	-	3827			253			4080			-	-



3.1 Urgent & Emergency Care – Exception report – No criteria to reside % of beds occupied.
3.2 Urgent & Emergency Care – Exception Report – Category 2 Ambulance Response Times.
3.3 Urgent & Emergency Care – Exception Report - Mean 999 Call Answering Times

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Appendix d

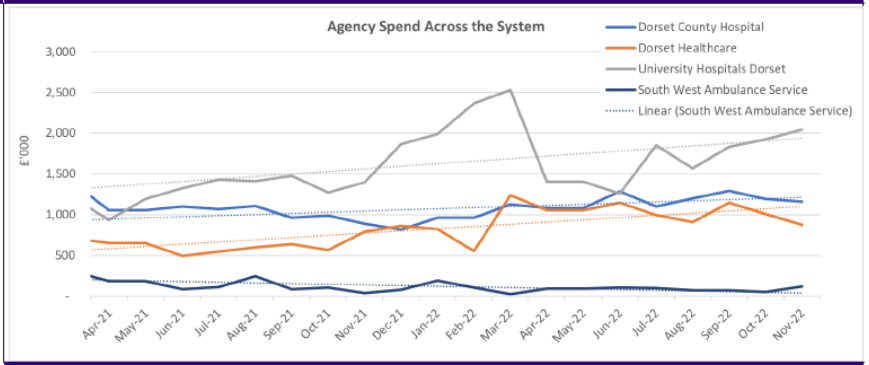
Finance - Dorset ICS

Month 8 system Financial Performance

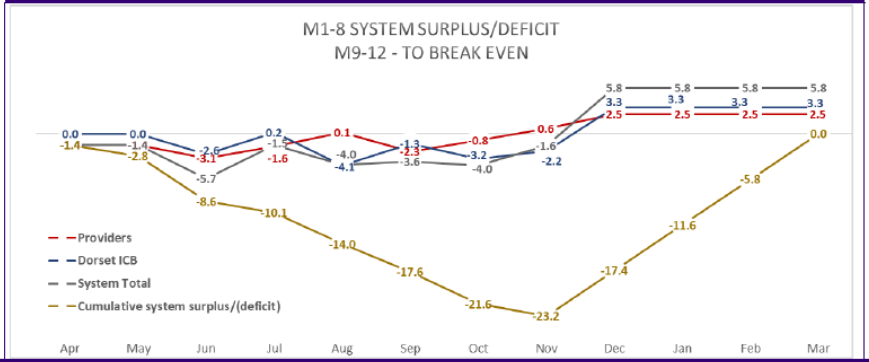
Dorset ICS performance YTD Month 8	Income		Expenditure		Financial Performance
	Plan £m	Surplus/ (Deficit) £m	Plan £m	Surplus/ (Deficit) £m	Surplus/ (Deficit) £m
Dorset County Hospital	166.2	6.2	(167.0)	(12.7)	(6.5)
Dorset Healthcare	225.2	6.6	(226.5)	(5.6)	1.0
University Hospitals Dorset	463.6	18.9	(463.1)	(23.4)	(4.4)
SWASFT	220.0	7.0	(220.0)	(7.0)	0.0
Dorset Provider Total	**1,074.9**	**38.7**	**(1,076.5)**	**(48.7)**	**(10.0)**
Dorset ICB	1,083.3	0.0	(1,083.3)	(13.2)	(13.2)
Dorset ICS Total					**(23.2)**

Dorset ICS performance FOT	Plan £m	Forecast £m	Surplus/ (Deficit) £m
Dorset Providers			
Income	1,613.6	1,670.7	57.1
Pay	(1,119.5)	(1,148.5)	(28.9)
Non-pay	(473.3)	(504.3)	(31.0)
Non Operation Items	(20.7)	(17.9)	2.8
Dorset Provider Total	**0.0**	**0.0**	**(0.0)**
Dorset ICB			
Acute Services	(655.9)	(660.6)	(4.7)
Mental Health Services	(122.6)	(125.4)	(2.9)
Community Health Services	(116.4)	(115.5)	0.9
Continuing Care Services	(78.6)	(90.1)	(11.5)
Primary Care Services	(141.7)	(149.1)	(7.4)
Delegated Primary Care	(102.2)	(102.9)	(0.7)
Other	(0.2)	28.6	28.8
ICB Running Costs	(11.1)	(11.1)	0.0
CCG (M1-3)	(397.0)	(399.5)	(2.5)
Dorset ICB Total	**(1,625.7)**	**(1,625.7)**	**(0.0)**

Agency



System run rate – Recovery trajectory required to break even



Meeting Title:	Board of Directors Meeting
Date of Meeting:	25 Jan 2023
Document Title:	**Board Assurance Framework (BAF) Review**
Responsible Director:	Nick Johnson – Interim CEO
Author:	Philip Davis – Head of Strategy

Confidentiality:	No
Publishable under FOI?	No

Prior Discussion		
Job Title or Meeting Title	**Date**	**Recommendations/Comments**
EMT	12 Jan 2023	BAF discussed and approved to take to QC. - several edits made since the last BAF draft in Nov-22, all approved.
Quality Committee (QC)	17 Jan 2023	QC considered that adequate assurance was being given on key risks. Jo Howarth interim Chief Nursing Officer to review all mitigations recorded in BAF under risks PL 1.1 and PL 1.5

Purpose of the Paper	Monitor Strategic Risks the Trust faces (in delivering the Trust Strategy and achieving the benefits therein) - Approved by Board Dec-21. The BAF is in its 8th round of 2 monthly reviews.						
	Note	✓	Discuss	✓	Recommend	✓	Approve	✓
Summary of Key Issues	There are 4 risks scored >20 (almost certain and with major consequences): Mitigations have been put in place against these, but as yet these have not driven a reduction in the risk scores. [A fifth risk had been scoring at 20, but was reduced to 16 in the last BAF review (Nov-22 PL1.3 now 16, risk of not reaching perf standards regarding Long waits)] ▪ **PL1.1** Inability to attract & retain clinically skilled clinical staff, will mean not meeting patient demand or required Care Standards or financial objectives. CNO. Quality Committee. The People Plan (underlying Trust Strategy) is being worked on HR, 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 Other mitigations include: - Maximizing opportunities through Health Education England & NHSEI funding, more apprenticeships, workforce planning enabling operating at top of license, strengthening protocols/Policies for clinical care, QI directed at improving care and driving compliance to national care standards, scrutiny at sub-board level Notable **gaps in control & actions** at this point: - National workforce shortage situation (stay & thrive project to counter) - uncertainty of Health Education England Funding & financial pressures hindering training (close liaison with regional teams to try and counter) - Cost of living crisis and local affordability of housing (key worker housing project as part of Strategic Estates is progressing) ▪ **PL1.5** Emerg & Urgent Care Pathways not meeting population demand, and 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. ▪ **PE1.2** Failing to attract & retain staff, more pressure on existing teams CPO. People & Culture Committee ▪ **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. Other Risks with Score of 15/16: PL1.2 Population demand for health greater than capacity (CNO) PL1.3 Failure to meet Performance Targets (COO) PL1.10 SHMI Risk score (CMO) PE1.1 Supporting Staff Wellbeing (CPO) PE3.2 Capacity for innovation (CEO) PL1.11 failure to deliver robust, accurate & timely coding data (CIO) PL 2.2 imbedding proper business case (CFO) PA 2.1 risk of not achieving financial breakeven (CFO) It was noted by CMO Alistair Hutchinson at the EMT meeting held 12-Jan-23, that the Trust SHMI mortality Index score has recently risen unexpectedly. It was agreed that when more information and data is available, and when clinical committees have fully considered this worsening position, this will be discussed in the context of the BAF and relevant Quality related risks therein. It was further noted at QC on 15-Jan-23 that Interim CNO Jo Howarth would review all the mitigations against risks PL1.3 and PL 1.5, in the light of recent initiatives and ongoing work.
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 adequacy of Mitigations in place, and make proposals for any changes to stated Risk Appetite in response. 3. **APPROVE** the final Jan-23 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 **Jan-23**

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	• 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: Inconsistent approach to recruitment, deployment and career progression across staff groups - International Recruitment Oversight Group to be established						
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		
								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	Strength of Control	Assurance/ Evidence	Strength of Control	Strength of Assurance	Target Risk Score	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 **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	Good	• Sub board reports: PCC; QC & RAC • Recruitment activity reports • Patient feedback • Staff feedback • Incident data • External assurance monitoring: CQC; CCG; auditors inc GIRFT/Networks • Corporate risk register actions and tolerated/managed risk	Good	Good	12	2024	
PL 1.2	QC	CNO	CNO - quality and safety CMO - Clinical Strategy and GIRFT CFO - Estates Strategy	**Risk description:** If the population demand is over the ability to create and deliver capacity that meets the constitutional standards and quality standards outline under the CQC regulatory framework then the clinical strategy will not be delivered and therefore the objective of high-quality care that is safe and effective will not be met.	4	4	16	• Capacity planning • Commissioning of capacity • Clinical pathways design and system working for sustained capacity • Estates strategy • Workforce planning including job planning • Quality Improvement to redesign pathways to more efficient or productive with funded capacity • Access policies and processes to ensure effective waiting list management in order of clinical need with consideration for health inequalities • Recovery plan and oversight of the delivery through sub-board committee • ICS partnership working through provider collaboratives • ICS governance framework • Clinical networks to support pathway design and resources based on population need **Gaps in Control and Actions:** - Gaps in patient pathways out of hospital for those with complex care needs. ACTION: ICS escalation and 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.	Good	• Sub-board committee FPC, QC & PC • Estates master plan and associated business cases • Performance scorecard • External performance monitoring (CQC; OFRG; NHSE/I) • Benchmarking data: clinical networks; GIRFT	Good	Strong	8	2025	
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	4	16	• 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 (completed) **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 Divisional exception reporting submissions	Good	• 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	
PL 1.4	FPC	COO	Head of EPRR	**Risk Description:** If we don't have Emergency Preparedness and Resilience Plans then we will not have a defined programme to manage safe services and the triggers for altering those services under change services, therefore the objective of high-quality care that is safe and effective will not be met.	3	2	6	• Emergency Preparedness and Resilience Review Committee (EPRR) reporting, EPRR Framework and review and sign off by CCG and NHSE **Gaps in Control and Actions:**	Good	• Reporting from EPRR Committee to Risk and Audit Committee and via assigned NED to Board. Yearly self assessment against EPRR core standards ratified by Local Health Resilience Partnership. Internal Audit reports	Good	Good	6	is at target	
PL 1.5	FPC - performance QC - Harm related concerns	COO	COO	**Risk description:** If our emergency and urgent care pathways do not meet the increase in unplanned attendances then patients will wait too long for appropriate care in emergency situations and therefore the objective of high-quality care that is safe and effective will not be met. Similarly the above concern would mean we are not contributing to a strong, effective Integrated Care System, focussed on meeting the needs of the population	4	5	20	• Reframed 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 Ah@H, added reablement beds - roll out phase Q3 **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)	Good	• Upward reporting and escalation from UECB to SLT and DCH Board. • Ward to Board reporting Home First Board and workstream documentation Home First (DCH) documentation Divisional reporting via Performance Meetings, FPC, Seasonal Surge Plan and reporting IMT Reporting ROI reporting against investment in ED15 model to UECB ED15 Steering Group through to FPC updates	Good	Good	12	Internal mitigations in place for winter 22/23 External mitigations through Home First delivery in 23/24	
PL 1.6	FPC - performance QC - Harm related concerns	COO	COO	**Risk description:** If we fail to work with our partners on effective criteria to admit, criteria to reside, and discharge pathways, then patients will have unnecessary and lengthy hospital stays leading to poorer outcomes and therefore the objective of high care that is safe and effective will not be met. Similarly the above concern would mean we are not contributing to a strong, effective Integrated Care System, focussed on meeting the needs of the population	3	4	12	• Home First Board membership • Urgent and Emergency Care Board - COO membership • Investments in ED capacity, SDEC 7-day working, 7-day discharge services, increased Acute Hospital at Home capacity. Target date: SDEC and Discharge 7 day services completed. Increased Hospital at Home - November 2022 • Home First (DCH) Steering Group - PAT, redesign of discharge support, CCTR, MDT working, strengthened front door multi-agency response. Completion date: via Patient Flow Program Winter 2022 • VSCE support front door and discharge response. Pilot in place (completed) Clinical and People Strategies for front door response. Target date: strategies agreed - key feature is Em Zone with phased delivery from 23/24 • Redesign of patient flows through the hospital with particular focus on ambulatory pathways and proactive discharge management - Target date: Winter 22/23 **Gaps in Control and Actions:** System actions currently in development, low level of confidence actions will meet needs. **Please see action detailed above.**	Requires Improvement	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	
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 Clinical and People Strategies (including physical capacity required). Strategies agreed **Gaps in Control and Actions:**	Good	• Reports to SLG and through to Board via Strategy updates	Good	Good	2	Internal transformation plan full delivery by March 23	
PL 1.10	QC?	CMO	CMO	**Risk description:** If the Trust's SHMI is out of range then it will suggest excess deaths are occurring regardless of the actual cause. So this will cause reputational damage and invite inspections by regulators, which are not necessary if coding is the underlying correctable cause.	4	4	16	• Scrutinising other care quality indicators to assure standards of care • Ensuring accuracy and timeliness of clinical coding by reporting by exception to FPC • The CMO receives a monthly update of number of uncoded SPELLS **Gaps in Control and Actions:**	Requires Improvement	• Regular reports to Hospital Mortality group, Quality Committee and Board.	Requires Improvement	Good	8	Ongoing	
PL 1.11	RAC	CIO	CIO	**Risk description:** If we do not deliver robust, accurate and timely coding then data submitted to NHSE and NHS Digital will not be reflective of the care delivered, so workload will be inaccurate and there will be a negative impact on reputation through 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. **Gaps in Control and Actions:**		Vacancies versus establishment Coding backlog Improvement in SHMI	Requires Improvement	Requires Improvement	6	?	
Place Objective 2: We will build sustainable infrastructure to meet the changing needs of the population															
PL 2.1	FPC	CFO	Strategic Estates Project Director	**Risk description:** If we do not commit sufficient resources to New Hospital Project and wider strategic estates development then plans and business cases will not be robust so we will not receive funding to deliver	5	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 **Gaps in Control and Actions:** - Regular reporting to FPC	Good	• NHSEI SOC Approval; - NHSEI NHP Deep Dive re. OBC, OBC submitted June 2022	Good	Good	10	Completion of FBC - circa 31/12/2022	
PL 2.2	FPC	CFO	Deputy Director of Finance	**Risk description:** If we do not embed appropriate business case approval processes then plans will not be sustainable so we will not be able to meet the needs of patients and populations	4	4	16	• Working group to inform SLG decisions • Business case templates and corporate report front-sheets **Gaps in Control and Actions:** - Lack of adherence to and application of agreed processes - Lack of knowledge of agreed processes - No review/check of business cases against required templates	Requires Improvement	• Working Group papers • External approval of business cases e.g. NHP	Requires Improvement	Requires Improvement	10	31/03/2023	
PL 2.3	FPC	CFO	CFO	**Risk Description:** If we do not work to improve our sustainability as an organisation then we will increase our environmental impact and so we will not improve the environmental, social and economic well-being of our communities, populations and people.	3	3	9	• Sustainability champions & Sustainability Travel Working Group in place at DCH to encourage long term improvements and sustainability • Sustainability Programme in development in line with the Kings Fund Sustainability Theory bringing together Social, Environmental and Economic factors • Social Value Pledge and Action Plan in place emphasising the commitment to improving the wellbeing of the population • Green plan published and monitored annually • Planned revision of annual report to support triple bottom line reporting **Gaps in Control and Actions:**	Good	• Regular reporting to Strategy and Transformation SLG • Annual reporting on Green Plan to FPC and Board	Good	Good	9	Ongoing	
Place Objective 3: We will utilise digital technology to better integrate with our partners and meet the needs of patients															
PL 3.1	FPC	CIO	CIO	**Risk description:** If we do not achieve a Dorset wide integrated electronic shared care record then we run the risk of not making the right information available to care professionals, so we will not be able to make sure the right information is available to the right person in the right place at the right time about the right patient increasing the likelihood of patient harm	1	3	3	Dorset Care Record project lead is the Director of Informatics at UHD. Project resources agreed by the Dorset Senior Leadership Team. Project structure in place overseen by ICS Digital Portfolio Director **Gaps in Control and Actions:**	Good	• Reports to the Dorset System Leadership Team. Updates provided to Dorset Operation and Finance Reference Group and the Dorset Informatics Group.	Good	Good	3	Achieved - currently at Target Risk	
PL 3.2	FPC/QC/RAC	CIO	CIO	**Risk description:** If we do not have adequate cyber security defences to protect the Trust's digital assets then we increase the likelihood of impact from a cyber event, so the Trust will suffer partial or complete loss of digital services including access to critical applications, data and/or digitised processes.	3	4	12	Patching of perimeter defences, firewalls, servers, switches, desktop/laptop equipment, penetration tests and regular audits **Gaps in Control and Actions:**	Good	• Annual Penetration Test Results and associated action plan • Annual DSPT submission • Regular reports to Quality Committee, Risk and Audit Committee, Trust Board • Annual Internal Audits • Annual renewal of ISO27001 accreditation • Tools deployed by the Trust to monitor and report on cyber threats • Use of tools made available by NHSE to monitor alerts/threats i.e. CareCERT • SIRO, Deputy SIRO, Information Security Manager, Data Protection Officer - all posts filled	Good	Good	9	Ongoing task, no fixed delivery date	
PL 3.3	QC/RAC	CIO	CIO	**Risk description:** If Trust staff are not trained sufficiently to minimise targeted and social engineering threat attempts then we increase the likelihood of the impact of a cyber event, so the Trust will suffer partial or complete loss of digital services including access to critical applications, data and/or digitised processes.	3	4	12	Part of DSPT annual assurance, digital training team providing training for all new starters and annual refresh training . Regular phishing campaigns. **Gaps in Control and Actions:**	Good	• Annual DSPT submission • Regular reports to Quality Committee, Risk and Audit Committee, Trust Board • Targeted training resulting from output of internal campaigns • Annual Internal Audits • Annual renewal of ISO27001 accreditation • Tools deployed by the Trust to monitor and report on cyber threats • Use of tools made available by NHSE to monitor alerts/threats i.e. CareCERT	Good	Good	9	Ongoing task, no fixed date	
Place Objective 4: We will listen to our communities, recognise their different needs and help create opportunities for people to improve their own health and wellbeing and co-designing services															
PL 4.1	Quality Committee	CNO	Alison Male - Patient Engagement Jo Hartley: Maternity voices partners	**Risk description:** If we fail to engage and work with partners and stakeholders to effectively maximise the opportunities to engage and co-design with our communities then services will not be meeting the needs of those that use then.	3	4	12	• Your Voice group of service users- 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 • Patient safety Partners appointed and commenced - patient partner at forefront of patient voice into safety **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.	Good	• PEG actions/ notes • Patient feedback • Healthwatch reports • CQC reports • Maternity Voices reports • Complaints including local MPs related to engagement • Local independent groups reports or complaints • Diis Data and Public Health reports • Health Inequalities data	Good	Good	4	Apr-24	
PL 4.2	QC	CNO & CMO	CIO - digital and BI Alison Male - Patient feedback CMO - AHSN CEO/Director 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 **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	Good	• HI group reports and actions • Benchmarking data • Patient feedback • Partners feedback • Data • National published reports or network reports • ICS Clinical reference group notes • National audits on outcomes	Good	Good	4	Apr-24	

