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 **29th March 2023** at **8.30 am to 12.10pm** at **Board Room, Trust Headquarters** and via **MS Teams.**

The agenda is as set out below.

Yours sincerely

Mark Addison
Trust Chair

AGENDA

1.	**Staff Story**	Presentation	Emma Hallett	Note	8.30-08.55
2.	**FORMALITIES** to declare the meeting open.	Verbal	Mark Addison Trust Chair	Note	08.55-9.00
	a) Apologies for Absence: Jo Howarth	Verbal	Mark Addison	Note	
	b) Conflicts of Interests	Verbal	Mark Addison	Note	
	c) Minutes of the Meeting dated 25th January 2023	Enclosure	Mark Addison	Approve	
	d) Matters Arising: Action Log	Enclosure	Mark Addison	Approve	
3.	**CEO Update**	Enclosure	Nick Johnson	Note	9.00-9.15
4.	**Balanced Scorecard**	Enclosure	Nick Johnson	Note	9.15-9.25
5.	**Board Sub-Committee Escalation Reports** (Feb 2023 and March 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	9.25-9.55
6.	**Gender Pay Gap Report** (March PCC)	Enclosure	Catherine Youers	Approve	9.55-10.05
Coffee Break 10.05-10.20					
7.	**Board Assurance Framework and Corporate Risk Register** (March RAC)	Enclosure	Paul Lewis Phil Davis Mandy Ford	Approve	10.20-10.30
8.	**Staff Opinion Survey Results** (March PCC)	Enclosure	Emma Hallett	Approve	10.30-10.50

9.	**Learning from Deaths Q3 report** (February QC)	Enclosure	Alastair Hutchison	Approve	10.50-11.00
10.	**CQC Report and Action Plan** (March QC)	Enclosure	Jo Howarth	Note	11.00-11.10
11.	**Maternity Update** (March QC)	Enclosure	Jo Howarth Jo Hartley	Note	11.10-11.20
12.	**Guardian of Safe Working Hours Quarterly Report** (March PCC)	Enclosure	Kyle Mitchell	Note	11.20-11.40
13.	**Committee Effectiveness Review** • Committee Terms of Reference • Annual Work Plans (March RAC)	Enclosures	Trevor Hughes	Approve	11.40-11.50
14.	**Well Led Action Plan Update**	Enclosure	Nick Johnson	Note	11.50-12.00
15.	**Questions from the Public**	Verbal	Mark Addison	Note	12.00-12.05
	CONSENT SECTION				All items 12.05-12.10
	The following items are to be taken without discussion unless any Board Member requests prior to the meeting that any be removed from the consent section for further discussion.				
16.	**Gifts and Hospitality Register and Register of Interests** (March RAC)	Enclosure	Trevor Hughes	Note	-
17.	**Going Concern Statement** (March RAC)	Enclosure	Chris Hearn	Approve	-
18.	**Charity Business Plan**	Enclosure	Simon Pearson	Approve	
19.	**ICB Board Minutes Part 1** (Standing Item)	Enclosure	Nick Johnson	Note	-
20.	**Any Other Business** Nil notified	Verbal	Mark Addison		-
21.	**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 31st May 2023 in the Board Room, Trust Headquarters, Dorchester** 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 25th January 2023 at Board Room, Trust Headquarters, Dorset County Hospital and via MS Teams videoconferencing.

Present:		
Mark Addison	MA	Trust Chair (Chair)
Ruth Gardiner	RG	Interim Chief Information Officer
Chris Hearn	CH	Chief Finance Officer
Jo Howarth	JH	Chief Nursing Officer
Alastair Hutchison	AH	Chief Medical Officer
Nick Johnson	NJ	Interim Chief Executive
Eiri Jones	EJ	Non-Executive Director
Stuart Parsons	SP	Non- Executive Director
Stephen Tilton	ST	Non-Executive Director
Attended via Videoconference:		
Sue Atkinson	SA	Non-Executive Director
Margaret Blankson	MB	Non-Executive Director
David Underwood	DU	Non-Executive Director (till 11.30am)
In Attendance:		
Phil Davis	PD	Head of Strategy and Corporate Planning (Item BoD22/100)
Trevor Hughes	TH	Head of Corporate Governance *(Minutes)*
Paul Lewis	PL	Deputy Director of Strategy, Transformation and Partnerships
Andy Willis	AW	Chair, Dorset Healthcare University NHS Foundation Trust
Jonquil Williams	JW	Corporate Business Manager
Members of the Public Attending via Video Conference:		
Sophie Wilson	SW	Bereavement Midwife (Patient Story)
Simon Bishop	SB	Public Governor
Judy Crabb	JC	Public Governor
Mandy Ford	MF	Head of Risk Management (Item BoD22/101)
Kathryn Harrison	KH	Public Governor
Jo Hartley	JHa	Head of Midwifery
Adam Savin	AS	Associate Director of Performance, Operations and Access
Lynne Taylor	LT	Public Governor
Joe Talora	JT	Correspondent, Health Service Journal (till 11.00am)
Apologies:		
Emma Hallett	EHa	Interim Chief People Officer
Anita Thomas	AT	Chief Operating Officer

BoD22/091	**Patient Story**	
	SW, Bereavement Midwife was introduced to the Board and explained that she had been supporting the parents of baby George who had not survived birth at 17 weeks gestation at the start of the pandemic. The parents had subsequently given birth to a healthy baby girl three months earlier. The parents were keen to share their experiences of the care and support that they had received when George was born and had worked with the Trust to make a training video for staff emphasising the importance of positive language used by staff surrounding the loss of their baby. Staff had been extremely compassionate and had exhibited good practice and exemplary care.	

	The video explained how, as parents, they had been supported and provided with a safe space to express their emotions and that communication about what was going on was clear, open and honest. Their clear memories of the time were of the positive language used by staff throughout and that their overwhelming was replaced by the affirmation that they were parents of the baby that they had lost. When they left hospital, they had been supported to make a memory box containing photos and his footprints. The parents commended the emotional literacy of the midwives who had been able to talk positively about George, acknowledging George as a real person. Hospital support continued at home from the bereavement team with regular calls and the language used continued to be positive. Funeral arrangements options were openly discussed, and the parents felt supported to make choices. A small kite, and the bear given to George by midwives, were placed in George's coffin. The parents continue to talk to family members about George and nieces and nephews refer to forget-me-nots as being 'George's flowers.' The family toast George at family events and a kite is flown on the anniversary of his birth. The video concluded with the parents expressing their gratitude to all the staff involved in providing support and noting that George's legacy would stretch forward helping to make positive changes. MA thanked the parents and SW for sharing their eloquent story and noted the application of learning about the use of positive language for care more widely and to end of life care. Hearing stories directly from patient was powerful and the Board acknowledged the benefits associated with storytelling via video. The Board was keen that the learning from the video be shared more widely, and the parents had consented to this. The video would be shared with neighbouring trusts and consideration was also being given to inclusion of the video in training packages as part of the national bereavement pathway. Learning could also be shared in non-educational environments in order to reach other professional disciplines, medical and administrative staff. In response to an enquiry about staff support, the Board heard that staff had regular supervision with a counsellor and that in traumatic cases there would be a senior team facilitated debrief. There was excellent collegial support and staff had access to the Chaplaincy team. Reflecting on discussion the previous month regarding the findings in respect to East Kent about the lack of team work, the Board highlighted that the video reflected the importance of team work across all disciplines and proposed that the video also be shared with the Regional Midwife to support changing attitudes. The Board acknowledged the outstanding leadership in bereavement services which were making continual improvements.	

	MA summarised that the Board • Reflected on and noted the importance of positive language use • The applicability of kindness and empathy beyond maternity services • The importance of consistent teamwork • Parents were happy for the wider sharing of their story • The Board had reflected on the benefits of direct storytelling and this would be considered going forward. MA extended the Board's thanks to SW and the maternity team. He especially thanked the parents for their courage in making the video and in helping to make continued improvements. He would write to the parents expressing the board's thanks.	
	Resolved that: the Patient Story be heard and noted.	
BoD22/092	**Formalities**	
	The Chair declared the meeting open and quorate and welcomed Governors, members of the press and the public to the meeting. Apologies for absence were received from Emma Hallett and Anita Thomas. AS attended the meeting on AT's behalf.	
BoD22/093	**Declarations of Interest**	
	There were no conflicts of interest declared in the business to be transacted on the agenda.	
BoD22/094	**Minutes of the Meeting held on the 30th November 2022**	
	The Minutes of the meeting dated 30th November were approved as an accurate reflection of the meeting noting the following clarifications: • Page 7 - ICU discharges to home had been impacted by patient flow issues. • Page 8 - BAF – the initial recommendation to reduce the performance risk score to 12 was not approved. • Page 9 - Ockenden visits were in planning. • Page 10 - NED Maternity Safety Champion – add JH was the Executive Lead.	
	Resolved: that the minutes of the meeting held on 30th November 2022 were approved.	
BoD22/095	**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. The Non-executive Directors reported that visit to see the hospital's green spaces had been a useful opportunity to also see the planned site developments and thanks were extended to the support team. The Board noted that new Sustainability Manager was now in post.	

	Resolved: that updates to the action log be noted with approval given for the removal of completed items.	
BoD22/096	**Operational Winter Update**	
	NJ acknowledged the current challenges arising from high numbers of respiratory illness, delays with the discharge of medically fit patients awaiting onward care packages (currently 20 – 25% of bed capacity), increased demand and planned industrial action. These pressures were national. The Christmas period had been particularly challenging with the Trust declaring a critical incident and similar demand pressures being seen across partners. The Incident Coordination Centre had been open over this period and pressures were noted to have reduced slightly more recently. The Board acknowledged the 'above and beyond' commitment of staff during this difficult time. The high number of patients with No Reason To Reside remained the key issue and a further £200m had been allocated to ICBs to support discharges until end of March 2023. Funding was yet be allocated and plans as to how this could be deployed were being developed. The funding was, however, short term. Sustainable benefits would be more difficult to realise but the funding should 'pump prime' longer term opportunities. AS added that Flu, RSV and COVID had required circa 100 patients to be isolated. Accompanied by the high numbers of patients with No Reason To Reside, almost half the hospital's bed capacity had been occupied. Teams had continued to deliver elective activity and trajectories were being met. The accuracy of modelling was acknowledged by the Board and was a credit to teams. The Board also acknowledged the work of the Infection Prevention and Control team in maintaining infection control standards and providing seven-day services and the digital team in resolving telephone system outage promptly. In order to maintain a patient safety focus, the Board heard that key metrics and incidents would be reviewed on a weekly basis alongside weekly patient afety team huddles. A quality improvement approach would be used to review live data focusing on risk or areas of concern to promote early detection and resolution of issues. The Board noted excellent performance and maintenance of elective activity through what had been the most difficult operating period members could recall and acknowledged the work of support staff in maintaining front line services	
	Resolved that the Operational Winter Update be noted.	
BoD22/097	**CEO Update**	
	NJ outlined the significant planning and preparations to deal ensure patient safety during the periods of industrial action by ambulance	

	workers and the RCN over recent weeks action. He emphasised the importance of individual choices being respected. Of the 704 RCN members able to strike, 85 members took action on the first day of action by the RCN and 62 on the second day. A small number of elective procedures had been rescheduled and some outpatient appointments were cancelled and rebooked. The picket line had been well supported by members of the public. The Board recognised the rolling programme of further industrial action across a range of professions and acknowledged that action was being taken in order to maintain professional coverage. The Board extended its thanks to staff on both sides of the picket line for their hard work and positive intent. In particular, the Board thanked JH and EH for their work in supporting colleagues and maintaining safe services. JH reported that staff had reflected that they had felt supported and that the visibility of the Executive team and senior managers during the period had been welcomed by staff. Wards had been safely staffed and staffing levels had been above derogated levels. Preparations for further planned industrial action in February were underway. The Hewitt Review and the role of ICBs in the national context was noted. NJ advised that the 2023/24 Operating Guidance would be presented to committees and Board over the coming weeks. There was a reduced number of metrics against which provider performance would be measured. The Trust remained on course to achieve the 78 week waiting list trajectory and reductions in agency expenditure were being made. There had been an increase in the number of bank staff and a marked shift in the use of agency staffing. NJ summarised further outstanding achievements and positive news as follows: • Maternity service best achievement in the country against CQC Outcomes – the service exceeded the measures • Award for Emergency Medicine • Granting of outline planning permission for the Emergency Department and Critical Care Unit • Further ward accreditations for care quality. NJ thanked teams for their continued efforts in delivering ongoing improvements.	

	The Board acknowledged the work of the workforce team, the access and performance team, the estates team and the finance team in supporting delivery of these achievements. NJ reported that the draft CQC Report following the inspection of mental health service provision for children August 2022 had been received and that factual accuracy check were being undertaken. The report would not impact the Trust's overall CQC ratings, all actions identified with the draft report had been addressed and a final report would be presented to the Board in due course. Matthew Bryant, joint CEO with Dorset Healthcare University NHS FT, would commence on 6th March, taking full responsibility as the Accountable Officer at the beginning of April 2023. PL reported that the ICP was developing a joint forward plan which would be presented to the Wellbeing Board and would include alignment of capital plans. Dorset had two Local Authorities and the need to work in collaboration was noted and emphasised. The Board commended the report which provided a good overview of performance, achievements and developments within the local health economy and noted the commitment and hard work of staff at all levels. Further discussion recognised the need to invest in Allied Health Professional (AHP) leadership and noted the business case and job description work in train to recruit a lead. Further consideration was being given to longer term collaboration opportunities with DHC and in order to develop the AHP research portfolio.	
	Resolved: that the CEO Update be received and noted.	
BoD22/098	**Performance Scorecard**	
	The Board acknowledged the work of the team in developing the SPC approach and that this was helping members to develop better questioning and receive greater assurances consequently. The report was still being refined and aimed to demonstrate improvements rather than absolute targets. The Board felt assured that safety was a key focus and noted the need to further consider the other two aspects of quality also; effectiveness and experience, in reporting going forward. There were no mixed sex accommodation breaches currently. Challenges persisted in respect to discharge summaries due to the availability of administrative support and matrons were reviewing and maintaining oversight.	
	Resolved that: the Performance Scorecard be received and noted.	

BoD22/099	Board Subcommittee Escalation Reports	
	The following subcommittee Escalation Reports were presented by respective committee Chairs who highlighted the following key points: **Finance and Performance Committee** ST noted the prior Board discussion around performance and the planned part 2 discussions on the agenda. He reported that early signs regarding agency spend reductions were positive and highlighted achievement of trajectories and that ambulance handover times had been reported by the BBC as the best in the region. **People and Culture Committee** Key points had already been discussed. The committee had noted discussion of AHP and pharmacy staff attrition recently. There had also been a renewed focus on staff retention. The January meeting had been detailed back due to operational pressures although the committee had considered advanced rostering as part of the agency spend reduction work. The hours that staff worked continued to be monitored in line with Working Time Directive requirements and to support staff wellbeing and appropriate rest periods. **Quality Committee** The committee noted withdrawal of the CQC Warning Letter. The patient story triangulated with maternity safety reports in affirming that the trust provided safe maternity services and further safety walkabout were being planned. The shortened meeting in January continued focus on safety. A new Coding Manager had taken up post and was reviewing and benchmarking current coding practices. All deaths in the Trust were reviewed by Medical Examiners and were supported by a programme of Structured Judgement Reviews. **Risk and Audit Committee** There had been a short meeting in January at which external partner members had been stood down. The committee had made recommendations to the Board and the Council of Governors in respect of the procurement processes for Internal and External Audit services. **Charitable Funds Committee** DU drew attention to the benefits of the Escalation Report process, highlighting that day room space for dementia patients, funded by the Charity and that had been used during pandemic to support operational pressures, had been released following escalation of the matter. **System Performance Update** The report had been taken from ICB Public Board papers and provided system performance triangulation and highlighted key issues**.** **Finance Subgroup** The January meeting had been stood down and monitoring of the financial position undertaken by the Group would be	

	included as part of Finance and Performance Committee business going forward. The Board discussed the Protocol for Reduced Attendance and Reporting at times of operational pressure. The Board were keen that operating reduced committees did not become normal practice and noted that the default position was the operation of committees in full unless there had been collective review by Committee Chairs and the Executive team and a proactive decision made to reduce committee agendas and attendance requirements.It was important that committees were clear in advance, what if any level of slim back was in place.	
	Resolved that: Board subcommittee Escalation Reports be received and noted.	
BoD22/100	**Board Assurance Framework (BAF) and Corporate Risk Register**	
	PD joined the meeting for this item. The report had been reviewed by the Quality Committee and the Executive Management Team and contained four risks that were red rated: • Two red rated risks related to people • One related to demand and delivering quality care and • One related to achieving financial breakeven. The Quality Committee had agreed to review mitigations further in anticipation of further risk score reductions. The people risks had been discussed earlier in the meeting and the Board had noted the focus on AHP leadership. A recruitment event was to be held the following weekend targeting nursing and Healthcare Assistants. 66 people had booked to attend and opportunities within DCH would be actively promoted. A refreshed approach was being taken to support the success of such events. The Board noted the importance of demonstrating that staff were valued, that there were significant opportunities for development and to work across the system in attracting new staff. DCH had unique opportunities as a provider of acute services in a rural location and this was a marketable asset. The Trust was also looking at ways to promote DCH employment opportunities through the use of social media platforms and engagement with education to create wider participation e.g. the use of sports science student placements in rehabilitation services. The Trust was working with partners to ensure that the revised bank offer was equitable and that a common framework was in place in place across the system. These shared principles would be shared across Dorset and with neighbouring organisations. The additional pastoral and accommodation support requirements associated with international recruitment were noted. The need to	

	review what more the Trust could do as an anchor institution in light of cost of living increases, inflexible and costly child care provision and an increasing number of retirees was also noted The Board noted the Medical Consultant vacancies within the Gastroenterology service and that there were several candidates for interview in near future. Alternative supporting roles were also being recruited and incentive schemes to aid recruitment such as 'Refer a Friend' and 'Warm Welcome' were being introduced and piloted. New models of care and alternative support roles needed to be further developed and clinical networking opportunities across the system also needed to be strengthened. A recruitment Plan would be developed and returned via the People and Culture Committee. The Board discussed the planned Emergency Department expansion, noting the considerable number of vacancies currently and the need to attract staff into the larger facility. A workforce planning afternoon was planned that would review the skill mix, upskilling the current workforce and planned additional roles in addition to current vacancies. **Corporate Risk Register** MF noted that the report had not been reviewed by committees and that a full review was planned in February. MF reported that: • COVID remained on the risk register although there had been more Flu cases that COVID cases. • Staffing items had been moved to 'tolerated risks' noting the considerable work ongoing and that the planned review would reframe the risk • The delivery of elective care activity remained on track. Discussion had already been had regarding the Clinical Coding risk and the mortality index. The Board was advised that the MHRA was due to reinspect Blood Sciences service the following day and that a report would be provided to the Quality Committee the following month.	**EH / JH / MB**
	Resolved: that the Board Assurance Framework and Corporate Risk Register be received and noted.	
BoD22/101	**Maternity Update**	
	JHa attended for this item and the report was taken as read. JHa reported that the Trust has not met the requirements for two standards within the Maternity Incentive Scheme submission which generated a 10% rebate on the maternity element of the Trust's premiums for the Clinical Negligence Scheme for Trusts. Whilst neither action constituted a patient safety risk, noncompliance attracted a financial consequence. The Board noted prior discussion	

	of the matter by the Quality Committee which had noted a change in the standards resulting in several, previously compliant organisations, now being non-compliant. The Board was assured that maternity services operated safely, that an action plan was in place to address the two areas of noncompliance and that the ICB were aware of the Trust's position in respect to the required submission and approved the submission. The Board noted that the Continuity of Carer Quarterly Report formed part of the main quality report presented to the Quality Committee. The item would be retitled in future.	
	Resolved: that the Maternity Update and the Continuity of Carer Quarterly Report be received and noted.	
BoD22/102	**ICP Strategy Update**	
	PL recalled that the draft ICP Strategy had been previously discussed by the Finance and Performance Committee and that the ICS was working with partners to deliver the wellbeing agenda. A Joint Forward Plan was to be developed which would be reviewed by the Health and Wellbeing Board, ensuring alignment with the strategy. DCH would consider the Joint Forward Plan as part of its own Strategy refresh later in the year. PL advised that the new joint leadership team would also need time to determine the way forward and the alignment of DCH and DHC plans. There were significant opportunities across both organisations and whilst the strategic framework had been set, priorities still needed to be identified. A number of examples of where the two trusts were already working together effectively were noted. The Board noted that the ICP Strategy demonstrated that what people in the community were saying was being heard and that the three priorities identified were strong. The expected outcomes over time provided a clear picture and DCH needed to develop clarity on the deliverables; those jointly deliverable with DHC and those more widely across the system.	
	Resolved that: the ICP Strategy Update be received and noted.	
BoD22/103	**Questions from the Public**	
	It was clarified that the Trust currently had three Gastroenterology Consultant vacancies. SB commented that the parents in the Patient Story appeared well balanced as a result of the support they had received. The Board noted that the parents had recently had a further child and that their relationship with the service had therefore been ongoing. There was	

	no definitive timeframe for the provision of bereavement support as this was dependent upon need. The multi-storey car park was open for patient and staff use. Testing of barriers and payment schemes was being undertaken. It was acknowledged that building work across the site was putting additional pressure on car park facilities although this was expected this to reduce. A cap on the number of car parking places the Trust was able to offer on site was put in place by the local planning authority.	
	CONSENT SECTION	
	The following items were taken without discussion. No questions were previously raised by Board members prior to the meeting.	
BoD22/104	**ICB Board Minutes – Part 1**	
	Resolved that: the ICB Board July Minutes Part 1 be noted.	
BoD22/105	**Any Other Business**	
	No other business was raised or notified.	
BoD22/106	**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.**	

Action Log – Board of Directors Part 1

Presented on: 29th March 2023

Minute	Item	Action	Owner	Timescale	Outcome	Remove? Y/N
Meeting Dated: 23rd January 2023						
BoD22/100	**Board Assurance Framework (BAF) and Corporate Risk Register**	A Recruitment Plan to be developed and returned via the People and Culture Committee to include service expansion requirements	**EH / JH / MB**	April 2023	Not due	
Actions from Committees…(Include Date)						

Report Front Sheet

1. Report Details			
Meeting Title:	Board of Directors		
Date of Meeting:	29th March 2023		
Document Title:	Chief Executive Report		
Responsible Director:	Nick Johnson – Interim CEO	Date of Executive Approval	21st March 2023
Author:	Jonquil Williams – Corporate Business 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	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

National:

- On 23rd January the Government announced mental health services will be boosted by £150m up to April 2025.
- On 9th February the National Audit Office published the progress in improving mental health services in England report.

System

- On 30 January 2023, NHS England published the delivery plan for recovering urgent and emergency care services.
- On 22 February 2023, the NHS Workforce Race Equality Standard (WRES) 2022 was published for NHS Trusts.
- On 03 February 2023, Dorset Police announced its new Chief Constable, Amanda Pearson

DCHFT

- Dorset County Hospital secured £2m to create a new, larger discharge lounge.
- £2m pledge from HELP Appeal to support the build of a new Helipad.
- On 6th March Matthew Bryant started with DCH as CEO Designate.
- Joint Chair interviews to be held on 30th March.
- 17th February – CQC report for Children and Young people with mental health issues, disability or autism was published.

5. Action recommended

The Board of Director is recommended to:

1. **NOTE** the 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 goal does this report link to / support?** Please summarise how your report contributes to the Dorset ICS key goals. (Please delete as appropriate)		
Improving population health and healthcare		**Yes**	**No**	If yes - please state how your report contributes to improving population health and health care
Tackling unequal outcomes and access		**Yes**	**No**	If yes - please state how your report contributes to tackling unequal outcomes and access
Enhancing productivity and value for money		**Yes**	**No**	If yes - please state how your report contributes to enhancing productivity and value for money
Helping the NHS to support broader social and economic development		**Yes**	**No**	If yes - please state how your report contributes to supporting broader social and economic development
Assessments		**Have these assessments been completed?** If yes, please include the assessment in the appendix to the report.. If no, please state the reason in the comment box below. (Please delete as appropriate)		
Equality Impact Assessment (EIA)		**Yes**	**No**	
Quality Impact Assessment (QIA)		**Yes**	**No**	

Chief Executive Report

1. Introduction

1.1 This report provides the Board with further information on strategic developments across the NHS and more locally within Dorset. It also includes reflections on how the system is performing and the key areas of focus.

2. Strategic Update – National Perspective

2.1 The Hewitt Review

The Hewitt Review, looking at how the oversight and governance of Integrated Care Systems (ICSs) can best enable them to succeed, continues with a first draft being shared with the Secretary of State for Health and Social Care at the end of January. The final report is expected by no later than 15 March 2023.

2.2 Mental Health Services Funding

On 23 January 2023, the Government announced mental health services will be boosted by £150M of funding. The £150M investment up to April 2025 aims to better support people experiencing – or at risk of experiencing – mental health crises to receive care and support in more appropriate settings outside of Emergency Departments, helping to ease pressures facing the NHS. The funding will allow for the procurement of up to 100 new mental health ambulances, which will take specialist staff directly to patients to deliver support on scene or transfer them to the most appropriate place for care. It will also fund 150 new projects centred on supporting the provision of mental health crisis response and urgent mental health care. The new projects include over 30 schemes providing crisis cafes, crisis houses and other similar safe spaces, as well as over 20 new or improved health-based places of safety which provide a safe space for people detained.

2.3 National Audit Office Mental Health Services Report

On 09 February 2023, the National Audit Office published the progress in improving mental health services in England report. The report concluded since 2016, the NHS has taken some important first steps towards closing the historical and acknowledged gap between mental and physical health services. A series of clear commitments and plans to expand and improve mental health services have been made nationally, but it is unclear what achieving full parity of esteem for mental health services would entail. Consequently, it is unclear how far the current commitments take the NHS towards its end goal, and what else is needed to achieve it. While funding and the workforce for mental health services have increased and more people have been treated, many people still cannot access services or have lengthy waits for treatment.

3. Strategic Update – Local Relevance

3.1 5 year Forward Plan update

On 2nd February a Board Development session was held to discuss the Joint 5 year forward plan. The aim of the day was to define and agree what great looks like in 5 years' time aligned to ICP strategy – prevention & early help, thriving communities, working better together; build a blueprint transformation plan to deliver this and to agree practicalities -leadership, governance, pump prime money, timescales. Following this session a draft Joint Plan was shared on 2nd March with final submission on 29th March.

The draft operational plan submission was submitted to NHSE/I on 23rd February at both Provider and System level progress is being made in developing a plan which achieves the operational requirements on performance such as 65 week wait, ED and cancer diagnostic and finance

3.2 Delivery Plan for Recovering Urgent and Emergency Care Services

On 30 January 2023, NHS England published the delivery plan for recovering urgent and emergency care services**.** The aim is to provide a blueprint to help recover urgent and emergency care services, reduce waiting times, and improve patient experience. The actions set out in the plan provide the opportunity to take a cross-system approach to improving patient care, ensuring patients are able to access the right care, in the right place, in a timely way. Locally, an Urgent and Emergency Care (UEC) Strategy Formation workshop is planned for 22 March 2023 where the strategy for Integrated UEC will be set including the Delivery Plan for 2023/24 including the five key areas outlined above.

3.3 Workforce Race Equality Standard (WRES) 2022

On 22 February 2023, the NHS Workforce Race Equality Standard (WRES) 2022 was published for NHS Trusts. The key findings indicated an increase in black minority ethnic staff working in the NHS and at senior levels however the experiences of black minority ethnic staff continue to be worse than white colleagues. Black minority ethnic staff continue to, experience a higher proportion of harassment, bullying or abuse from staff and the public, be more likely to enter a formal disciplinary process, be less likely to be appointed from shortlisting, and significantly less than half believe their Trust provides equal opportunities for career progression. Health partners will be able to review their WRES results at an organisational level and highlight areas of concern. The South West region has now agreed a regional Equality, Diversity, and Inclusion Strategy. Following the agreement to have one equality, diversity, and inclusion approach across the Dorset system, ICB Chief People Officer will support partners with the implementation of this strategy.

3.4 Ambulance Commissioning

On 31 January 2023, Dorset System held their regular Ambulance Joint Commissioning Committee with systems from across the region. NHS Dorset has been identified as the Lead Commissioner for this regional service, moving away from a coordinating commissioner model. Work is underway to establish the practicalities of this.