Risk Ref:	Committee	Accountable Executive	Risk Owner	Risk Description/Risk Owner:	Consequence Score	Likelihood Score	Risk Score	Existing Mitigation/ Controls	Assurance/ Evidence	Strength of Control	Strength of Assurance	Target Risk Score	Mitigations Target Date	# Partnership risks: 12
Partnership Objective 1: We will contribute to a strong, effective Integrated Care System, focussed on meeting the needs of the population														
PA 1.1	Board	CEO	CEO/Director of Strategy	**Risk description:** If the Trust decision-making processes do not take due account of system elements then the Trust will not be able to engage proactively within the system so the impact of the Trust on the system will be diminished	4	2	8	• SLG and Corporate Governance includes system updates and information • Membership of Provider Collaboratives and system other forums • Board feedback and monitoring of system engagement	• 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	4	16	• ICS Financial framework and Financial Strategy. • Current operating plan delivers a breakeven and does not require external financing, but are heavily reliant on non recurrent funding and 2.5% CIP.	• 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														
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 breach 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	Jan-22	Mar-22	May-22	Jul-22	Sep-22	Nov-22	Jan-23	Trend
PE 1.1	16	16	16	16	16	16	16	16	Unchanged
PE 1.2	20	20	20	20	20	20	20	20	Unchanged
PE2.1	12	12	12	12	12	12	12	12	Unchanged
PE 3.1	8	8	8	8	8	8	8	8	Unchanged
PE 3.2	12	12	15	15	15	15	15	15	Worsening
PE 3.3	12	12	12	12	12	12	12	12	Unchanged
PE 3.4	6	6	6	6	6	6	6	6	Unchanged
PL 1.1	20	20	20	20	20	20	20	20	Unchanged
PL 1.2	16	16	16	16	16	16	16	16	Unchanged
PL1.3	16	20	20	20	20	20	16	16	Improving
PL 1.4	6	6	6	6	6	6	6	6	Unchanged
PL 1.5	20	20	20	20	20	20	20	20	Unchanged
PL 1.6	12	12	12	12	12	12	12	12	Unchanged
PL1.7	12								Unchanged
PL1.8	16								Unchanged
PL 1.9	2	2	2	2	2	2	2	2	Unchanged
PL 1.10	16	16	16	16	16	16	16	16	Unchanged
PL 1.11			16	16	16	16	16	16	Worsening
PL 2.1	15	20	15	15	15	10	10	10	Improving
PL 2.2	16	16	20	16	16	16	16	16	Unchanged
PL 2.3	9	9	9	9	9	9	9	9	Unchanged
PL 3.1	6	9	3	3	3	3	3	3	Improving
PL 3.2		12	12	12	12	12	12	12	Unchanged
PL 3.3		12	12	12	12	12	12	12	Unchanged
PL 4.1	12	12	12	12	12	12	12	12	Unchanged
PL 4.2	12	12	12	12	12	12	12	12	Unchanged
PA 1.1	8	8	8	8	8	8	8	8	Unchanged
PA 1.2	9	9	9	9	9	9	9	9	Unchanged
PA 1.3	6	6	6	6	6	6	6	6	Unchanged
PA 1.4	12	12	12	12	12	12	12	12	Unchanged
PA 2.1	20	20	20	16	16	16	16	16	Improving
PA 2.2	12	12	12	12	12	12	12	12	Unchanged
PA 2.3	6	6	6	6	6	6	6	6	Unchanged
PA 3.1	8	8	8	8	8	8	8	8	Unchanged
PA 3.2	8	8	8	8	8	8	8	8	Unchanged
PA 3.3	16	16	16	12	12	12	12	12	Improving
PA 4.1	9	9	9	9	9	9	9	9	Unchanged

Report Front Sheet

1. Report Details			
Meeting Title:	Board meeting		
Date of Meeting:	25th January 2023		
Document Title:	**Maternity Safety Report January 2023**		
Responsible Director:	Jo Howarth, CNO	Date of Executive Approval	16/01/2023 (verbal)
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**
Quality Committee	17 Jan 2023	

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 December 2022 and where relevant, quarter three. This is to provide assurance of maternity quality and safety and effectiveness of patient care with evidence of quality improvements to the Trust Board

- Data from Power BI provided
- Maternity staffing is improving
- Current audits noted
- New guidelines noted
- One complaint about our failure to facilitate a caesarean as planned.
- Training figures have improved
- Five ongoing RCAs/Sis. No new HSIB cases
- New risks
  1) reduction of access to rooms on the midwife-led unit due to an ongoing rainwater leak
  2) emergency buzzers not heard consistently throughout the maternity unit
  3) Triage and the use of BSOTS (Birmingham Symptom Specific Obstetric Triage System)
- The evidence required for the MIS for 2022/2023 have grown considerably in complexity and there is a risk that we will not meet every requirement. Key risks are around our transitional care service and our CO monitoring. Following review with the CNO and the NED Safety Champion on the 13th January, the recommendation is to submit without full compliance. To be discussed at Quality Committee and then Board
- New claim received.
- Report about babies born in the wrong place

	• All obstetric consultants have signed up to the document Roles and responsibilities of the consultant workforce report (May 2022 update) (rcog.org.uk) as required by the Maternity Incentive Scheme https://rcog.org.uk/media/1e0jwloo/roles-and-responsibilities-of-the-consultant-workforce-report-may-2022-update.pdf
4. Action recommended	The Board is recommended to: 1. **NOTE** the report 2. **DISCUSS** any performance issues particularly the Maternity Incentive Scheme and the non-compliance with 2 of the safety actions 3. **AGREE** the key points, risks & concerns including signing off the MIS submission

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

January 2023 (December activity)

Submitted by Jo Hartley, Director of Midwifery & Neonatal Services

Executive sponsor: Jo Howarth CNO

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Executive Summary

This report sets out to the Trust Quality Committee the quality and safety activity covering the month of December 2022 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.

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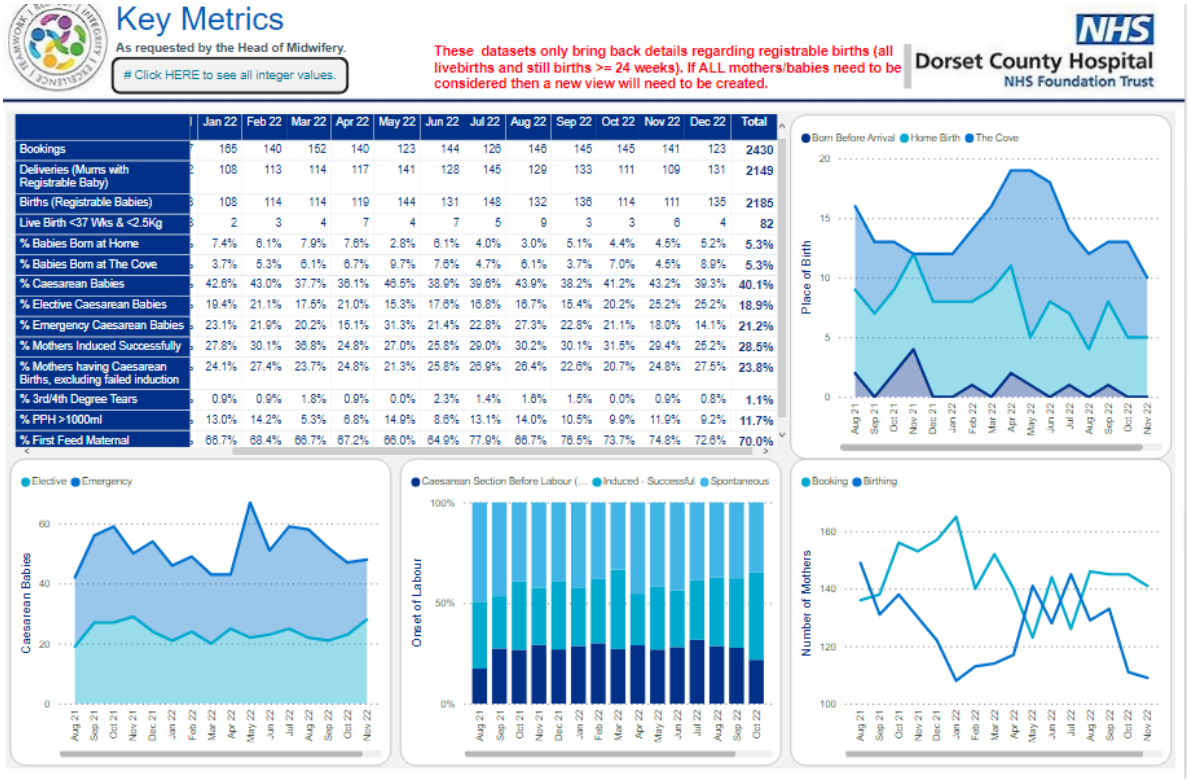
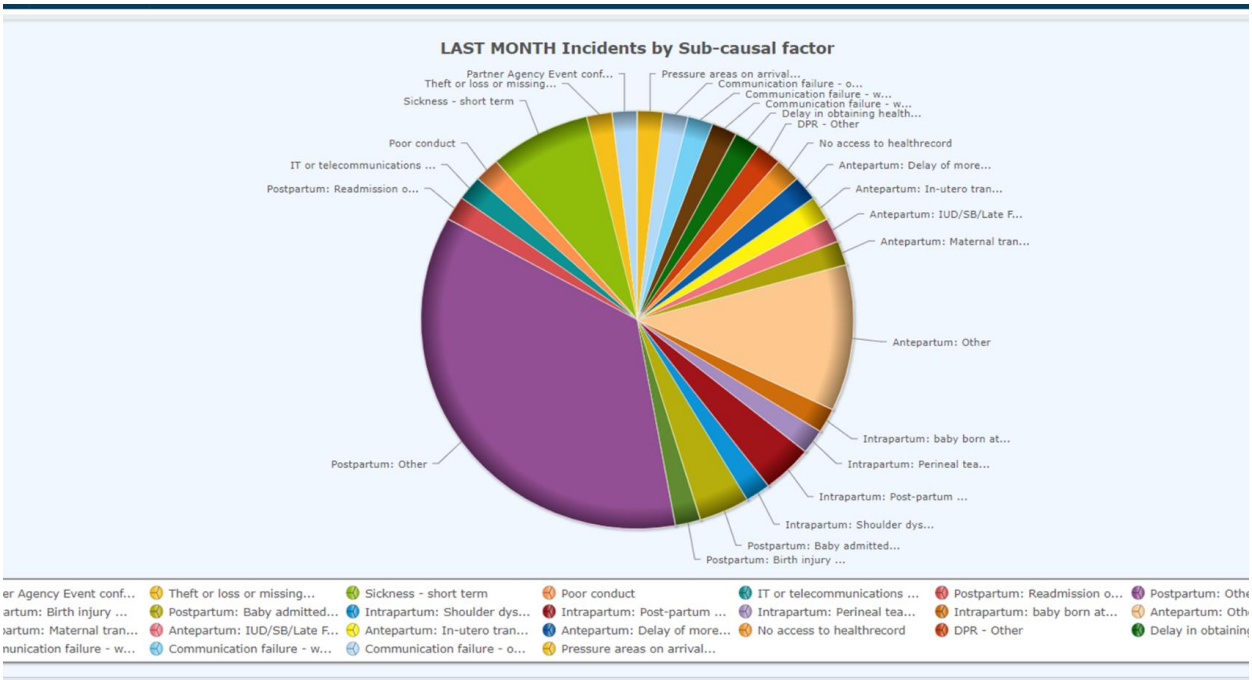
- Report about babies born in the wrong place including three examples and discussion points.
- All obstetric consultants have signed up to the document Roles and responsibilities of the consultant workforce report (May 2022 update) (rcog.org.uk) as required by the Maternity Incentive Scheme

Activity



	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Total
Bookings	165	140	152	140	123	144	126	146	145	145	141	123	2430
Deliveries (Mums with Registrable Baby)	108	113	114	117	141	128	145	129	133	111	109	131	2149
Births (Registrable Babies)	108	114	114	119	144	131	148	132	136	114	111	135	2185
Live Birth <37 Wks & <2.5Kg	2	3	4	7	4	7	5	9	3	3	6	4	82
% Babies Born at Home	7.4%	6.1%	7.9%	7.6%	2.8%	6.1%	4.0%	3.0%	5.1%	4.4%	4.5%	5.2%	5.3%
% Babies Born at The Cove	3.7%	5.3%	6.1%	6.7%	9.7%	7.6%	4.7%	6.1%	3.7%	7.0%	4.5%	8.9%	5.3%
% Caesarean Babies	42.6%	43.0%	37.7%	36.1%	46.5%	38.9%	39.6%	43.9%	38.2%	41.2%	43.2%	39.3%	40.1%
% Elective Caesarean Babies	19.4%	21.1%	17.5%	21.0%	15.3%	17.6%	16.8%	16.7%	15.4%	20.2%	25.2%	25.2%	18.9%
% Emergency Caesarean Babies	23.1%	21.9%	20.2%	15.1%	31.3%	21.4%	22.8%	27.3%	22.8%	21.1%	18.0%	14.1%	21.2%
% Mothers Induced Successfully	27.8%	30.1%	36.8%	24.8%	27.0%	25.8%	29.0%	30.2%	30.1%	31.5%	29.4%	25.2%	28.5%
% Mothers having Caesarean Births, excluding failed induction	24.1%	27.4%	23.7%	24.8%	21.3%	25.8%	26.9%	26.4%	22.6%	20.7%	24.8%	27.5%	23.8%
% 3rd/4th Degree Tears	0.9%	0.9%	1.8%	0.9%	0.0%	2.3%	1.4%	1.6%	1.5%	0.0%	0.9%	0.8%	1.1%
% PPH >1000ml	13.0%	14.2%	5.3%	6.8%	14.9%	8.6%	13.1%	14.0%	10.5%	9.9%	11.9%	9.2%	11.7%
% First Feed Maternal	66.7%	68.4%	66.7%	67.2%	66.0%	64.9%	77.9%	66.7%	76.5%	73.7%	74.8%	72.6%	70.0%



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

Total Number of Incidents for January 2022-December 2022

Jan	Feb	Mar	Apr	May	June	July	Aug	Sep	Oct	Nov	Dec
64	43	55	70	93	79	76	70	63	74	62	60
Number of incidents overdue: 17						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	2 maternity, 1 SCBU
RF2	Missed medication	0
RF3	Delay in providing or reviewing an epidural in labour	0
RF4	Delay of more than 30 minutes between arrival and admission in ANDAU -	Please see new risk registered
RF5	Full examination not carried out when presenting in labour	0
RF6	Delay of ≥2 hours between admission for induction of labour & starting process	1
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 reduction in datix correlates to increased staffing. Although adversely affected by STS, overall staffing is improving

RF4 as above

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

SI number & Initials	Date of incident	Progress	Notes	If there are Learning & service changes Ockenden Recommends 6 months to implement
72663 (Case review)	5/06/22	Low PaPPA aspirin process amended Awaiting SOP from USS for changing scan dates Then take back to CIA	Baby MRI normal Awaiting the SoP for management of ultrasound appointments when women request cancellation or change of date	Dec 2022 – out of date due to SoP required
76489 (PMRT)	16/09/22	72 hour report heard at CIA PMRT 27/10/22 (UHD and UHS present as fetal medicine input from UHS) Needs to be heard at CIA/LIP	Care graded as A and A. Difficult to ascertain cause of death as PM declined. For follow up with Fetal medicine consultant at DCH.	March 2023
73197 (PMRT)	5/05/22	PMRT completed Has had postnatal follow up with consultant. LIP panel 9/12/22	Learning identified surrounding communication of how her baby may look after birth.	Nov 2022
77894 (case review)	6/11/22	Obstetric and Anaesthetic Consultants identified to review.	RCA review underway.	May 2023
76500 (SI)	13/09/22	Staff requested for statements RCA/SI underway (Consultants identified to lead on review). In contact with parents.	Review nearly complete	March 2023

Closed SIs

Risk Register

ID	Title	Risk Statement	Open	Risk	Risk Level
	Triage and the use of BSOTS (Birmingham Symptom Specific Obstetric Triage System)	Recent CQC inspections have focused on the importance of timely triage of women attending the Maternity Day Assessment Service - ideally the use of BSOTS. The concern focuses on women being risk assessed and then seen promptly as required. DCH does not currently use BSOTS (it is available within BadgerNet but requires training and an agreed "activation with the provider). Although the time women arrive at DCH for ANDAU is noted, with the team reminded about escalation, this process is not formalised or tracked. **January 2023** Although there have been no poor outcomes linked to the lack of an informal triage system, the service is currently working towards BSOTS with relocation and expansion of ANDAU. It is likely an extra midwife will be required for ANDAU at the weekend as the triage system requires two midwives as a minimum.	08/01/2023 Monthly review	high	Care group
1569	Birthing room out of use in The Cove, reducing the availability of the birthing unit by 50%. Due to a significant leak over the window	a significant leak above the window in one of the two labour rooms in the midwife-led-unit, The Cove, is severely restricting women's access to using the unit. The ceiling above the window is starting to flake off. Water pours across the floor when it rains requiring towels to mop it up. This has been ongoing for several weeks already with no prospect of a repair and returning the room to use. **January 2023** The Estates team have reviewed the problem and noted there is no cavity tray above the window. An interim fix is being considered so the room can be used, with building required to address the problem in the long-term	03/01/2023 Monthly review	moderate	divisional
1497	Emergency buzzers not heard consistently throughout the Maternity unit when activated	There has been an occasion when the emergency buzzers were not heard consistently throughout the maternity unit when activated. This may lead to delay in staff response to an emergency situation. There is an upgrade planned for Maternity in Q4 **January 2023** Interim emergency call bell system identified and agreed with Estates – for priority installation		high	corporate

	lack of capacity within the neonatal network, impacting on in-utero transfer	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 Dec 2022** – this remains a concerns and is linked to available neonatal cots and labour ward beds. Although risk remains, use of the QUIP app that triangulates risk recently avoided an inutero transfer that would have been required prior to the QUIP app being introduced **Update January 2023** This problem continues with a recent case of a woman who required transfer. Local neonatal unit had available cots but their Labour Ward unable to accept.. Woman transferred out of area.	14/07/2022 Quarterly review	moderate	Care group
1506	Lack of access to point of care testing for neonates due to lack of access to Transcutaneous Bilirubinometers	Transcutaneous bilirubin monitoring is a necessary and standard procedure in neonates at risk of jaundice. Testing is undertaken in the community POCT to ascertain if admission to the unit for further testing and management is necessary. In Caucasian babies the POCT is only undertaken if jaundice is suspected visually. Babies from a black or minority ethnic heritage require this test at every contact as visually it isn't possible to determine if jaundice is present with enough assurance. We use a Transcutaneous Bilirubinometer (TcB) at every contact. **Update Dec 2022 -** Maternity have recently received 3 TcBs. However they are required to be calibrated against 10 x SBR results which need to be 25.2mmol maximum difference between readings for it to pass, and only once these are complete then they can be taken out to community bases. **Updated January 2023** A much-improved situation with the TcBs now working and returned to the community teams. Thereby improving access to this screening tool for all families requiring this test. Risk remains at moderate as new TcBs only recently allocated	01/08/2022 Quarterly review	moderate	Service specific

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 Dec 2022** Whilst the number of women tested for CO has increased significantly, we have still not quite achieved the requirement for the Maternity Incentive Scheme. Key to this is the way in which data around the CO reading at booking is collected. Currently considering collecting the data manually if possible **Update Jan 2023** >80% women have CO monitoring at 36 weeks of pregnancy. Currently auditing those at first contact/booking. It may meet the required threshold.	17/03/2022 Quarterly review	moderate	Care group
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 January 2023** Assessments completed on both rooms and awaiting results	24/12/2019	High	Division
1127	Maternity Staffing	**Update:** staffing remains challenging. Recruitment continues with interviews soon for band 5 &6 posts. but there is a high number of midwives retiring. However, sickness rates have improved considerably (see end of paper). The mitigation remains the same - reallocating staff, asking staff to work extra shifts, utilising bank staff. **Update Dec 2022.** Staffing is improving with modifications made to roster in relation to night shifts, prior to publishing **Update January 2023** Rotas are improving particularly during day shifts although STS is a concern. Less IOLs delayed and no escalation during December. Business case submitted for confirmed funding for staffing required to deliver against Ockenden	20/07/2021 Quarterly review	moderate	division

Complaints

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

Update & learning
The director of midwifery has apologized to the woman and acknowledged the impact on her of the incident.
Specific learning
The importance of documenting all care on Badgernet contemporaneously
Midwives talking quietly at night (the woman heard midwives talking about the poor staffing)
A low threshold for doing a caesarean if required, rather than waiting until the morning, or the Monday (to be discussed at the next consultant meeting)
A thoughtful approach to conversations with women in this situation

Exception reporting for babies born in the wrong place (in relation to neonatal care)

DCH has a level one Special Care Baby Unit
LNU – Local Neonatal Unit (UHD)
NICU – Neonatal Intensive Care Unit

Dorset County Hospital NHS Foundation Trust:
LNU pathway for:

- **Above 27 weeks and below 32^{+0} weeks gestation**
- **Above 800gms and below 1250gms**
- **Neonates requiring more than short term high dependency care (48 hours review)**

NICU pathways for:

- **below 27+0 weeks**
- **below 800 grams**
- **below 28+0 week gestation twins**

below 30+0 week gestation multpiples of 3+

- **neonates over 27 weeks who receive or are likely to require ventilation for more than 48 hours and/or whose condition is deteriorating**
- **neonates who require cooling**
- **neonates requiring specialist care e.g. nitric oxide**
- **Complex intensive care including neonates with symptoms of additional organ failure**

Birth in the wrong place

Gestation	2021	2022
24/40		1
25/40		1
28/40	1	2
29/40	1	2
30/40	1	
31/40	4	3
Total	**7**	**9**

Learning and discussion points

Maternity/Obstetric:
Foetal monitoring
Identifying impact of maternal social issues
Identifying risk factors for pre-term birth
Availability of cots within region
Use of QUIPP app
Pre-term optimisation – antenatal steroids/MgSO4/maternal antibiotics

Neonatal:
Timing of repatriation
Pre-term optimisation (deferred cord clamping/normothermia/breast milk)
Discussions with SONET regarding babies who do not require transfer

Morbidity including M&M meetings

No meeting prior to Quality Committee

Audit update

- CO monitoring at booking/first face-to-face contact
- CO monitoring at 36 weeks
- Transitional care
- Aspirin audit (completed, for review)

- Clexane TTOs (completed, for review)
- Trial without catheter reaudit (in progress)
- Repeat risk assessment audit (in progress)
- SCBU contemporaneous records (2 or 3 sets of notes twice a year) in progress
- Annual Screening audits x 4
- Audit of controlled drugs checking
- Antenatal Day Assessment waiting times
- Safeguarding audits x 3
- March '23 use of steroids relating to premature birth
- Consultant attendance on ward rounds
- Women seeing named consultant
- Care plans for complex women
- Personal care and support plans in place

Current Maternity Safety Guidelines and SoPs published recently

Substance Misuse in Pregnancy and After Birth
Conflict of Clinical Opinion
Guideline for the Care of Women Involved in Surrogacy
Independent Midwives Caring for Women at DCHFT
Birth Outside Guidance Standard Operating Procedure
PGD Aspirin tablets for individuals at high risk of pre-eclampsia or fetal growth restriction
Antenatal Care

Claims

Received Dec 2022		Relates to care during pregnancy	Initial response provided

Training

Maternity staff compliance for training

Training	Staff grade	Percentage of attendance
PROMPT (Practical Obstetric Emergency Procedure Training)	**Obstetric Anaesthetists**	100%
	Obstetric Consultants	100%
	Doctors (Reg/SHO)	60% *
	Midwives	91% ***
	MSW	93% **
NLS (4 yearly accredited course)	**Senior Midwives & Homebirth Midwives**	96.5%

NLS (yearly update)	**Midwives**	94%

- *New trainees commenced with 4 requiring training. Three booked for 17/21/2023
- **MSW to be allocated to PROMPT during the next two months.
- *** New midwives to Trust and preceptors to attend training as soon as possible

Maternity Staffing

Sickness absence	December 2022
midwives	8.7%

Sickness absence	December 2022
MSW	5.7%

Medical cover has been managed effectively with one episode of a consultant 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 usually provided by a midwife).

Maternity Incentive Scheme exception report

The evidence required for the MIS for 2022/2023 have grown considerably in complexity and there is a risk that we will not meet every requirement. Key risks are around our transitional care service. This relates to the audits required of every baby receiving transitional care. Also our CO monitoring at booking. This relates to the timing of the first face to face appointment.

Following review with the CNO and the NED Safety Champion on the 13th January, the recommendation is to submit without full compliance. To be discussed at Quality Committee and then Board

The spreadsheet required for sign off will be presented as part of this report but submitted separately

Service user feedback

Report Front Sheet

1. Report Details			
Meeting Title:	Board of Directors Part 1		
Date of Meeting:	25th January 2023		
Document Title:	Publication of the Dorset Integrated Care Strategy		
Responsible Director:	Paul Lewis, Deputy Director Strategy, Transformation & Partnerships	Date of Executive Approval	09 January 2023
Author:	Paul Lewis, Deputy Director Strategy, Transformation & Partnerships		
Confidentiality:	No		
Publishable under FOI?	Yes		
Predetermined Report Format?	No		

2. Prior Discussion		
Job Title or Meeting Title	**Date**	**Recommendations/Comments**
Board Development Session	14 Dec 22	Noted
Finance and Performance Committee	16 Jan 23	Noted

3. Purpose of the Paper	The purpose of the paper share the recent publication of the Dorset Integrated Care Strategy (ICP). The committee is requested to note the strategy and discuss its impact on the Trust.						
	Note (✓)	✓	*Discuss (✓)*	✓	*Recommend (✓)*		*Approve (✓)*	
4. Key Issues	In December 2022, the Board of Directors received a draft version of the ICP strategy and discussed the impact on the Trust. Later in December, the final version of the strategy was published. This report shares this final version. The strategy is actually titled ***working better together***. Its vision states; 'Dorset Integrated Care System works together to deliver the best possible improvements in health and wellbeing.' **Key priorities & Delivery through ' Making Integration Work'** <u>Prevention & early help</u> Helping you to stay well by providing prevention support as early as possible. <u>Thriving communities.</u> Investing in communities, building strong networks and developing high quality spaces in the community where we can work together. <u>Working better together.</u> Consider your needs at all stages of your journey through health and care services. <u>Building mental wellbeing</u> Making mental health everyone's business <u>Falls and frailty</u> Recognising frailty conditions much earlier. Across our organisations there are lots of opportunities for us to intervene and prevent these falls from happening. **Next Steps**						

	According to the strategy, the next phase is just as important. 'We want a live, clearly focused strategy that is developed and written through the results of that engagement. It needs to reflect what people and organisations are saying, and develop real ownership and desire to now co-design the solutions and innovative work that will lead to lasting change.' The next steps in the strategy development process should consider the following issues, and ensure they are captured in an ongoing development programme • Continue employee engagement to understand how organisations can support their teams to put you at the heart of care and improve workplace wellbeing • Ensure clinical and care professional leadership is aligned with this ICP strategy, and that there are strong links to the clinical strategy • Understand how to reduce duplication in plans and strategies. Make sure there is better alignment and understanding in our system of agreed priorities, from the ICP strategy through to health and wellbeing strategies and place-based commissioning • Involve people in setting and reviewing priorities, and progress in meeting them From the ICP strategy, the Integrated Care Board is developing the 5 year forward joint plan (JFP): This is refreshed annually. The JFP is developed by the ICB and its partners, including the Trust. Typically, the JFP is finalised by 31 Mar of each year. This year, NHSE have requested the final draft is prepared by 31 Mar 23 and approved by NHSE and Health & Wellbeing Boards by 30 Jun 23. The ICP strategy and the JFP will inform the Trust strategy refresh
5. Action recommended	The Board is recommended to note and discuss the ICP Strategy

6. Governance and Compliance Obligations				
Legal / Regulatory Link		~~**Yes**~~	**No**	*If yes, please summarise the legal/regulatory compliance requirement. (Please delete as appropriate)*
Impact on CQC Standards		~~**Yes**~~	**No**	*If yes, please summarise the impact on CQC standards. (Please delete as appropriate)*
Risk Link		~~**Yes**~~	**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**~~	**No**	If yes, please summarise how your report contributes to the Trust's Social Value Pledge
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 ICP strategy will inform the Trust's strategy refresh		
	Place	The ICP strategy will inform the Trust's strategy refresh		
	Partnership	The ICP strategy will inform the Trust's strategy refresh		
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**~~	The ICP strategy informs the ICS objectives and priorities including Improving population health and healthcare
Tackling unequal outcomes and access		**Yes**	~~**No**~~	The ICP strategy informs the ICS objectives and priorities including tackling unequal outcomes and access
Enhancing productivity and value for money		**Yes**	~~**No**~~	The ICP strategy informs the ICS objectives and priorities including enhancing productivity and value for money

Helping the NHS to support broader social and economic development	**Yes**	~~**No**~~	The ICP strategy informs the ICS objectives and priorities including helping the NHS to support 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)	~~**Yes**~~	**No**	
Quality Impact Assessment (QIA)	~~**Yes**~~	**No**	

Working Better Together

Dorset's Integrated Care Partnership Strategy 2022/23




Our Dorset
Your Local NHS and Councils Working Together

Contents

Introduction

Welcome to the first integrated care partnership (ICP) strategy for Dorset.