3.5 SWAST New Appointments

Jane Chandler has joined the South Western Ambulance Service as Executive Director of Quality Patient Care following Jenny Winslade's departure as Executive Director of Quality and Clinical Care. Jane was Deputy Chief Nurse at the Royal Berkshire NHS Foundation Trust for eight years and will ensure the safe provision of high-quality patient focused care across the Trust.

Justine McGuinness has taken up the role of Director of Communications and Public Affairs. She joins the South Western Ambulance Service from The Hillingdon Hospitals NHS Foundation Trust

3.6 New Chief Constable

On 03 February 2023, Dorset Police announced its new Chief Constable, Amanda Pearson following the Dorset Police and Crime Panel. Amanda will take over from Scott Chilton who is leaving the county to become Chief Constable for Hampshire Constabulary. Amanda will join Dorset Police on 01 March 2023 from the Metropolitan Police Service. She has worked in policing for 29 years, with forces including Hertfordshire, City of London, and Thames Valley.

3.7 Dorset Healthcare – Community Hospital Gold Standards Framework Accreditation

Staff working at Sherborne's Yeatman Hospital and Alderney Hospital in Poole have been honoured for providing outstanding palliative and end-of-life care. Two wards on the Willows unit at Yeatman Hospital (Beech and Rowan) and three wards at Alderney Hospital (Guernsey, Jersey and St Brelades) have been reaccredited by the Gold Standards Framework (GSF) – a national programme to help improve care for people in their final days. Herm and St. Brelades wards at Alderney Hospital became the first local mental health wards to receive accreditation since 2018 – with St Brelades also scooping the 'Ward of the Year' award. Staff at the Willows unit were awarded the GSF Platinum Award in recognition of their efforts to maintain high standards during the pressures of managing COVID-19. Alderney Hospital was also one of 75 hospitals, care homes, hospices, primary care practices, retirement villages and domiciliary care agencies from around the UK to receive the prestigious quality hallmark.

3.8 Hospital Reconfiguration

Patients in Dorset will see the benefits of the £250m investment in services at University Hospitals Dorset 18 months earlier than planned. On 25 January 2023, the Trust Board decided the planned care hospital at Poole Hospital, and major emergency hospital at Royal Bournemouth Hospital will be established from spring 2025 - making the most of the new developments as they become available. Facilities currently under construction include the new 22,650m² BEACH Building (standing for births, emergency and critical care, children's health) on the Royal Bournemouth site, housing a new purpose-built maternity unit, children's unit, enhanced emergency department and critical care unit. The finishing touches are also being made at Poole Hospital to the new theatre complex – an extension to the existing hospital building comprising of a brand-new purpose-built five storey tower.

3.9 University Hospital Dorset CQC

CQC inspected 3 of UHD services in September and November 2022. These were Medicine across both Poole and Bournemouth and Maternity at Poole. CQC rated Poole Hospital Maternity service as inadequate and that Poole Hospital surgery requires improvement. Poole Hospital overall rating is that is requires improvement.

4. DCHFT – Latest News

4.1 Joint CEO/Chair Collaboration

We would like to welcome Matthew Bryant as CEO designate, he started with us on Monday 6th March and will take up his position as Joint CEO on 1st April 2023. Matthew has had the opportunity to walk around the hospital site and meet with members of the team in ED, Cardiology and wards on Division B. The recruitment of the Chair position is still on going with interviews due to take place on 30th March. The recruitment process for the Joint Chair is expected to conclude on 3 April, when the Council of Governors of both Trusts are scheduled to confirm the appointment. The Joint Chair's office arrangements are in hand, with a proposal developed.

The Collaboration Programme structure has been developed with lead directors allocated to each of seven workstreams. Dawn Dawson and Nick Johnson are joint Senior Responsible Owners (SROs) for the Programme. They co-chair the monthly Programme Board meeting, which receives highlight reports from the workstreams and reviews risks to ensure mitigating actions are built into the project. A Memorandum of Understanding setting out the principles of working together has been drafted and will be shared with the Trust Boards for comment during April. A longlist of potential areas for clinical collaboration has been considered by the Executives. This includes a number of areas where clinical teams are being encouraged and enabled to continue with their joint work, with the Programme Board inputting to remove barriers as required. Wider engagement with the clinicians will commence during the Spring to help shape our flagship clinical pathways.

4.2 Performance

The reporting month of February 2023 for the non-elective standards shows deterioration against ambulance handover delays, the 4 hour standard and those waiting over 12 hours in the ED department. Industrial action, increased infection issues and reduced staffing (particularly over half term which affected roles across all admission/discharge pathways) from both infection related absences and childcare related absences in half term and school closures for IA. Elective standards improved slightly but is off trajectory, cancer performance has improved n month with 28-day standard recovering to 74.5% again a target of 75% and diagnostic performance has improved in month with a reducing waiting list. No Criteria to Reside patients still remains a great risk.

4.3 Industrial Action

January and February saw several strike days from nursing and ambulance colleagues.
Health partners carefully planned and coordinated the arrangements for strike days to ensure they could operate at safe levels and maintain patient flow. Health partners stood-up Incident Coordination Centres during the strike action to support the system providing oversight and coordination. Picket lines were set up across several locations around Dorset which were well attended, with colleagues demonstrating immense support, respect, and compassion for one another.

Further Royal College of Nursing (RCN) strikes were planned for 01 and 02 March 2023 with different arrangements, with no emergency provision provided. However, these were paused due to discussion with the Secretary of State and on 16th March an offer was announced of 2 consolidated one off payments for the current financial year and a 5% increase for 2023/24.

On 13-16th March, the British Medical Association junior doctors staged a 72-hour walkout and the result of this was 778 cancelled appointments. BMA has agreed to meet with the Health Secretary to discuss a pay deal however we are unsure of the outcome.

4.4 Discharge Lounge

Dorset County Hospital (DCH) has secured £2millon to help free up hospital beds by creating a new, larger discharge lounge facility. DCH submitted a bid to NHS England after the Government announced an additional £50million in capital funding to expand hospital discharge lounges and ambulance hubs. Discharge lounges are designated areas for patients that are waiting for their medication or transport once they are medically fit to leave hospital. The funding will be used to install a single-storey modular building that will be pre-made using modern methods of construction and then assembled on site. Instead of the one room that the Trust currently has, the new building will provide a much larger space

for patients to stay while they wait to be discharged, freeing up beds in the meantime for patients that need to be admitted. It will be situated in the North Wing Entrance 2 Car Park, which means that some parking spaces designated for blue badge holders and chemotherapy patients will be re-allocated elsewhere on the hospital site as part of the project.

4.5 New Hospital Programme – Helipad
Plans to build a new helipad at Dorset County Hospital (DCH) have taken a major step forward thanks to a £2million pledge from the HELP Appeal – the only charity in the country that funds NHS hospital helipads.

Dorset County Hospital plans to build a brand-new Emergency Department and Critical Care Unit on the former Damers School site as part of the Government's New Hospital Programme, that will see 40 new hospitals built by 2030. As part of the build, the Trust plans include a new helipad on the roof. This will replace the existing landing pad based at ground-level next to the current Emergency Department which would not be able to accept flights with the new building. The new helipad will also be fitted with DIFFS, a firefighting system that will, if ever needed, put out a fire within 15 seconds.

The HELP Appeal has donated over £35million in non-repayable grants to fund life-saving helipads at Major Trauma Centres and A&E hospitals around the country since 2009.The charity has pledged its support to DCH and presented the first £1million instalment, which will fund the helipad's construction on the rooftop of the new Emergency Department and Critical Care Unit. The new state-of-the-art rooftop helipad will allow a patient to be transferred quickly and comfortably via a lift directly into the hospital, maintaining their privacy and dignity.

4.6 CQC – Children and Young People with Mental Health Issues, Learning disabilities or Autism.
17th February - Dorset County Hospital has recognised areas for improvement and stressed the importance of partner agencies working closely together following a focussed Care Quality Commission (CQC) inspection around children and young people with mental health issues, learning disabilities or autism. The CQC report identified four areas for improvement which 'must' be addressed, and action has already been taken around these since August 2022. The action plan has been presented to Quality Committee and to Board of Directors.

4.7 Ward accreditation and Celebrating Success
I am delighted to announce that we have had even more wards completing the Ward Accreditation Programme during February and March 2023. The programme offers a framework for clinical teams to provide evidence of quality of care and leadership. The process is a leadership self-assessment by the clinical area lead, evidence of quality data, leadership presentation and clinical area visit. The team were clearly engaged and work well together.

The panel were delighted to award:

Lulworth Ward the 'SILVER' award. Well done to Rachel and her team.

Barnes/Day Lewis Wards the 'SILVER award'.

Fortuneswell Ward the SILVER award. Well done to Sarah and her team.

Abbotsbury Ward received a GOLD award in the Ward Accreditation Programme. Abbotsbury Ward, led by Sister Cheryle Bakker

I was pleased to learn that we have been awarded a Silver Covenant Award, in recognition of our ongoing support to the Armed Forces. We are proud to support staff who are reservists and to have several ex-military staff working within the Trust, and look forward to this continuing.

Congratulations to everyone in the Radiology Department which has become one of the first departments in the country to achieve the new Quality Standard for Imaging set by UKAS (the United Kingdom Accreditation Service). This is a huge achievement for the department and a credit to the team given the ongoing pressures we are facing. Well done to all involved in this.

Report Front Sheet

1. Report Details			
Meeting Title:	Board of Directors		
Date of Meeting:	Wednesday 29th March 2023		
Document Title:	Balance Scorecard		
Responsible Director:	Nick Johnson, Interim CEO	Date of Executive Approval	22-03-2022
Author:	Laura Pearson, Deputy Head of Business Intelligence Phil Davis Head of Strategy and Corporate planning		
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. Cancer performance improved in month, with the 28 day standard recovering to 74.5% against the 75% target. 2. Performance of the elective standards improved but is slightly off trajectory, Finance 1. Capital expenditure is marginally behind plan due to timing of Medical Equipment and Digital purchases 2. The Trust has delivered a surplus position of £4.7 million for the month of February 2023 against a planned surplus of £0.4 million after technical adjustments and in line with the Trust's revised trajectory to reach break even position by the end of the financial year and reflects the non recurrent Dorset ICB funding agreed to support the Trust in reaching a break even position by the end of the financial year.							
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)
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**	

Executive Dashboard March 2023 Board

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

Dorset County Hospital NHS Foundation Trust

Summary of Data

Report Reference
Executive Dashboard

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. Refer to glossary page for further information.
This report is a snapshot report taken at an agreed point in the month in line with Committee and Board Meetings.

Known Data Quality Issues
Metrics that are manually collected can not be verified in the BI Data Warehouse.

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

pdf version

Executive Dashboard (Refreshed Live)

Making Data Count

Understanding and Interpreting SPC Charts

DCHFT Power BI User Guide
DCHFT BI Gateway User Guide

Business Intelligence Gateway

2023-03-13 07:46:38
data last refreshed:

30 April 2019
metric data from:

28 February 2023
to:

Report Version 2.0 (Mar-23)
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 | Glossary | Useful Links | Appendix A: SPC Basics | Appendix B: SPC Icon Descriptions

Executive Summary

Select an icon to view relating metrics

Variation

Assurance

PEOPLE

Metric Name	Assurance	Variation	Value	Target
Appraisal rate	F	L	72%	90%
Essential Skill Rate	F	H	90%	90%
Sickness rate (one month in arrears)	?	L	5%	3%
Staff Turnover Rate	P	H	12%	12%
Vacancy Rate (substantive)	F	H	10%	5%

PERFORMANCE

Metric Name	Assurance	Variation	Value	Target
Cancer (ALL) - 104 days from referral to treatment			17	
Cancer (ALL) - 28 day faster diagnosis standard	?		74%	75%
Diagnostic - % Patients waiting less than 6 weeks for a diagnostic test	F	L	69%	99%
ED - 12 Hour Waits		H	496	
ED - Ambulance Handover Delays Average Time Lost per Day	F	H	26.65	0.83
ED - Overall 4 Hour Performance %	?		72%	76%
Elective Recovery - Day Case Activity vs 2019/20	?	H	119%	104%
Elective Recovery - Elective Inpatients Activity vs 2019/20	F		60%	104%
Elective Recovery - Outpatient Activity vs 2019/20	?		94%	104%
Elective Recovery - Total Elective Activity vs 2019/20	?		95%	104%
Inpatient - Percent Bed Occupied by No RTR		L	22%	
Outpatient - Virtual Activity %	F	H	23%	25%
RTT - 52+ week waits			1197	
RTT - 78+ week waits	F	L	60	50
RTT - Waiting List Size	?	H	19397	16931
Theatre - Utilisation	F		68%	85%

QUALITY & SAFETY

Metric Name	Assurance	Variation	Value	Target
Complaints - Total number received (Informal & Formal)			107	
Friends and Family - Overall - Recommend Rate	?		91%	94%
Incidents - Never Events	F	L	0	0.02
Incidents - Number of falls resulting in fracture or severe harm or death		H	1	
Incidents - Number of Medication Incidents			56	
Incidents - Pressure Ulcers - Hospital acquired (grade 3) confirmed avoidable			1	
Incidents - Serious Incidents investigated and confirmed avoidable	?		0	0
Infection Control - C-Diff Hospital Onset Healthcare Associated	?		4	3
Infection Control - Gram Negative Blood Stream Infections	?		4	5
Inpatient - % Emergency Re-Admissions (16+ & <30 Days) (1 month arrears)	P	L	6%	13%
Inpatient - Percentage of EDS available within 24 hours of discharge	F	H	83%	90%
Inpatient - Percentage of EDS available within 7 days of discharge	F	H	91%	100%
Inpatient - SHMI Value			1.16	

FINANCE

Metric Name	Assurance	Variation	Value	Target
Agency % of pay expenditure	F	H	8%	5%
Agency Spend (Monthly)		L	-559	
Capital Expenditure (Monthly)	?		1197	2708
CIP - (cost reduction plans)	F	H	1456	-718
Finance Spend	?		7	197
Total Substantive Workforce Pay Cost		H	20495	

Matrix Overview

Dorset County Hospital NHS Foundation Trust

Variance \ Assurance	P	?	F		Total
H		1	4		5
L	1	1	2	2	6
		10	2	6	18
H	1	1	4	3	9
L			2		2
Total	2	13	14	11	40

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

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

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

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

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

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

Performance

Group: 0 - Total

Metric: All

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

Dorset County Hospital NHS Foundation Trust

Commentary

Cancer performance has improved in month, with the 28-day standard recovering to 74.5% against the 75% target. The trust has returned to achieving the 31-day standard. The volume of cancer treatments has reduced, but the waiting list and backlog numbers have remained static, supporting that the treatment volumes were not there to be treated.

Diagnostic performance improved in month, with a reducing waiting list size and reducing backlog. This was driven by improvements in CT, Cardiology and Audiology remain the biggest backlogs for the trust, caused by a demand and capacity miss match, which is seen locally and nationally.

Non-elective standards show deterioration against ambulance handover delays, the 4 hour standard and those waiting over 12 hours in the ED department. Industrial action, increased infection issues and reduced staffing (particularly over half term which affected roles across all admission/discharge pathways) from both infection related absences and childcare related absences in half term and school closures for IA.

Performance of the elective standards improved but is slightly off trajectory. The impact of industrial action has resulted in 12, 78+ week breaches forecast for the end of March 2023. The trust maintained its position on zero 104+ week waiters.

VariationIcon	Pass	Hit or Miss	Fail	Empty	Total
Empty					
Neither					
Concern		1	2	1	4
Common Cause		4	2	2	8
Improvement		1	2	1	4
Total		**6**	**6**	**4**	**16**

Metric	Group	Latest Month	Value	Target	Variance to Target	PY - Month Value	YTD Value	Variation	Assurance
Cancer (ALL) - 104 days from referral to treatment	0 - Total	Feb-23	17			19	17		
Cancer (ALL) - 28 day faster diagnosis standard	0 - Total	Feb-23	74%	75%	-1.00%	68%	74%		
Diagnostic - % Patients waiting less than 6 weeks for a diagnostic test	0 - Total	Feb-23	69%	99%	-30.00%	90%	69%		
ED - 12 Hour Waits	0 - Total	Feb-23	496			235			
ED - Ambulance Handover Delays Average Time Lost per Day	0 - Total	Feb-23	26.65	0.83	25.82	16.37	26.65		
ED - Overall 4 Hour Performance %	0 - Total	Feb-23	72%	76%	-4.00%	65%	72%		
Elective Recovery - Day Case Activity vs 2019/20	0 - Total	Feb-23	119%	104%	15.00%	93%	119%		
Elective Recovery - Elective Inpatients Activity vs 2019/20	0 - Total	Feb-23	60%	104%	-44.00%	62%	60%		
Elective Recovery - Outpatient Activity vs 2019/20	0 - Total	Feb-23	94%	104%	-10.00%	95%	94%		
Elective Recovery - Total Elective Activity vs 2019/20	0 - Total	Feb-23	95%	104%	-9.00%	94%	95%		
Inpatient - Percent Bed Occupied by No RTR	0 - Total	Feb-23	22%			33%	22%		
Outpatient - Virtual Activity %	0 - Total	Feb-23	23%	25%	-2.00%	23%	23%		
RTT - 52+ week waits	0 - Total	Feb-23	1197			1719	1197		
RTT - 78+ week waits	0 - Total	Feb-23	60	50	10.00	519	60		
RTT - Waiting List Size	0 - Total	Feb-23	19397	16931	2,466.00	17128	19397		
Theatre - Utilisation	0 - Total	Feb-23	68%	85%	-17.00%	70%	68%		

Quality and Safety

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

Group: 0 - Total

MetricName: All

Dorset County Hospital NHS Foundation Trust

Commentary

Assurance	Improvement	Common Cause	Concern	Neither	Empty	Total
Pass	1					1
Hit or Miss		4				4
Fail	3					3
Empty		3	1			4
Total	**4**	**7**	**1**			**12**

SAFE

Metric	Group	Latest Month	Value	Target	Variance to Target	PY - Month Value	YTD Value	Variation	Assurance
Incidents - Never Events	0 - Total	Feb-23	0	0.02	-0.02	0			
Incidents - Number of falls resulting in fracture or severe harm or death	0 - Total	Feb-23	1			0			
Incidents - Number of Medication Incidents	0 - Total	Feb-23	56			52			
Incidents - Pressure Ulcers - Hospital acquired (grade 3) confirmed avoidable	0 - Total	Feb-23	1			0			
Incidents - Serious Incidents investigated and confirmed avoidable	0 - Total	Feb-23	0	0	0.00	0			
Infection Control - C-Diff Hospital Onset Healthcare Associated	0 - Total	Feb-23	4	3	1.00	3			
Infection Control - Gram Negative Blood Stream Infections	0 - Total	Feb-23	4	5	-1.00	2			

EFFECTIVE

Metric	Group	Latest Month	Value	Target	Variance to Target	PY - Month Value	YTD Value	Variation	Assurance
Inpatient - % Emergency Re-Admissions (16+ & <30 Days) (1 month arrears)	0 - Total	Jan-23	6%	13%	-7.00%	7%	6%		
Inpatient - Percentage of EDS available within 24 hours of discharge	0 - Total	Feb-23	83%	90%	-7.00%	81%	83%		
Inpatient - Percentage of EDS available within 7 days of discharge	0 - Total	Feb-23	91%	100%	-9.00%	91%	91%		

CARING

Metric	Group	Latest Month	Value	Target	Variance to Target	PY - Month Value	YTD Value	Variation	Assurance
Complaints - Total number received (Informal & Formal)	0 - Total	Feb-23	107			99			
Friends and Family - Overall - Recommend Rate	0 - Total	Feb-23	91%	94%	-3.00%	90%	91%		

People

Group: 0 - Total

MetricName: All

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

Dorset County Hospital NHS Foundation Trust

Balanced Scorecard

Commentary

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

Metric	Group	Latest Month	Value	Target	Variance to Target	PY - Month Value	YTD Value	Variation	Assurance
Appraisal rate	0 - Total	Feb-23	72%	90%	-18.00%	67%	72%		
Essential Skill Rate	0 - Total	Feb-23	90%	90%	0.00%	91%	90%		
Sickness rate (one month in arrears)	0 - Total	Jan-23	5%	3%	2.00%	4%	5%		
Staff Turnover Rate	0 - Total	Feb-23	12%	12%	0.00%	9%	12%		
Vacancy Rate (substantive)	0 - Total	Feb-23	10%	5%	5.00%	6%	10%		

Finance

Group: 0 - Total

MetricName: All

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

Dorset County Hospital NHS Foundation Trust

Commentary

Capital expenditure is marginally behind plan due to timings of Medical Equipment and Digital purchases expected. Regarding Substantive Pay costs, additional medical sessions within Urology, ED, Gastroenterology, Anaesthetics and Dermatology are also contributing to the adverse pay position.

Higher than planned costs incurred have been the result of undelivered efficiencies against the core £5.7m target, pressures incurred using high cost agency expenditure largely due to additional cover for nursing and medical vacancies, ongoing sickness, heightened challenging patient acuity and supporting safe staffing levels. February half term absences and lower temporary staffing workforce availability contribute to the agency overspend.

Please note that some of these figures are pending validation.

The Finance spend position is over plan largely due to the above pay pressures in conjunction with activity driven increases in consumables and high-cost drugs, with further increased inflationary pressures associated with utilities, rates and catering provisions.

The Trust has delivered a surplus position of £4.7 million for the month of February 2023 against a planned surplus of £0.4 million after technical adjustments and in line with the Trust's revised trajectory to reach break even position by the end of the financial year and reflects the non recurrent Dorset ICB funding agreed to support the Trust in reaching a break even position by the end of the financial year.

Assurance	Improvement	Common Cause	Concern	Neither	Empty	Total
Pass						
Hit or Miss		2				2
Fail			2			2
Empty	1		1			2
Total	**1**	**2**	**3**			**6**

Metric	Group	Latest Month	Value	Target	Variance to Target	PY - Month Value	YTD Value	Variation	Assurance
Agency % of pay expenditure	0 - Total	Jan-23	8%	5%	3.00%	8%	8%		
Agency Spend (Monthly)	0 - Total	Feb-23	-559			964			
Capital Expenditure (Monthly)	0 - Total	Feb-23	1197	2708	-1,511.00	2661			
CIP - (aggressive cost reduction plans)	0 - Total	Jan-23	1456	-718	2,174.00	0			
Finance Spend	0 - Total	Jan-23	7	197	-190.00	239			
Total Substantive Workforce Pay Cost	0 - Total	Jan-23	20495			11497			

Glossary

Metric Name

All

Dorset County Hospital NHS Foundation Trust

MetricName	MetricDescription
Cancer (ALL) - 104 days from referral to treatment	Number of patients waiting longer than 104 days from cancer referral to treatment following a screening service referral. Sourced from the DCH Cancer Performance Portal.
Cancer (ALL) - 28 day faster diagnosis standard	Percentage of patients meeting the 28 day faster diagnosis cancer standard (from referral to point where given an all clear or confirmed diagnosis). Sourced from the DCH Cancer Performance Portal.
Complaints - Total number received (Informal & Formal)	Number of formal and informal complaints received. Sourced from Datix.
Diagnostic - % Patients waiting less than 6 weeks for a diagnostic test	Percentage of Patients waiting less than 6 weeks for a diagnostic test in line with DM01 methodology. Sourced from DM01 Monthly Position.
ED - 12 Hour Waits	Number of patients with an unplanned DCH Emergency Department visit lasting longer than 12 hours. Excludes patients marked as streamed. Sourced from ED Agyle/PAS information.
ED - Ambulance Handover Delays Average Time Lost per Day	Average time lost per day for DCH ambulance handovers that took longer than 15 minutes. Sourced from ED SWAST information.
ED - Overall 4 Hour Performance %	Percentage of patients with an unplanned Emergency Department/MIU visits lasting longer than the 4 hour peformance standard. Sourced from ED Agyle/PAS and MIU information.
Elective Recovery - Day Case Activity vs 2019/20	Percentage of day case elective versus financial year 2019-20 for admissions and outpatient classification. Excludes activity not against Urgent or Surgical divisions, overseas visitors and RDAs. Sourced from PAS EMPG information.
Elective Recovery - Elective Inpatients Activity vs 2019/20	Percentage of elective inpatient activity versus financial year 2019-20 for admissions and outpatient classification. Excludes activity not against Urgent or Surgical divisions, overseas visitors and RDAs. Sourced from PAS EMPG information.
Elective Recovery - Outpatient Activity vs 2019/20	Percentage of outpatient activity versus financial year 2019-20 for admissions and outpatient classification. Excludes activity not against Urgent or Surgical divisions, overseas visitors and RDAs. Sourced from PAS EMPG information.
Elective Recovery - Total Elective Activity vs 2019/20	Percentage of total elective activity versus financial year 2019-20 for admissions and outpatient classification. Excludes activity not against Urgent or Surgical divisions, overseas visitors and RDAs. Sourced from PAS EMPG information.
Fin - Agency % of pay expenditure	Percentage of agency pay expenditure. Sourced from Finance team.
Fin - Agency Spend (Monthly)	Agency Spend (£000). Sourced from Finance team.
Fin - Capital Expenditure (Monthly)	Capital Expenditure (£000). Sourced from Finance team.
Fin - CIP - (aggressive cost reduction plans)	Paid CIP (£000) for aggressive cost reduction plans. Sourced from Finance team.
Fin - Finance Spend	Finance Spend (£000). Sourced from Finance team.
Fin - Total Substantive Workforce Pay Cost	Total substantice workforce pay Cost (£000). Sourced from Finance team.
Friends and Family - Overall - Recommend Rate	Percentage of overall Friends and Family recommendation. Sourced from the Patient and Public Experience team.
Incidents - Never Events	Number of occurances of confirmed Never Events based on updated date. Sourced from Datix.
Incidents - Number of falls resulting in fracture or severe harm or death	Number of occurances of falls catagorised as severe or death severity of harm caused, based on updated date. Sourced from Datix.
Incidents - Number of Medication Incidents	Number of occurances of medicine incidents based on reported date. Sourced from Datix.
Incidents - Pressure Ulcers - Hospital acquired (grade 3) confirmed avoidable	Number of occurances of hospital acquired category 3 pressure ulcers confirmed as avoidable by panel date. Sourced from Datix.
Incidents - Serious Incidents investigated and confirmed avoidable	Number of occurances of serious incidents investigated and confirmed avoidable by panel date. Sourced from Datix.
Infection Control - C-Diff Hospital Onset Healthcare Associated	Number of occurances of hospital onset healthcare associated Clostridium difficile (C. diff) incidents by specimen date. Sourced from HCAI data.
Infection Control - Gram Negative Blood Stream Infections	Number of occurances of hospital onset gram negative blood stream infection incidents by specimen date. Sourced from HCAI data.
Inpatient - Percent Bed Occupied by No RTR	Percentage of total adult G&A beds occupied (as per reported in UEC Daily SitRep) by No Reason To Reside (NRTR) patients (as per reported in EPPR Daily Discharge SitRep). Original source PAS / Patient Action Tracker.
Inpatient - Percentage Emergency Re-Admissions (16+ & within 30 days) (1 month in arrears)	Percentage of emergency re-admissions to hospital within 30 days of previous admission. Excludes patients under the age of 16 on original admission. Sourced from Emergency Readmission reporting, original source PAS.
Inpatient - Percentage of EDS available within 24 hours of discharge	Percentage of electronic discharge summaries (EDS) available for GPs to access within 24 hours of discharge from an inpatient spell. Sourced from EDS reporting, original source ICE / PAS.
Inpatient - Percentage of EDS available within 7 days of discharge	Percentage of electronic discharge summaries (EDS) available for GPs to access within 7 days of discharge from an inpatient spell. Sourced from EDS reporting, original source ICE / PAS.

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.