The point of a strategy document is to explain where we are now, what we hope to achieve, and how we're planning to do that. This document builds on previous plans for Dorset like the Sustainability and Transformation Plan and the NHS Long Term Plan. It sets out how the NHS, councils, and other partners within our ICP will work together to make the best possible improvements in the health and wellbeing of local people. This means changing the way we work to provide the right health and care services across Dorset.

We need to do this to tackle the challenges around high demand for care and support. We also know that different people have different experiences when using health and care services – differences in what access they have to services, how they feel when using the services, and the outcome those services have on their health and wellbeing. These differences lead to inequalities in health that are both unjust and costly for people and communities.

Not only do we want to make sure everyone in Dorset has access to the right services at the right time, it's also a legal duty for us to look at how we are reducing inequalities in health across our integrated care system (ICS), as stated in the 2022 Health Act. In this strategy we present the main things that people in Dorset have told us affect them, both good and bad. Where things aren't working, we will look at what we can do to make things fair for everyone.

Together, we will:

- make sure our resources are used where they're needed to meet health and care needs
- look at how public, independent and voluntary organisations can provide joined-up care together
- listen to people, and involve them in making decisions about their care and how they get it
- look at how well things are working for our communities, and make changes if things aren't right.

It's not just health and care services that make a healthy person. You've told us how important family and friends are to staying well. We know that talking to volunteers and people with similar conditions can have a big impact when we're recovering from an injury or illness. This strategy puts you at the heart of health and care planning wherever possible.

Through a document called the Joint Strategic Needs Assessment, we've researched the needs of Dorset's population. We've spoken to people working in frontline health and care and young people working with Healthwatch Dorset. We've gathered information from the BCP Council Resident's Survey and Big Conversation, and the Community Action Network's State of the Sector report. We've also spoken to people from all over Dorset through our 100 Conversations project.

Understanding what you need to stay well means better outcomes for everyone. This strategy is just the start of that journey.

Differences you will see

Putting people and communities at the heart of all we do and focusing on the things that are most important to you will help us in supporting everyone to live happy and healthy lives from cradle to old age.

You will:

- be more involved in your care and in the decisions that are made about what care you'll be receiving and why
- be able to access information more easily in a format that is suitable for your needs
- be considered as a person rather than a patient, your care will be tailored to suit you, not your condition or injury
- be listened to and where things aren't right, your experiences will be used to make improvements
- be able to access services closer to home, not passing from service to service. This will save you time and money by not having to make multiple trips to hospital settings
- be able to access Dorset's natural environment to stay well and use green spaces to improve your physical and mental wellbeing
- have the right tools to stay well and independent for longer, so you can manage your own health and wellbeing successfully, and recognise when things aren't right or when you may need extra support.

'Integrated care systems are all about improving outcomes and tackling inequalities. I'm excited by the opportunity working as a single system brings – only by working together and listening to local people will we make the changes we need to.'

Jenni Douglas-Todd – Interim Chair, Dorset Integrated Care Partnership

'I'm encouraged by the focus in integrated care systems of using our collective assets to improve prospects for people who don't get the chances of a decent job, or home or support network. These factors are so crucial to health we mustn't underestimate what we could do together to help.'

Spencer Flower – Leader of Dorset Council, Integrated Care Board member

'When we talk to communities about what makes a great place, people mention the importance of our natural environment to boost wellbeing. This is where councils can make a real contribution to integrated care systems, aiming to be the best place for wellbeing and healthy living.'

Drew Mellor – Leader of Bournemouth, Christchurch and Poole Council, Integrated Care Board member

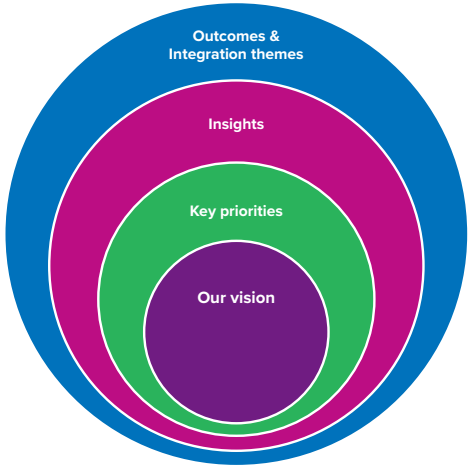
Our vision and priorities

Our vision

Dorset Integrated Care System works together to deliver the best possible improvements in health and wellbeing.

Key priorities

1. **Prevention and early help**
   Helping you to stay well by providing prevention support as early as possible.
2. **Thriving communities**
   Investing in communities, building strong networks and developing high quality spaces in the community where we can work together.
3. **Working better together**
   Consider your needs at all stages of your journey through health and care services.



Insights

From our community conversations we have a good understanding of what people in Dorset feel are the most important when it comes to your health and wellbeing.

If things were working well and services were being delivered seamlessly people would think, feel and do:

- Listened to and involved
- A sense of purpose and belonging
- Not passed around services
- Access services closer to home
- Remain independent 'give me the tools'
- Use natural environment for wellbeing
- Considered as a whole person or family

Joint Strategic Needs Assessment tells us these are the important factors:

- Mental health and wellbeing
- Fairness in access to services, including digital
- Loneliness and social isolation
- Rising cost of living, hidden poverty
- Children's health and social care
- Workforce and ability to help support people with more complex needs
- Lack of maturity in working as one system to improve quality – demand and pressures
- Integrated mental and physical health

Outcomes

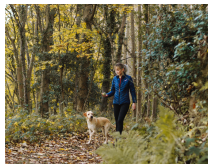
- Joined-up health and wellbeing, consider mental and physical health
- Invest in and involve informal care and support
- Care closer to home
- Children's health, and best start in life
- Inequality, or 'fairness' in access, outcomes and experience
- Social isolation, loneliness
- Listen and involve people in solutions

Integration themes

- Greater involvement of voluntary sector and social networks to keep you well – invest seriously in prevention
- Consider high quality spaces where this work could happen between formal and informal services
- Care closer to home as default
- Communication, listening and treating people as humans not patients; respect employees and their wellbeing too
- Access and experience really critical – focus on the person's experience and outcomes will improve
- Tackle variation in outcomes, 'fairness' in access to services and support, consider who is waiting and the impact on health
- Integrate physical and mental health care where possible
- Encourage our organisations to look for and promote opportunities for good jobs and decent housing.

01 Where we are now

What you say our places are like



Dorset is a great place to live and grow – over half the county is an area of outstanding natural beauty. The mix of coastal, urban and rural areas offers variety in both the landscape and activities that can support health and wellbeing.

"I've always done outdoorsy things. Whether that is just going for a really long walk on a Sunday afternoon or playing sport or walking a dog... Anything nature, animals and outdoorsy or water based. That is what makes me feel calm and happy."

100 Conversations

Our town centres are places to connect and be part of a community. People want to feel proud to live there, to be part of the history of the place, and to celebrate its specific culture.

"People felt really strongly about their local town centre. For example, Christchurch is not just a place to shop, but the essence of the community. A place where people could go to have a conversation, or chat at a shop checkout or at the bus stop. These casual encounters are important for people's mental health, a chance to connect and feel part of something bigger."

BCP Future Places

Dorset has almost 100 miles of coastline, including England's only natural World Heritage site, the Jurassic Coast. We also have rolling downs and woodland – Dorset is full of places to get out into nature and explore.

"My husband and I really like to get out into nature, and we do lots of walking. We've got kayaks and bikes, so we do a lot of exploring."

100 Conversations

While beautiful, our rural areas have several challenges. Young people are particularly affected, with access to transport one of the main barriers stopping them from taking part in social activities or using support services.

"'For young people who live rurally, their location is an added barrier to accessing health and care services. They could not access support without their parent's knowledge or without their parent being present, because their parent had to provide transport."

Healthwatch Dorset Young Listener Project

Youth voices

The VoiceX survey aimed to capture the voices of young people across the county to explore what it's like living and growing up in Dorset. 371 young people took part in the survey.

Top three barriers preventing young people from using clubs, groups and support:

- Not knowing other people taking part
- Money
- Transport

59.8% of young people take an active role in their community

57.7% feel they belong in their community

42% feel they are not taken seriously

One system, two places

Where and how we live plays a huge role in our health and wellbeing. Dorset is split into two 'places' – the area covered by Bournemouth, Christchurch and Poole (BCP) Council, and the area covered by Dorset Council. We need to know how these two places shape the health and wellbeing of the people living there.

Bournemouth, Christchurch and Poole Council (BCP)

Around 400,000 people live in the BCP Council area. The population is higher than the national average, but also includes a higher number of people aged 19-25 than other areas due to its three universities. This also means the population changes regularly as people move in and out of the area.

We have a growing population from diverse ethnic groups – more so than in the Dorset Council area.

People's health is about the same or better than the national average, and people who live in the area are generally happy with their lives. How long and how well people live can vary though – BCP has some of the richest and poorest areas in the country.

There is less unemployment than rates in England, but more jobs in lower paid areas like accommodation and food services. Wages are low, and there is a shortage of affordable housing.

Dorset Council

Lots of people are moving to Dorset, with the population growing by 3,000 each year, despite our birth rates being lower than the national average. Many people choose to retire in Dorset – out of the 380,000 people living here, 29% are aged 65 and older, compared with 19% across England.

Younger people often move away from the area due to lack of opportunities, low wages and high housing costs. Around 25% of families in Dorset live in poverty, and 27% of people are earning below the living wage.

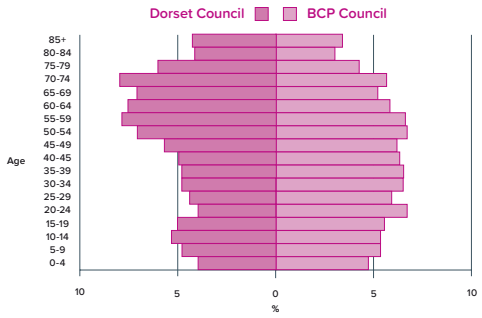
While crime is low, anti-social behaviour and rural crime are an ongoing concern.

The population is more than 90% white British. Fewer than 5% of residents are from ethnic diverse communities.

In summary

- Coastal communities have much poorer health outcomes than other areas. More people are living with diabetes, heart disease and cancer
- High house prices make it difficult to attract people to health and care jobs
- Coastal areas have fewer consultants, medical trainees and nurses compared to inland areas, despite having older populations with greater needs
- The ageing population could be an asset rather than a problem. Many older retired people volunteer or care for people and have huge life experience
- Health inequality affects health and wellbeing from early years to later in life in both BCP and Dorset council areas.

Graph showing the population of Dorset by age category



Across the whole of Dorset:

13.1% people earning or living below the minimum living wage

5.9% armed forces veterans

11.9% carers (both paid and unpaid)

12.5% working age adults self employed

30.6% number of households with only one adult in the house

13.5% number of children living in poverty

What our partners say

In Dorset most of us get good care when we can access it, but many aren't getting the care they need. More people are having to wait longer. More health and care staff are leaving, and it's difficult to recruit new people to fill the gaps. There's a greater need for adult social care, and we are struggling to keep up. Funding is also still an issue, and we've been through a lot of political changes in recent years. These everyday pressures make it difficult to step back and plan for the longer term, but we need to do this if we want to make a difference for the people of Dorset in the future.

Working together as a system can help people to live better lives. By making the best use of funding, and looking at who is best placed to deliver a service, we can make sure communities are getting the right care in the right place at the right time.

"Meeting primary needs of having your home, your food, your warmth is getting harder and harder because, obviously, inflation is going up and people's wages haven't gone up for a very long time."

Joint Strategic Needs Assessment

Being part of an integrated care system means:

- a joint vision to meet the needs of people in Dorset
- being open and honest when making decisions
- making the best use of our collective resources to benefit people and communities
- focusing on prevention and early intervention
- taking a place-based view of things when planning services
- making sure people and communities are at the heart of everything we do
- having open and honest conversations with people
- working together as equal partners

"Work within teams where we have a complete multi-agency partnership between health, social care, mental health, between all agencies... How we work together would work better, in a way, like a jigsaw like that. We'd have an understanding [of how people's] mental and physical needs work together, their housing needs, how everything fits in together."

Joint Strategic Needs Assessment

Councils have an important role to play in tackling issues linked to health inequality. They also have close connections with their communities.

Working together we can:

- strengthen community services for people living with long-term conditions
- improve support for mental health in the community and in schools
- improve support for carers
- use technology to support older people to stay living in their own homes
- provide care closer to home, away from hospitals
- tackle concerns early on before they become bigger problems
- tackle issues such as homelessness.

"There should be things like a community café in every town, because it's a really good thing. It will help address a lot of problems. I think that those are the bits that I see as gaps."

Joint Strategic Needs Assessment

"Working to support disadvantaged communities is a key priority for BCP Council. Being part of the integrated care system gives us the opportunity of working together at place level to tackle these inequalities in health outcomes, access, and experience. This strategy offers us the chance to accelerate this work across Bournemouth, Christchurch and Poole."

Cllr Jane Kelly – Chair, BCP Council Health and Wellbeing Board

"Working better together gives us the opportunity to invest scarce public sector resources in the best possible way. Our integrated care system, if it is working well, should be less about our individual organisations' priorities, and more about planning care and support for people to enable them to live independently for as long as possible."

Cllr Peter Wharf – Chair, Dorset Council Health and Wellbeing Board

02 Making integration work

Our Vision

Developing our first integrated care partnership strategy has involved talking with a wide range of people. Some have been leaders of our health and care organisations. Some have been people working on the frontline, providing services in the community and in hospitals. Many have been people that live and work in Dorset who we have not spoken to before, through our 100 Conversations project. We've asked ordinary people what keeps them well, and what more we can do to support them.

Some issues stood out clearly. Leaders agreed that our strategy should focus on helping people maximise their wellbeing, and on treating people as humans first, not patients. This must consider how we support people to have the best start in life, right through to older age. They also agreed that services or organisations should not define what this means. It should come from the conversations we have been having with people and communities.

Through regular discussion with leaders in the system there is widespread support for the following vision statement:

'Dorset's integrated care system works together to deliver the best possible improvements in health and wellbeing'

The issues we are contending with are complex, and often the factors that drive them lie outside of the direct control of health and care services. Throughout this strategy and the research and engagement we have carried out to support it we have used three perspectives: prevention and early help, thriving communities, and working better together.

To support the vision, we have used these perspectives to set out under three headings what we are doing to make this happen.

Prevention and early help

We listen and involve you in decisions about your health and wellbeing, and care and support needs. We make adjustments where needed to improve your outcomes, access or experience, to improve equity and reduce inequalities in health.

Thriving communities

We work more closely with communities and voluntary sector organisations to support you and improve your health and wellbeing. We provide more opportunities for friends, family and peer supporters to help you thrive, or to recover when you are unwell. We look at variation in how well people are supported who live with long-term conditions.

Working better together

We put people's and communities' needs at the heart of how we plan care and support. Our organisations work together to provide care as close to you as possible. We value the strength of voluntary and community organisations in this partnership. We focus on improving your outcomes, access, and experience, and are careful with scarce resources like time and money.

"We have a clear vision – working together to achieve the best possible improvements in people's health and wellbeing, but we recognise we need to do more to build strength in citizenship.

We will be more responsive to people, community driven, empowering, and engage with local people wherever we can.

If we are going to reverse the social gradient that we see in health outcomes, we need to be serious about achieving equity of access, experience and outcome in all that we do – and not make assumptions about how people are living their lives. This is what we mean by being ambitious, working in partnership and being community driven."

Patricia Miller – Chief Executive Officer, NHS Dorset

Prevention and early help

We tend to worry about health and healthcare when we get ill or our health begins to suffer. There are many benefits for people who have the tools and support to live and stay well: increased self-esteem, feeling able to take control, feeling connected and less isolated, reduced anxiety, and improvement in mood. People also feel empowered to challenge and question health professionals, being recognised as experts in their condition, and have the ability to provide peer support.

"If you give me the tools to self-manage I can look after my own physical and mental health."

100 Conversations

You've told us that you value having meaning and purpose in your day. You want to be involved in conversations about your health and wellbeing.

"They don't look at my points of view. My needs weren't considered at all. I didn't feel listened to."

Healthwatch Dorset Young Listener Project

When people can manage their own health and our communities are supported to build groups and networks, we can link people together and help each other to stay well.

"Not being able to do things that I normally would do was difficult. I'm fortunate to live near a green space where we can walk our dog. We've become part of a community now, we know our neighbours and that makes a massive difference. I didn't need to tell them I was ill, they just knew. Dog walking was a natural situation where we could have a conversation. I'm lucky that I've got people around me. You know – it takes a village; I've got a village, I've got a really good village."

100 Conversations

In Dorset we want to improve emotional health and wellbeing support for children and young people. To do this we have to make sure young people have the right support at the right time and in the right place, and that they are actively involved in decisions about their care.

Roughly half of all lifetime mental health disorders start by the mid-teens and three quarters by mid-20s. Introducing support at an earlier stage, even before a diagnosis, can help children, young people and their families feel more looked after and can prevent some conditions from worsening.

As children grow and develop, they may need different kinds of support. For this to work, we as an integrated care system need to listen to the needs of local children, young people and their families and invest resources to reflect this. This means looking at how well our services work to support people.

Waiting times for accessing children and young person's health services in Dorset are higher than many other areas in the South West. One in 20 people referred are offered an appointment within four weeks – much lower than the target of 95%.

"Technically you can [access support] but waiting times are so long you don't get it."

Healthwatch Dorset Young Listeners Project

Not getting help quickly can make some behaviours, like self-harm, worse. This lack of early support not only costs children and young people, but it has a knock-on effect for services, with extra emergency department visits, police and ambulance time, inappropriate stays in hospital, and social work and care coordinator time.

"The key with young people is early intervention work and it's really difficult. Most of that work can't be measured because it's holistic work, it's working as a whole. Some of it can't be measured, but it's the stuff that works... the hand holding... it's the things that gets them motivated."

Joint Strategic Needs Assessment

Safeguarding families

Post pandemic, many local authorities have seen a rise in child protection cases. A new approach to social work will mean we have the right support for families to enable and affect positive change.

Safeguarding Families Together brings specialist adult services workers alongside children's social workers, with an approach to keeping children safe in the family home. It is based on 'whole family working' to meet both the child and adult needs by working together and sharing information between professionals to provide the right support at the right time.

Case study – Family A:

Dorset Council worked on and off with one family for 14 years. All four children (aged between 1 and 13) have had some sort of interaction from children's services since they were born – meaning social workers have been around for their whole life. Research shows this constant presence will have had a negative impact on the families' wellbeing. If a whole family approach had been available to the parents and empowered them to recognise the changes they needed to make early on, they could have avoided the impact this had on the family.

Children with social workers or who have experienced care can face a range of challenging social and health outcomes, including poorer educational results, higher rates of mental health problems and even higher rates of homelessness and unemployment later in life. In Dorset children aged 0-4 years continue to represent the highest number of new child protection cases.

Key priorities

- Help people to stay well by providing prevention support as early as possible
- Reduce the variation in how well people are supported with long-term conditions like heart disease, high blood pressure and diabetes

Making integration work: prevention and early help

In Dorset many people are living with long-term conditions. These include high blood pressure, heart disease or diabetes. There is also wide variation in the number of people who have these conditions under control.

'Under control' means managing the risk factors that could lead to the need for hospital care, or even early death. Information on how many people have good control is available from each GP practice.

We can use this information to understand how to improve care. But it is vital we work with people to understand how we can best support them to make the changes that will help.

This could be clinical care, such as prescribing medicines that can help risk factors. Supporting people to make changes to their lifestyle and stay well is also important. For people living with high blood pressure or type 2 diabetes it is possible to reduce your risk factors. This could be by being more active or changing what you eat. Quitting smoking or drinking less alcohol can also help. People are more likely to make these changes if they feel supported and engaged in their care.

Our vision of an integrated care system goes beyond professional, clinical roles. It looks at how we better support people, and the importance of having a strong network of social support. This can help motivate people to stay well and improve their lifestyles. To achieve this we must understand what matters to you to keep you well. We should also consider how best to provide more social support, and see this as part of our offer to people. Using our data and insight is also important. We will measure how well we are doing. Do more people feel better supported in managing their condition? And is the variation in people who have good control of their condition reducing?

1 year

Data and insights: Population health data used to build a picture of who is not getting the support they need to successfully manage their condition.

Involving people: People who are living with long-term conditions and finding it difficult to achieve control are involved in developing better support options.

Inequalities: Primary care teams supporting different communities understand what adjustments are needed to support more people to achieve control of their condition. Local support from voluntary sector organisations is on hand to help with this.

Experience: People are regularly asked if they feel listened to and involved in their care. They are also asked whether they have the right support to help manage their condition.

Outcomes: We measure progress on improving outcomes, and whether the variation in people who achieve control of their condition is going down.

3 to 5 years

There is less variation in the number of people who are achieving control of their long-term conditions compared to three years before.

Primary care teams are working alongside people from voluntary sector and community organisations to provide more joined-up care. These 'neighbourhood teams' include GPs, nurses, social workers and a wide range of people from the voluntary sector. The team's job is to understand how to deliver personal care and support, and to ensure outcomes, experience and access are as good as they can be.

A mix of support is on hand to help people living with conditions like diabetes or heart disease.

More people agree that they have enough support to help manage their condition when asked.

5+ years

Neighbourhood teams are supported by champions – people who have experience of living with a long-term condition. They work together to provide more options to better support people to achieve control of their condition. Champions act as care advocates, ensuring the right care at the right time, closest to home.

More people are engaged in their care, and understand their condition. This is helped by being able to access their own personal care record.

Early support to improve health and wellbeing is paying benefits. More people are diagnosed early with their condition, and more people are successfully controlling the main risk factors. This is leading to fewer people needing emergency hospital care for conditions like heart attacks, strokes or diabetes and respiratory conditions.

Reduced need for hospital care of long-term conditions has led to more of the workforce being able to work in the community, in these neighbourhood teams. The focus on improving care and experience is leading to increased job satisfaction and wellbeing among team members.

Thriving communities

Being socially connected helps us live longer, healthier, and happier lives. But it isn't just our family ties, close friendships, or group membership that make a difference. Having connections and building networks with neighbours and the wider community helps us feel part of something and gives us a sense of belonging. Networks with community spirit and purpose can make a whole community a better place to live.

"I live on my own so for me having a job and volunteering gives me that social aspect... helping at the food bank people start to recognise you and realise they can talk to you. It improves the links people have."

100 Conversations

Having friends and social support plays an important role in increasing resilience to illness, helping recovery and improving wellbeing.

The work of the Voluntary and Community Sector (VCS) is extremely varied. It can cover wide areas of Dorset, or small villages and streets. It can offer support to everyone, or focus its work on small groups and individuals.

VCS activities can also cover all kinds of interests and needs. These can include arts, faith, culture, finance, environment, sport, social care, health, heritage, advocacy, advice, and more. The VCS works with individuals, families and communities, and people of all ages.

I've lost having structure in my day... A local charity café is desperate for volunteers so I'm thinking of doing that. Volunteering gives me a purpose."

100 Conversations

The scale and variety of organisations in the VCS offers many opportunities for them to work together, as well as with public and private sector partners. There is a strong desire in the VCS to work more closely with the public sector to meet the needs of local communities.

The community roots of the VCS bring a vital point of view to the planning and design of public sector services. This viewpoint increases the chance of successful partnership working in communities. The links between the sectors increases the support available, and improves the strength and stability of the services that are developed.

Working in partnership and building on the communities' strengths creates trust. This trust enables services to fit the local need more appropriately. Services that fit better are more efficient and economical, and meet the communities' needs more directly.

"I came here as a volunteer and a job came up, and I've been here now five years, and it was something totally different. I've never worked in a charity before. It's more fulfilling [...] Every day is different. But you also feel like you give something back to the community."

100 Conversations

Neighbourhoods play an important role in building local networks: businesses providing goods, services and employment, town and parish councils representing communities, and patient groups who provide a voice for people at GP practice level. Working together with all elements of our communities we can make a difference and improve the quality of life for everyone.

"The Dorset VCS Assembly was created in 2022. It aims to provide a point of contact and connection for the VCS, and a link to partners in the public sector. The Assembly gives space for the VCS to talk together and share ideas and issues. It also provides VCS representatives for meetings with partners, and is a contact point for engagement with those partners."

Jon Sloper – CEO, Help and Kindness

How many voluntary organisations are there? **7700**

What does the voluntary sector do in Dorset?

- **58%** Health and wellbeing
- **28%** Community development
- **23%** Social care

1 in 4 people volunteer regularly

50% of the population have volunteered at least once

% of Dorset's workforce in the VCS **15%**

Economic contribution of volunteers in Dorset is approximately **£700M**

The value of hours given by volunteers is approximately **£560M**

Total annual income of the VCS in Dorset is approximately **£640M - £940M**

Key priorities

- Invest to grow a strong network representing all our communities to help with integration challenges and design solutions with professionals
- Develop high quality spaces in the community where professionals and volunteers can work together to provide joined-up support and inclusive services

Making integration work: thriving communities

From our 100 Conversations work it is clear what keeps us well can often be found close to home. It's having family, friends and support close by. You also said that when you aren't well, it isn't just health and care services that were important.

The integrated care system provides an opportunity to really embrace what it would mean to be community driven, working in partnership with people, communities and the voluntary sector; our goals are similar.

Many of the current challenges facing communities – cost of living and access to food, mental health, loneliness and isolation – are being met with a strong community driven response with food banks and warm spaces.

In mental health prevention, formal services have realised that working directly with communities can have a much bigger reach. The Light on campaign taking action to improve men's mental health works with more than 300 local businesses, all passionate about making a difference. A small amount of funding from health services has enabled a far greater reach and impact by trusting a key community asset – our business sector.

In the very real challenge of social isolation and loneliness an innovative charity Chat Café Local has been providing the space and time for people to meet up and simply share stories, building empathy and emotional resilience. Since its launch in February, the charity has helped nearly 3,000 people. The charity is expanding with new cafés opening in Dorchester and Weymouth.

"Loneliness underpins everything – addiction, the need for support – people can start to see everyone as the enemy if they are stuck with loneliness. The only thing that heals people is letting them tell their story. We are inviting people to come and have a cup of tea and tell their story."

Anne Anderson – Founder, Chat Café Local

"Look at the work of the CAN Wellbeing Collaborative. It's so important. We connect people to personalised information and support from local charities and community services, so they can live their best possible life at home."

Karen Loftus – CEO, Community Action Network

1 year

We continue to involve communities in designing solutions to our challenges. The 100 Conversations project we started to help develop this strategy grows into an active network. People in this network are keen to help design solutions to the challenges of delivering inclusive services to all.

The integrated care partnership places great value on working with communities. We recognise they are best placed to understand challenges like poverty and loneliness, but we also know communities need help and resources to tackle these challenges.

The Voluntary and Community Sector Assembly becomes an important way to carry out this work with communities. The assembly helps us identify how to work together to tackle the challenges.

We start to identify priority areas for support, understanding what communities need to be able to deliver those services.

3 to 5 years

Integrated care in Dorset works hard to bring people and professionals together. There are more opportunities to deliver formal health services alongside volunteer support. We involve people and communities at the start of plans and projects to improve care.

When designing new care offers, we value what each partner brings. Professionals have more time to focus on clinical support. People feel better supported in their wellbeing from the voluntary and community sector.

There are new and creative ways of involving people in care and support. This even reaches people who may have never accessed support before. Working with communities has increased people's interest in their health and wellbeing.

In some areas, new health spaces are being designed with the community that offer a range of support. These wellbeing hubs focus first on what the community needs. Access to high quality health services is there when needed, as well as a range of other support.

Health and care organisations use their power as local employers to offer a route to good jobs. There is a focus to ensure this help goes to neighbourhoods most in need.

5+ years

Several community wellbeing hubs are now providing support to people and families. Local people lead and run these hubs working in partnership with professionals. Hubs provide a focus for a vibrant network of community support. They support people to keep them well and work hard to build trust. They are welcoming spaces where people feel at ease and are treated as equal partners in their care.

Councils also recognise the strengths of communities. There are more opportunities to deliver a wider range of council and health services through these hubs. More communities are running these spaces, including some libraries and community centres. People access a wide range of services, from paying council tax to getting early help for families. More support is on hand from volunteers or professionals if needed.

People working in these services know how to work with people putting them at the heart of any decisions. 'Nothing about us without us is for us,' is at the heart of this. People feel respected and trusted as equal partners. They are more willing to look for solutions in their support network first.

Building mental wellbeing

In England, one in four people will experience a mental health problem each year. One in six will experience a common mental health problem, like anxiety or depression, in any given week. The impact of the COVID-19 pandemic and uncertainties tied to the increasing cost of living could also see more people experiencing mental distress and ill health. We have high levels of hospital admissions for self-harm in 15-24 year-olds and growing numbers of those diagnosed with autism experiencing mental ill health.

In Dorset, people experiencing mental health problems may seek help through care settings like their GP surgery, local emergency department and/or local community health team. However, it can be confusing to know when and where to seek help, which can lead to involvement by the police or social services if things escalate, or for people to simply suffer in silence.

"It absolutely never crossed my mind that I would go and speak to a GP about feeling anxious or depressed. Usually with a GP I would only ever go there for physical issues."

100 Conversations

1 in 4 people will experience a mental health problem each year.

By making mental health everyone's business, Dorset ICS wants to make sure our workforce is equipped with the skills to ensure people experiencing mental ill health have access to the right level of support at the right time, and know what services are available to them.

Over recent years, we've been working to improve support for people in mental health crisis. Although we have been working on adult mental health crisis, we are still a long way away from getting this right for children and young people.