SPC Basics

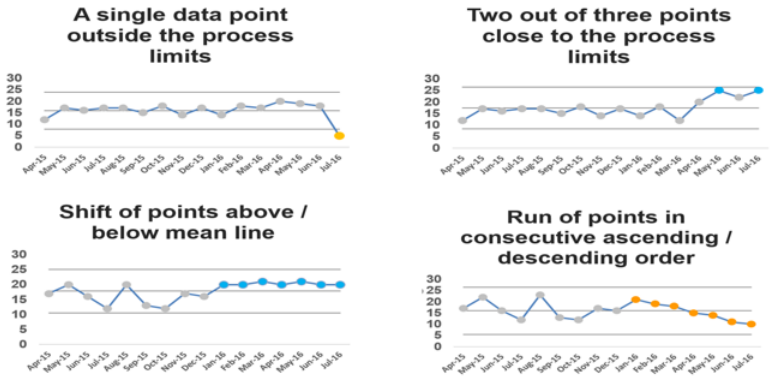
Dorset County Hospital
NHS Foundation Trust

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?

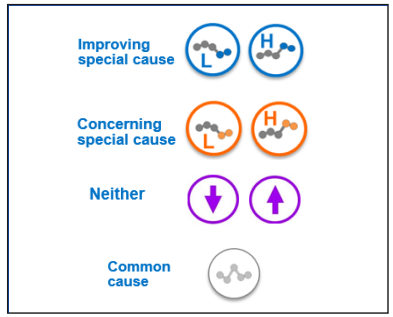
Blue icons indicate significant improvement or low pressure.

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?

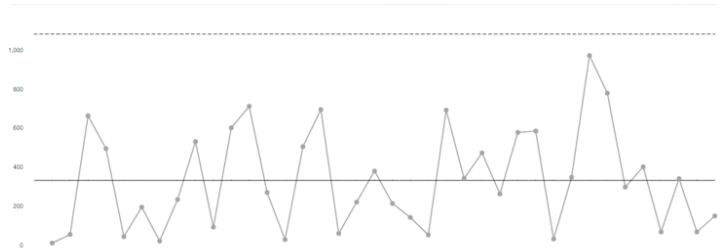
Moving range chart (seen on right) helps to assess the variation in a process by taking the absolute difference between consecutive points.

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: (none)
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.
(none)	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.

INTEGRITY | RESPECT | TEAMWORK | EXCELLENCE

NHS
Dorset County Hospital
NHS Foundation Trust

Escalation Report

Executive / Committee: Finance and Performance Committee

Date of Meeting: Monday 20th February 2023

Presented by: Stephen Tilton (Chair)

Significant risks / issues for escalation to Committee / Board for action	• The impact of industrial action by ambulance staff and the Royal College of Nursing including continued concerns about patients with no criteria to reside and not being able to empty beds as planned, and concerns about the impact of further action in March • A positive month in terms of performance; zero 104-week waits and the Trust being taken out of tiering. However diagnostics continue to be a problem and cancer figures are slightly down • Review of the 2023/24 draft planning submission, with thanks to those involved for a very detailed plan

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 a relatively positive month given the operational pressures in the reporting month:
	  ○ Improvement in the 4-huor wait standard
	  ○ Reduction in 12-hour waits
	  ○ Reduction in follow-up backlog and improvements in delivering PIFU
	• Draft 2023/24 Planning submission was reviewed and discussed
	• Finance report noting the forecast breakeven position for year-end
	• The Finance subgroup had been suspended given the improved grip on the CIP
	• Divisional Escalation Reports were stood down due to service pressures
	• Managed Print Service Contract
	• International Nurse Recruitment Plan

Decisions made by the Committee	• The award of the Managed Print Service Contract be recommended to the Board for approval. • The International Nurse Recruitment Plan be recommended to the Board for approval.
Implications for the Corporate Risk Register or the Board Assurance Framework (BAF)	• Nil new.

Items / issues for referral to other Committees	• For People and Culture Committee: matters regarding international nurse recruitment:
	  ○ Support with OSCE accreditation
	  ○ Support with integrating in to the local community

INTEGRITY | RESPECT | TEAMWORK | EXCELLENCE

NHS
Dorset County Hospital
NHS Foundation Trust

Escalation Report

Executive / Committee: Finance and Performance Committee

Date of Meeting: Monday 20th March 2023

Presented by: Stephen Tilton (Chair)

Significant risks / issues for escalation to Committee / Board for action	• The 2023/24 Business Planning submission is recommended to the Board for approval. • The Committee Terms of Reference and annual Work Plan are recommended to the Board for approval. •

Key issues / matters discussed at the Committee	The meeting considered the following items:
	• Theatre Productivity Update noting plans in place to deliver activity trajectories for the forthcoming year and the wider system focus on elective performance.
	• The Performance Report noted:
	  ○ The impact of industrial action in other sectors impacting the workforce, patient flow and elective recovery.
	  ○ An increase in the number of infectious disease cases in the community and also impacting the workforce.
	  ○ A reduction in the number of patients remaining in hospital with No Reason to Reside.
	  ○ Transition of the Audiology service to DHC in April
	  ○ Continued good work to deliver an improved follow up position (now at August 2021 level) and the highest number of Patient Initiated Follow Up appointments to date.
	• Divisional Escalation Reports were stood down due to service pressures
	• Finance Month 11 Report noting
	  ○ An in month surplus position
	  ○ Increase in Agency spend.
	  ○ Resolution of the multistorey car park CDEL issue.
	• The 2023/24 Business Planning submission was being finalised
	• There were no contracts for review or approval.
	• The Committee Terms of reference and annual Work Plan were reviewed and are recommended to the Board for approval.
	• The Premises Assurance Model Update was noted.
	• Escalation Reports from the following subgroups were noted:
	  ○ Capital Planning and Space Utilisation Group
	  ○ Digital Board Portfolio Group
	  ○ Medical Devices Group
	• ICB Finance Committee Minutes.

Decisions made by the Committee	• The 2023/24 Business Planning submission was approved and is recommended to the Board for approval. • The Committee Terms of Reference and annual Work Plan were approved and are recommended to the Board for approval. A review of committee priorities and setting committee priorities for 2023/24 would be returned to the committee in April.

Implications for the Corporate Risk Register or the Board Assurance Framework (BAF)	• Nil new.

Items / issues for referral to other Committees	• For People and Culture Committee: matters regarding international nurse recruitment:
	  ○ Support with OSCE accreditation
	  ○ Support with integrating into the local community

INTEGRITY | RESPECT | TEAMWORK | EXCELLENCE

Dorset County Hospital NHS Foundation Trust

Escalation Report

Executive / Committee: People and Culture Committee

Date of Meeting: Monday 20th February 2023

Presented by: Margaret Blankson (Chair)

Significant risks / issues for escalation to Board for action	• Broadly static people performance indicators • The positive way we are communicating to staff about strike action, noting the importance of civility and respect • Bank and agency usage report, noting the importance of non-clinical roles in effective use of clinical roles.

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:
	  ○ Sickness increased in December
	  ○ New health and wellbeing triage service launched in January
	  ○ Introduction of two recruitment initiatives for hard to fill posts
	  ○ Reduction in agency spend to December
	• Bank and Agency Usage Quarterly Update

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 20th March 2023

Presented by: Margaret Blankson (Chair)

Significant risks / issues for escalation to Board for action	• Staff Opinion Survey Results • The Gender Pay Gap Report is recommended to the Board. • The Guardian of Safe Working Hours Update is recommended to the Board. • The committee Terms of Reference and annual Work Plan are recommended to the Board for approval. • The Freedom to Speak Up Fresh Eyes Report is recommended to the Board for information.

Key issues / other matters discussed by the Committee	Divisional representation at the meeting was stood down due to service operational pressures and recent industrial action.
	The meeting considered the following items:
	• People and Performance Report and Dashboard noting:
	  ○ Reducing sickness absence
	  ○ An increase in agency expenditure in February due to the holiday period and reduced availability of bank staff and the need to cover periods of industrial action.
	• Agency Reduction Project update
	• Equality, Diversity and Inclusion Strategy Refresh
	• Staff Opinion Survey Results noting
	  ○ A general decline in overall scores
	  ○ DCH remained above the national average in eight of the nine themed areas
	• Gender Pay Gap Report is recommended to the Board prior to publication on the trust website.
	• Freedom to Speak Up Insights
	• Guardian of Safe Working Hours Update
	• ICB People Committee Minutes.

Decisions made by the Committee	• The committee Terms of Reference and annual Work Plan were approved and are recommended to the Board for approval. A review of Committee Priorities and setting of committee priorities for 2023/24 will be presented to the committee in April.
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: 21st February 2023

Presented by: Eiri Jones / Jo Howarth

Significant risks / issues for escalation to Board for action	• Two ward closures due to norovirus • The Trust not currently using Birmingham Symptom Specific Obstetric Triage System (BSOTS) which was the preferred CQC maternity triage system. This was likely to be noted at any upcoming CQC visit to maternity. • Entonox levels remain too high in two maternity rooms • The importance of strengthening governance and focus on reducing unwarranted variation • The impact of upcoming RCN industrial action

Key issues / matters discussed at the Committee	The committee received, discussed and noted the following reports:
	• Quality and Safety Performance Report noting:
	  ○ Stable quality metrics within the context of sustained operational pressures
	  ○ The CQC's final report of their review of the Trust's children and young people mental health services had been published. Action plan to be submitted by 27th March
	  ○ Two ward closures due to norovirus
	• Maternity Safety Report noting:
	  ○ Improved maternity staffing
	  ○ Disappointing VTE risk assessment audit; work continues to address this
	  ○ Temporary solution to emergency bells not being heard had been identified
	  ○ Detailed review of individual cases in the MBRRACE report
	• Learning from Deaths Q3 report noting a SHMI above range, but no other data corroborating this position. Further action being undertaken to confirm assurances around the SHMI.
	• Transformation update
	• Completion of the Annual Safe Staffing Return, identifying an uplift of staffing required in four wards

Decisions made by the Committee	• Nil
Implications for the Corporate Risk Register or the Board Assurance Framework (BAF)	• Nil new
Items / issues for referral to other Committees	• Nil

INTEGRITY | RESPECT | TEAMWORK | EXCELLENCE

NHS
Dorset County Hospital
NHS Foundation Trust

Escalation Report

Committee: Quality Committee

Date of Meeting: 21st March 2023

Presented by: Eiri Jones / Jo Howarth

Significant risks / issues for escalation to Board for action	• The number of patients with no criteria to reside who have died whilst waiting for an onward package of care (approx. four a month) • Ongoing concerns regarding the clinical coding position; further assurances being sought on medical record keeping and coding sepsis. • The impact of ongoing industrial action. • Suspension of microbiology from UKAS accreditation; a three-week period to get a full report from UKAS. For Quality Committee review in April. • Pilot scheme of a change to inpatient oncology service due to issues with staffing. Patients requiring specialist care would be admitted to Poole. This is a short-term solution, conscious to not let it become the status quo.

Key issues / matters discussed at the Committee	The committee received, discussed and noted the following reports:
	• Quality and Safety Performance Report and Industrial Action Impact Update noting:
	  ○ Openness, transparency and review of harm to patient with no criteria to reside.
	  ○ There remains a strong focus on quality and there has been effective planning for industrial action.
	  ○ Clear learning is emerging from industrial action that will become quality improvement opportunities. Increase in PALS and complaints from the recent junior doctor industrial action.
	• Maternity Safety Report noting:
	  ○ One formal and one informal complaint received. Improvement in training figures.
	  ○ Issues remain with Entonox level and emergency call bells with actions to address both being pursued.
	  ○ Detailed discussion of the serious incidents.
	• Board assurance Framework
	• IPC Winter Board Assurance Framework
	• Clinical Audit Bi-annual Report
	• No subcommittee Escalation Reports were received.
	• ICB Quality and Safety Committee Minutes.

Decisions made by the Committee	• Subject to some changes the CQC Report Action Plan was approved. • The Annual Review of Committee: Terms of Reference and Workplan were approved.
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: 21st March 2023

Presented by: Stuart Parsons

Significant risks / issues for escalation to Board for action	• Revisions to the trust's Standing Financial Instructions are recommended to the Board for approval noting increases in delegated financial authority limits. • The committee Terms of Reference and annual Work Plan are recommended to the Board for approval. • The Going Concern Statement is recommended to the Board for approval • The updated Board Assurance Framework is recommended to the Board.

Key issues / other matters discussed by the Committee	The committee considered the following items:
	• Review of Accounting Policies and Areas of Estimation
	• Charitable Funds Consolidation Review
	• Internal Audit progress Report including the following audit reports:
	  ○ Operational Business Planning Report
	  ○ Financial Governance Report
	  ○ DSP toolkit Report
	• External Audit Plan
	• Value for Money Risk Assessment.
	• Annual Clinical Audit Assurance Report was not received
	• Board Assurance Framework
	• Corporate Risk Register
	• Subgroup Escalation Reports from
	  ○ The Information Governance Group noting actions to address increasing Freedom of Information Act demand and limited capacity
	• ICB Risk and Audit Committee Minutes

Decisions made by the Committee	• As Above
Implications for the Corporate Risk Register or the Board Assurance Framework (BAF)	• Board Assurance Framework and Corporate Risk Register discussion noted the plans to embed risks with relevant committee reports and for greater dialogue between the BAF and the risk register going forward.
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: 17 January 2023

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 (Q3 22/23) to be held by Charity Strategy Group on 3.2.23.
Key issues / matters discussed at the Committee	**DCHC Charitable Funds Committee (17.1.23)** • **DCH Charity Business Plan 2023/24 (incl. Capital Appeal Plan (ED/CrCU)** recommended to Board for approval. • **DCH Charity Finance/Income 22/23** reports (M8 Nov 2022) received. Reserves at the end of November provided a surplus of £55k over the reserves target of £200k. • **DCHC Reserves Policy** updated policy and reserves level set at £220K for 23/24 (previously £200K). • **DCHC Policies Review (3-year)** review underway of all DCH Charity policies. Agenda item for Charitable Funds Committee on 21.3.23
Decisions made by the Committee	• DCH Charity Business Plan 2023/24 recommended to Board for approval for March meeting. • DCH Charity reserves level approved at £220K for 23/24.
Implications for the Corporate Risk Register or the Board Assurance Framework (BAF)	• Nil
Items / issues for referral to other Committees	• Nil

INTEGRITY | RESPECT | TEAMWORK | EXCELLENCE

NHS
Dorset County Hospital
NHS Foundation Trust

Escalation Report

Executive / Committee: Charitable Funds Committee

Date of Meeting: 21 March 2023

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 (Q3 22/23) held by Charity Strategy Group on 3.2.23. Agreed to hold no further quarterly reviews currently as charity's reserves position is sufficient. Further reviews will be held during 2023/24 if deemed necessary.
Key issues / matters discussed at the Committee	**DCHC Charitable Funds Committee (21.3.23)** • **DCH Charity Business Plan 2023/24** submitted to Board (meeting on 29.3.23) for approval. • **DCH Charity Finance/Income 22/23** reports (M11 Feb 2023) received. Reserves at the end of February provided a surplus of £220,316 over the reserves target of £220k. • **Capital Appeal (ED/CrCU)** report received. £255K income/pledges to date as of February 2023. Appeal Board in development. Grants programme ongoing. Donor Engagement Events programme for 2023. • **DCH Charity Policies Review (3-year)** All DCH Charity policies reviewed. Submit to Board for approval.
Decisions made by the Committee	• **DCHC Policies Review (3-year)** All DCH Charity policies reviewed. Submit to Board for approval.
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:	29th March 2023		
Document Title:	System Performance Report		
Responsible Director:	Nick Johnson, Interim CEO	Date of Executive Approval	20th March 2023
Author:	Jonquil Williams, Corporate Business Manager		
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	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 most significant issue affecting a wide range of metrics remains the lack of system flow. The number of patients Not meeting the Criteria to Reside (NCTR) remains high including in community hospitals. This impacts timely access to Emergency Departments with consequences in ambulance handover delays and planned inpatient activity including cancer.							
5. Action recommended	The Board of Directors is recommended to: 1. **NOTE** System Performance 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**	

System Performance Report

1. Introduction

1.1 This report updates the ICB Board on the current Performance Issues in the Dorset health system.

2. Key performance Issues – Elective Care

2.1 Progress on reducing long waiters continues with individual trust plans in place for areas of highest risk but operational pressures remain. The total waiting list size is higher than plan across the system.

2.2 The 104 week wait position, at DCH (Dorset County Hospital) is forecasting one patient waiting at the end of February (the patient had to cancel their appointment due to flu) but zero patients at the end of March 2023. UHD (University Hospitals Dorset) are currently forecasting that there will be zero patients waiting at the end of February and March 2023.

2.3 The number of patients waiting > 78 weeks at UHD is forecast to be one hundred and twenty three (123) across 4 specialties at 31 March 2023. These are all due to capacity issues and the trust is working towards reducing this figure as much as possible including seeking support from the National Mutual Digital Aid Service. DCH are reporting zero patients waiting at the end of March 2023.

3. Key performance issues: Patient Initiated Follow Ups (PIFU) and Advice and Guidance.

3.1 In 22/23 there is an expectation that 5% of follow-up outpatient appointments are converted to Patient Initiated Follow Ups. Dorset is currently not meeting this target and is unlikely to do so by March 2023. However, the Dorset system is fifth within the South West and ninth nationally by achieving 3.5% in December 2022. Dorset County Hospital and Dorset Healthcare are expected to achieve compliance by April 2023. When compared nationally Dorset is 'mid pack' with the national average being 2% and Dorset hovering around 2.2%. It should be noted that Dorset trusts are seeing or discharging to PIFU more patients than ever before. One major barrier holding up this workstream is the allocation of IT resources to allow changes to be made to current systems.

3.2 Sixteen specialist Advice and Guidance (A&G) requests per 100 first outpatient appointments should be achieved by the end of March 2023 but within Dorset UHD turnaround times for A&G are currently approximately 16 days whilst DCH are turning requests around in 3 days (the target for turnaround time is two days). There are both technical and cultural barriers to achieve this target. Dorset is not expected to achieve this target by the end of the year. Work is ongoing in UHD to reduce the length of turnaround time. However, diversion rates for Dorset (requests that are redirected, advice given or rejected as inappropriate) are amongst the best in the country.

3.3 There is a national ambition that twenty five percent (25%) of outpatient activity is conducted virtually. Whilst virtual performance peaked during Covid (2021) it has been in decline ever since and is settling around 21%. Virtual appointments are better suited to follow up activity, however, national target to reduce follow up activity means less opportunity to conduct virtual appointments. Work is ongoing system wide to increase virtual activity where possible, this includes reviewing clinic templates and adjusting for increased virtual activity, producing benchmarking for trusts to identify areas of good practice, using outpatient

manager forums to review performance. Anticipated compliance for this standard is expected by September 2023.

4. Key Performance Issues – Diagnostic

4.1 Activity recovery is generally good driving a strong performance on the cohort of patients waiting less than six weeks and less than twenty-six weeks although there are problems in endoscopy, echo cardiography and audiology. Sustained increased delivery and more equitable access will be facilitated if the Community Diagnostic Centre (CDC) business case is supported. In particular, issues in echocardiography are due to lack of capacity, increasing demand and workforce shortages. These are national not just local issues. NHS Dorset is working with NHSE South West network to discuss initiatives and address common problems. There is an overseas recruitment plan in place as well as level four apprenticeship posts as well as the continued use of insourcing to increase capacity. There is an additional Echo room being added to DCH.

4.2 Lack of capacity, increasing demand, workforce issues (including sickness rates) and strike action have impacted on the number of patients waiting longer than six weeks for an Endoscopy. Insourcing, mobile endoscopy service, recruitment drives and a longer term plan for the Dorset Endoscopy strategy are in place. The Strategy will ensure additional capacity towards the end of 23/24 and into 24/25.

4.3 Capacity for Audiology Services sees a similar issue with regards to increasing demand and workforce shortages. Dorset Healthcare are outsourcing to the independent sector to assist recovery. There is a workforce plan in place to recruit with agency staff being used in the interim. Additional capacity as part of the CDC programme will be available from mid 23/24.

5. Key Performance Issues – Cancer

5.1 The percentage of patients waiting less than 62 days for a first definitive cancer treatment remains challenging. Colorectal, Gynaecology, Head and Neck Upper GI and skin pathways all have plans in place to address issues but compliance is not expected across most pathways until July 2023. Two week waits referrals are much higher than pre pandemic rates, especially for patients waiting for colorectal and dermatology appointments. Improvement plans are in place with the development of the “FIT (Faecal Immunochemical Test) less than 10” pathway which commenced on 9th January 2023. Teledermatology usage (triage using images of skin lesions) is expected to release dermatology capacity with an IT solution being scoped. The target remains challenging and compliance is not expected for all relevant tumour sites until June 2023.

6. Key Performance Issues – Urgent and Emergency Care

6.1 Due to the Christmas and New Year period numbers of patients with No Criteria to Reside (NCTR) deteriorated but have now stabilised, however, there is limited evidence of sustained improvement despite additional capacity. Further work is underway through the mobilisation of an additional 90 beds during December and January coupled with the streamlining of Multi-Disciplinary Team (MDT) decision making processes, and the development of a Discharge to Assess programme, as well as efforts to improve communication with patients and families.

6.2 The level of challenge and the constraints affecting the system mean that it is not currently possible to predict when the situation will have significantly improved. Included in these figures are patients who have remained in hospital for more than 21 days and this number is steadily increasing. These patients are seeing increasing levels of frailty and acuity

within the inpatient setting. Targeted improvement work ongoing under oversight of the Discharge and Flow cell with focus on: Early Discharge Planning, Design of bespoke discharge solutions for patients not supported with core intermediate care offers and additional system capacity is being used to support long length of stay discharges where appropriate (but often limited by complexity).

6.3 Category 2 mean ambulance response times have not been compliant with the target of 18 minutes since May 2021. Initial December data saw the average response time for the South West at 160 minutes with Dorset reporting 102 minutes. Recent validated data shows response times have been met on occasion and somewhat due to the 'reset' that the industrial action achieved, as behaviour of the public reduced demand. The industrial action has impacted less on performance than anticipated and good plans have been put in place by organisations and across the system. The three priority workstreams to further improve this include: transfer of lower acuity incidents to the Dorset UCR (Dorset Urgent Community Response) from December 2022, 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. Planned strikes by SWASFT personnel on in December and January saw reduced activity with improved response times but this returned to usual levels immediately after the strike day. Further ambulance strike action is planned for February 2023.

6.4 Ambulance Handover delays across all sites continue. During December Dorset ICS lost 7,194 hours. Reasons for the continued low performance is due to lack of patient flow through the hospitals (including NCTR patients), increased numbers of patients in the Emergency Department and no capacity in ED to enable timely handovers. There is a system-wide plan and a SWASFT handover escalation policy is now in place across all sites. Enhanced Care Services (ECS) have been commissioned by UHD to support ED cohorting, ongoing clinician to clinician learning across sites and a joined up approach with the discharge and flow programme.

7. Mental Health

7.1 The number of patients accessing specialist perinatal mental health services is an increasing local target. Dorset is currently not meeting the local target of 616 patients. This has been due to delays in the recruitment to posts (now resolved), the Maternal Mental Health Service data not being captured and the actual birth rate being lower than the Office of National Statistics (ONS) indicator. However, Dorset is now seeing sustained monthly incremental improvement, vacant posts have now been successfully recruited and there is a process in development to capture Maternal Mental Health Service data. It is anticipated that compliance will be met by the end of September 2023.

7.2 There remains limited capacity due to availability of workforce in Gateway Service & Core Child and Adolescent Mental Health service (CAMHS). There is agreement to undertake rapid and focused work with partners to transform current CAMHS offer at place level – Bournemouth CAMHS team identified as starting point. Compliance is not forecast until Q4 23/24.

7.3 Dorset is currently above its target for Children and Young Persons with a learning disability placed in an inpatient setting (7 patients against a target of 1). This has been due to an increased number of primary mental health presentations involving neurodiversity, lack of community options to safely manage presenting risk, delays with sourcing community placements and an additional diagnosis of a patient following transfer from a secure children's home. The system is working to develop a more effective Dynamic Support Register linked to new requirement outlined within the new Care and Treatment Review guidance (Jan 23), Children's and Young Persons (CYP) project worker in progress aimed to work with those identified as being most at risk of hospital admission, scoping development of a CYP Community Front Room offer and

enhancement of the CAMHS Crisis offer to complement the Provider Collaborative Close 2 Home team. Anticipated compliance is December 23/24.

7.4 The system continues to see growth in out of area beds in mental health driven by local inpatient capacity, delayed transfers (linked to delays in accessing care packages and supported housing). The New Hospital programme will increase bed stock locally but not until 2026. In the meantime, planning is underway to develop dedicated step-down beds within the Voluntary, Community and Social Enterprise (VCSE) sector. Beds at Marchwood Priory Hospital have been block booked to minimise distance away from Dorset. Fortnightly multi-agency discharge review meetings are held to improve flow through acute beds.