We want to place more emphasis on prevention and put local communities at the heart of what we do. We'd like to make improvements within community mental health support. We will continue to work with the community and voluntary sector and others at a neighbourhood level to build community-based buildings. We will focus on the needs of the whole person and not just their diagnosis, giving people more control over their care and recovery.

Case Study: Light on

The Light on campaign was set up by a group of like-minded Dorset business leaders to improve men's mental health and wellbeing. By working creatively and collaboratively with businesses, public services and charities, the team are building a community where people can talk more openly about mental health. Tragically, suicide is the biggest killer of men under 45, but Light on is increasing knowledge and understanding with the aim of changing that.

"Over the years, I've supported Dorset Mind and other charities due to my experiences with mental ill health and, sadly, losing friends to suicide. What became even more apparent during the pandemic was how many people were suffering in silence.

"Light on is built on the fundamental principle that we can improve people's mental health by simply talking with one another. Light on aims to create a community in Dorset where people feel confident talking and supporting better mental health and tackling the stigma around mental ill health.

"In May 2022, we launched our Business Wellbeing Summit, bringing together Dorset organisations from key sectors. Eighty-four organisations attended, pledging their support for a universal workplace wellbeing standard across the county and becoming our first-year adopters of the Light on Workplace Wellbeing guidelines.

"In 2023 we will launch our champions programme, with thirty-five people across Dorset becoming our ambassadors, sharing our ambitions across their communities. These incredible people showing their strength to create a new normal by talking about mental health."

Andy Coleman – Founder, Light on

The major highlight of Light on is the unique willingness and drive of different organisations to unite under one brand's vision to tackle mental health in Dorset. Businesses, charities, prominent individuals, local authorities, NHS services and communities are working together to amplify messaging, share best practices and, most importantly, take a united position on changing the norm around mental wellbeing.

Case Study: Jon's Story

Jon Bartlett moved to North Dorset recently and was surprised how easy it was to access the mental health support that he needed.

"Whilst I was looking forward to moving back to my home county, I was also nervous. What would the care for my mental health be like? It had taken a long time to get a good treatment regime in my old county – one which, like Dorset, was heavily skewed by a large urban area at one end and rural districts elsewhere.

"I registered at my new GP and found that the doctors had seen my records and booked time to speak with me and welcome me to their surgery, whilst checking what specialist support I might need for my mental health. I was anxious as I spoke to a new GP but they set me at my ease quickly (often tricky by phone) and outlined what they would do next and where I should look to find some community supports. By the end of the same day I had a call from the community mental health team and a couple of days later the social prescribing team had called to connect me up with local peer support groups and various activities.

"I was genuinely surprised how many groups/events were going on. There seemed to be something for everyone and certainly plenty of people ready and willing to help. We hear all the time about waiting lists and delays in mental health services and those things are undoubtedly still an issue, but the service is full of staff who care, and there are plenty of people in the community to help you on a day to day basis."

Working better together

Integrated care is about how we work better together. This means understanding how we need to work differently to implement the priorities and ambition in this strategy. Our vision is working together to deliver the best possible improvements in health and wellbeing. This section shares some insights about how we might achieve this when thinking about how our services need to change.

At a basic level, we should be moving more resources – such as money and people – to areas of health and care where needs are greatest. This could mean areas where health outcomes are not as good as the rest of the county, or health and care services that need more funding and people to provide high quality care.

For many years funding has flowed into our main health and care providers – the hospitals, our community and mental health trust and GPs. Most of the money is used to pay the salaries of the people needed to provide health and care. It can feel as if this has been organised in a way that suits how our health and care providers are used to working. We need to listen to people's experiences and understand how to change this so that care is planned and delivered around people's needs, not organisations.

How we collect and use information about you, and how we share it across our organisations, is also important to working better together. We've heard a lot from people who have not always experienced good communication when accessing health and care. We still ask people to repeat their story many times, and information about what matters to them is not always used to involve them in decisions about their care.

Alongside people and communities, our workforce will play a vital role in helping make these changes happen. We know there are shortages of key workers in parts of the health and care system, as well as more people needing to be seen, especially since services were reduced during the pandemic. When people don't have a good health and care experience, it's not because employees don't care – pressures make it hard for them to provide care to the best of their ability.

We need to share our resources where they will make the most difference, and the starting point for this has to be understanding how best to meet people's needs, not the needs of organisations. This is going to take time as it's a new way of working, but together we're confident that we can make a difference for people in Dorset.

"We've all been working in our silos. We don't know what the other [organisations] are involved in or what resources are available [in the] voluntary sector. There will be a number of projects that the council are running that we could work with, huge opportunities if we can just keep these talks going and keep people sitting around the tables"

Joint Strategic Needs Assessment

Case study: prevention built in

When waiting times grew for people needing surgery after the pandemic the local health service took a different approach. Extra clinics were needed to clear the waiting lists. These would review patients with joint problems who need orthopaedic surgery. Usually the solution would be to try to find extra space at our hospitals. But the Think Big project took the clinics to the high street in Dorchester and Poole instead. One clinic was at the former council headquarters close to the high street in Dorchester. The other was in the former Beales department store in the Dolphin Shopping Centre, Poole.

This was a chance to work in a different way. Traditional clinics would offer appointments to assess and prepare people for their surgery. At the new high street clinics, people receive advice on staying well, as well as information before their operation. Health coaches work alongside orthopaedic surgeons and physiotherapists to provide joined-up care.

The clinics have been open since April 2022. Since then health coaches have supported more than 2,790 people with advice to stay well. These were all people needing an orthopaedic operation who would not usually have such joined-up care. About six percent of these people have gone on to register for prevention help from the LiveWell Dorset service. But the most important part of this journey is the support and prompts to think about staying well.

As we develop integrated care, embedding prevention support at every opportunity will be a priority. Evidence shows that even very brief advice to be more active can lead one person in every 10 to take action. It doesn't take much time, and is a fraction of the cost of treating the consequences of not being active enough.

Key priorities

- Develop joined-up personal care plans for people at increased risk of needing more care and support
- Consider your needs at all stages when designing integrated care. This includes mental and physical health, and what you tell us matters to you

Making integration work: working better together

Evidence shows that people have better health and wellbeing if they are cared for at or close to home compared with being in hospital.

Unfortunately, when admitted to hospital, older people can lose their independence and find it harder to return home. They may also develop further health issues because of changing their regular routine. Providing care closer to home is a key ambition for integrated care. It means you should receive more responsive, suitable care for you and your situation. It also means understanding what matters to you. If we are getting it right, you'll will be able to make informed decisions and help design your own care.

This is not only good for you, it's good for our planet too. Meeting your needs closer to home helps us reach our net zero targets for climate change. In 2018 people travelling to and from hospitals across Dorset generated an estimated 15,646 tonnes of CO_2. This is the same as flying from the UK to Australia and back 2,688 times.

Our health and care system could also do more to improve health and wellbeing at an early stage. Prevention support can be effective, especially when people have a more serious health condition. When people need hospital care in Dorset, everyone is now offered support to quit smoking. And before many routine operations, people now receive lifestyle support from health coaches.

Care closer to home and prevention support at the same time as clinical care should be key ambitions for integrated care.

To get there we will need to understand how best to use data and information to help plan personal care. We also need to understand what is stopping us from working differently. Are there barriers for our workforce? How could information flow better between organisations? Can we collect information once from people, and understand their journey, making it as smooth as possible? How do we capture your needs and make this available to teams when needed? And what aspects of care and support are best carried out by the voluntary and community sector?

As people's needs increase, technology can also help to keep people well without needing lots of care. We also want to offer help to people to regain independence after a crisis, without having to go to hospital first. Offering services early can often avoid the need for hospital or more intensive care.

In Dorset we have already developed some excellent data tools to identify people with higher risks, such as being frail, at risk of falling. We know from this data who is more at risk of having a poorer outcome. This data is important in understand how well we are implementing integrated care. But we must also ask people how well they feel supported and involved in their care. Together, this information will show whether we are making a difference.

1 year

Data and insights: Data is used to understand who needs more support to achieve a good level of control of their condition. Personal plans start to look at how best to support people at an early stage who have increasing need for support. Plans put people at the heart of the care process. As well as clinical support, plans set out what matters to the person to keep them well. This approach supports the growing partnership between voluntary sector services and health and care services. Volunteers and community organisations may be best placed to offer non-clinical support. Prevention and wellbeing support is on hand.

Experience: People feel valued and better supported. Personal care plans are clear in setting out their wishes. Professionals involved in their care can access these records out of working hours. There is increasing choice of ways to support people living at home who are starting to need more support. Technology is being used to support more people to remain at home. Urgent response teams are on hand to resolve any support issues around the clock.

Outcomes: Personal care records help to reduce the number of older people who need hospital care, especially out of hours. Fewer people have extended hospital stays, risking loss of independence. Care needs are increasingly met in a planned way, involving the person and their family or carer.

3 to 5 years

Workforce: Home care services can focus on person-centred care due to more investment. People value the importance of care closer to home. Our workforce are valued and motivated.

Organisations have worked hard to reduce differences in how we recruit, train and pay employees. Lower cost housing for key workers developed through a joined-up approach.

People can move easily between health and social care roles. There is more flexibility, as people work closer to where care is most needed.

There has been a shift in the focus of newer health and care roles in the system. The focus is on developing support for integrated neighbourhood teams.

Services are in the community as well as in hospital to help people stay independent. Following a hospital stay people get the help they need to stay well at home. Fewer people are in hospital who would be better cared for in the community. This has reduced pressure on hospitals and ambulance services. More investment in neighbourhood teams reduces this demand. People in frontline health and care roles have time to listen and consider people's wider needs. Improvements in quality and how well supported people feel. Our workforce feel supported to do the best they can for people.

5+ years

Services are better connected than ever before. Information and communication has improved by putting people at the centre of decisions. Professionals can access instant information about any stage of people's journey. This improves people's experience, but also reduces waste and inefficiency.

There has been a sustained focus on understanding customer journeys. Working with and listening to the experiences of people using our health and care system has been key to this.

This has been used to better understand how to make the experience seamless, compassionate and considerate. Organisations work hard to make sure customer needs are put first. It is easy to understand where people are in their care journey and what they can expect next. Communication, engagement and trust has improved over the past few years due to this concerted focus. And with this, there is clear evidence that people are more engaged with their care. There are fewer missed appointments, and more people acting on what they need to do to stay well or recover. The partnership between professionals and the voluntary sector is stronger than ever. Community teams often include people with lived experience, peer expertise and coaching skills to help people feel they have the right level of support to stay well.

Falls and frailty

In Dorset, there are nearly 10,000 people aged 65 or more with a moderate or high risk of falling within the next year.

A high percentage of falls that happen in the community or at home will require an ambulance to attend, and many will require a stay in hospital due to an injury.

A lot of falls will result in a hip fracture which reduces a person's independence and life expectancy. Research shows that 20% of people who sustain a hip fracture are likely to die within a year of their injury.

You are also 12% more likely to be admitted as an emergency for a fractured hip from a fall if you are over 65 and live in the BCP Council area compared with the national average.

We need to recognise frailty conditions much earlier. Across our organisations there are lots of opportunities for us to intervene and prevent these falls from happening.

Dorset & Wiltshire Fire and Rescue Service work with other agencies to offer support and advice in a variety of different areas. This targeted engagement with a vulnerable group within the community is a good example of partner collaboration by linking the fire service with areas that have identified people at medium to high risk of a fall.

During 2021/22 4,441 Safe and Well visits were completed in Dorset. Of those 2,293 were in the BCP Council area and 2,148 in the Dorset Council area.

"Our Safe and Well visits are designed to provide appropriate advice and support to residents so they can remain safe in their own homes. The free visit covers a variety of areas including fire safety, slips, trips and falls and the ability for us to recommend or refer to other ICS partners, resulting in £5.31 of societal benefit for every £1 invested."

Marc House – Head of Prevention, Dorset & Wiltshire Fire and Rescue Service

Case Study: Primary care working in partnership with Dorset Healthcare and BCP Council

The team works to support people with a degree of frailty who are at risk of hospital admission. They provide early support with the aim of keeping people living as independently as possible and in their own homes.

The aim is to help people manage their long-term conditions and to look at future care needs before they become urgent.

"Working with others, such as the voluntary sector, means we can help address issues of social isolation and loneliness. We can also link with other support, such as mental health services, so support can be put in place quickly when it's needed."

Frailty team, North Bournemouth

Case Study: Anticipatory Care team

A highly innovative Falls Buddy scheme has been set up by the Blackmore Vale Partnership. The aim of the scheme is to reduce social isolation, reduce the risk of falls, and encourage vulnerable adults to engage with social activities in their local community.

The service aims to promote independence and is offered to people at a lower risk of falls and targeted to those living alone. Support is given for 8-12 weeks and focuses on maintaining mobility, functional strength, and balance as well as social confidence.

"As a result of participating in the Altogether Better initiative, Blackmore Vale Partnership has worked collaboratively with volunteer Health Champions for several years. This experience continues to demonstrate the importance to wellbeing of feeling connected to your local community. Volunteers are trained by a Community Rehabilitation Team physiotherapist and support people with exercises linked to regular social activity. The feedback so far suggests that the scheme can be equally beneficial to the volunteer as it is to the person they are 'buddied' with."

Keith Harrison, wellbeing team lead

In the last year...

1,389 people were admitted to hospital due to a fall

1,238 calls to 999 related to a fall

1,300 fall related calls from Dorset care homes

1,346 emergency department admissions for hip and femur fractures of which 1,163 were for people aged 65+

05 Where we are headed

People and communities

In Dorset we have a range of ways to engage with you. Healthwatch Dorset, young listeners, the voluntary sector and patient experiences all gather information that helps make decisions about health and care services.

Having a 'continuous conversation' with these groups is important if we want to get the best health outcomes for people in Dorset. It ensures that your voices are heard when we are planning services and gives us the ability to feed back to communities with 'you said, we did'.

We want to practically support the other things that can have an impact of our day-to-day lives – things like family, friends, work, community activities, the environment, and where we live.

We want to have honest conversations about what we can and can't deliver, and to start those conversations with you as early as possible. If we have to stop doing things, we'll be clear about why.

By putting people and communities at the heart of everything we do, we can move away from 'them and us' culture to work in a more 'all of us' culture as people of Dorset.

We are:

- working together with people and communities
- listening more so we can learn by trying to understand your lived experiences
- seeking out people we don't usually reach, giving them the chance to share what they think and to work with us
- making sure we carry out 'equality impact assessments' – these make sure we're thinking about everyone in Dorset
- looking at how we check the impact of working together with local people and communities.

Although talking with people and communities isn't a new concept, we want to do things differently to how we've done them in the past.

To truly reflect the voice of our communities, we've been gathering stories about the lives of over 100 people living across the county through the 100 Conversations project. Working with industry experts The Point of Care Foundation we have trained over 45 interviewers from a range of backgrounds to have a conversation with people from all walks of life in Dorset, including people from deprived communities, minority communities and disability groups. We will reflect on what we've heard from people to make sure we've got it right.

A lot of what you've read in this strategy has come directly from the people and communities that live in Dorset. The engagement we've started through the 100 Conversations project will continue at an even more local level as we look to understand people's priorities in what we need to do, how to do it, and who to work with to provide services that are built to last.

"I felt privileged, and a bit in awe actually, of the people I've interviewed so far. Their journeys have been quite powerful to listen to.

"I have great anticipation that this will enable us to understand our communities better, and I hope that we can continue to listen on an ongoing basis to as many people as want to share their experiences as possible."

100 Conversations interviewer

Next steps

Creating this strategy has followed a different process from the start. When speaking with system leaders, there was a sense that previous high level 'system' strategies tend to be ignored. This is because they are often non-specific, not built through engagement and ownership, and reflect a long list of national priorities, often framed as negatives.

We have tried to take a different approach by engaging continuously with our leaders, organisations, public and employees throughout the past 11 months. The work is not yet complete, but the interim strategy presented here is a good start.