1.0 Service Delivery Scorecard – Elective Performance

Elective Care Recovery	Latest Period	Target	UHD				DCH				Dorset				South West		National	
			Plan	Actual	Variance	Assurance	Plan	Actual	Variance	Assurance	Plan	Actual	Variance	Assurance	Actual	Rank	Actual	Rank
Elective Recovery - Total Waiting List															7 SW ICBs		42 ICBs *Oct 22 Position*	
Total Waiting List Size	Dec 22	-	66,551	70,259	-	-	17,165	19,484	-	-	83,716	92,192	-	-	-	-	-	-
>104 Week waits	Dec 22	0 Jun 22	25	25	-		1	1	-		26	26	-		-	5	-	27
>78 Week Waits	Dec 22	0 Mar 23	167	473	-		100	99	-		267	574	-		-	4	-	13
>65 Week Waits	Dec 22	0 Mar 24	-	1,195	-		-	343	-		-	1,538	-		-	-	-	-
>52 Week Waits	Dec 22	0 Mar 25	3,158	3,472	-		1,300	1,218	-		4,458	4,982	-		-	3	-	8
Elective Recovery Productivity/Transformation																		
Total Ouptatient - Virtual (%)	Dec 22	25.0%	29.4%	19.2%			18.0%	20.9%			25.6%	20.9%			21.3%	4	-	-
Patient Initiative Follow ups % (PIFU)	Nov 22	5.0%	-	2.3%			-	2.5%			-	2.6%			-	-	-	-
Advice & Guidance % of 1st Outpatient	Oct 22	16.0	-	-	-	-	-	-	-	-	-	9.7			-	-	-	-
Diagnostic Recovery																		
Total Diagnostic Waiting List	Dec 22	-	-	11,771			-	5,528			-	17,299		-	-	-	-	-
% waiting over 6 weeks	Dec 22	25% Regional 1% National	-	14%			-	32%			-	20%			34%	1	-	-
Number waiting over 26 weeks	Dec 22	0		30	-		-	246	-		-	277	-		-	-	-	-
Cancer Recovery																		
Faster Diagnosis Standard (FDS) 28 days	Nov 22	75%	-	61%			-	75%			-	66%			65.10%	5	68.60%	26
Number of patients waiting <62 days to 1st definitive treatment	Nov 22	85%	-	64%			-	71%			-	66%			65%	2	-	-
62 day backlog	Dec 22	<220	-	248			-	63		-	-	298			-	-	-	-
Number of patients waiting <31 days to treatment	Nov 22	96%	-	97%			-	98%			-	96%			93%	1	-	-
Cancer two week wait	Nov 22	93%	-	-	-	-	-	65%			-	-	-	-	-	-	-	-
Cancer 2ww referrals	Nov 22	-	-	-	-	-	-	-	-	-	-	4,198		-	-	-	-	-
104 days back stop	Dec 22	-	-	62		-	-	21		-	-	76		-	-	-	-	-

1.1 Elective Recovery – Exception Report – Waiting List >104 Weeks
1.2 Elective Recovery – Exception Report – Waiting List >78 Weeks
1.3 Elective Recovery – Exception Report – Waiting List >65 Weeks
1.4 Elective Recovery – Exception Report – Waiting List >52 Weeks
1.5 Elective Recovery – Exception Report – Total Outpatients – Virtual (%)

1.6 Elective Recovery – Exception Report – Patient Initiated Follow Ups (PIFU)
1.7 Elective Recovery – Exception Report – Advice and Guidance (A&G)
1.8 Elective Recovery – Cancer – Exception Report – Faster Diagnostics Standard 28 Days
1.9 Elective Recovery – Cancer – Exception Report – 62 day backlog
1.10 Elective Recovery – Exception Report – Number of patients waiting <62 days to 1st definitive treatment

2.0 Service Delivery Scorecard – Elective Activity Recovery

NHS
Dorse

Elective Recovery	Latest Period (4 week rolling average)	Target	UHD			DCH			Dorset			SW Region		National	
			19/20	22/23	% recovery	19/20	22/23	% recovery	19/20	22/23	% recovery	% recovery	Rank	% Act	Rank
Elective Activity												7 SW ICBs			
Elective Ordinary Spells	08 Jan 23	100.00%	190	209	110.0%	43	28	65.1%	232	237	102.2%	85.0%	1	-	-
Elective Day Case Spells	08 Jan 23	104.00%	1179	1319	111.9%	386	449	116.3%	1672	1628	97.4%	91.0%	2	-	-
Outpatient attendances - First Attendance	08 Jan 23	104.00%	3192	3222	100.9%	729	791	108.5%	3921	4013	102.3%	97.6%	4	-	-
Outpatient attendances - Follow up Attendance	08 Jan 23	75.00%	4282	3937	91.9%	1481	1485	100.3%	5763	5422	94.1%	95.7%	3	-	-
Diagnostic Activity														42 ICBs *Oct 22 Position*	
Imaging: Diagnostic Recovery %	08 Jan 23	120%	2950	3112	105.5%	1167	1235	105.8%	4116	4347	105.6%	105.2%	5	105.2%	30
Physiological Measurement: Diagnostic Recovery %	08 Jan 23	120%	433	464	107.2%	160	108	67.5%	592	572	96.6%	92.2%	2	100.8%	20
Endoscopy: Diagnostic Recovery %	08 Jan 23	120%	251	416	165.5%	144	141	98.1%	395	556	141.0%	122.9%	1	90.1%	2

	Latest Period (4 week rolling average)	Target	UHD			DCH			Dorset			SW Region		National	
				% Act	Rank		% Act	Rank		% Act	Rank		Rank	% Act	Rank
Value Weighted Activity (VWA)										SW Rank: 2					
Elective Ordinary Spells	15 Jan 23			114.0%	1		55.6%	12							
Elective Day Case Spells	15 Jan 23			91.3%	11		115.5%	1							
Outpatient attendances - First Attendance	15 Jan 23			96.7%	10		109.4%	5							
Outpatient attendances - Follow up Attendance	15 Jan 23			89.8%	5		100.0%	8							

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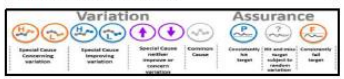
Dorset County Hospital
NHS Foundation Trust

2.0 Service Delivery Scorecard – Elective Diagnostics

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
Diagnostic Performance																
Total Diagnostic Waiting List	Dec 22	-	-	11,771			-	5,528			-	17,299		-	-	-
% waiting over 6 weeks	Dec 22	25% Regional 1% National	-	14%			-	32%			-	20%			34%	1
Number waiting over 26 weeks	Dec 22	0		30	-		-	246	-		-	277	-		-	-
Diagnostic Modality																
Audiology - Audiology Assessments	Dec 22	25% Regional 1% National	-	-	-	-	-	31.9%				31.9%			36.7%	6
Cardiology - Echocardiography			-	33.4%			-	71.5%				55.1%			48.5%	5
Colonoscopy			-	49.1%			-	24.7%				44.4%			48.4%	3
Computed Tomography			-	1.6%			-	8.7%				3.0%			23.6%	1
Cystoscopy			-	20.8%			-	3.4%				12.5%			32.6%	1
DEXA Scan			-	0.6%			-	3.7%				1.6%			31.8%	1
Flexi Sigmoidoscopy			-	43.6%			-	12.5%				40.0%			42.9%	4
Gastroscopy			-	27.4%			-	12.2%				24.0%			35.3%	6
Magnetic Resonance Imaging			-	1.7%			-	1.2%				1.6%			24.3%	1
Neurophysiology			-	0.9%			-	0.0%				0.8%			8.5%	2
Non-obstetric Ultrasound			-	4.2%			-	14.1%				6.9%			30.6%	2
Respiratory physiology			-	35.8%			-	6.5%				27.7%			47.7%	2
Urodynamics - Pressures & Flows			-	-	-	-	-	40.0%				40.0%			40.6%	3



2.1 Elective Recovery – Exception Report – Endoscopy Waiting Times
2.2 Elective Recovery – Exception Report – Echocardiography Waiting Times & Activity Performance
2.3 Elective Recovery – Exception Report – Audiology Waiting Times

INTEGRITY | RESPECT | TEAMWORK | EXCELLENCE

NHS
Dorset County Hospital
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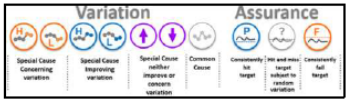
3.0 Service Delivery Scorecard – Urgent & Emergency Care

NHS Dorset

Urgent & Emergency Care Scorecard	Latest Period	Target	UHD			DCH			Dorset			South West		National	
			Actual	Variance	Assurance	Actual	Variance	Assurance	Actual	Variance	Assurance	Actual	Rank	Actual	Rank
Urgent Care Access												7 SW ICBs		42 ICBs	
Non-Elective Admissions v 19/20 actual - Month	Dec 22	8,914 (19/20)	5,972 (6,968 - 19/20)	-	-	1,804 (1,946 - 19/20)	-	-	4,936	-	-	-	-	-	-
A&E attendances V 19/20 actual - Month	Dec 22	25,228 (19/20)	13,689 (16,622 - 19/20)	-	-	7,734 (8,606 - 19/20)	-	-	21,423	-	-	-	-	-	-
12 hour breaches ED	Nov 22	-	332		-	50		-	382		-	3,906	3	-	-
No criteria to reside (NCTR) number of patients (Daily)	19 Jan 23	-	244		-	75		-	319		-	-	-	-	-
No criteria to reside % of beds occupied (Daily)	19 Jan 23	-	23.9%		-	26.1%		-	24.4%		-	22.3%	5	15.3%	40
Length of Stay >21 days number of patients (average)	Dec 22	-	61			54			59			-	-	-	-
Adult general and acute type 1 bed occupancy (Daily)* Data being reveiwedby UHD	19 Jan 23	<92%	92.2%			93.9%			92.6%			96.90%	2	95.90%	26

Urgent & Emergency Care Scorecard	Latest Period	Target	UHD			DCH			Dorset			SWAST / DHC	
			Actual	Variance	Assurance	Actual	Variance	Assurance	Actual	Variance	Assurance	Actual	Rank
Urgent Care Compliance												11 Providers	
Mean 999 Call answering times (Minutes/Seconds)	Dec 22	00:00:10	-	-	-	-	-	-	00:02:06			00:02:06	11
Category 1 Ambulance Response Times (Minutes)	Dec 22	7	-	-	-	-	-	-	12			10.1	8
Category 2 Ambulance Response Times (Minutes)	Dec 22	18	-	-	-	-	-	-	102			159	8
111 Call abandonment (Dorset HealthCare)	Nov 22	<=3%	-	-	-	-	-	-	3.8%			12%	3
Average Hours Lost to ambulance handover delays per handover (Hours)	Dec 22	-	1.9			0.4			1.4			2	-
Total Hours lost to ambulance handover delays (month)	Dec 22	-	6686			507			7194			-	-
SWAFST - Category 2 Ambulance Response Times (Minutes)	Dec 22	18	-	-	-	-	-	-	159			159	8
SWAFST - Average Hours Lost to ambulance handover delays per handover (Hours)	Dec 22	-	-	-	-	-	-	-	2.02			2.02	-



3.1 Urgent & Emergency Care – Exception Report – 12 hour ED breaches
3.2 Urgent & Emergency Care – Exception Report – No criteria to reside % of beds occupied (NCTR)
3.3 Urgent & Emergency Care – Exception Report – Length of Stay (LoS) >21 days number of patients
3.4 Urgent & Emergency Care – Exception Report – Category 2 Ambulance Response Times
3.5 Urgent & Emergency Care – Exception Report – Handover Delays

4.0 Service Delivery Scorecard – Mental Health

NHS
Dorset

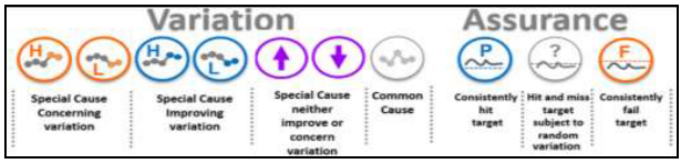
Mental Health Scorecard	Latest Period	National Target (March 2023)	Local Target	DHC		
				Actual	Variance	Assurance
Mental Health - Access						
IAPT Waiting Times - 6 Weeks	Dec-22	75%	75%	98%		
IAPT waiting times withing 18 weeks	Dec-22	95%	95%	100%		
IAPT Recovery Rate	Dec-22	50%	50%	50%		
Perinatal Access	Dec-22	714	616	555		
Access Early Intervention in Psychosis (%of prevalence)	Dec-22	60%	60%	86%		
CYP Urgent Access to Eating Disorders <1week	Dec-22	95%	70.59%	60.00%		
CYP Routine Access to Eating Disorders <4weeks	Dec-22	95%	45.45%	50.00%		
CYP access (1+contact)	Dec-22	7,813	7,492	5,504		-
CAMHS Gateway <4weeks (28 days)	Dec-22	-	95%	11%		
Adult CMHT RTA <28 days	Dec-22	-	95%	83%		
OP CMHT <28 days	Dec-22	-	95%	98%		
Mental Health Indicators						
SMI Health Checks in last 12 months	Dec-22	60%	60%	54%		
LD inpatients CYP	Dec-22	1	1	7		
LD inpatients adult	Dec-22	20	20	16		
Adult Acute Out of Area Placement number	Dec-22	0	0	12		
Adult Acute Out of Area Placement (occupied bed days)	Dec-22	0	0	527		
Mental Health Referrals	Dec-22	-	-	4,937		-

4.1 Mental Health – Exception Report – Number of Patients Accessing Specialist Perinatal Mental Health Services

4.2 Mental Health – Exception Report – Child & Adolescent Mental Health Services (CAMHS) Gateway <4weeks (28 days)

4.3 Mental Health – Exception Report – Learning Disability (LD) inpatients Children & Young Persons

4.4 Mental Health – Exception Report – Adult Acute Out of Area Placement (occupied bed days)



Report Front Sheet

1. Report Details			
Meeting Title:	Board of Directors, Part 1		
Date of Meeting:	29 March 2023		
Document Title:	**Gender Pay Gap Report (2022)**		
Responsible Director:	Emma Hallett, Acting Chief People Officer	Date of Executive Approval	13 March 2023
Author:	Vicky Douglas, HR Project Manager Catherine Youers, Acting Deputy Chief People Officer / Head of HR		
Confidentiality:	N/A		
Publishable under FOI?	Yes		
Predetermined Report Format?	Yes		

2. Prior Discussion		
Job Title or Meeting Title	**Date**	**Recommendations/Comments**
People and Culture Committee	20/03/2023	Noted, escalated to Board

3. Purpose of the Paper	To review and approve the Gender Pay Gap report. All UK employers have a legal requirement to publish their gender pay data on an annual basis.							
	Note (✓)		*Discuss (✓)*		*Recommend (✓)*		*Approve (✓)*	✓
4. Executive Summary	The gender pay gap calculation is based on the average hourly rate paid to men and women. This calculation makes use of two types of averages: a mean average and a median average. The mean is the average hourly rate and the median is the mid-point hourly rate for men and for women in the workforce. The mean figure is the figure most commonly used. This report for Dorset County Hospital NHS Foundation Trust reviews the latest data set, which covers the 12-month period ending 31 March 2022.							
5. Action recommended	The Board is asked to: 1. **APPROVE** the Gender Pay Gap report 2022 for submission & publication on government portal and DCHFT internet.							

6. Governance and Compliance Obligations			
Legal / Regulatory Link	**Yes**		Annual statutory requirement
Impact on CQC Standards		**No**	
Risk Link	**Yes**		The analysis of the gender pay gap results has assisted in identifying key areas of concern and potential risk and these were incorporated into the action plan.
Impact on Social Value	**Yes**		As per People strategic objective below
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	DCH will be recognised locally as a highly attractive place to develop long term clinical and non-clinical careers, contributing to population health and wellbeing across Dorset.		
	Place			
	Partnership			
Dorset Integrated Care System (ICS) Objectives		**Which Dorset ICS Objective does this report link to / support?** *Please summarise how your report contributes to the Dorset ICS key objectives.* *(Please delete as appropriate)*		
Improving population health and healthcare		**Yes**		As above
Tackling unequal outcomes and access			**No**	
Enhancing productivity and value for money			**No**	
Helping the NHS to support broader social and economic development			**No**	
Assessments		**Have these assessments been completed?** *If yes, please include the assessment in the appendix to the report..* *If no, please state the reason in the comment box below.* *(Please delete as appropriate)*		
Equality Impact Assessment (EIA)		**Yes**		The gender pay gap results show the difference in the average pay between all men and women in the Trust**.**
Quality Impact Assessment (QIA)			**No**	

Title of Meeting	**Board of Directors, Part 1**
Date of Meeting	**20 March 2023**
Report Title	**Gender Pay Gap – annual report 2022**
Author	**Vicky Douglas, HR Project Manager** **Reviewed by, Catherine Youers, Acting Deputy Chief People Officer / Head of Human Resources**

1. The Trust's Overall Results

1.1 From 2017, as an employer who has a headcount of 250 or more on a 'snapshot date' we must comply with regulations on gender pay gap reporting. Gender pay gap calculations are based on employer payroll data drawn from a specific date each year. This specific date is called the 'snapshot date'. For the purpose of this report the snapshot date is 31 March 2022.

1.2 Across our entire workforce our mean gender pay gap is 25%. This means that the average hourly pay rate for men is 25% higher than for women. This is a 1% change on the pay gap of 26% recorded in 2021. Our overall median gender pay gap is 8%. This means that the mid-point hourly rate for men is 8% higher than for women. This is a change of 1% since 2021 where the overall median gender pay gap was 9%.

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

2. The difference between gender pay and equal pay

2.1 It is important to be clear about the difference between gender pay and equal pay. The solutions to equal pay and gender pay are different. Closing the gender pay gap is a broader societal as well as organisational issue. Though we have a gender pay gap due to our disproportionate representation of men and women within the workforce (as reflected across the NHS), we are confident that we pay fairly in accordance with the nationally recognised Agenda for Change, Medical & Dental and our locally recognised Senior Manager and Director pay structures.

2.2 The NHS Job Evaluation Scheme, part of the Agenda for Change NHS pay structure introduced in 2004 was developed as a means of determining pay bands for posts. The key feature in both the design and implementation of this scheme was to ensure equal pay for

work of equal value. The scheme has been tested legally and has been found to be equal pay compliant.

2.3 The six basic calculations the Trust is required to report:

- mean gender pay gap;
- median gender pay gap;
- mean bonus gender pay gap;
- median bonus gender pay gap;
- proportion of males and females receiving a bonus payment;
- proportion of males and females in each quartile band.

As with any data analysis, the most critical aspect of the process is not just about reviewing the results but being clear about what needs to be done differently in future.

3. Purpose of this Report

3.1 This report will help the Trust to understand any underlying causes for their gender pay gap and take suitable steps to minimise it. Taking these steps will help us to continue to develop a reputation for being a fair and progressive employer, attracting a wider pool of potential recruits for vacancies and the enhanced productivity that can come from a workforce that feels valued and engaged in a culture committed to tackling inequality.

4. Methodology

3.1 Reports developed by our colleagues from the Electronic Staff Record (ESR) help organisations calculate GPG data. These are available via ESR and accessible via the dashboard of ESR Business Intelligence.

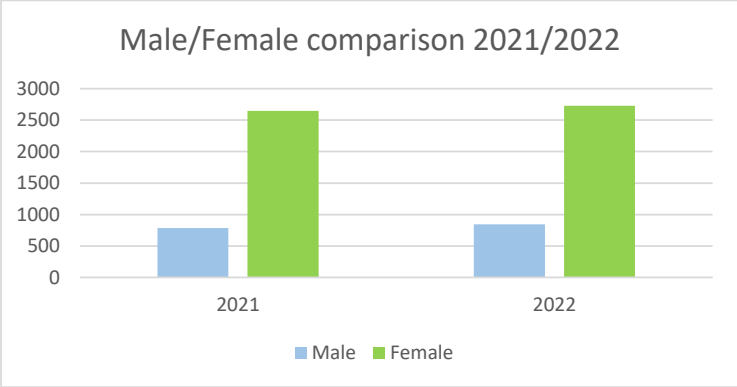
5. Gender Pay Gap Data

5.1 Our gender pay gap results (based on the hourly pay rates our employees received on 31 March 2022) are as follows:

- Our mean gender pay gap is 25%
- Our median gender pay gap is 8%
- Our mean bonus gender pay gap is 22%
- Our median bonus gender pay gap is 67%
- Our proportion of males within whole Trust receiving a bonus payment is 5%
- Our proportion of females within whole Trust receiving a bonus payment is 0.40%
- Our proportion of eligible males receiving a bonus payment is 36%
- Our proportion of eligible females receiving a bonus payment is 26%

5.2 The Trust collected data on 31 March 2022 when the workforce consisted of 2728 women and 845 men.

5.3 There has been some increase in staff numbers this year. Female members of staff have increased by 81 and males have increased by 62. There is a 1% shift from female to male employees in the workforce.



5.4 Quartile Analysis

5.4.1 The table below shows the proportion of males and females in each of the quartile bands. (The quartile information is created by sorting all employees by their hourly rate of pay and then splitting the list into 4 equal parts to create 4 pay quartiles).

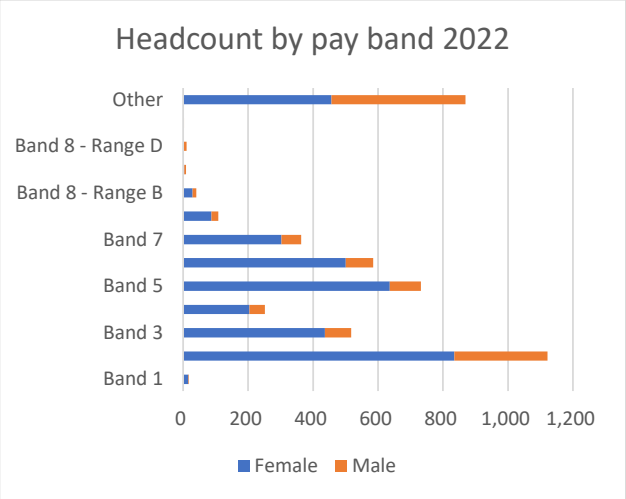
	2021/22				2020/21			
Quartile	Female	Male	Female %	Male %	Female	Male	Female %	Male %
1	676	216	76	24	674	183	79	21
2	719	174	81	19	685	173	80	20
3	716	153	82	18	713	142	83	17
4	617	302	67	33	575	285	67	33

5.4.2 The proportion of male and female employees in the lowest pay quartile is 76% female and 24% male, compared to the proportion of male and female employees in the highest pay quartile which is 67% female and 33% male.

5.4.3 There is an increase of male and female employees in all quartiles. The biggest increase in numbers for female employees was in quartile 4, the biggest increase for male employees was quartile 1.

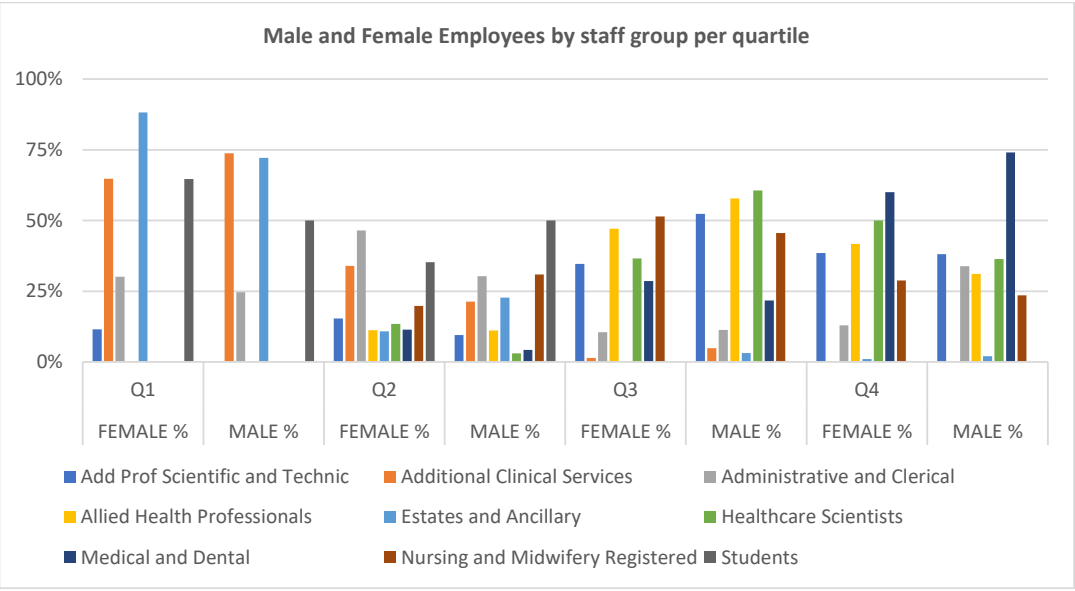
5.4.4 In quartiles 2, 3 and 4 the percentage change between 2021 and 2022 was not significant, i.e. 1% or less. In quartile 1 the male employees increased by 3%, whilst female employees decreased by 3%. However, both increased in number employed.

5.4.5 The graph below shows the percentage breakdown of pay bands by gender. Female employees are dominate in all pay bands, with the exception of bands 8C and 8D, although in 8C and 8D the numbers are small. In band 9 there are 2 female employees and 1 male.



	Female	Male
Band 1	16	2
Band 2	835	287
Band 3	436	81
Band 4	204	48
Band 5	636	96
Band 6	501	84
Band 7	303	60
Band 8 - Range A	87	21
Band 8 - Range B	29	12
Band 8 - Range C	4	5
Band 8 - Range D	3	8
Band 9	2	1
Other	457	412

The graph below shows the percentage break down of male and female employees by staff group in each quartile.



5.5.6 This shows the majority of our students beginning their NHS careers with us are female. Students dominate in quartile 2. In quartile 4 female employees equate for a higher proportion in all staff groups other than medical and dental which remains predominantly male.

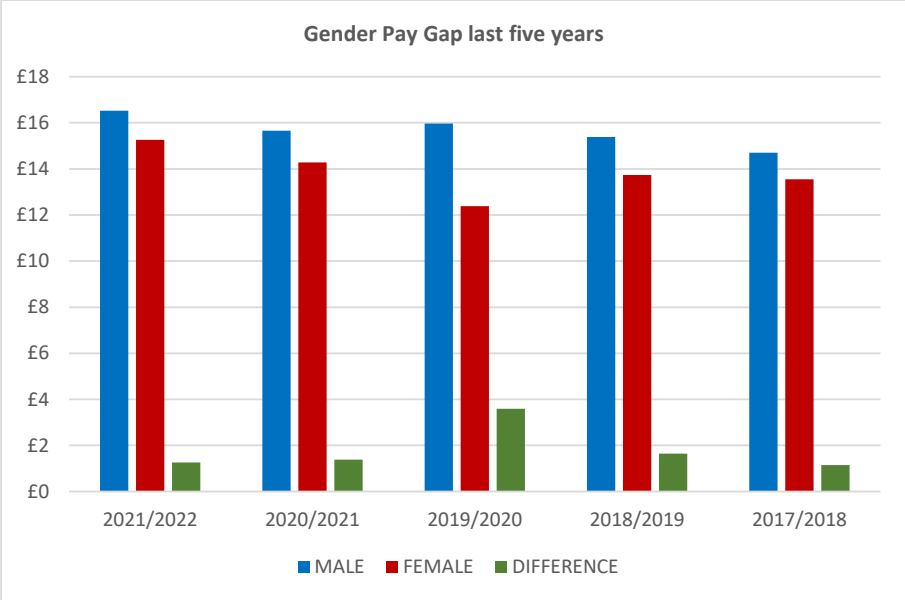
5.6 Mean & Median Hourly Rates

Gender	2021/2022				2020/2021			
	Avg. Hourly Rate	Movement in year	Median Hourly Rate	Movement in year	Avg. Hourly Rate	Movement in year	Median Hourly Rate	Movement in year

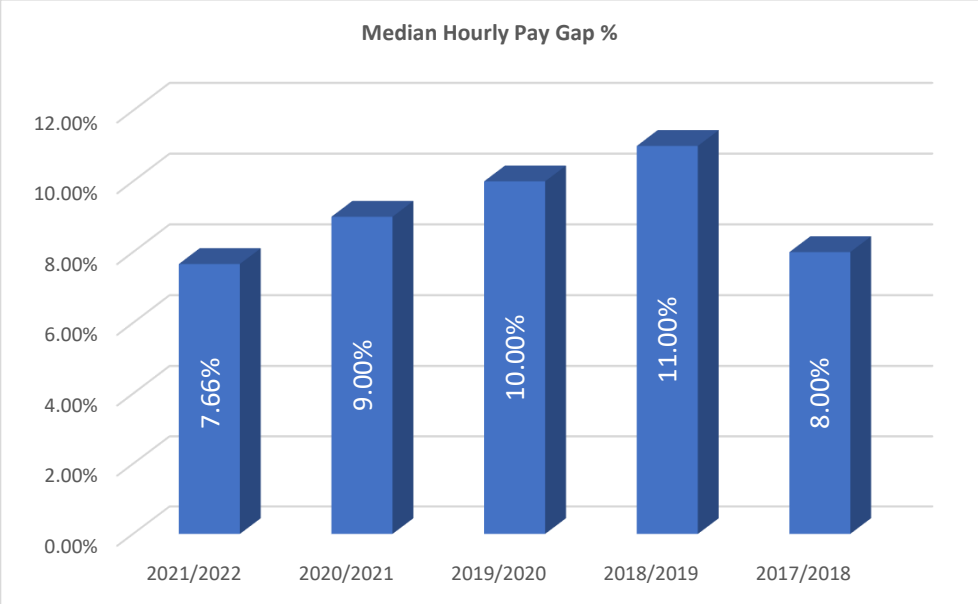
Male	£22.42	£0.57	£16.52	£0.86	£21.85	0.05	£15.66	-£0.31
Female	£16.90	£0.74	£15.26	£0.98	£16.16	£1.17	£14.28	£1.90
Difference	£5.52	-£0.17	£1.27	-£0.10	£5.69	-£1.12	£1.37	-2.22
Pay Gap %	25%		8%		26%		9%	

5.6.1 The Trust's mean gender pay gap is 25% in favour of men (women earn 25% less than men) compared to the national average of 8.3% (full time employees/14.9% all employees) in favour of men (source: Gender Pay Gap in the UK: 2022 Office for National Statistics, April 2022).

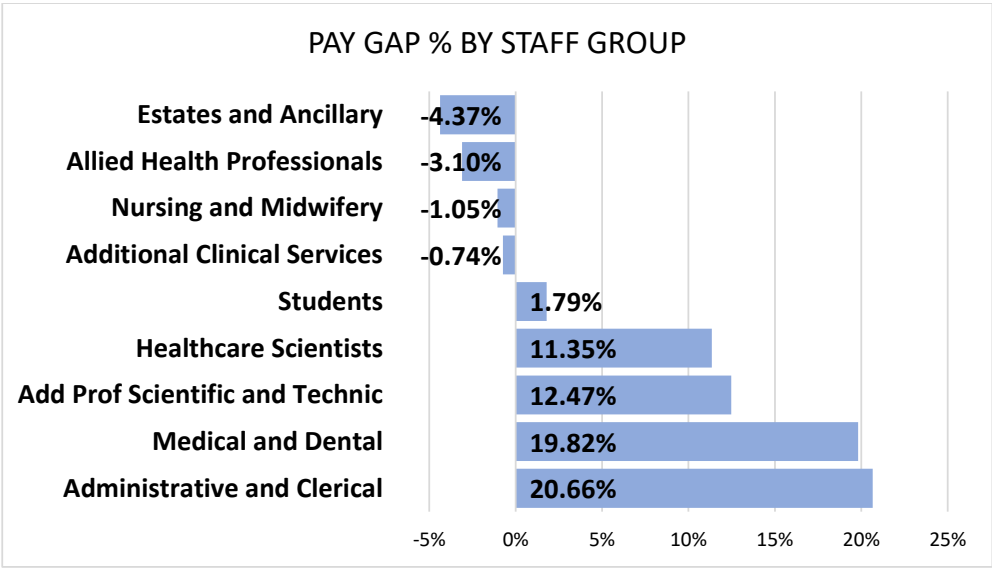
5.6.2 Reviewing the Gender Pay Gap data for the past five years shows our progress over that time. The gap between male and female median hourly rates of pay is less than since 2017/18, with a difference of £1.26 per hour. The difference peaked in 2019/20 with a difference of £3.59 per hour, as shown in the chart below.



5.6.3 We saw the median hourly pay gap increase to 11% in 2018/2019 and reduce each of the following years, with 2021/22 seeing a further reduction of1.34% to 7.66%.



5.6.4 In order to gain a better understanding of what is creating our gender pay gap we have carried out analysis by staff group. This shows quite a variance across the groups. Ranging from a 20.66% pay gap for Administrative and Clerical and 19.82% pay gap for Medical & Dental, to a minus pay gap of 4.37% for Estates, 3.10% Allied Health Professionals, 1.05% Nursing and Midwives and 0.74% for Professional and Technical staff.



5.6.5 The main reason for the gender pay gap at the Trust is that there is a higher proportion of males in more senior bands and females in lower bands within the Trust.

5.7 Gender Bonus Pay Gap Results

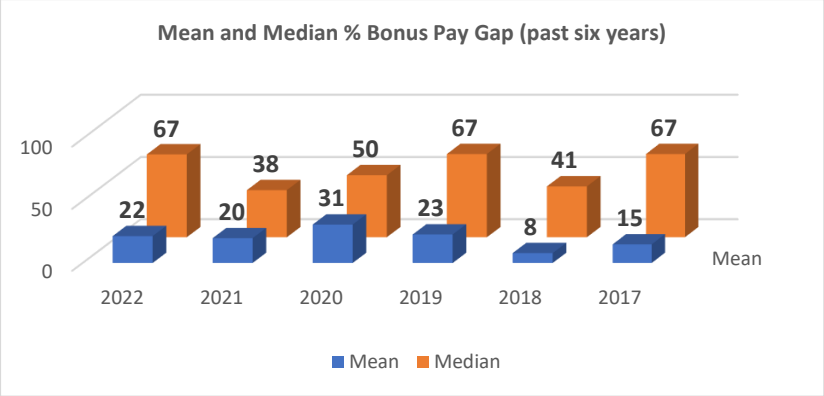
5.7.1 For Gender Pay Gap calculations, our bonus payments relate to Clinical Excellence Awards only. Traditionally, these award Consultants who perform 'over and above' the standard expected of their role there are 12 levels of award, awarded locally and nationally. However, in the absence of a national agreement and for the last three years of award rounds the funds have been divided equally between eligible consultants.

5.8 Bonus Pay Summary

5.8.1 The table below shows the summary of male and female employees receiving a bonus payment. The only bonus payments paid by the Trust are local and national Clinical Excellence Awards, paid to eligible Consultants.

Gender	Mean Pay	Median Pay
Male	12,586.24	9,048.00
Female	9,866.44	3,015.96
Difference	2,719.80	6,032.04
Pay Gap %	21.61	66.67

5.8.2 As can be seen in the graph below the mean % pay gap has a small increase this year and the median % bonus pay gap has increased by 29%, similar to 2019.



5.9 Bonus Ratio

5.9.1 The number of employees eligible for a bonus is 190. Of that number 50 employees are female and 140 male.

5.9.2 The proportion of female employees (24%) eligible for bonus payments is considerably lower than eligible male employees (76%). This is due to the lower number of female employees progressing to consultant level. As a Trust we have followed the national guidance by sharing the CEA funds equally across all eligible Consultants.

5.9.3 The below table shows the proportion of male employees and female employees within the whole Trust receiving a bonus payment. Of those who were eligible, 36% of males and 26% of females received a bonus.

Gender	Employees Paid Bonus	Total Relevant Employees (inc bank)	%
Female	13	3258	0.40%
Male	50	1000	5.00%

6. Understanding our Gender Pay Gap

6.1 Male employees make up 24% of the workforce, which means the 33% of males in the highest paid quartile is a disproportionate number. However, female employees occupy 67% of the highest paid quartile. This represents a higher proportion of females than in the general population of England and Wales, which according to national statistics is 51%. In the latest available data (2021) 56% of NHS England's upper quartile senior staff are female.

6.2 76% of employees in the lower quartile (lowest paid) jobs were female and although this is 3% fewer than 2021, male employees remain more highly represented in higher paid jobs. This demonstrates that a significant driver for the pay gap is a consequence of having a lower proportion of male employees in lower pay bands relative to their share of the population.

6.3 The Trust's median gender pay gap is 8% in favour of male employees (female employees earn 25% less than male employees) compared to the national average of 8.3% (full time employees/14.9% all employees) in favour of males (source: Gender Pay Gap in the UK: 2022, Office for National Statistics, April 2022). This is not the same as saying females and males are being paid differently for doing the same job (which would be an equal pay issue).

6.4 At the Trust, whilst we have a higher proportion of female staff in our workforce, we also have a significant proportion of our male workforce now at the point in their careers where they are senior medical staff and therefore are higher up the pay grades than some more junior members of staff.

6.5 This is reflected in our overall gender pay gap and, as a Trust, we recognise that this is a generational and societal issue. We know, however, that an increasing number of females are choosing to pursue medicine and other previously male-dominated roles as a career.

7. Addressing our Gender Pay Gap/ Recommendations

7.1 Reducing our gender pay gap indicates a need to either increase the number of male employees in lower grades or increasing the number of female employees in the more senior roles.

7.2 To implement change there is a need to address the barriers for female employees and target the inequalities faced by females belonging to specific groups, based on characteristics such as ethnicity, age and profession. It remains that there are fewer female employees in senior medical roles.

7.3 There is movement on the focus of advanced practice roles, which are Band 7 and above and therefore likely to have a positive impact on female senior post holders.

7.4 Further possible barriers that may be contributing to the pay gap could be addressed by:

- Ensuring equality of recruitment, including unidentifiable external recruitment.
- Flexible working options, including hybrid working/working at home. The Trust made many changes to the way in which it worked during the pandemic and as such there are many more employees now working from home on a regular basis. This has allowed these employees to address their work life balance in a positive way.
- Further promoting our Flexible Working policy and ensuring staff and managers are aware of broader flexible working options, such as hybrid working, adjusted hours, types of contracts and trialling possible changes etc.
- Supporting managers in having health and wellbeing conversations that cover flexible working in annual appraisals, regular 1:1 meetings and with new starters as part of their induction. As a healthcare setting it is also important to recognise there are some roles that cannot be performed at home.
- Our current Staff Networks continuing to offer networking and peer support for females in the workplace.
- Supporting the development of female employees through talent progression opportunities, mentoring and leadership development. Giving focus to our female employees in the lower bands to equip them with the skills and confidence to apply for our more senior posts.
- Continued work underpinned by our People Plan and our goal to be recognised as a highly attractive place to develop a long term clinical and non-clinical career.

7.4 Whilst we have commenced our work with local communities to build a sustainable and representative workforce we could continue to do so giving access and increased opportunity to vacancies at the Trust.

8. References

Estimates of the population for the UK, England, Wales, Scotland and Northern Ireland - Office for National Statistics (ons.gov.uk)

Gender pay gap in the UK - Office for National Statistics (ons.gov.uk)

gov.ie - What is the Gender Pay Gap Information Act 2021? (www.gov.ie)

B0986_iii_Gender-Pay-Gap-Report_2021.pdf (england.nhs.uk)

9. Recommendation

9.1 The Board is asked to approve the report and authorise the submission of gender pay data to the Government portal by the national deadline of 31 March 2023, and the publication of this report on the Trust's intranet.

Meeting Title:	Board of Directors, Part 1
Date of Meeting:	29 Mar 2023
Document Title:	**Board Assurance Framework (BAF)**
Responsible Director:	Chris Hearn – Chief Financial Officer
Author:	Philip Davis - Head of Strategy

Confidentiality:	*n/a*
Publishable under FOI?	*Yes*

Prior Discussion		
Job Title or Meeting Title	**Date**	**Recommendations/Comments**
EMT Meeting	16/03/23	Additional feedback from Anita Thomas re. COO risks. CEO designate Matthew Bryant asked for clarification on BAF changes going into forthcoming FY23/24
Execs	w/c 06/03/23	Distributed to Exec team for feedback, edits made by Chris Hearn CFO
Finance and Performance Committee, Quality Committee, and Risk and Audit Committee	20 and 21/03/2023	Noted

Purpose of the Paper	To give assurance to Board Committees that the Risks to Delivery of our Trust Strategy (and the benefits therein) are understood, and actions to mitigate them have been put in place.							
	Note	✓	*Discuss*	✓	*Recommend*	✓	*Approve*	✓
Summary of Key Issues	**BAF** - BAF Is in 8th iteration and has been running bimonthly since publication of the Trust Strategy in Nov-21. **Risks Scored >20 (Extreme Risk)** PE 1.2 Owned by PCC with CPO as Accountable Exec. *If we fail to attract and retain the right people with the right skills then more pressure on existing teams* Mitigations have been put in place and monitored across FY22/23, including implemting Workforce Business Partner Model, System attract & retain, Career pathways and CESR Academy, local approaisal & development, developing temp staffing team, Management Matters (as part of People Plan) PL1.1 Owned by QC with CNO as Accountable Exec. *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.* Mitigations have been put in place and monitored across FY22/23, including Wellbeing support, international recruitment, Apprenticeships, Training, Retention Programme (as part of People Plan) PL1.5 Owned by FPC & QC with COO as Accountable Exec. *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*							

	Mitigations have been put in place and monitored across FY22/23, including reframed URG and EM Care Boards, Performance Framework Reporting, redesign through ED15, 7 day SDEC offering, Internal Home First Workstreams (as part of Clinical Strategy) The following risks have had their scores reduced in March BAF report. PL 2.2 from Risk 16 to 12: Business Case approval process and Governance hjas been tightened and is working. PL1.3 from 20 to 16. The Planning Guidance set us for FY22/23 from NHSE and in our local plan will be met in part. Industrial action has made an impact in Mar-23.
Action recommended	Board is asked to: 1. **NOTE** the March BAF 2. **Review** and **Comment** on the risks and mitigations, especially those risk 20 or scores changed this month. 3. **Recommend** the changes in this iteration (marked in Red). 4. **APPROVE** taking to Board on 29/03.

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	*N*
Impacts CQC Standards?	Y/N	*Y - Clinical Plan is closely focused on improving Patient Outcomes & Patient Experience, and People Plan strongly focused on staff wellbeing*
Impacts Social Value ambitions?	Y/N	*Y - Social Value Action plan sits within Sustainability & Efficiency Workstream, underlying the Trust Strategy.*
Equality Impact Assessment?	Y/N	*N*
Quality Impact Assessment?	Y/N	*N*

BOARD ASSURANCE FRAMEWORK - SUMMARY
DATE **Mar-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 PL2.2	16 PE1.1, PL1.2, PL1.10, PL1.11, PL1.2, PL1.3	20 PL1.1, PL1.5, PL1.3
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:						
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.	• 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	Assurances/ Evidence	Strength of Control	Strength of Assurance	Target Risk	Mitigations Target Date	1st Place Index - 1
Place Objective 1: We will deliver safe, effective and high-quality personalised care for every patient focussing on what matters to every individual														
RL L1	QC (triangulation with PCC)	CND	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 • Review of skills mix and new roles with redesign of roles to enable clinicians to practice at the top of their licence • Increased opportunities for supported training places • Stay and thrive programme to aid retention Controls non HR/OD: • Protocols and policies for clinical care • Quality improvement work to streamline care or improve effective patient care • Compliance with national standards to support patient care • Engagement with service users to assist in re-design effective and efficient care to maximise workforce efficiencies • Sub-board oversight of standards delivery and interventions as part of strategic objectives	• Sub-board reports: PCC; QC & R&C • Recruitment activity reports • Patient feedback • Staff feedback • Incident data • External assurance monitoring: CQC; CCG; auditors inc GIAP/Deloitte • Complaints risk register actions and lessons/managed risk	Good	Good	12	2026	
RL L2	QC	CND	CND - 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 • Risk management 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 in impacting on potential delivery of longer term care in the right place and therefore clinical outcomes. Escalated to partners and working with partners.	• 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	9	2025	
RL L3	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 to 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 2022 Maintain Waiting List at 2019/20 size Deliver 62 day backlog to the same size as 19/20 Increase cancer 1st treatments (2k 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 monitored through PTL meetings via weekly performance clinics/performance and EPMG to FPC/Quality crews. 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 • Clinical prioritisation processes and clinical prioritisation aligned to operational planning guidance. Performance Framework - triggers for interventions/support. Target date: completed and reporting through SLG/EPC • 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&PMG report and the Divisional exception reporting arrangements. Mar-22: Trust was predicted to meet the key planning asks in March 2022 however industrial Action across all key workforce elements within the QK have reduced available capacity - potential to miss 78 wk target by <10 patients. W/L size has gown during the period - aligned to C&P/ referral growth and well understood, also in keeping with other Trusts in WK	• Division and work stream action plans. External contracting reporting to ICS. Divisional exceptions at FPC Committee Performance reporting via weekly PTL meetings, Managing EPMG and monthly Divisional Performance Meetings (through to Sub-Board and Board) Weekly meetings with ELR/Region and positive movement noted	Good	Good	12	All monitoring in place. 6monthly updates to be reviewed at FPC	
RL L4	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 learning for altering those services under change services, therefore the objective of high-quality care that is safe and effective will not be met.	3	2	6	• Emergency Preparedness and Resilience Review Committee (EPRR) reporting, EPRR Framework and review and sign off by CCG and NHSE	Reporting from EPRR Committee to Risk and Audit Committee and via assigned NED to Board. Yearly self assessment against EPRR core standards ratified by Local Health Resilience Partnership. Internal Audit reports	Good	Good	3	in at target	
RL L5	FPC - performance QC - Harm related concerns	COO	CDO	**Risk description:** If our emergency and urgent care pathways do not meet the requirements of increased attendances then patients will not be long the 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	• Refreshed UEC & EM care Boards and ICPCS Boards objectives linked to the Boards delivery plan. CEO is the system SRO health inequalities • Urgent and Emergency Care Board - COO membership • Redesign through ED15 to increase estate and flow within current dept including commitment to increased workforce. Target date: completed • Increase to 7 day SDEC offer across medicine and surgical specialties. Target date – 7 day service completed. Surgical element requiring further refinement but delivered in first iteration • Ambulance Handover Initiative addressing emergency flow. Target date: strategies established with individual delivery timeframes - most significant is Eye Zone - delivery phased from 20/26. Home First Board work streams, October 2022 - first stage of integration / Went to begin. Target date: winter 22/24 for full delivery of integrated model - HF now replaced by ICB led ICA program with a delivery date of first iteration from 1 April 2023 • Internal Home First work streams - 7 day discharge services, strengthened front door multi-agency response, FAT. Target date: Key frameworks in place and implemented by winter 22/23 with full delivery by winter 23/24 (available resources- Target date Winter Plan - December 22 - March 23 Winter schemes - added Key workers, increased Trusted Assessor support, Care Hub/Home Borough Team, added Hours dedicated to #who_what_matters, Red to Green Days, Criteria Led Discharge, Discharge Lounge • Implementation of Phase 1 of the refresh of the Patient Flow Program underway - mapped to emerging winter plans. Focus on Pathway 0 patients and front door (ED/Bi-Border) 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,	• Upward reporting and escalation from UECB to SLT and DCH Board • Home First 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 BCI 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	
RL L6	FPC - performance QC - Harm related concerns	COO	CDO	**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 - As Q2 QA This is now integrated Neighbourhoods' Clare • Urgent and Emergency Care Board - COO membership • Investments in IED capacity, SSDC 7-day working, 7-day discharge services, front door multi-agency response, FAT. Target date: Winter Plan - December 22 - March 23 7-day services completed. Increased Hospital at Home - Focussed Closing awarded for the 'winter schemes' due to success in reduction of NBTR • Home First (DCH) Steering Group - FAT, redesign of discharge support, ECTT, MDT working, strengthened front door multi-agency response. Completion date- via Patient Flow Program Winter 2022 • VSCS support front door and discharge response. Plan in place (completed) Clinical and People Strategies for front door response. Target date: strategies agreed - key feature is Eye Zone with phased delivery from 20/24	Home First Board papers UECB papers Divisional reporting to FPC Performance Report - FPC BCI reporting to UECB on investments into patient flow 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	
RL L9	FPC	COO	CDO	**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: Outpatient Transformation Plan published. PIds pack implemented in June 22. Full roll out of virtual offer by March 23	• Reports to SLG and through to Board via Strategy updates	Good	Good	2	Internal transformation plans full delivery by March 23	
RL L10	QC?	CMO	CMO	**Risk description:** If the Trust's SHMI is out of range then it will suggest excess deaths are occurring regardless of the actual cause. So this will cause reputational damage and invite inspections by regulators, which are not necessary if coding is the underlying correctable cause.	4	4	16	• Scrutinising other care quality indicators to assure standards of care • Ensuring accuracy and timeliness of clinical coding by reporting by exception to FPC • The CMO receives a monthly update of number of uncoded SPELLS	• Regular reports to Hospital Mortality group, Quality Committee and Board.	Requires improvement	Good	8	Ongoing	
RL L11	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 in 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 19/5/23. **Gaps in Control and Actions:**	Vacancies versus establishment Coding backlog Improvement in SHMI	Requires improvement	Requires improvement	8	*	
Place Objective 2: We will build sustainable infrastructure to meet the changing needs of the population														
RL 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	5	10	• Full Programme Structure in place with dedicated team • SHP Project Board, Clinical Assurance Group, • Finance and Performance Committee into Trust Board • Lobbying of NHSE/I/HMP team re. need funding at all levels - SEED funding for 2022/23 now agreed **Gaps in Control and Actions:** - Regular reporting to FPC	• NHSE/I SOC Approval; • NHSE/I/HMP Deep Dive re. OBC; OBC submitted June 2022	Good	Good	10	Ongoing	
RL 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	3	12	• 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 reviews/tests of business cases against required templates	• Working Group papers • External approval of business cases e.g. NHP	Good	Good	10	31/03/2023	
RL 2.3	FPC	CFO	CFO	**Risk description:** If we do not work to improve our sustainability as an organization then we will increase our environmental impact and so we will not improve the environmental, social and economic well-being of our communities, populations and people.	3	3	9	• Sustainability champions & Sustainability Travel Working Group in place at DCH to encourage long term improvements and sustainability • Sustainability Programme in development in line with the Kings Fund Sustainability Theory bringing together Social, Environmental and Economic factors • Social Value Pledge and Action Plan in place emphasising the commitment to improving the wellbeing of the population • Green plan published and monitored annually • Planned revision of annual report to support triple bottom line reporting **Gaps in Control and Actions:**	• Regular reporting to Strategy and Transformation SLG • Annual reporting on Green Plan to FPC and Board	Good	Good	9	Ongoing	
Place Objective 3: We will safely digital technology to better integrate with our partners and meet the needs of patients														
RL 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	5	3	15	Dorset Care Record project lead is the Director of Informatics at UHD. Project resources agreed by the Dorset Senior Leadership Team. Project structure in place overseen by ICS Digital Portfolio Director **Gaps in Control and Actions:**	• Reports to the Dorset System Leadership Team. Updates provided to Dorset Operation and Finance Reference Group and the Dorset Informatics Group.	Good	Good	3	Achieved - currently at Target Risk	
RL 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.	4	4	12	Patching of perimeter defences, firewalls, servers, switches, desktop/laptop equipment, penetration tests and regular audits **Gaps in Control and Actions:**	• Annual Penetration Test Results and associated action plan • Annual DSPT submission • Regular reports to Quality Committee, Risk and Audit Committee, Trust Board • Annual Internal Audits • Annual renewal of ISO27001 accreditation • Tools deployed by the Trust to monitor and report on cyber threats • Use of tools made available by NHSE to monitor alerts/threats i.e. CareCERT • SIRO, Deputy SIRO, Information Security Manager, Data Protection Officer - all posts filled	Good	Good	8	Ongoing task, no fixed delivery date	
RL 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 accurance, digital training team providing training for all new starters and annual refresh training. Regular phishing campaigns.	• Annual DSPT submission • Regular reports to Quality Committee, Risk and Audit Committee, Trust Board • Targeted training resulting from output of internal campaigns • Annual Internal Audits • Annual renewal of ISO27001 accreditation • Tools deployed by the Trust to monitor and report on cyber threats • Use of tools made available by NHSE to monitor alerts/threats i.e. CareCERT	Good	Good	8	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														
RL 4.1	Quality Committee	CND Alison Hale: Patient Engagement Jo Hartley: Maternity voices partners	Alison Hale: Patient Engagement CND - AHSN	**Risk description:** If we fail to engage and work with partners and stakeholders to effectively maximise the opportunities to engage and co-design with our communities, then services will not be meeting the needs of those that use them.	4	4	12	• Your Voice group of service users- Target date: complete process in place and ongoing (reports to PEG and then QC) • Engagement with Dorset Race Equality 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 HEIG and QC • Engagement with Dorset Healthcare University and Dorset Research Ambassador Network: 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) • Digital engagement and coordinated 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.	• PEG actions/ notes • Patient feedback • Complaints reports • CQC reports • Maternity Voices reports • Complaints including local MPs related to engagement • Local independent groups reports or complaints • Dita Data and Public Health reports • Health Inequalities data	Good	Good	8	Apr-24	
RL 4.2	QC	CND & CMO	CIO - digital and tel Alison Hale: Patient feedback CMO - AHSN CIO/Director of IT 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	• Skills dataset • Partnership in ICS with Public health and Local authority at PLACE level • Digital data sources • Digital data sources with shared records • Business intelligence resources across the system • ICS Health inequalities group • ICS integrated working on pathways • Clinical networks membership with data sharing • Academic Healthcare science networks • ICS governance **Gaps in Control and Actions:** - Gap in analytics of data capacity to support clinical leads: ACTION: part of the One Dorset approach to digital and business intelligence resources aligned to the ICS digital strategy development	• HI group reports and actions • Benchmarking data • Dashboard data • Partners feedback • Data • National published reports or network reports • ICS Clinical reference group notes • National audits on outcomes	Good	Good	8	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: Mitigating schemes to support the Trust delivering a breakeven position have been identified, with work ongoing to deliver these opportunities						
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: Completed Working with DHC on UTC developments in the West - Target date for delivery is 23/24 South Walks initiative with system partners including Local Authority and	• 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 and is in the process of determining its agenda for 22/23. DCH/DHC collaboration on transformation in development						
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 Inadequate/poor performance rating Severely critical report

DOMAIN C5: FINANCIAL IMPACT OF RISK OCCURING

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

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

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

Risks	RAC Dates: Nov-21	11-Jan-22	15-Mar-22	10-May-22	12-Jul-22	20-Sep-22	22-Nov-22	20-Mar-23 pending	Trend
PE 1.1	16	16	16	16	16	16	16		Unchanged
PE 1.2	20	20	20	20	20	20	20		Unchanged
PE2.1	12	12	12	12	12	12	12		Unchanged
PE 3.1	8	8	8	8	8	8	8		Unchanged
PE 3.2	12	12	15	15	15	15	15		Worsening
PE 3.3	12	12	12	12	12	12	12		Unchanged
PE 3.4	6	6	6	6	6	6	6		Unchanged
PL 1.1	20	20	20	20	20	20	20		Unchanged
PL 1.2	16	16	16	16	16	16	16		Unchanged
PL1.3	16	20	20	20	20	20	16		Improving
PL 1.4	6	6	6	6	6	6	6		Unchanged
PL 1.5	20	20	20	20	20	20	20		Unchanged
PL 1.6	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		Unchanged
PL 1.10	16	16	16	16	16	16	16		Unchanged
PL 1.11			16	16	16	16	16		Worsening
PL 2.1	15	20	15	15	15	10	10		Improving
PL 2.2	16	16	20	16	16	16	12		Improving
PL 2.3	9	9	9	9	9	9	9		Unchanged
PL 3.1	6	9	3	3	3	3	3		Improving
PL 3.2		12	12	12	12	12	12		Unchanged
PL 3.3		12	12	12	12	12	12		Unchanged
PL 4.1	12	12	12	12	12	12	12		Unchanged
PL 4.2	12	12	12	12	12	12	12		Unchanged
PA 1.1	8	8	8	8	8	8	8		Unchanged
PA 1.2	9	9	9	9	9	9	9		Unchanged
PA 1.3	6	6	6	6	6	6	6		Unchanged
PA 1.4	12	12	12	12	12	12	12		Unchanged
PA 2.1	20	20	20	16	16	16	16		Improving
PA 2.2	12	12	12	12	12	12	12		Unchanged
PA 2.3	6	6	6	6	6	6	6		Unchanged
PA 3.1	8	8	8	8	8	8	8		Unchanged
PA 3.2	8	8	8	8	8	8	8		Unchanged
PA 3.3	16	16	16	12	12	12	12		Improving
PA 4.1	9	9	9	9	9	9	9		Unchanged

1. Report Details			
Meeting Title:	Board of Directors, Part 1		
Date of Meeting:	29 March 2023		
Document Title:	Corporate Risk Register		
Responsible Director:	Jo Howarth Interim Chief Nursing Officer	Date of Executive Approval	16/03/2023
Author:	Mandy Ford, Head of Risk Management and Quality Assurance		
Confidentiality:	*n/a*		
Publishable under FOI?	*No*		
Predetermined Report Format?	*No*		

2. Prior Discussion		
Job Title or Meeting Title	**Date**	**Recommendations/Comments**
Relevant staff and executive leads for the risk entries	Various	Risk register and mitigations updated,
Risk and Audit Committee	21/03/2023	Noted

3. Purpose of the Paper	The Corporate Risk Register assists in the assessment and management of the high level operational risks, escalated from the Divisions and any risks from the annual plan. The corporate risk register provides the Board with assurance that corporate risks are effectively being managed and that controls are in place to monitor these. The risks detailed in this report are to reflect the operational risks, rather than the strategic risks reflected in the Board Assurance Framework.							
	Note (✓)	✓	*Discuss (✓)*		*Recommend (✓)*	✓	*Approve (✓)*	✓
4. Summary of Key Issues	The most significant risks which could prevent us from achieving our strategic objectives are detailed in the tables within the report. All current active risks continue to be reviewed with the risk leads to ensure that the risks are in line with the Risk Management Framework and the risk scoring has been realigned. All risks have been aligned with the revised Board Assurance Framework. Please note: the Risk Management Framework is currently under review following the revision of the Risk appetite.							
5. Action recommended	The Board is recommended to: • review the current Corporate Risk Register • note the Extreme and High risk areas and actions • consider overall risks to strategic objectives and BAF • request any further assurances							

6. Governance and Compliance Obligations			
Legal / Regulatory Link	**Yes**		*Duty to ensure identified risks are managed*
Impact on CQC Standards	**Yes**		*This will impact on all Key Lines of Enquiry if risk is not appropriately reported, recorded, mitigated and managed in line with the Risk Appetite.*
Risk Link	**Yes**		*Links and mitigations to the Board Assurance Framework are detailed in the individual risk entries.*
Impact on Social Value	**Yes**		*This will impact on the Trust's ability to provide high quality safe services and the recruitment and retention of staff.*
Trust Strategy Link	**How does this report link to the Trust's Strategic Objectives?**		

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

Audit and Risk Committee
Corporate Risk Register as at 13.03.2023

Executive Summary
The Board will note that the highest risks are associated with the impact of delayed patient treatment, and the recruitment and retention of staff.

The Board may be aware that during February the Trust Board held a workshop to look at reframing and reviewing the Trust Risk Appetite statement. Once finalised and agreed by the Board, the whole risk register will be reviewed and realigned with the new risk appetite. Work is ongoing with the relevant Executives and Teams to review and reframe risks that have been on the Register for a period of 18 months or longer.

1. Introduction

1.1 This report provides an update from the report presented to the January 2023 Trust Board Committee meeting and to highlight any new and emerging risks from within the Trust. It should be noted that this report details the Trust position as at 13.03.2023 unless otherwise stated and is reflective of the operational risks.

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

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

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

2. Top Themes:

2.2 1221 - Tackling the backlog of elective care (Extreme (20))

2.2.1 The guidance within the delivery plan for tackling the Covid-19 Delivery plan for tackling backlog of elective care with focus on four areas of delivery published 08.02.2022:

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

2.2.2 The access team are continuing to keep contact with patients on the waiting list. Patients are being called in clinical priority with consultants having oversight of the lists. The Board will receive performance reports in terms of progress against trajectories.