The next phase is just as important. We want a live, clearly focused strategy that is developed and written through the results of that engagement. It needs to reflect what people and organisations are saying, and develop real ownership and desire to now co-design the solutions and innovative work that will lead to lasting change.

If we get this right, we will have a strong evidence base to guide how integration should develop over the next few years.

This includes:

- understanding what people say gets in the way of them living as healthily as possible, and how we can support
- how we build on assets and strengths in focusing on improving people's resilience, and providing earlier support
- being clear where working together as a local system can reduce inequalities in health and improve social determinants of health and wellbeing
- ensuring we can identify necessary changes, measure and report back on improvements in people's access, experience and outcomes from health and care.

The next steps in the strategy development process should consider the following issues, and ensure they are captured in an ongoing development programme:

- Continue employee engagement to understand how organisations can support their teams to put you at the heart of care and improve workplace wellbeing
- Ensure clinical and care professional leadership is aligned with this ICP strategy, and that there are strong links to the clinical strategy
- Understand how to reduce duplication in plans and strategies. Make sure there is better alignment and understanding in our system of agreed priorities, from the ICP strategy through to health and wellbeing strategies and place-based commissioning
- Involve people in setting and reviewing priorities, and progress in meeting them
- Consider what issues should be driven by the integrated care partnership, and what can be driven by places and neighbourhoods
- Deepen the engagement with residents by exploring the main themes raised – use these to guide our co-production approach when starting to develop solutions
- Ensure the ICP strategy process embeds the legal requirement to tackle inequalities in health, and promote equity of access and outcomes for all residents. Once published, we intend to develop a programme of workshops to assess whether the priorities and recommendations will help achieve the equity and equality ambitions
- In time develop a consistent method of equality impact assessment, to support the equality delivery system in the NHS and for wider public services.

Your voice

Your voice matters to us and we want to listen to what you have to say. We want to make it easy for you to get involved and give us your views. There are many opportunities to have your say and influence local health, care and wellbeing decisions. We want to be inspired by you, and empower you to help us improve health and care services for the better.

We want to help everyone live longer, happier and healthier lives. This work starts with people and communities in Dorset; putting people, patients and carers in the driving seat. Together, we can make things better.

Visit www.ourdorset.org.uk/100

December 2022
Publish strategy, supporting evidence and start digital engagement on the 100 Conversations themes

March 2023
Publish NHS Dorset's Forward Plan – showing clear links to the strategy recommendations; develop a shared outcome framework based on the strategy

May 2023
Review Health and Wellbeing Board strategies for each place to ensure alignment with ICP strategy

October – November 2023
Strategy review and refresh process

December 2023
Public feedback on progress

04 Supporting information

Population

National

Life expectancy is how long you can expect to live, on average, if you were born today. It has slowed to a stop in the past 10 years after going up for the previous four decades. Rising food, energy and housing costs and low wages all count towards this fall in the health of our society.

While employment rates are rising, wage growth is low and not distributed equally.

Child poverty rates are increasing. Disadvantaged children are not doing as well at school as their more affluent peers. Both of these factors affect long term health outcomes.

After the pandemic fewer people were physically active. More adults report drinking at harmful levels in the past two years, and deaths from liver disease rose.

People report more work-related stress, anxiety and depression since the pandemic. More children and young people have mental health disorders compared with pre-pandemic years.

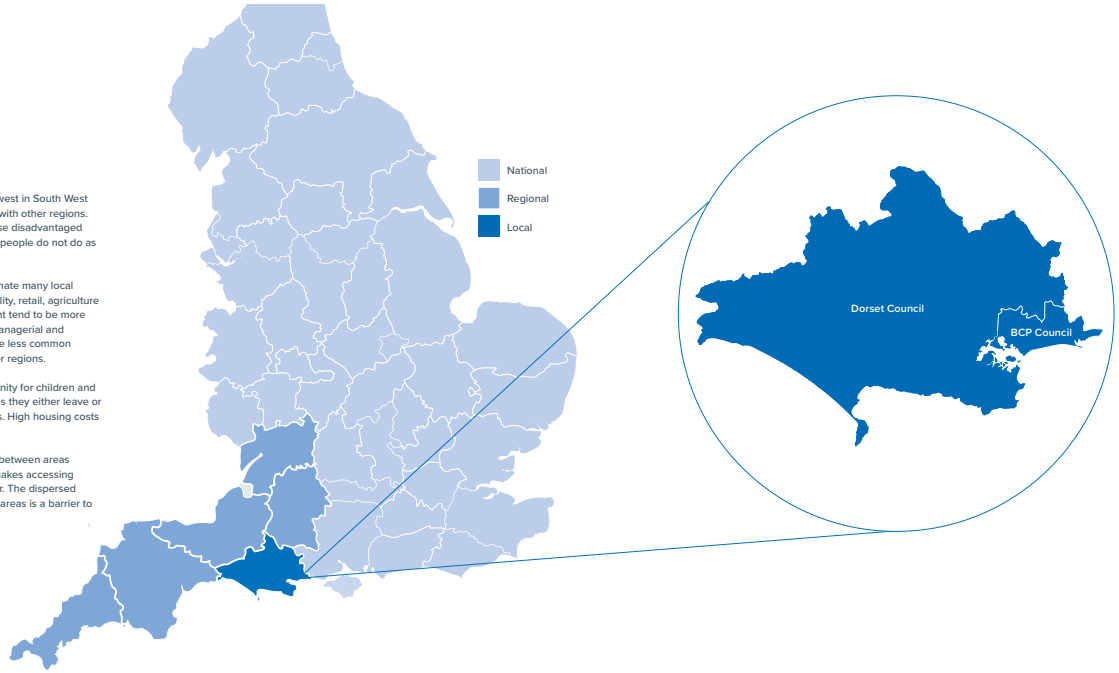
Regional

Social mobility is lowest in South West England compared with other regions. This is partly because disadvantaged children and young people do not do as well at school.

Low paid jobs dominate many local economies. Hospitality, retail, agriculture and self-employment tend to be more common sectors. Managerial and professional jobs are less common compared with other regions.

This lack of opportunity for children and young people means they either leave or stay in low paid jobs. High housing costs make this worse.

Lack of connection between areas in the South West makes accessing opportunities harder. The dispersed population of many areas is a barrier to inward investment.



Local

Across BCP Council and Dorset Council areas we have good health outcomes compared with England, but variations in health are due to inequality, and this affects length and quality of life at all ages.

Children and young people

From before birth to age three access to services that support parent and infant health vary. Take up of early maternity services could be higher.

There are a growing number of children with complex needs and children and young people with special educational needs. These needs have a long-lasting impact on their lives.

Readiness for school varies due to level of disadvantage. Support for early speech and language development is critical. Improved access to dentistry and oral health in early years is important.

Emotional health and wellbeing support at an early stage is a real need. Late diagnosed mental health disorders affect children's outcomes for many years. Things that can help us cope better can stop issues getting worse.

Working age adults

Unhealthy behaviours like smoking and harmful alcohol use are more common in disadvantaged areas. Putting the right things in place to help people change is vital.

Support for mental health and wellbeing could be better by focusing on early support in the community. Building capacity for suicide-safer communities could be key.

There is unacceptable variation in outcomes for people with long-term conditions, and we need to close the gap. Taking a person-centred approach will help us find what will work best.

Being more active and maintaining a healthy weight will improve healthy life expectancy and mental wellbeing.

Healthy ageing

Mobility, risk of falling and frailty are all key determinants of health in later life. By assessing risks, supporting people earlier, and fostering independence we can make big improvements.

Social isolation and a lack of access to digital services are important issues to local people. Dorset volunteers provide vital services helping maintain older people's independence for longer.

Prevention and early help

How long people live varies depending on if they live in deprived or less deprived areas. Poverty affects people's wellbeing, health and opportunities. It can affect how long someone lives. This can include not having enough money for food, clothes and other basic needs. Poverty is one aspect of inequality, and also one of its effects. People in Dorset come from all walks of life. Some find it harder to find information, and to get care and treatment. This includes groups that face health inequalities because of age, disability, race, sexual orientation or ethnicity.

"The more people are connected to others, the more likely they are to look after themselves."

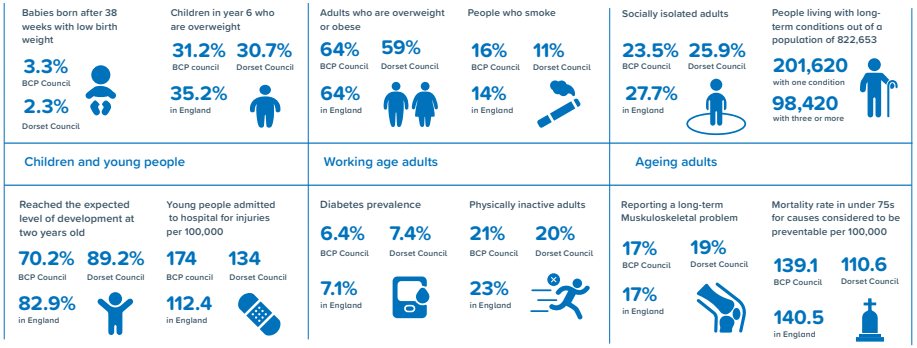
100 Conversations

Health inequalities are the unfair and avoidable differences in people's health. These often exist across social groups and between different populations. In Dorset generally we are healthier and live for longer compared to England. But that headline figure hides as much as it shows. There is roughly 10 years difference in life expectancy between the most and least deprived areas. This is the case for both men and women.

Life expectancy is an important measure of population health, alongside healthy life expectancy. Life expectancy has increased steadily but has now stalled. Time lived in poor health is increasing for both men and women. Our population is living longer but spends a greater proportion of life in poor health. Higher deprivation is linked with spending more time living in ill health. Someone living in a deprived area is likely to be living with a disability before the state pension age. Only the 20-30% least deprived (in England) get their state pension before developing a disability.

People who live in affluent areas live longer than those who live in more deprived areas. The number of years difference in their life expectancy are:

8.9 years between BCP males	**6.1 years** between BCP females
5.3 years between Dorset males	**5.3 years** between Dorset females



Thriving communities

There are many factors that go into making up each person's health and wellbeing. The communities we live in impact on our physical and mental health. We can group some of these factors together to look at:

- the place and environment we live in, education and learning where we are
- opportunities for work and the local economy
- whether people feel a part of a community and get involved.

Everyone has different individual personal circumstances and experiences. Sometimes groups of people have a worse experience because of the way our society works.

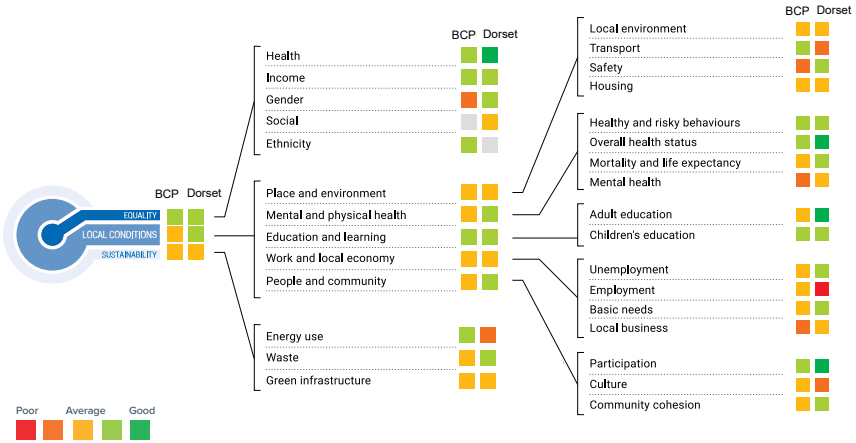
Sometimes the way society works creates problems for the future. If we only think about the current economic impacts of what we do, then this will continue to be a problem. So, we need new ways of thinking and new measures to ensure future generations have what they need to live well.

The thriving places index brings these ideas together to show how well places do this.

The index helps to answer three important questions. Are we creating the right local conditions for you to thrive? Are we doing that fairly, so everyone can thrive, and are we doing that sustainably, so current and future generations can thrive?

A thriving place provides the conditions for everyone to find good work, feel supported, live healthily, and have their needs met fairly, both now and in the future.

By looking at this we can see what we are doing well and where we can make things better.



Working better together

Understanding how and when care and support should be provided differently is important. By looking at this, we can begin to change so that everyone can have better access to services, outcomes, and experience of health and care. We can only do this by working with you and your communities.

There are many challenges. More people need health and care support following the delays to treatment caused by the pandemic. Too many of us still end up in hospital and are not supported quickly enough to return home independently. The cost of living puts pressure on communities, and damages health and wellbeing.

Public finance constraints mean our organisations have fewer resources to respond. Attracting people to work in vital frontline roles, whether in the NHS or social care, has been challenging for some time, and there are shortages of clinical roles, such as GPs, in our system, for which there are no short-term fixes.

Finance

Overall system budget: **£2.2B**

For every £100 spent, this is used:

- **£38** on hospitals and ambulances
- **£17** on primary care and community services through the NHS
- **£13** on adult social care through the councils with some NHS joint funding
- **£7** on mental health and learning disabilities through the NHS
- **£6** on children's services including education
- **£8** on other NHS commissioning
- **£6** on other council services including bins, street cleaning and libraries
- **£4** on supporting services and central functions including transformation
- **£1** on public health services including prevention

Performance

Overall inspection ratings from CQC and Ofsted (excluding schools):

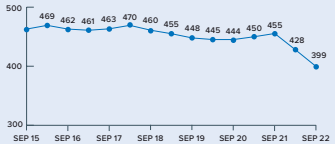
23	349	33	5	5
Outstanding	Good	Requires improvement	Inadequate*	Not yet inspected**

Workforce

Overall workforce (full time staff):

17,077 NHS Trusts	**2,285** Primary care	**3,928** Dorset Council
3,971 BCP Council	**446** NHS Dorset	**23,000** Voluntary and community sector

Dorset GP workforce: (full time staff):



*Following an inadequate rating, the organisation has a turnaround period. Inspectors will return in six months expecting to see improvements. The inspectors can sometimes take urgent enforcement action if appropriate.