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

2.2.4 However, due to the industrial action by Junior Doctors, there is a potential of 8 x 78wk waiters where rebooking these patients is extremely difficult. NHS England are aware and whilst they would rather the Trust did not have any waiters at the end of the month, they appreciate the cumulative impact of all of the Industrial Action in Q4.

2.2.7 There is also a potential 104wk waiter as they require a specifically designed prosthetic, but doing all we can to minimize this wait.

2.2.7 ED performance continues to be impacted by increased attendances and ambulance conveyances. There is also an increase of patients experiencing a 12-hour delay in ED due to the volume of patients and the lack of available hospital beds.

2.3 Mortality

- 641 – Clinical coding (High 15) (update as at 15.02.2023)
- 464 – Mortality Indicator (Moderate 12) (update as at 15.02.2023)

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

2.3.2 Discussion at the 15 February 2023 HMG noted :-

- Both the Mortality and Clinical Coding risks had been open on the Risk Register for some time. These now need to be reviewed and reframed as the reporting requirements and positions had changed. This is anticipated to have been completed for the start of the new financial year.
- When SHMI was added to risk register it was a single item. At that stage the risk was thought to be associated to partly coding of medical issues and due to staffing levels in the coding department we were asked to separate for the risk register back in 2020.
- CMO will discuss coding on risk register with the Interim Chief Information Officer with a view to moving this risk to that portfolio.
- New clinical coding manager commenced in post and is having an impact.
- The SHMI remains high as quite a few cases are still being sent in uncoded. However, the depth of coding has improved significantly over time. The new Coding Manager has plans to remove backlog altogether.
- The report shows a decline in expected deaths which does tend to mirror the SHMI.

2.4 Staffing

Staffing across the Trust remains challenging. This is being mitigated by the use of agency and bank staff as well as redeploying staff from wards to other services areas to support safe patient care and safer staffing. Work is ongoing to look at reducing the use of high cost agency, and staff continue to report shortages in staffing across all services. Staffing levels continue to be closely monitored to ensure safe staffing is maintained. No red flag or unsafe shifts have been reported and staffing levels are mitigated by review of patient acuity and dependency levels, moving existing staff to other areas, use of local incentive payments or by using bank staff or agency staff.

2.4.1 With effect from 23 December 2022 all substantive clinical staff who undertook a bank shift, including RNDA/TNA staff and staff in non-ward areas, were paid their substantive hourly rate. This is a permanent change and not time limited. Substantive staff are encouraged to pick up bank shifts within safe limits.

2.4.2 Additional wellbeing advice has also been promoted via the Trust communications, with staff being encouraged to seek support as needed.

3 UPDATES:

3.1 461- High volume of patients with no criteria to reside (Extreme (20))

3.1.1 We still have a high volume of patients residing in the hospital with no medical need or reason to remain in a hospital bed which is impacting on the patient's well-being and the flow of patients. As at 13 March 2023, the total across all pathways stands at 75 patients. This was reported in January 2023 as 96 patients. (This was reported as 73 at last Committee)

3.1.2 Predominantly, this cohort of patients are waiting for some form of care package, or placement within a residential or nursing home setting, or a mental health facility. Some patients are delayed by legal processes, such as Court of Protection, where there is some family dispute over placement, or the patient's capacity to make a decision on their care.

3.1.3 As patients are having longer stays there is an increased risk of patients suffering pressure damage, falls, loss to mobility and independence, requiring a greater care package, or they are at risk of getting an infection. It should also be noted that prolonged hospital stays for some patients is affecting staff well-being in some areas, support is being provided to those areas. For February 2023, we reported 4 incidents where patients had come to some level of harm due to their prolonged stay. (3 related to pressure damage, 1 related to delays in obtaining CHC palliative care funding (patient admitted 11.11.2022 died 02.01.2023 - day funding was agreed))

3.1.4 Clinical teams continue to report incidents for patients that have no reason to reside due to the impact on their physical and mental well-being, whilst this is difficult to evidence fully, we are aware that delays in discharge are affecting patients. As their condition deteriorates, their care needs increase, which means the assessment and brokerage process has to be recommenced.

3.2 1252 – Financial Sustainability 2022/23 (

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

3.2.2 The Dorset system have submitted a plan to reach breakeven, however, it contains significant risk in delivery and requires a full delivery of cost improvement programmes and financial improvement programmes. The current year to date position is £2.8m worse than plan for the Trust. This was reported at £5.8m in the January 2023 report, £4.7m in the November 2022 report, and £3.4m in the September report.

3.2.3 There are a number of workstreams in progress across the Dorset system which should improve the position. There is ongoing work across the divisions and corporate services to explore all opportunities to contribute to achieving the financial plan. Robust Chief Executive Officer and Chief Finance Officer support is in place via regular meetings to discuss the financial rigor governance and delivery of cost improvements.

3.2.4 A programme of work to reduce high-cost agency spend is ongoing and with increased focus on daily, medium term and longer term mitigations.

3.3 1251 – Critical Failings in hospital blood bank (MODERATE 12 (previously HIGH 15))

The Trust underwent an MHRA visit in January 2022, where a number of issues were identified that required some corrective action. Failure to take corrective action could result in the service receiving a 'Cease Service' order. This would have severe consequences for services across the Trust.

3.3.1 The main areas for concerns are:

- Demand for service outstripping capacity and staffing shortfalls leading to the Quality Management System not being maintained. This would result in tests not being reported in a timely manner.
- Delays in blood test results reporting leading to delays in resulting in delays in ED.
- Staff competencies in using the equipment not maintained.
- Risk of losing the UCAS accreditation
- Vacancy for Blood bank Lead

3.3.2 Update as at 13.03.2023

- The MHRA responded to the last two-monthly report noting the positive progress being made and will consider their next steps after the next submission due February. They would like us to advise of any significant staff losses.
- Divisional meetings now monthly; Executive updates now two-monthly (to oversee MHRA submission).
- Re-inspection has occurred and there are still 4 actions that are outstanding. No significant concerns were highlighted by the re-inspection.
- As a result of the re-visit, the risk score has been reviewed and amended from High to Moderate, with it likely to drop further in the next risk register report.

Full update is provided in the appendices.

3.4 472: Community Paediatric Long Waits for ASD Patients (Scored as 4 Major x 5 Certain =20 Extreme)

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

3.4.2 Update provided by service as at 06.02.23, current wait times are 18 months. Patients are being booked into be seen 6 weeks in advance of a confirmed clinic date. The triage service is prompt when referred, and patients are being clinically prioritized and sign-posted to other support services whilst waiting to be see. If a patient is deemed to be high risk clinically the patient will be fitted in to a clinic.

3.4.3 Referrals are being graded and added to PAS by Central Admissions. Referrals are being rejected and returned to the referrer if all required information not included. Meetings are ongoing with NHS Dorset to look at potential changes to pathway. There are no vacancies within the team but the backlog of referrals remains, patients under 5 years are being prioritised.

3.4.3 Patients and parents are given safety netting advice, and the signposting varies depending on the patient's condition whilst waiting to be seen.

3.4.4 The agreed funding reported in previous reports of £76k to be used to potentially outsource assessments via Psicon to assist with the backlog and waiting list.

3.5 Emerging Risks from Divisions:

3.5.1 Urgent and Integrated Care

3.5.1.1 Pharmacy service

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

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

  Update (13.03.2023):
  - Action Plan progressing
  - Estates work is being planned currently to remove and relocate sink
  - Estates technical agreement has been written and in discussions now
  - Procurement for additional microbiological testing is underway. Bristol QC labs likely to take it on – circa £30k/year cost pressure
  - Ongoing IT issues with remote Pharmacist which means capacity still a challenge
  - Quality Manager now in post full-time
  - Paper being written to submit to ICB on fragility of aseptic services across Dorset Intrathecal service being restarted.
  - Further staff member leaving which will create capacity challenges. Additional bd5 approved through Business Planning which will significantly improve capacity challenges if we can recruit
  - Back out to advert for Aseptic Lead Pharmacist with the refer a friend and golden handshake scheme.

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

  Update (13.03.2023):
  - Recruited to 2 x Band 6
  - Had multiple candidates withdraw before interview, or after accepting the job (being seen across the SW)

- Rough estimate is there are circa 500 vacancies across the SW, with Dorset having around 35 vacant Band 6 Pharmacist posts – DCH currently the only ones to have recruited
- Remote roles are working well (except Haem/Onc which has IT issues with Mosaiq)
- Paid advertising now live
- Challenges are now extending to Pharmacy Technicians where roles are becoming challenging to recruit to
- Pharmacy Away Days were well received by the team

3.5.2 Family Services and Surgical Division

As reported in the January report, Ophthalmology was emerging as a risk. It was noted that an update would be provided in the March 2023 report, and further details are provided as below.

3.5.2.1 **1475 Ophthalmology Long wait new patients (scored as 3 Moderate x 4 Likely = 12 MODERATE)** Update provided:03.03.2023

Due to capacity within service we are unable to see patients within the 18 week pathway standard.

Mitigations currently in place:

- Business case for additional workforce to utilise non-medical staffing for further capacity
- Band 4 Technicians running assessment clinics to release clinicians time for needed f2f appointments
- Discussions around mutual aid with UHD to assist in national targets to reduce 78 week waiters for the system

Progress:

- Plans to reduce risk of 78 week waiters with weekly focused meetings.
- Job planning in final stages and then plans to agree Specialty Doctors rotas.

3.5.2.2 **1474 Ophthalmology FOWL long waiters (scored as 4 Major x 4 Likely = 16 HIGH)** Update provided:03.03.2023

Due to capacity within service, we are unable to see the follow ups in the appropriate timeframe.

Mitigations currently in place:

- 18 Week insourcing to addressing Glaucoma and Macular follow ups and injection demand, which will continue into 23/24.
- B4 Technicians running assessment clinics to release clinicians time for needed f2f appointments
- Virtual reviews running in conjunction with the assessment clinics to reduce further clinicians time needed for routine reviews.

Progress:

- In sourcing confirmed up to June 2023, which will assist in the provision of additional activity to assist with the ability to see follow ups during the week.
- Awaiting outcome of business case for 1 WTE Orthoptist

3.5.2.3 **1477 Ophthalmology Clinical Space (scored as 4 Major x 4 Likely = 16 HIGH)** Update provided:02.03.2023

Lack of clinical space means we are unable to meet the needs of the service.

Mitigations currently in place:

- 18 week running activity at weekends for Cataract, Macular & Glaucoma
- Use of Community locations where possible - Increased possibilities due to diagnostic equipment purchased
- Exploring Procedure room to relocate outside of REI

Progress:

- Outpatient waiting area still has a capacity issue to fully increase capacity.
- Continued work needed to utilise identified clinical space within the department, currently used as office space.
- OCT purchased at Blandford to allow for further utilisation of capacity for Macular/ Glaucoma service.
- VF machine purchased at Yeatman Hospital to assist with what activity is able to run within community location.
- Community equipment has required DCH to train staff to support with this.
- Band 4 is delivering education to the Blandford nursing team which will enable OCT's to take place at this site.
- In sourcing confirmed up to June 2023, this assists with the delivery of additional activity.

3.5.3 Trust wide:

3.5.3.1 **699 Industrial Action (scored as 3 Moderate x 3 Possible = 9 LOW)** Update provided:02.03.2023 (aligned to National reporting on the Emergency Planning Risk Register)

Risk Event - Ability to provide appropriate health care.

Cause - Industrial action by staff or industrial action by non health staff that affects staff attending work or the services we provide.

Impact - Significant impact on individual health organisation to respond to business as usual or critical functions.

Mitigations:

- HR Department - Workforce Team assisting with rotas
- Bank staff Office - assisting with securing of Bank and Agency staff
- Volunteers to support the wards with drink rounds for staff and patients
- rapid deployment team
- cancellation of non -essential services where appropriate
- re-deployment of staff not taking industrial action as necessary
- Derogation of critical service
- Fully staffed ICC running during period of industrial action.
- Shadow staffing on e-roster.
- strike day staffing escalation process established.
- volunteer/reserve staff holding area established.

Progress**:**

- ICC running on strike days to ensure that areas are safely staffed
- Agreed areas of derogation with the relevant Unions.
- Working closely with the relevant Union representatives when strike action agreed, participating in walkarounds with Union representatives
- Ensuring regular review of the risk level depending on the impact on service delivery.
- Linking with the wider system to support safe patient care and staffing.

- Escalating areas of concern.
- Monitoring incidents with regards to any patients that have come to harm due to the delays caused by strike action.
- Ensuring forward planning is happening for further industrial actions, capturing the learning from each event.

6. Conclusion

Risks continue to be regularly reviewed and updated in line with the Risk Management Framework and is linked to the Board Assurance Framework. Mitigations are in place for all identified risk items and actions are in place. The Risk team continue to work with the Divisions to review and challenge, open and active entries on the live risk register to ensure that scoring is correct and that risks are being reviewed and appropriately followed up and actions being followed through.

7. Recommendation

The Board is recommended to:

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

Name and Title of Author:
Mandy Ford, Head of Risk Management and Quality Assurance
Date: data correct as at 13.03.2023
Appendices

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

Heat Map (active risks only) **Appendix 1**

		Likelihood Score				
score		1	2	3	4	5
		Rare (this will probably never happen 1x year)	Unlikely (Do not expect it to happen but it is possible 2 x year)	Possible (might happen occasionally - monthly)	Likely (will probably happen - weekly)	Certain (will undoubtedly happen – daily)
Impact/Consequence Score	5 Catastrophic	5	10	15	20	25
	4 Major	4	8	12 (450, 690, 919)	16 (474)	20 (472,1221,1252, 1509)
	3 Moderate	3	6 (1513)	9	12 (464, 1251↓)	15 (641)
	2 Minor	2	4	6	8	10
	1 Negligible	1	2	3	4	5
	KEY	(↓number) (↑number)	Risk score has decreased since previous report Risk score has increased since previous report **Please note that no arrow indicates no change to previous risk score.**			
	Managed/Tolerated risks	463 (High – next review date 28.02.23)Workforce Planning & Capacity for Nursing and Allied Health Professional and Health Sciences staff; and 468 (Extreme –next review date 28.02.23) Recruitment and retention of Medical staff across specialities				
	Closed	469 - Temporary Medical Workforce Planning & Capacity (this was reframed as 468) 456 - (Low) Patient Transport Provision & Urgent Patient Transfers 973 - (Very low) Public Disorder 709 - (Extreme) Failure to meet constitutional standards 710 - (Extreme) Follow up waiting list backlog 449 - (Moderate) Financial Sustainability 21/22 979 - (Low) Removal/reduction of education funding from HEE commencing April 21.				

Corporate Risk Register **Appendix 2**

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

Movement on Risk Register: 	Risk Statement Added to Risk Register 01/04/2022	CURRENT RISK RATING (Following review and mitigations)	Extreme (20) Consequence: Major Likelihood: Certain Reviewed:09.03.2023
1252	**Financial Sustainability year 2022/23**	Previous Rating	Extreme
Impact on Strategic Objectives		Lead Executive	Chris Hearn
Strategic Objective: People **Strategic Objective: Place** **Strategic Objective: Partnership** The final plan for 2022/23, submitted in April, reflects a £17m deficit which threatens the financial sustainability strategic objective. However since then NHSI requested all deficit systems to resubmit operational plans for the 20.06.2022 demonstrating how they would achieve a break even position. The Dorset system have submitted a plan to reach breakeven, however, it contains significant risk in delivery and requires a full delivery of cost improvement programmes and financial improvement programmes. The current year to date position is £2.8m worse than plan for the Trust and delivering the planned year end position will be challenging to recover.		Local Manager	Claire Abraham
Current position As at 09.03.2023(data correct as at 13.03.2023)		TARGET RATING Target date:	Low (6) Consequence: Moderate Likelihood: Unlikely 31.03.2023
Mitigation: Exploring additional options to mitigate risks against plan not delivering, which will link back to the Trust risk appetite and Board decisions when escalated through FPC **Update:** There are a number of workstreams in progress across the Dorset system which should improve the position. Ongoing working across the divisions and corporate services to explore all opportunities to contribute to achieving the financial plan. Robust CEO and CFO support is in place via regular meetings to discuss the financial rigor governance and delivery of cost improvements. A programme of work to reduce high cost agency spend is also underway.		Next review date **ACTIONS ONGOING TO MANAGE FINANCES**	31.03.2023

Movement on Risk Register: 1251 	Risk Statement Added to Risk Register 05.05.2022 Escalated to Corporate Risk Register 12.05.2022 Critical failings in hospital blood bank	CURRENT RISK RATING (Following review and mitigations) Previous Rating	High (12) Consequence: Moderate Likelihood: Likely Reviewed:13.03.2023 High (15)
Impact on Strategic Objectives		Lead Executive	Anita Thomas
Strategic Objective: People **Strategic Objective: Place** **Strategic Objective: Partnership** **How this risk has been scored:** **Consequence: Major** **Patient safety** – Incident leading to death, mismanagement of patient care with long term effects **Quality/complaints/audit** - multiple complaints, low performance rating, non-compliance with national standards with significant risk to patients if unresolved. **Adverse publicity** - national media coverage with <3 days service below reasonable public expectation **Service/business interruption** - major impact on service Catastrophic impact on all health systems especially acute hospitals being unable to cope with demand, plus mortuary capacity overload. **Finance pressure**: Cost of agency, locum and bank staff. **Likelihood:** Certain		Local Manager	Graham Smith Andrew Miller Sonia Gamblen
Current position As at 13.03.2023(data correct as at 13.03.2023)		TARGET RATING Target date:	Low (9) Consequence: Moderate Likelihood: Possible 31.05.2023
Mitigation: • Action plan regularly reviewed • Rolling recruitment plan in place • Training plan in place. • Monthly updates supplied to MHRA • Electronic blood tracking system purchased. **Update:** The MHRA responded to the last two-monthly report noting the positive progress being made and will consider their next steps after the next submission due February. They would like us to advise of any significant staff losses. Divisional meetings now monthly; Executive updates now two-monthly (to oversee MHRA submission). STAFFING		Next review date	30.04.2023

• New 0.5WTE Band 2 Biomedical Support Worker for the Transfusion Practitioners (TP), and a permanent Hospital Transfusion Laboratory (HTL) Band 6 posts as part of the Demand and Capacity Plan presented to the MHRA have yet to be advertised. • No staffing levels below Level 2 reported - supported by locum and bank staff, and overtime hours by substantive staff. • Full complement of staff recruited to wider Blood Sciences team but will need HTL training and competency-assessment before being available to HTL. • Permanent HTL Manager will start 30 January, 2023. • Band 7 TP on phased return after long-term (two month) absence. Unable to find backfill secondment so some delay to TP duties (Datixes, NCs, training, etc.). • Funding secured for temporary support to help cover Haemonetics BloodTrack system implementation. TRAINING • This is all on track in accordance with the plan presented to MHRA QMS • SOP reviews have slipped a little over Christmas, with seven now being beyond their review date. SOP rewrites prioritised according to risk. Many SOPs will need to be rewritten for the Blood Track system. • Open NCs stand at 25. Fourteen lie with the HTL team (remainder with Path IT), eight of the HTL NCs are within target date. • Audit meeting to be re-scheduled from 10.11.22 • BloodTrack system on course for completion 31st July 2023. Paper-based traceability system will end at that time.		

Movement on Risk Register: 	Risk Statement **DATE ADDED TO RISK REGISTER 25.03.2020**	CURRENT RISK RATING (following review and mitigations)	Moderate (12) Consequence: Moderate Likelihood: Likely Reviewed: 20.02.2023
919	Covid- 19	Previous Rating	Extreme (20)
This will impact on all of our strategic objectives.		Lead Executive	Anita Thomas
Strategic Objective: People **Strategic Objective: Place** **Strategic Objective: Partnership** **How this risk has been scored:** **Consequence: Major** **Patient safety** – Incident leading to death, mismanagement of patient care with long term effects **Quality/complaints/audit** - multiple complaints, low performance rating, non-compliance with national standards with significant risk to patients if unresolved. **Adverse publicity** - national media coverage with <3 days service below reasonable public expectation **Service/business interruption** - major impact on service Catastrophic impact on all health systems especially acute hospitals being unable to cope with demand, plus mortuary capacity overload. **Finance pressure**: Cost of agency, locum and bank staff. **Likelihood:** Certain		Local Manager	Ian Kilroy
Current position As at 20.02.23 (data correct as at 09.03.2023)		TARGET RATING Target date:	Low (9) Consequence: Moderate Likelihood: Possible **Undetermined**
Mitigation: • Regular weekly virtual IMT meeting • Filtering face piece class 3 (FFP3) respirators and fluid resistant surgical masks • Eye and face protection and disposable aprons, gowns and gloves • Outpatients and visitors required to wear masks within clinical areas, unless they are exempt. • FFP3 lead appointed and will be supported by the Health, Safety and Security manager and staff from the Divisions. **Update:** • Numbers of patients requiring ITU intervention remains low • IPC guidance changed to PPE in clinical areas only, but this continues to be monitored. • PPE is still available • Action cards revised		Next review date **All actions constantly reviewed following national and IPC guidance.**	31.03.2023

Movement on Risk Register: 	Risk Statement Community Paediatric Long Waits for ASD Patients **Date added to Corporate Risk Register 09.06.2021** **Opened by Service 10.09.2018 – reviewed monthly** **Escalated to Division 08.06.2021 request to escalate to Corporate**	CURRENT RISK RATING (Following review and current mitigations)	Extreme (20) Consequence: Major Likelihood: Certain Reviewed: 06.02.2022
472	There has been a significant increase in referrals to the ASD (Autism Spectrum Disorder) service, alongside ongoing commissioning issues for the service.	Previous Rating	High (15)
Impact on Strategic Objectives		Lead Executive	Anita Thomas
Strategic Objective: People **Strategic Objective: Place** **Strategic Objective: Partnership** **How the risk has been scored:** **Consequence: Major** **Impact on patient safety** - major injury leading to long term incapacity/ disability, mismanagement of patient care with long term effects **Quality/complaints/audit** - non-compliance with national standards with significant risk to patients if unresolved, multiple complaints, low performance rating **Statutory duty** - multiple breeches in statutory duty, low performance rating **Adverse publicity** - National media coverage <3-day service well below reasonable public expectation **Finance including claims** - Claims between £100k and £1m **Likelihood:** Certain		Local Manager	James Male (service Manager)
Current position As at 09.02.2022 (data correct as at 09.03.2022)		TARGET RATING Target date	Very Low Risk (4) Consequence: Minor Likelihood: Unlikely 31.03.2023
Mitigation: • Interviews for specialist grade took place 08.10.21. Post was appointed to start date 01.02.2022. Target date amended to reflect the start date. Staff member appointed and in post • Validation needed for ASD pathway and current waiting list • All Age Autism Review led by CCG underway • Specialist Grade, Community Paediatrics now in post • ASD funding awarded from the CCG to be spent in 21/22, to support patients awaiting ADOS assessment • Meeting to discuss ASD database arranged – 11/2 **Update:** • Current wait times are 18 months. • No vacancies within the team but a backlog of referrals remains, under 5 years prioritised. • Referrals being graded and added to PAS by Central Admissions. Referrals being rejected and returned if all required information not included. • Meetings with NHS Dorset to look at potential changes to pathway. Looking into the possibility of rejecting referrals when parents have not accessed first line interventions. • Funding of £76k to be used to potentially outsource assessments via Psicon.		Next review date **OTHER ACTIONS ONGOING TO MANAGE WAITING LIST.**	31.03.2023

Movement on Risk Register: 	Risk Statement **Date added to Risk Register 22.02.2022**	CURRENT RISK RATING (Following review and mitigations)	Extreme (20) Consequence: Major Likelihood: Certain Reviewed: 13.03.2023
1221	Tackling the backlog of elective care	Previous Rating	Extreme (20)
Impact on Strategic Objectives		Lead Executive	Anita Thomas
Strategic Objective: People **Strategic Objective: Place** **Strategic Objective: Partnership** **How this risk has been scored:** **Consequence: Major** **Patient safety** - major injury leading to long term incapacity/ disability. **Quality/complaints/audit** - multiple complaints, low performance rating, non-compliance with national standards with significant risk to patients if unresolved. **Adverse publicity** - national media coverage with <3 days service below reasonable public expectation (no access for RESUS teams) **Likelihood:** Certain		Local Manager	Adam Savin All speciality leads
Current position As at 13.03.2023 (data correct as at 13.03.2023)		POST MITIGATION RATING (TARGET) Target date	Very Low (8) Consequence: Minor Likelihood: Likely 31.03.2025
Mitigation: • Escalation process in place if clinical priority needs reviewing • Validation of waiting lists to ensure capacity utilised for those remaining on the list • Harm review process in place to monitor and mitigate where possible **Update:** • Due to the industrial action by Junior Doctors (13-16.03.2023), there is a potential of 8 x 78wk waiters where rebooking these patients is extremely difficult. NHS England are aware and whilst they would rather the Trust did not have any waiters at the end of the month, they appreciate the cumulative impact of all of the Industrial Action in Q4. • There is also a potential 104wk waiter as they require a specifically designed prosthetic, but doing all we can to minimize this wait.		Next review date	30.04.2023

Movement on Risk Register: 	Risk Statement **Date added to Risk Register 12.09.2018**	CURRENT RISK RATING (Following review and mitigations)	High (16) Consequence: Major Likelihood: Likely Reviewed: 01.02.2023
474	Review of Co-Tag system and management of issuing/retrieving tags to staff	Previous Rating	Extreme (20)
Impact on Strategic Objectives		Lead Executive	Chris Hearn
Strategic Objective: Place **How this risk has been scored:** **Consequence: Major** **Patient safety** - major injury leading to long term incapacity/ disability. **Quality/complaints/audit** - multiple complaints, low performance rating, non-compliance with national standards with significant risk to patients if unresolved. **Adverse publicity** - national media coverage with <3 days service below reasonable public expectation (no access for RESUS teams) **Service/business interruption** - major impact on environment **Likelihood:** Certain		Local Manager	Don Taylor
Current position As at 01.02.2023 (data correct as at 13.03.2023)		TARGET RATING Target date	Very Low (2) Consequence: Negligible Likelihood: Unlikely 31.05.2023
Mitigation: • Estates managing ad-hoc issues as the arise; Communications on management of site security; Site security in place Update: • Delayed delivery due to issue with DCH supporting resource, expected completion April / May 23		Next review date	30.04.2023

Movement on Risk Register: 	Risk Statement **Date added to Risk Register 12.07.2019**	CURRENT RISK RATING (Following review and mitigations)	High (15) Consequence: Moderate Likelihood: Certain Reviewed: 16.02.2023
641	Clinical Coding	Previous Rating	Extreme
Impact on Strategic Objectives		Lead Executive	Ruth Gardiner
Strategic Objective: Place **Strategic Objective: Partnership** **How this risk has been scored:** **Consequence: Moderate** **Impact on patient safety** - mismanagement of patient care with long term effects **Quality/Complaints/Audit** - Non-compliance with national standards, critical report. Human resources - loss of key staff, low staff morale. **Statutory duty** - multiple breeches in statutory duty, improvement notices, low performance rating, critical report. **Adverse publicity** - National media coverage (being outliers) **Business objectives** - key objectives not met. **Finance including claims** - Non delivery of key objectives loss of >1% of budget, loss of contracts and payment by results **Likelihood:** Certain		Local Manager	Victoria Stevens (commenced in post Nov 2022)
Current position As at 16.02.2023 (data correct as at 13.03.2023)		TARGET RATING Target Date:	Low (6) Consequence: Minor Likelihood: Possible 31.05.2023
Mitigation: • Monitor other data for assurance on mortality, Escalation of any variance from plan for consideration of resources and prioritisation where possible. **Update:** • Both the Mortality and Clinical Coding risks had been open on the Risk Register for some time. These now need to be reviewed and reframed as the reporting requirements and positions had changed. This is anticipated to have been completed for the start of the new financial year. • CMO will discuss coding on risk register with the Interim Chief Information Officer with a view to moving this risk to that portfolio. • New clinical coding manager commenced in post and is having an impact. • The SHMI remains high as quite a few cases are still being sent in uncoded. However, the depth of coding has improved significantly over time. The new Coding Manager has plans to remove backlog altogether.		Next review date: **ACTIONS ONGOING AND CURRENTLY ON TARGET**	30.04.2023 FOLLOWING JANUARY HMG MEETING – RSIK TO BE REVIEWED AND ALLOCATED TO INTERIM CIO

Movement on Risk Register: 	Risk Statement **Date added to Risk Register 26.10.2017**	CURRENT RISK RATING (Following review and mitigations)	Moderate (12) Consequence: Major Likelihood: Possible Reviewed: 01.11.2021
450	Emergency Department Target, Delays to Care & Patient Flow	Previous Rating	High
Impact on Strategic Objectives		Lead Executive	Anita Thomas
Strategic Objective: People **Strategic Objective: Place** **Strategic Objective: Partnership** **How the risk has been scored:** **Consequence: Major** **Impact on patient safety** - major injury leading to long term incapacity/ disability, mismanagement of patient care with long term effects **Quality/complaints/audit** - non-compliance with national standards with significant risk to patients if unresolved, multiple complaints, low performance rating **Human resources** - Uncertain delivery of key objectives/ service due to lack of staff, loss of key staff, very low staff morale **Statutory duty** - low performance rating Adverse publicity - National media coverage <3 day service well below reasonable public expectation **Business objectives** - Key objectives not met. **Finance including claims** - Claims between £100k and £1m **Likelihood: Possible**		Local Manager	Samantha Hartley
Current position As at 01.11.2021(data correct as at 03.11.2021)		TARGET RATING Target date:	Moderate (12) Consequence: Major Likelihood: Possible 31.11.2022
Mitigation: • Increase in activity is being managed with IMT • ED area increased during pandemic to assist with flow and capacity. • Building works commenced to enlarge ED 2021 - now complete • ED performance continues to be impacted by increased attendances and ambulance conveyances. This is being partially mitigated by increased ambulatory care activity and focused work on super stranded patients and delayed transfers of care. Whilst this standard is not being achieved, the Trust performance remains above the national average. Update: • Minor service has relocated to Weymouth UCC 28 June 2021 to assist with patient flow and attendances at ED		Next review date **ACTIONS ONGOING, BUILDING WORK CONTINUES TO ENLARGE FOOTPRINT. ADDRESSING FOOTPRINT VIA MASTERPLAN**	30.09.2022 (annual review) REVIEW OVERDUE REQUESTED UPDATE 31.12.2022 – requested again 17.01.2023 HoRM to meet with ED staff to look at closing and reframing this risk due to ED15 being completed.
OTHER RISK REGISTERS LINKED TO RISK 450		**Current rating following local review**	**Target rating following completion of all actions**
1060 ED Footprint not fit for purpose		Low risk	Very Low risk

1061 Workforce requirements for new ED 709 – Failure to achieve constitutional standards (now closed).	Moderate risk	Very Low risk

Movement on Risk Register: 	Risk Statement **Date added to Risk Register 11.11.2020**	CURRENT RISK RATING (Following review and mitigations)	Moderate (12) Consequence: Moderate Likelihood: Likely Reviewed:16.02.2023
464	Mortality Indicator	Previous Rating	Low
Impact on Strategic Objectives		Lead Executive	Alastair Hutchison
Strategic objective: Place **How the risk has been scored:** **Consequence: Moderate** **Impact on patient safety -** major injury leading to long term incapacity/ disability, mismanagement of patient care with long term effects **Quality/complaints/audit - non**-compliance with national standards with significant risk to patients if unresolved, multiple complaints, low performance rating **Human resources -** Uncertain delivery of key objectives/ service due to lack of staff, loss of key staff, very low staff morale **Statutory duty -** multiple breeches in statutory duty, low performance rating **Adverse publicity - National** media coverage <3 day service well below reasonable public expectation **Business objectives -** Key objectives not met. Likelihood: Possible		Local Manager	Alastair Hutchison
Current position As at 16.02.2022 (data correct as at 13.03.2023)		TARGET RATING Target date:	Low (9) Consequence: Moderate Likelihood: Possible 31.03.2023
Mitigation: Triangulation of other data for assurance on mortality; SJR process; Medical Examiners escalation process; Learning from deaths Mortality report reviewing situation and learning. **Update:** • Both the Mortality and Clinical Coding risks had been open on the Risk Register for some time. These now need to be reviewed and reframed as the reporting requirements and positions had changed. This is anticipated to have been completed for the start of the new financial year. • CMO will discuss coding on risk register with the Interim Chief Information Officer with a view to moving this risk to that portfolio. • New clinical coding manager commenced in post and is having an impact. • The SHMI remains high as quite a few cases are still being sent in uncoded. However, the depth of coding has improved significantly over time. The new Coding Manager has plans to remove backlog altogether. • The report shows a decline in expected deaths which does tend to mirror the SHMI.		Next review date **SHOULD BE READ IN CONJUCTION WITH RISK 641**	UPDATE FOLLOWING JANUARY HMG MEETING – Risk to be reviewed and reframed for next report.

Movement on Risk Register: 	Risk Statement **Added to the Risk Register 16.09.2016 reviewed in line with national policy and national risk register annually (unless incident occurs)**	CURRENT RISK RATING (Following review and mitigations)	Moderate (12) Consequence: Major Likelihood: Possible Reviewed: 20.02.2023
690	Malicious attack - Cyber-attack on the NHS / Internal ICT failure	Previous Rating	Moderate
Impact on Strategic Objectives		Lead Executive	Ruth Gardiner
Strategic Objective: People **Strategic Objective: Place** **Strategic Objective: Partnership** **How this risk has been scored:** **Consequence: Moderate** **Impact on patient safety** - mismanagement of patient care with long term effects **Quality/Complaints/Audit** - Non-compliance with national standards, critical report. Human resources - loss of key staff, low staff morale. **Statutory duty** - multiple breeches in statutory duty, improvement notices, low performance rating, critical report. **Adverse publicity** - National media coverage (being outliers) **Business objectives** - key objectives not met. **Finance including claims** - Non delivery of key objectives loss of >1% of budget, loss of contracts and payment by results		Local Manager	Simon Brown Ian Kilroy
Current position As at 20.02.2023 (data correct as at 13.03.2023)		TARGET RATING Target Date:	Moderate (12) Consequence: Major Likelihood: Possible 31.03.2025
PLEASE NOTE: EXTENAL RATING FROM NATIONAL RISK REGISTER OF CIVIL EMERGENCIES is Medium – low risk. POSITION: This risk is linked to the ICT and Emergency Planning risk register. Linked to this risk there are others which are specific to the Trust infrastructure and Firewalls. **Mitigation:** There are full mitigations and actions in place, and these risks are reviewed monthly to ensure no concerns to counter the risk. * Cyber specialist employed by Trust in ICT * Cyber Policy * Training & Exercise * BC Plans **Update:** DTI continue to raise awareness of the risks of a Cyberattack through regular Trust-wide communications. Communications have also gone out to enforce a password change – DTI have targeted staff who have a weak password that is identified by the use of algorithms.		Next review date **ACTIONS AND MITIGATION EFFECTIVE AND ONGOING**	30.04.2023

Report Front Sheet

1. Report Details			
Meeting Title:	Board of Directors, Part 1		
Date of Meeting:	29th March 2023		
Document Title:	**2022 Staff Survey Results**		
Responsible Director:	Emma Hallett – Acting Chief People Officer	Date of Executive Approval	13/03/2023
Author:	Julie Barber		
Confidentiality:	No		
Publishable under FOI?	Yes		
Predetermined Report Format?	Yes		

2. Prior Discussion		
Job Title or Meeting Title	**Date**	**Recommendations/Comments**
People and Culture Committee	20/03/2023	Noted

3. Purpose of the Paper	The purpose of the paper is to provide a high-level summary of the 2022 NHS Staff Survey results and to showcase both positive and negative trajectories. The full results are also shared.							
	Note (✓)	*x*	*Discuss (✓)*		*Recommend (✓)*		*Approve (✓)*	
4. Key Issues	The 2022 NHS Staff Survey was conducted between October and December last year. A response rate of 43.3% was achieved (1404 employees). The median response rate for our benchmarking group (Acute and Acute & Community Trusts) was 44%. Since 2021, the questions in the NHS Staff Survey have been aligned to the People Promise and are made up of 7 People Promise elements and 2 themes (Staff Engagement & Morale). This means that for many questions, we only have comparison data over 2 years rather than 5 years. There has been a downward trend in all but one of the nine People Promise elements/themes of the survey (‘*We are a team’* has remained static). Our scores remain above the NHS average in eight of the nine elements/themes and equal to the national average in one element (‘W*e are safe and healthy’).* The Employee Engagement index continues to have a score out of 10. This remained static at 7.2 during 2018-20 but declined in 2021 to 7.1 and has further declined this year to 6.9. The theme of Morale has followed a similar pattern, with a decline since 2020 from 6.2 to 5.8. Overall, around 31% of our scores have positive increases and around 65% have had downward trajectories, with a few scores remaining static. Only around 12% of our scores are lower than the national average. Average scores are not a benchmark we aspire to. Ongoing work in the areas of inclusion, speaking up, staff health & wellbeing and leadership/management development will help make inroads into improving the staff experience at DCH.							

5. Action recommended	The Board is asked to **note** the Report.

6. Governance and Compliance Obligations				
Legal / Regulatory Link		**Yes**		The Staff Survey is a Regulatory Requirement of all NHS Trusts
Impact on CQC Standards		**Yes**		The results of the Staff Survey are used when assessing the Well-led element of the CQC standards
Risk Link		**Yes**		PL 1.1 - the risk of a continuing inability to reliably recruit or retain sufficiently skilled staff to meet patient demand
Impact on Social Value		**Yes**		We wish to be a local employer of choice and staff satisfaction and reputation will influence this.
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 Staff Survey is a key indicator of progress in relation to the DCH People Plan.		
	Place			
	Partnership			
Dorset Integrated Care System (ICS) goals		**Which Dorset ICS goal does this report link to / support?** *Please summarise how your report contributes to the Dorset ICS key goals.* *(Please delete as appropriate)*		
Improving population health and healthcare		**Yes**		An engaged and motivated workforce is required to meet the ICS system goals
Tackling unequal outcomes and access		**Yes**		As above
Enhancing productivity and value for money		**Yes**		As above
Helping the NHS to support broader social and economic development		**Yes**		As above
Assessments		**Have these assessments been completed?** *If yes, please include the assessment in the appendix to the report..* *If no, please state the reason in the comment box below.* *(Please delete as appropriate)*		
Equality Impact Assessment (EIA)			**No**	
Quality Impact Assessment (QIA)			**No**	

2022 STAFF SURVEY RESULTS

Executive Summary

The purpose of the paper is to provide a high-level summary of the 2022 NHS Staff Survey results, to showcase both positive and negative trajectories and to highlight work ongoing within the Trust which will impact on areas explored within the Survey.

The 2022 NHS Staff Survey was conducted between October and December last year. A response rate of 43.3% was achieved (1404 employees). The median response rate for our benchmarking group (Acute and Acute & Community Trusts) was 44%.

Since 2021, the questions in the NHS Staff Survey have been aligned to the People Promise and are made up of 7 People Promise elements and 2 themes (Staff Engagement & Morale). This means, for many questions we only have comparison data over 2 years rather than 5 years. This makes it more difficult to identify trends.

There has been a downward trajectory in all but one of the nine People Promise elements/themes of the survey ('*We are a team*' has remained static). Our scores remain above the NHS average in eight of the nine elements/themes and equal to the national average in one element ('*We are safe and healthy*').

The Employee Engagement index continues to have a score out of 10. This remained static at 7.2 during 2018-20 but declined in 2021 to 7.1 and has further declined this year to 6.9. The theme of Morale has followed a similar pattern, with a decline since 2020 from 6.2 to 5.8.

Results to be celebrated include those within the sub-theme of **Inclusion** (theme: *'We are compassionate & inclusive'*)**,** where we have upwards trajectories in staff reporting that they feel valued by their team and that people they work with are understanding and kind to one another. In the sub-theme of **Autonomy & Control** (theme: '*We each have a voice that counts'),* staff continue to feel they are trusted to do their job and that there are frequent opportunities to show initiative in their roles.

There has been a downward trend in the sub-theme **Raising Concerns** (theme: *'We each have a voice that counts'*), where the % of staff reporting that they feel safe to speak up about anything that concerns them in the organisation has *incrementally declined* over 3 years. In the sub-theme of **Negative Experiences** (theme: *'We are safe and healthy'*) we have a significant increase in staff reporting they are coming to work despite not feeling well enough to perform their duties.

We continue to utilise the results to identify positive outcomes, areas to improve and any trends worthy of note. A number of overall work programmes are already underway which will help to address concerns and build on successes to date. At a local level divisional leaders will be cascading results and team leads will facilitate 'time to talk' conversations with their teams to co-design, embed and own local action plans.

This paper is shorter than usual for the Staff Survey report as it follows the publication of the results on 9 March 2023 and serves as a supplement to the detailed survey report.

1. Introduction

The 2022 NHS Staff Survey was conducted between October and December last year. A response rate of 43.3% was achieved (1404 employees). The median response rate for our benchmarking group (Acute and Acute & Community Trusts) is 44%. Given this response rate, it is important that the survey results are used alongside all other sources of staff feedback including the quarterly Pulsecheck results, freedom to speak up data and the experiences of staff collated via departmental visits.

Each year we utilise the results to identify positive outcomes, areas to improve any trends worthy of note. For some questions we have up to five years of trend data, providing a much more reliable indication of whether the most recent results represent a change from the norm rather than only comparing the most recent results with the previous year. However, for many questions, we only have comparison data over 2 years.

The Board is asked to note the contents of the Report.

2. Survey Results

2.1 Overview of People Promise elements and themes

Since 2021, the questions in the NHS Staff Survey have been aligned to the People Promise and are made up of 7 People Promise elements and 2 themes (Staff Engagement & Morale).

There have been downward trajectories in all but one of the nine People Promise elements and themes (‘*We are a team’* has remained static). Our scores remain above the NHS average in eight of the nine elements/themes and equal to the national average in one element (‘W*e are safe and healthy’).*

In **three areas** our 2022 scores are defined as **statistically significantly lower** than 2021.

People Promise/Theme	2021 Score	2022 Score	Statistically significant change?	Sector Score 2022	+/- comparison with Sector average
PP1: We are compassionate & inclusive	7.5	7.3	Significantly lower	7.2	+
PP2: We are recognised & rewarded	6.1	5.9	Significantly lower	5.7	+
PP3: We each have a voice that counts	6.9	6.8	Not significant	6.6	+
PP4: We are safe & healthy	6.0	5.9	Not significant	5.9	=
PP5: We are always learning	5.6	5.5	Not significant	5.4	+
PP6: We work flexibly	6.3	6.2	Not significant	6.0	+
PP7: We are a team	6.8	6.8	Not significant	6.6	+
Theme: **Staff Engagement**	7.1	6.9	Significantly lower	6.8	+
Theme: **Morale**	5.9	5.8	Not significant	5.7	+

2.2 Improved scores - some examples

Question No.	Statement	% positive change since 2021	% Score
5b	*I have a choice in deciding how to do my work*	**1.6**	**58.2**
6d	*I can approach my immediate line manager to talk openly about flexible working*	**0.8**	**69.1**
7b	*The team I work in often meets to discuss the team's effectiveness*	**1.9**	**60.6**
7h	*I feel valued by my team*	**1.0**	**72.1**
8b	*The people I work with are understanding and kind to one another*	**1.0**	**71.3**
22b	*There are opportunities for me to develop my career in this organisation*	**1.6**	**58.2**

The table above shows positive improvements in our staff having a level of autonomy in how they undertake their work and they continue to have opportunities for flexible working patterns. Feeling valued, benefitting from kindness within teams and discussions around team effectiveness all have positive trajectories.

2.3 Downward trajectories - some examples

Question No.	Statement	% negative change from 2021	% Score
9a	*My immediate manager encourages me at work*	**2.3**	**71.7**
7e	*I enjoy working with the colleagues in my team*	**2.6**	**82.6**
11d	*In the last 3 months have you ever come to work despite not feeling well enough to perform your duties?*	**4.2**	**57.5**
9d	*My immediate manager takes a positive interest in my health and wellbeing*	**1.7**	**70.0**
23e	*I feel safe to speak up about anything that concerns me in this organisation*	**3.0**	**61.5**

The continued consequences of coping with the ongoing impact of Covid, staff shortages, sickness absence and operational pressures are reflected in some of the results that have seen a decline since 2021. The appointment of a new Freedom to Speak Up Guardian and the increased focus on Health & Wellbeing will ensure a continued focus on these key areas.

2.4 Staff Engagement/Employee Engagement Index (EEI) score

Theme	Questions/Statements	2022 Score %	2021 Score %	2020 Score %	National Average 2022 %
Motivation	Q2a: Often/always look forward to going to work	**54.7**	**57.4**	**62.3**	**52.5**
	Q2b: Often/always enthusiastic about my job	**71.4**	**73.1**	**76.7**	**66.7**
	Q2c: Time often/always passes quickly when I am working	**72.5**	**75.5**	**75.9**	**72.5**
Involvement	Q3c: Frequent opportunities for me to show initiative in my role	**78.0**	**77.3**	**74.5**	**72.8**
	Q3d: Able to make suggestions to improve the work of my team/department	**74.6**	**75.0**	**77.6**	**70.9**
	Q3f: Able to make improvement happen in my area of work	**58.0**	**58.7**	**57.8**	**54.7**
Advocacy	Q23a: Care of patients/service users is my organisation's top priority	**75.8**	**78.7**	**83.6**	**73.5**
	Q23c: I would recommend my organization as a place to work	**61.0**	**66.4**	**71.9**	**56.5**
	Q23d: If a friend/relative needed treatment I would be happy with the standard of care provided by this organisation	**65.9**	**74.6**	**80.0**	**61.9**

The Staff Engagement theme has an overall score out of 10. The DCH score has declined from 7.1 to 6.9 in 2022. The individual question scores shown above show that only one statement had improved scores. In 8 out of 9 questions, the DCH score is significantly above the national average. On one question (Q2c) we equal the national average. Whilst it is disappointing to see a reduction in the number of staff who recommend the Trust as a place to work or to receive treatment, the national context will inevitably be playing a part in this.

2.5 Morale

The theme of Morale has followed a similar pattern to Staff Engagement, with a decline since 2020 from 6.2 to 5.8. The questions included to measure morale cover: work pressure and stressors**.** Whilst scores for stressors had, in the main, improved from the previous year, **work pressures** showed significant downward trends, particularly in relation to conflicting demands and staffing levels.

Question	2022 % Score	2021 % Score	2020 % Score	National Av. 2022 %
Q3g: I am able to meet all the conflicting demands on my time at work	40.3	40.8	45.4	42.9
Q3i: There are enough staff at this organisation for me to do my job properly	21.9	22.8	35.6	25.1

2.5 WRES

In comparison with the 2021 scores, there are improvements for BME staff in 2 out of 4 questions. There has been a significant and encouraging reduction in BME staff experiencing harassment, bullying or abuse from patients and relatives. However, this is still unacceptably high for all colleagues and will continue to be an area of focus.

Our Dignity and Respect at Work Programme continues to support staff to challenge unacceptable behaviour and call out bullying and harassment in all its forms.

Question – WRES data DCH	BME 2022	BME 2021	BME 2020	WHITE 2022	WHITE 2021	WHITE 2020
% of staff experiencing harassment, bullying or abuse from **patients or relatives** in last 12 months	29.8	34.0	27.5	25.0	24.5	21.4
% of staff experiencing harassment, bullying or abuse from **staff** in last 12 months	32.4	29.1	40.4	24.9	26.0	26.2
% of staff who feel the organisation provides equal opportunities for career progression or promotion	47.0	55.0	36.3	60.7	62.6	62.3
% of staff who experienced discrimination at work from manager/team leader or colleague in last 12 months	16.6	18.7	20.0	6.1	5.6	6.6

2.6 Workforce Disability Equality Standard (WDES)

When comparing scores to the previous year, improvements are seen on 3 questions and declines on the other 6. Non-disabled staff show improvements on only 2 questions and neither of these were for the same questions as disabled staff.

It is encouraging that there is a reduction in the number of staff experiencing bullying and harassment from patients and from managers, and that more disabled staff are reporting incidences than previous years.

Question – WDES data DCH	Disabled 2022	Disabled 2021	Disabled 2020	Non-Disabled 2022	Non-Disabled 2021	Non-Disabled 2020
% of staff experiencing harassment, bullying or abuse from **patients or relatives** in last 12 months	28.8	32.4	23.5	24.5	23.4	21.5
% of staff experiencing harassment, bullying or abuse from **managers** in last 12 months	16.0	17.2	20.7	9.9	9.2	8.7
% of staff experiencing harassment, bullying or abuse from **other colleagues** in last 12 months	28.8	26.5	32.1	18.9	20.4	19.1
% of staff who reported last experience of harassment, bullying or abuse	52.0	50.8	44.1	42.8	44.2	43.3
% of staff who feel the organisation provides equal opportunities for career progression or promotion	59.1	60.7	56.0	58.6	61.7	60.6
% of staff who felt pressure from their manager to come into work when not feeling well enough	28.6	27.8	30.8	18.1	19.6	21.4
% of staff who are satisfied with the extent the organisation values their work	36.5	39.8	37.8	46.4	47.0	49.4
% of staff who say their employer has made reasonable adjustments to enable them to carry out their work	71.9	74.1	75.5	N/A	N/A	N/A
Staff Engagement Score	6.6	6.9	6.9	7.1	7.2	7.3

2.7 Further action and focus areas

2.7.1 The Management Matters Programme launched last Autumn and a range of sessions are offered to develop management competence in undertaking appraisals, safe and effective wellbeing conversations, career conversations, managing sickness absence and much more. **Developing skills and competence in all managers and supervisors supports culture change and will improve staff experience**.

2.7.2 The appointment of a new Freedom to speak Up Guardian has already reaped rewards with evidence of more staff feeling able to speak up. **Further developing the Speaking Up culture will be a key focus in 2023.**

2.7.3 An improved approach to supporting staff health and wellbeing, using a triage method has been introduced which will more effectively signpost staff to the most appropriate support. We have also recently implemented a trauma response process across the Trust to support staff who have experienced traumatic events at work. However, it is clear from the Staff Survey results that work pressures are getting worse not better. **The focus on recruiting to existing hard to fill roles alongside new workforce roles and models of care needs to continue, so that we can prevent ongoing harm to our staff.**

2.7.4 Inclusion continues to be the 'golden thread' in all that we do. Our Staff Networks continue to thrive and grow. We have secured funding to focus on recruitment and retention issues for our Overseas Staff who form an intrinsic part of our workforce. We have also developed a bespoke onboarding programme for staff joining us from overseas and a career development framework to accelerate their progression. **We must continue our focus on the representation, experience and development of staff who have protected characteristics.**

2.7.5 Following this report to PCC, our high level Staff Survey results will be presented to SLG and to the Trust Board. From mid-March onwards, survey results will be shared at Divisional and Care Group/Department level. Divisional leaders will be cascading results and team leads will facilitate 'time to talk' conversations with their teams to co-design, embed and own local actions. The focus at this local level will be on identifying small changes that can be made that have a big impact on staff experience day to day.

3. Conclusion

3.1 The purpose of the staff survey is to provide a health-check of employee engagement at DCH and identify areas of strength and weakness. Overall, the picture remains a largely positive one, with the Trust's People Promise scores being significantly better than the sector scores for similar organisations and scoring higher nationally in 8 out of 9 elements/themes of the People Promise and equaling the *'we are safe and healthy'* element.

3.2 The Trust response rate declined this year and we recognise more needs to be done to increase engagement for the 2023 survey and beyond. Increased engagement will make

the survey results more meaningful, but it is equally as important that all other sources of ongoing staff feedback are considered.

3.3 The survey results indicate that the experiences of disabled staff and those from minority ethnic groups are less positive than other groups of staff. Whilst we recognise there is more to do, we must also celebrate the significant progress that has been made, particularly in the reduced numbers of staff experiencing harassment, bullying or abuse from patients or relatives in last 12 months, and for disabled staff an improvement in manager behaviours.

3.4 Finally, the ongoing effect of the pandemic, operational pressures, industrial action and workforce shortages are impacting all NHS organisations and are likely to have influenced the general downturn in survey results. That being said, we must continue to do all we can at a local level to mitigate the ongoing and increasing pressures staff are facing.

4. Recommendation

The Board is recommended to:

1. **NOTE** the report

Name and Title of Author: Julie Barber, Head of Organisational Development
10th March 2023

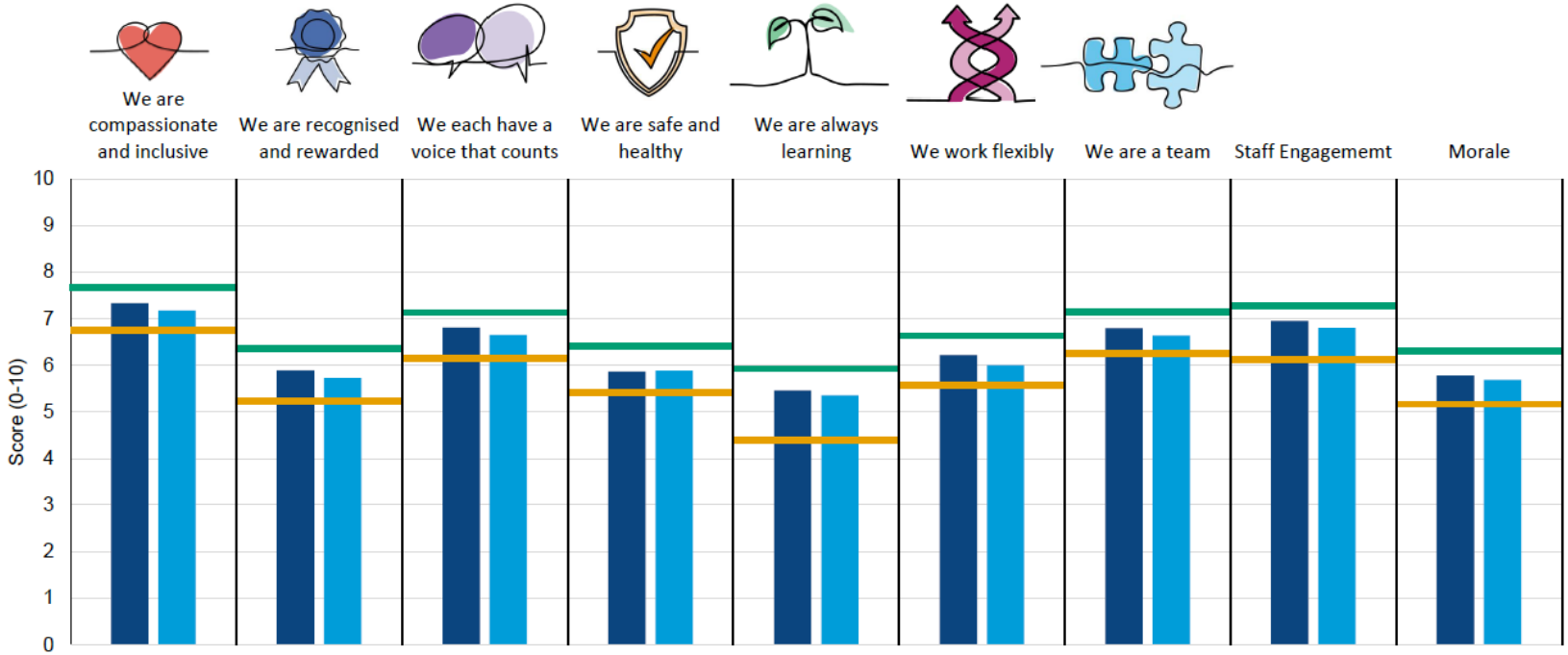
Appendix A: People Promise Elements & Themes: Overview

APPENDIX A

People Promise Elements and Themes: Overview

Survey Coordination Centre NHS

All of the People Promise elements, themes and sub-scores are scored on a 0-10 scale, **where a higher score is more positive than a lower score**.