**These are new services, usually smaller children's homes.

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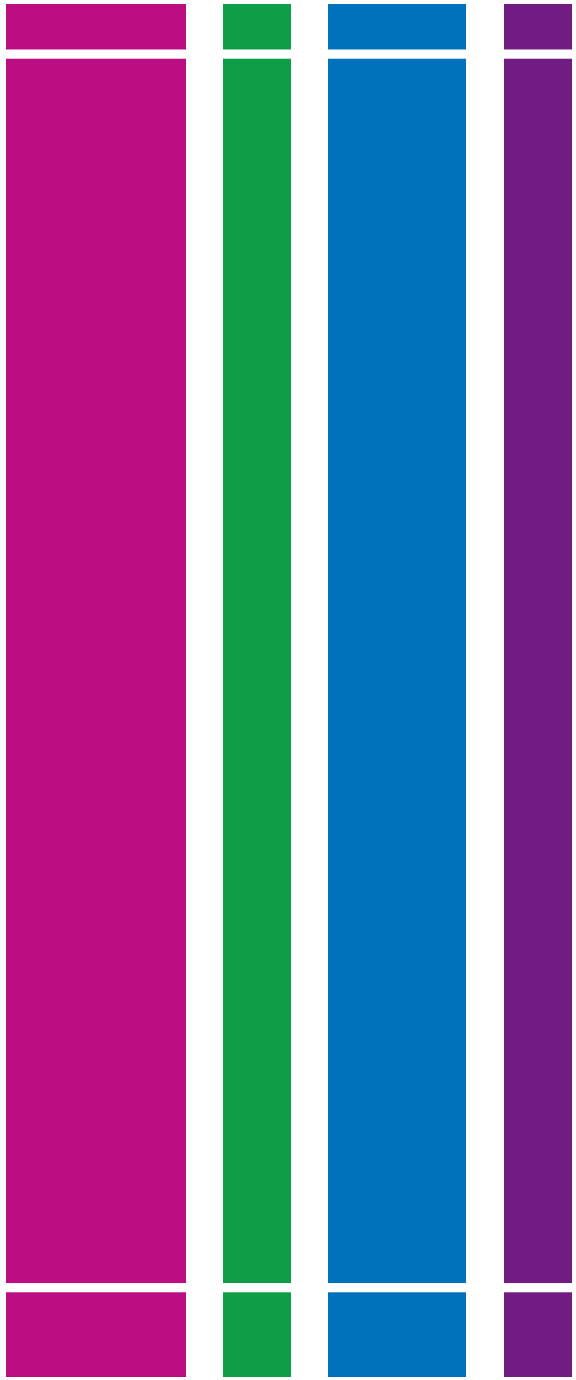

For more information on health and care plans in Dorset, and how to get involved, visit
www.ourdorset.org.uk

NHS DORSET INTEGRATED CARE BOARD
ICB BOARD
THURSDAY 3 NOVEMBER 2022
MINUTES

A meeting of the ICB Board was held at 10am on Thursday 3 November 2022 in the Board Room at Vespasian House, Barrack Road, Dorchester, DT1 1TG

Members Present:		
	Jenni Douglas-Todd (JDT)	ICB Chair
	John Beswick (JB) (virtual)	ICB Non-Executive Member
	Cecilia Bufton (CB)	ICB Non-Executive Member
	Jonathon Carr- Brown (JCB) (virtual)	ICB Non-Executive Member
	Dawn Dawson (DD)	Acting Chief Executive Dorset Healthcare NHS Foundation Trust and ICB NHS Provider Trust Partner Member
	Spencer Flower (SF)	Leader Dorset Council and ICB Local Authority Partner Member (West)
	Siobhan Harrington (SH)	Chief Executive University Hospitals Dorset NHS Foundation Trust and ICB NHS Provider Trust Partner Member
	Paul Johnson (PJ)	ICB Chief Medical Officer
	Drew Mellor (DM)	Leader Bournemouth, Christchurch and Poole Council and ICB Local Authority Partner Member (East)
	Patricia Miller (PM)	ICB Chief Executive
	Rob Morgan (RM)	ICB Chief Finance Officer
	Ben Sharland (BS)	Primary Care Partner Member
	Debbie Simmons (DSi)	ICB Chief Nursing Officer
	Kay Taylor (KT)	ICB Non-Executive Member
	Dan Worsley (DW)	ICB Non-Executive Member
	Simone Yule (SY) (Virtual)	Primary Care Partner Member
Invited Participants Present:		
	Neil Bacon (NB)	ICB Chief Strategy and Transformation Officer
	Louise Bate (LBa) (virtual)	Manager, Dorset Healthwatch
	Graham Farrant (GF) (virtual)	Chief Executive, Bournemouth, Christchurch and Poole Council
	David Freeman (DF)	ICB Chief Commissioning Officer
	Dawn Harvey (DH)	ICB Chief People Officer
	Leesa Harwood, (LH)	ICB Associate Non-Executive Member
	Nick Johnson (NJ) (virtual)	Interim Chief Executive Officer, Dorset County Hospital NHS Foundation Trust
	Matt Prosser (MP)	Chief Executive, Dorset Council
	Stephen Slough (SS)	ICB Chief Digital Information Officer
	Dean Spencer (DSp)	ICB Chief Operating Officer
In attendance:		
	Liz Beardsall (LB) (minutes)	ICB Company Secretary

	Sam Best (SB) (observing)	ICB Principal Lead for Children and Young People
	Tim Bossenger (TB) (virtual – item 6)	Head of Recruitment and Resourcing, Dorset HealthCare NHS Foundation Trust
	Gaurika Kapoor (GK) (observing)	Deputy General Manager for Cancer Care, University Hospitals Dorset
	Natalie Violet	Business Manager to the ICB Chief Executive
Public:		
	10 members of the public via Livestream	
Apologies:		
	Sam Crowe (SC)	Director of Public Health Dorset
	Manish Tayal (MT)	ICB Interim Non-Executive Member

1. Apologies

The Chair welcomed everyone present to the meeting, especially Liz Beardsall, Ben Sharland and Debbie Simmons who were attending for their first meeting of the ICB Board.

2. Quorum

It was agreed that the meeting was quorate and could proceed.

3. Declarations of Interest

There were no declarations of interest made in relation to items on the agenda.

4. Minutes

The Part 1 minutes of the meeting held on 1 September 2022 were approved as a true and accurate record subject to clarification by the ICB Chief Finance Officer (ICB-CFO) of minute 9.3.6 regarding adult and children social care funding, which would be provided outside the meeting.

ACTION: RM

Resolved: the Board approved the minutes of the Part 1 meeting held on 1 September 2022 subject to inclusion of the clarification above.

5. Matters Arising

It was noted that all actions were complete as detailed in the previously circulated report.

The Board requested that future actions were presented as an actions log, rather than a matters arising report.

ACTION: LB

Resolved: The Board noted the report matters arising from the Part 1 minutes of the meeting held on 1 September 2022.

6. Patient Story – Nurses from Overseas

The ICB Chief Nursing Officer (ICB-CNO) introduced the patient story video from some of the system partners' overseas recruits regarding their experiences.

The interviews highlighted the issues overseas recruits faced regarding administration, including visa and bank account applications for those who were recruited outside an international recruitment programme, as well as accommodation and transport issues in Dorset. The recent work undertaken by Dorset County Hospital (DCH) and Dorset HealthCare (DHC) was noted, including the dedicated pastoral support for recruits from overseas.

The Board discussed the issues raised in the story. It was noted that significant work had already been undertaken to improve the support available to overseas recruits and additional work was underway regarding some of the challenges raised including:

- a planned round-table discussion with local authority partners regarding housing
- listening events at University Hospitals Dorset (UHD) and a review of their race equality strategy.

Other aspects which needed to be addressed included:

- broader cultural aspects, including greater recognition of individual's skills and the value of overseas training, providing better progression opportunities and maximizing overseas recruits' experience to improve services and challenge how the NHS works
- reciprocal arrangements so that domestic recruits could experience and learn from other health services
- how the system could give back to home countries who were losing staff to the NHS
- an integrated support package for overseas recruits across Dorset, including all sectors not just NHS staff
- a common approach to induction
- the possibility of establishing the system as a Certificate of Eligibility for Specialist Registration (CESR) academy, which would increase the ICS's reputation internationally.

It was noted that the system workforce approach and priorities would form part of the system People Plan, although practical steps could be taken now to help improve the experience of overseas recruits. The Board asked the ICB Chief Executive (ICB-CEO) and Chief People Officer (ICB-CPO) to bring a programme of action to the Board, regarding both immediate actions that could be taken and longer-term plans.

ACTION: DH/PM

Resolved: the Board noted the patient story.

7. Chief Executive Officer's Report

The ICB-CEO introduced the previously circulated Chief Executive Officer's Report which was taken as read. It summarized the key strategic developments across the NHS and within Dorset, and reflections on how the system was performing and the key areas of focus. The key issues were:

- the appointments of a new Prime Minister and Secretary of State for Health and Social Care, since the report was written
- the commencement of the COVID Inquiry
- the publication of the National Audit Office report regarding the introduction of Integrated Care Systems
- the publication of the NHS England Operating Framework, and the resulting work on the system operating framework and priorities

- work which was underway on the Integrated Care Partnership strategy
- work that was underway with the Integrated Care Board (ICB) executive team and Pricewaterhouse Coopers (PwC) to develop Place, and the need for conversations between the ICB and local authority partners to ensure Place was ready for mobilisation in April
- winter pressures and the need to mobilise out of hospital models quickly.

The Board welcomed the updates from partners in the report and requested that future reports contained an update from primary care as well.

ACTION: NV

The Joint CEO and Joint Chair appointments between DHC and DCH were noted. The Board asked that background information and a summary on progress to date was circulated.

ACTION: DD

The Board discussed the operational pressures on the system and the need for prioritisation, the importance of the out-of-hospital work, and the need for an understanding of where capacity was available in the system.

Consideration was given to the need for a dynamic system risk assessment which linked to live data. The Board requested partners work with the ICB-CNO, in conjunction with the ICB Chief Operating Officer (ICB-COO), to agree what this would look like.

ACTION: Partners, DSi, DSp

Upcoming pilots for Provider Collaboratives and a National Care Leavers Covenant were noted. These would be considered further by the ICB executive team.

ACTION: ICB Executives

The Chair thanked the ICB-CEO for her report.

Resolved: the Board noted the Chief Executive Officer's report.

8. Items for Decision

8.1 Committee Terms of Reference and Work Plans

The Company Secretary introduced the revised committee Terms of Reference (ToRs) and work plans which were circulated in the meeting papers along with details of the review process.

The ToRs and work plans had been approved by the relevant committees in October, and both would be reviewed again as part of the year-end review, to reflect the strategic objectives and enabling plans. The Quality and Safety Committee and Risk and Audit Committee work plans were to follow.

The ToRs and workplans were approved, subject to the correction of Director of Nursing/Medical Director to Chief Nursing Officer/Chief Medical Officer in the Clinical Commissioning Committee ToRs.

ACTION: LB

Resolved: the Board approved the committee Terms of Reference and Work Plans.

9. Items for Noting

9.1 Quality Report

The ICB-CNO introduced the previously circulated Quality Report highlighting the key quality issues in the system. Key items included:

- ambulance handover delays and the resulting impact on patient safety
- delays to completion of Initial Health Assessments
- positive initial feedback from the Care Quality Commission's Section 117 inspection
- the publication of the 'Reading the Signals: Maternity and Neonatal Services Report' into maternity and neonatal services at East Kent Hospitals University NHS Foundation Trust. Four areas for action were identified: monitoring, compassionate and kind care, teamwork and organisational behaviour. The Local Maternity and Neonatal System (LMNS) was reviewing the report and would provide an assurance report addressing these areas, alongside those arising from the Ockenden Report. NHS England were developing a combined national delivery plan on these action areas, and the ICB were looking to strengthen its leadership of maternity in the Dorset system.

The format of the Quality Report would be revised for future meetings, focusing on escalations and providing detail on the implications of the data and resulting actions. These proposed changes were welcomed by the Board.

Resolved: the Board noted the Quality Report.

9.2 Performance Report

The ICB-COO introduced the previously circulated Performance Report detailing operational performance in the Dorset health system. The report had been reduced in length from previous iterations and would be moving to a dashboard approach in future, which was welcomed by the Board. Key items included:

- for elective care: progress on reducing long waiters and the risk related to delivery of these plans due to winter and emergency care pressures
- for emergency care: increasing category two ambulance response times, continuing challenges relating to delayed ambulance handovers, and the upcoming Winter Improvement Collaborative
- for cancer services: treatment times were positive but there remained some delays in the diagnosis pathway. Work was ongoing to address this.

The Board requested that the ICB-COO worked with the ICB Chief Commissioning Officer (ICB-CCO) on the development of relevant and appropriate Key Performance Indicators (KPIs) for primary care, noting that increased standardisation in primary care would be required to make comparison of data possible.

ACTION: DSp, DF

The Board discussed the importance of harm reviews and noted the good work done regarding these by the South Western Ambulance Service and University Hospitals Dorset (UHD). Consideration was given to the need for a holistic approach to winter pressures encompassing prevention and admission avoidance in addition to discharge.

Resolved: the Board noted the Performance Report.

9.3 Finance Report

9.3.1 The ICB Chief Finance Officer (ICB-CFO) introduced the previously circulated Finance Report, which outlined the financial performance of the system as at August 2022 (month 5). The ICS was reporting a deficit of £14.0 million against a breakeven plan, with NHS Dorset and the two acute providers reporting deficits. Since the report was written, cost pressures had increased notably driven by agency spend, prescribing and Personal Health Commissioning. The system has committed to continuing to deliver a balanced plan and this would be reviewed again in month 7.

No questions were raised by the Board in relation to the report. The Finance and Performance Committee reported that in addition to the cost drivers above, it had also discussed the risks around Cost Improvement Programme (CIP) slippage.

Resolved: the Board noted the Finance report.

9.4 Quality Assurance of Mental Health and Learning Disabilities Inpatient Services

The ICB-CNO and ICB-CCO introduced the previously circulated Quality Assurance of Mental Health and Learning Disabilities Inpatient Services Report. The report was in response to the letter from the National Director for Mental Health to all mental health, learning disability and autism providers following a BBC Panorama report regarding patient abuse and organisational culture.

The Acting Chief Executive Dorset Healthcare NHS Foundation Trust provided an overview of the report. A root and branch review had been undertaken, providing good internal assurance, and a gap analysis was also underway. Measures in place included independent clinical reviews, regular unannounced Care Quality Commission (CQC) visits, independent mental health advocates, engagement with people with lived experience and the Freedom to Speak Up process.

It was suggested that non-executive directors were invited to attend the ICB's quality assurance visits, and that outcomes of the visits should be added to the Quality and Safety Committee workplan.

ACTION: DSi, LB

Consideration was given to the need for assurance on these issues beyond that which a narrative report could provide and the Board requested a possible deep dive was added to the forward plan.

ACTION: LB

Resolved: the Board noted the Quality Assurance of Mental Health and Learning Disabilities Inpatient Services.

9.5 Reading the Signals: Maternity and Neonatal Services

The ICB-CNO confirmed that this has been covered as a verbal update under the Quality Report (item 9.1) above.

Resolved: the ICB Board noted the verbal update on maternity and neonatal services provided under item 9.1.

10. Items for Consent

There were no items for consent.

11. Public Questions

The following question was received from a member of the public:

Payment Scheme

NHS England is currently running engagements on the new Payment Scheme and intends to begin consulting on the Scheme in October / November. According to the engagement session on 2023 finance and payment, NHS England "don't believe a variable payment linked to any acute non-elective activity would be appropriate, given the aims to reduce this demand where possible."

a) do the ICB agree that there should be no variable payment linked to any acute non-elective activity?

b) if so, how do the ICB propose to fund acute non-elective care for patients diagnosed with cancer, heart disease, stroke, or other life-threatening illness if the Fixed element for acute non-elective care is used up before the end of the financial year?

c) if not, do the ICB intend to object formally to any such proposal during the consultations on the Payment Scheme?

d) do the ICB agree that the inability of an NHS organisation to keep the cost of acute non-elective activity below a financial target in the Plan may indicate a problem with the target and/or the Plan and/or the forecasting model on which they are based?

The Chair provided the following response:

We are aware that the Payment Mechanisms for 2023/24 are being developed and we are keen to understand the proposals fully and engage with the consultation process when this is issued. Whilst we understand and agree with the rationale for the potential to move back to a tariff-based payment for elective activity and for not doing so for non-elective activity; we are keen to understand the wider payment structure given the risks inherent with this approach. Specifically, the impact that increases in non-elective activity, and the delays in safely discharging patients from acute hospitals has on a provider's ability to deliver elective activity. Only once we have understood and considered the impact of the whole package, will we be able to formulate our response.

12. Any Other Business

There was no further business.

13. Date and Time of Next Meeting

The next meeting of the ICB Board would be held on Thursday 5 January 2023 at 10am, in the Boardroom, Vespasian House, Barrack Road, Dorchester, Dorset DT1 1TG

14. Exclusion of the Public

The Board resolved that representatives of the press and other members of the public, be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity of which would be prejudicial to the public interest.

The Chair introduced the HSJ nominees, who were joining the Board for lunch to celebrate their nominations. The Board welcomed the nominees for the Digitising Patient Care Award, Integrated Care System of the Year: Dorset ICS Medical Examiner Programme and Think Big; Performance Recovery Award: Think Big; and Using Data to Connect Services Award: Transforming COPD.

Signed by: 

Jenni Douglas-Todd, ICB Chair

Date: 05 January 2023