	We are compassionate and inclusive	We are recognised and rewarded	We each have a voice that counts	We are safe and healthy	We are always learning	We work flexibly	We are a team	Staff Engagememt	Morale
Your org	7.3	5.9	6.8	5.9	5.5	6.2	6.8	6.9	5.8
Best	7.7	6.4	7.1	6.4	5.9	6.6	7.1	7.3	6.3
Average	7.2	5.7	6.6	5.9	5.4	6.0	6.6	6.8	5.7
Worst	6.8	5.2	6.2	5.4	4.4	5.6	6.3	6.1	5.2
Responses	1403	1396	1391	1399	1336	1392	1397	1402	1402

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NHS

Dorset County Hospital NHS Foundation Trust

NHS Staff Survey Benchmark report 2022

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Introduction

Please note, where there are less than 11 responses for a question this data is not shown in the chart to protect the confidentiality of staff and reliability of results.

About this Report

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About this report

This benchmark report for Dorset County Hospital NHS Foundation Trust contains results for the 2022 NHS Staff Survey, and historical results back to 2018 where possible. These results are presented in the context of best, average and worst results for similar organisations where appropriate*. Data in this report are weighted** to allow for fair comparisons between organisations.

Please note: Results for Q1, Q10a, Q24d, Q25a-c, Q26a-c, Q27, Q28, Q29, Q30a, Q31a-b, Q32a-b and Q33 are not weighted or benchmarked because these questions ask for demographic or factual information.

Full details of how the data are calculated and weighted are included in the Technical Document, available to download from our results website.

How results are reported

For the 2021 survey onwards the questions in the NHS Staff Survey are aligned to the People Promise. This sets out, in the words of NHS staff, the things that would most improve their working experience, and is made up of seven elements:

In support of this, the results of the NHS Staff Survey are measured against the seven People Promise elements and against two of the themes reported in previous years (Staff Engagement and Morale). The reporting also includes sub-scores, which feed into the People Promise elements and themes. The next slide shows how the People Promise elements, themes and subscores are related and mapped to individual survey questions.

*The data included in this report are weighted to the national benchmarking groups. The figures in this report may be different to the figures produced by your contractor.
**Please see Appendix C for a note on the revision to 2019 historical benchmarking for Mental Health & Learning Disability and Mental Health, Learning Disability & Community Trusts, and Community Trust benchmarking groups.

People Promise elements, themes and sub-scores

Survey Coordination Centre NHS

People Promise elements	Sub-scores	Questions
We are compassionate and inclusive	Compassionate culture	Q6a, Q23a, Q23b, Q23c, Q23d
	Compassionate leadership	Q9f, Q9g, Q9h, Q9i
	Diversity and equality	Q15, Q16a, Q16b, Q20
	Inclusion	Q7h, Q7i, Q8b, Q8c
We are recognised and rewarded	No sub-score	Q4a, Q4b, Q4c, Q8d, Q9e
We each have a voice that counts	Autonomy and control	Q3a, Q3b, Q3c, Q3d, Q3e, Q3f, Q5b
	Raising concerns	Q19a, Q19b, Q23e, Q23f
We are safe and healthy	Health and safety climate	Q3g, Q3h, Q3i, Q5a Q11a, Q13d, Q14d
	Burnout	Q12a, Q12b, Q12c, Q12d, Q12e, Q12f, Q12g
	Negative experiences	Q11b, Q11c, Q11d, Q13a, Q13b, Q13c, Q14a, Q14b, Q14c
We are always learning	Development	Q22a, Q22b, Q22c, Q22d, Q22e
	Appraisals	Q21a*, Q21b, Q21c, Q21d *Q21a is a filter question and therefore influences the sub-score without being a directly scored question.
We work flexibly	Support for work-life balance	Q6b, Q6c, Q6d
	Flexible working	Q4d
We are a team	Team working	Q7a, Q7b, Q7c, Q7d, Q7e, Q7f, Q7g, Q8a
	Line management	Q9a, Q9b, Q9c, Q9d
Themes	**Sub-scores**	**Questions**
Staff Engagement	Motivation	Q2a, Q2b, Q2c
	Involvement	Q3c, Q3d, Q3f
	Advocacy	Q23a, Q23c, Q23d
Morale	Thinking about leaving	Q24a, Q24b, Q24c
	Work pressure	Q3g, Q3h, Q3i
	Stressors	Q3a, Q3e, Q5a, Q5b, Q5c, Q7c, Q9a

Questions not linked to the People Promise elements or themes

Q1, Q10a, Q10b, Q10c, Q11e, Q15, Q16c, Q17, Q18a, Q18b, Q18c, Q18d, Q24d, Q30b

Report structure

Survey Coordination Centre NHS

Introduction

This section provides a brief introduction to the report, including how questions map to the People Promise elements, themes and sub-scores, as well as features of the graphs used throughout.

Organisation details

This slide contains **key information** about the NHS organisations participating in this survey and details for your own organisation, such as response rate.

People Promise Elements, Themes and Sub-scores: Overview

This section provides a high-level **overview** of the results for the seven elements of the People Promise and the two themes, followed by the results for each of the **sub-scores** that feed into these measures.

People Promise Elements, Themes and Sub-scores: Trends

This section provides trend results for the seven elements of the People Promise and the two themes, followed by the trend results for each of the sub-scores that feed into these measures.

All of the People Promise elements, themes and sub-scores are scored on a 0-10 scale, where a higher score is more positive than a lower score. For example, the Burnout sub-score, a higher score (closer to 10) means a lower proportion of staff are experiencing burnout from their work. These scores are created by scoring questions linked to these areas of experience and grouping these results together. Your organisation results are benchmarked against the benchmarking group average, the best scoring organisation and the worst scoring organisation. These graphs are reported as percentages. The meaning of the value is outlined along the y axis. The questions that feed into each sub-score are detailed on slide 5.

The Covid-19 pandemic

This section contains results for the People Promise elements and themes split by staff experience related to the Covid-19 pandemic.

Questions not linked to People Promise

Results for the questions that do not contribute to the result for any People Promise element or theme are included in this section.

Workforce Equality Standards

This section shows that data required for the indicators used in the **Workforce Race Equality Standard (WRES)** and the **Workforce Disability Equality Standard (WDES).**

About your respondents

This section provides details of the staff responding to the survey, including their **demographic and other classification questions**.

Appendices

Here you will find:

- Response rate.
- Significance testing of the People Promise element and Theme results for 2021 vs 2022.
- Data in the benchmark reports.
- Additional reporting outputs.
- Tips on action planning and interpreting the results.
- Contact information.

Please note, where there are less than 11 responses for a question this data is not shown to protect the confidentiality of staff and reliability of results.

Using the report

Survey Coordination Centre NHS

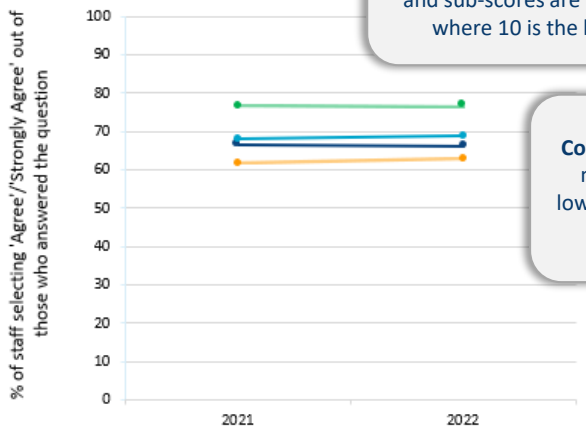
Please note this is example data

Key features

Question-level results are always reported as percentages; the **meaning of the value** is outlined along the axis. Summary measures and sub-scores are always on a 0-10pt scale where 10 is the best score attainable.

Question number and text (for summary measure) specified at the top of each slide.

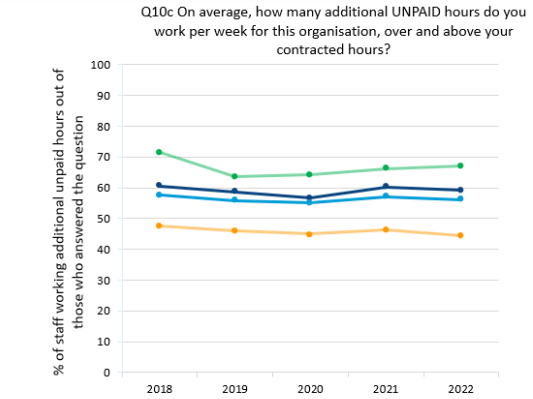
The home icon on each slide is **hyperlinked** and takes you back to the contents page (which is also hyperlinked to each section).



	2021	2022
Your org	66.5%	66.3%
Best	76.8%	76.8%
Average	68.0%	68.7%
Worst	61.9%	62.8%

Colour coding highlights best / worst results, making it easy to spot questions where a lower percentage is better – in such instances 'Best' is the bottom line in the table.

Number of responses for the organisation for the given question.



	2018	2019	2020	2021	2022
Your org	60.5%	58.7%	56.8%	60.2%	59.2%
Best	71.4%	63.6%	64.2%	66.1%	67.3%
Average	57.7%	55.9%	55.1%	57.0%	56.3%
Worst	47.7%	46.0%	45.0%	46.5%	44.6%

'Best', 'Average', and 'Worst' refer to the **benchmarking group's** best, average and worst **results.**

Tips on how to read, interpret and use the data are included in the Appendices

Please note: charts will only display data for the years where an organisation has data. For example, an organisation with two years of trend data will see charts such as q10c with data only in the 2021 and 2022 portions of the chart and table.

Survey Coordination Centre

NHS

Organisation details

Please note, where there are less than 11 responses for a question this data is not shown in the chart to protect the confidentiality of staff and reliability of results.

Organisation details

Survey Coordination Centre NHS

Dorset County Hospital NHS Foundation Trust

2022 NHS Staff Survey

Organisation details

Completed questionnaires	1404
2022 response rate	43%

This organisation is benchmarked against:

Acute and Acute & Community Trusts

Survey details

Survey mode	Mixed

2022 benchmarking group details

Organisations in group: 124

Median response rate: 44%

No. of completed questionnaires: 431292

For more information on benchmarking group definitions please see the Technical document.

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NHS

People Promise Elements, Themes and sub-score results

Please note, where there are less than 11 responses for a question this data is not shown in the chart to protect the confidentiality of staff and reliability of results.

Survey Coordination Centre

NHS

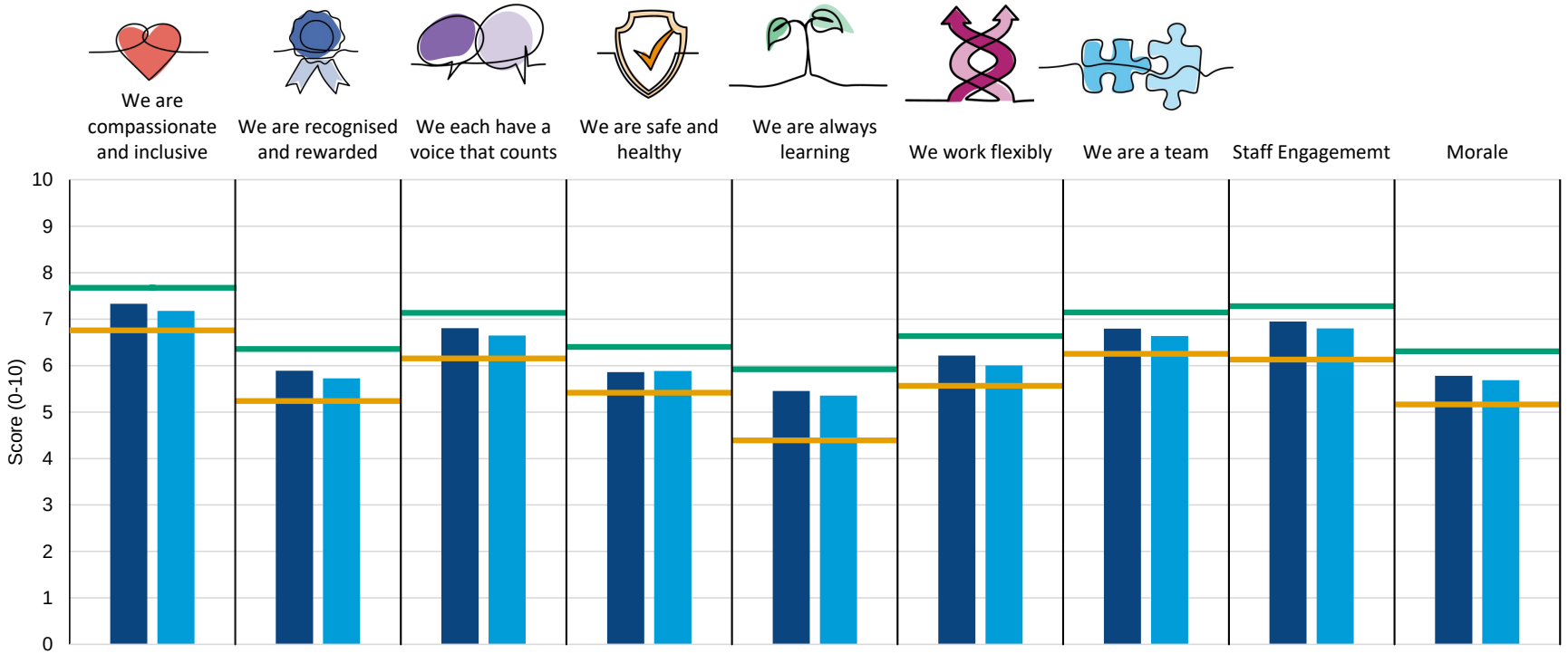
People Promise Elements, Themes and Sub-scores: Overview

Please note, where there are less than 11 responses for a question this data is not shown in the chart to protect the confidentiality of staff and reliability of results.

People Promise Elements and Themes: Overview

Survey Coordination Centre NHS

All of the People Promise elements, themes and sub-scores are scored on a 0-10 scale, **where a higher score is more positive than a lower score**.



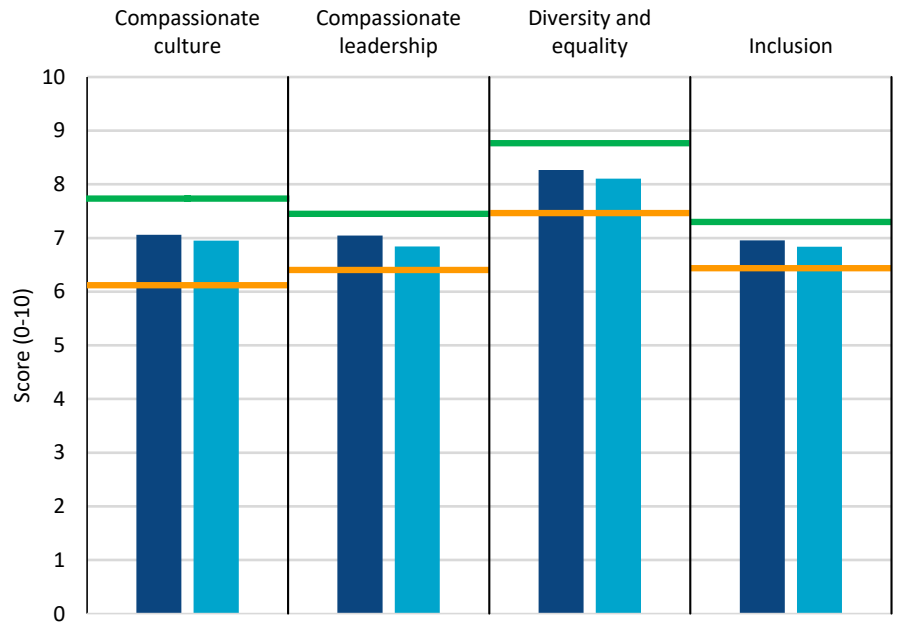
	We are compassionate and inclusive	We are recognised and rewarded	We each have a voice that counts	We are safe and healthy	We are always learning	We work flexibly	We are a team	Staff Engagememt	Morale
Your org	7.3	5.9	6.8	5.9	5.5	6.2	6.8	6.9	5.8
Best	7.7	6.4	7.1	6.4	5.9	6.6	7.1	7.3	6.3
Average	7.2	5.7	6.6	5.9	5.4	6.0	6.6	6.8	5.7
Worst	6.8	5.2	6.2	5.4	4.4	5.6	6.3	6.1	5.2
Responses	1403	1396	1391	1399	1336	1392	1397	1402	1402

People Promise Elements, Themes and Sub-scores: Sub-score Overview

Survey Coordination Centre NHS

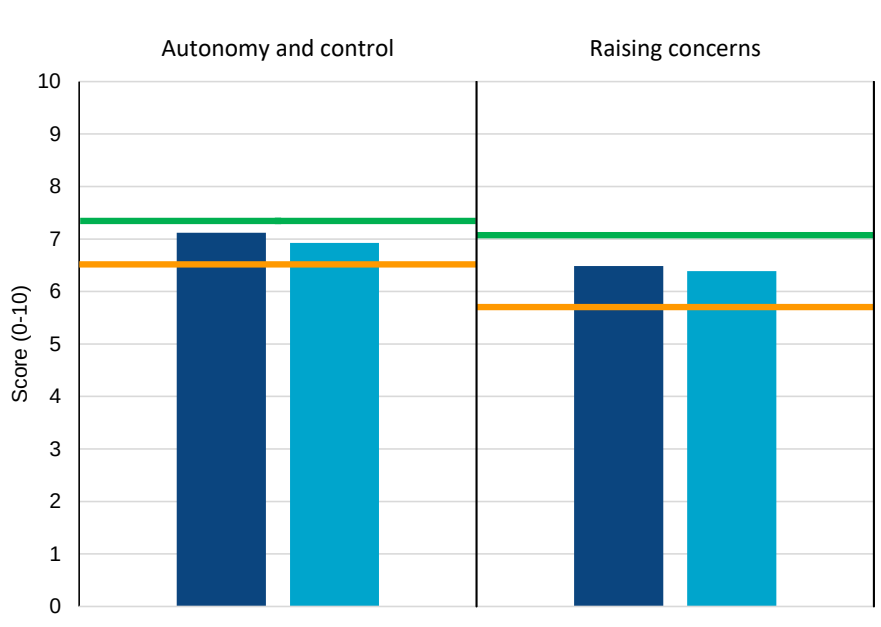
All of the People Promise elements, themes and sub-scores are scored on a 0-10 scale, **where a higher score is more positive than a lower score**.

Promise element 1: We are compassionate and inclusive



	Compassionate culture	Compassionate leadership	Diversity and equality	Inclusion
Your org	7.1	7.0	8.3	7.0
Best	7.7	7.4	8.8	7.3
Average	7.0	6.8	8.1	6.8
Worst	6.1	6.4	7.5	6.4
Responses	1399	1398	1402	1397

Promise element 3: We each have a voice that counts



	Autonomy and control	Raising concerns
Your org	7.1	6.5
Best	7.3	7.1
Average	6.9	6.4
Worst	6.5	5.7
Responses	1400	1395

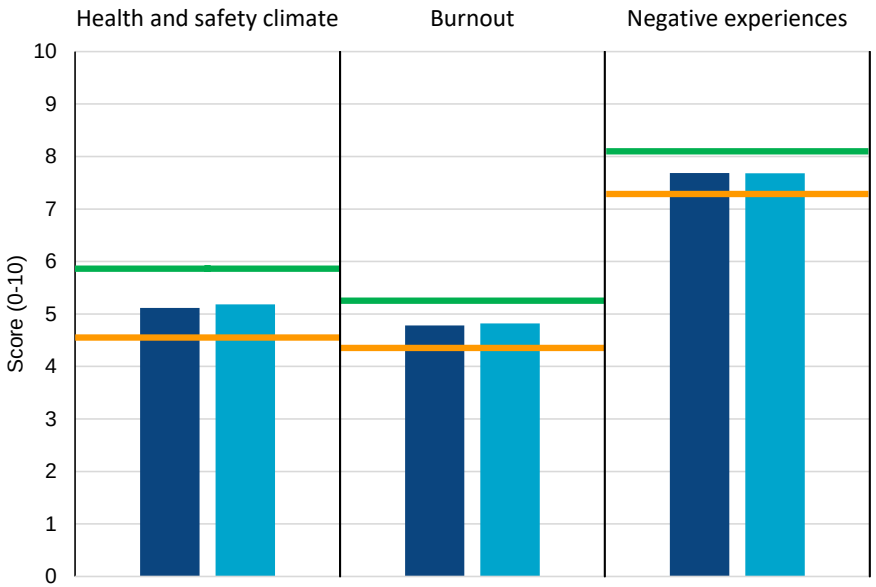
N.B. People Promise Element 2 'We are recognised and rewarded' does not have any sub-scores. Overall trend score data for this element is reported on slide 20.

People Promise Elements, Themes and Sub-scores: Sub-score Overview

Survey Coordination Centre NHS

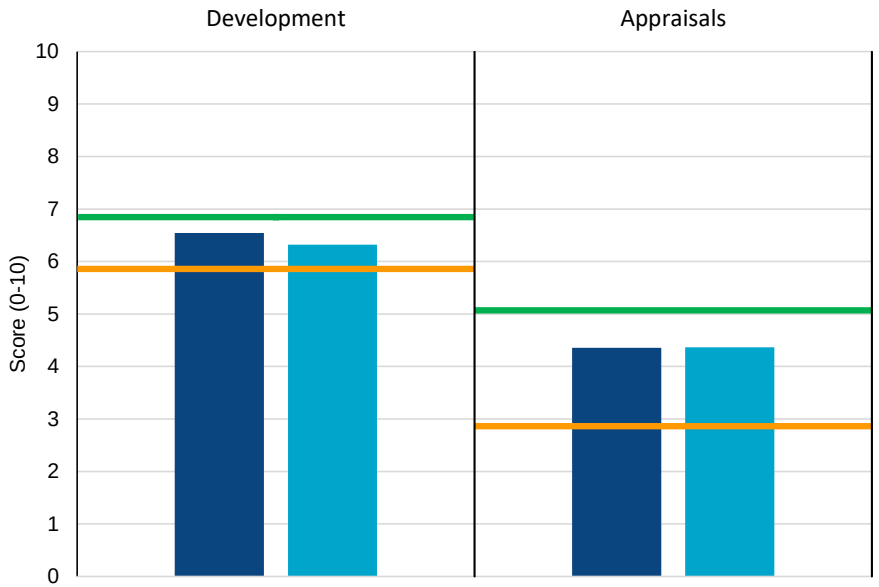
All of the People Promise elements, themes and sub-scores are scored on a 0-10 scale, **where a higher score is more positive than a lower score**.

Promise element 4: We are safe and healthy



	Health and safety climate	Burnout	Negative experiences
Your org	5.1	4.8	7.7
Best	5.9	5.3	8.1
Average	5.2	4.8	7.7
Worst	4.6	4.4	7.3
Responses	1400	1404	1403

Promise element 5: We are always learning



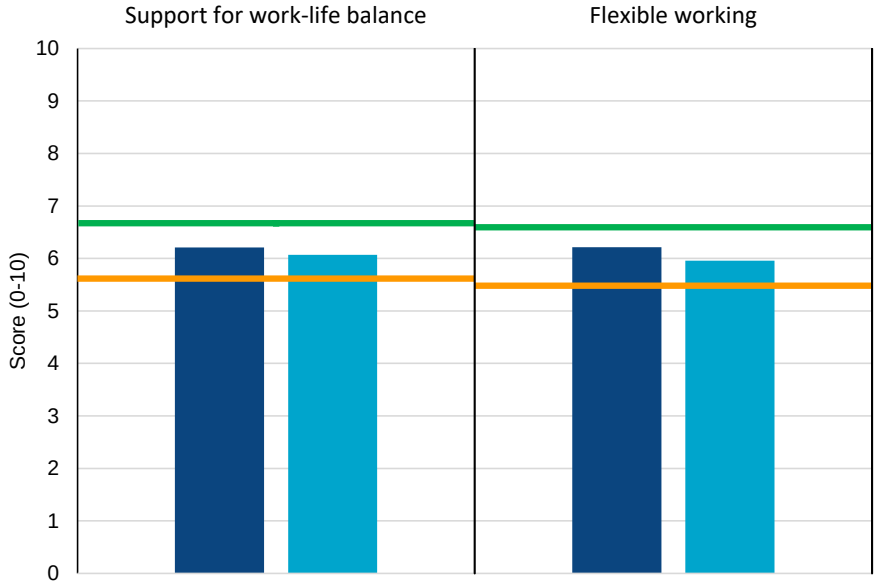
	Development	Appraisals
Your org	6.5	4.4
Best	6.8	5.1
Average	6.3	4.4
Worst	5.9	2.9
Responses	1396	1341

People Promise Elements, Themes and Sub-scores: Sub-score Overview

Survey Coordination Centre NHS

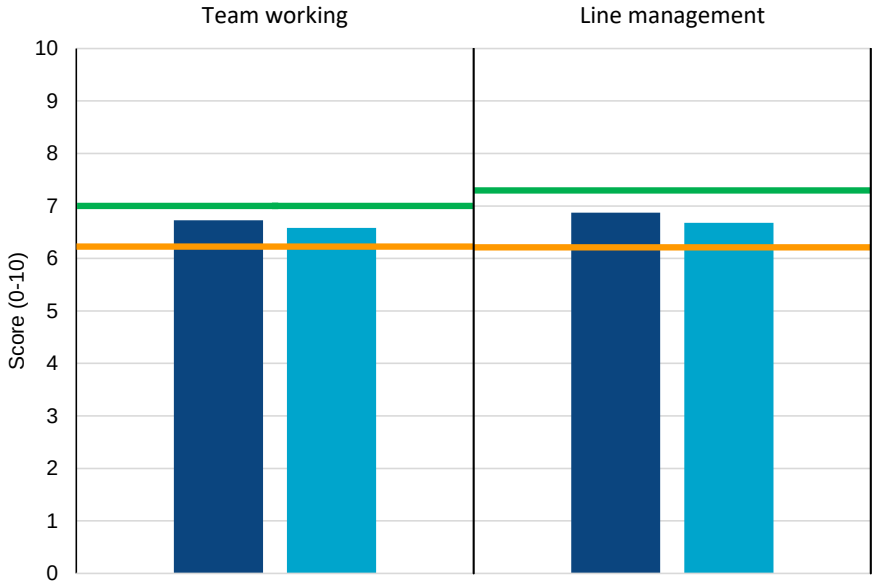
All of the People Promise elements, themes and sub-scores are scored on a 0-10 scale, **where a higher score is more positive than a lower score**.

Promise element 6: We work flexibly



	Support for work-life balance	Flexible working
Your org	6.2	6.2
Best	6.7	6.6
Average	6.1	6.0
Worst	5.6	5.5
Responses	1401	1394

Promise element 7: We are a team



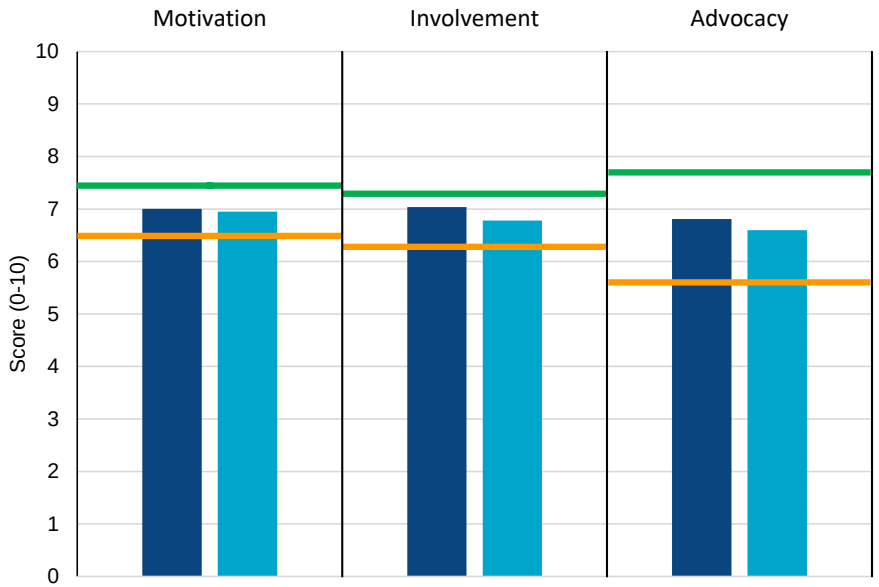
	Team working	Line management
Your org	6.7	6.9
Best	7.0	7.3
Average	6.6	6.7
Worst	6.2	6.2
Responses	1401	1399

People Promise Elements, Themes and Sub-scores: Sub-score Overview

Survey Coordination Centre NHS

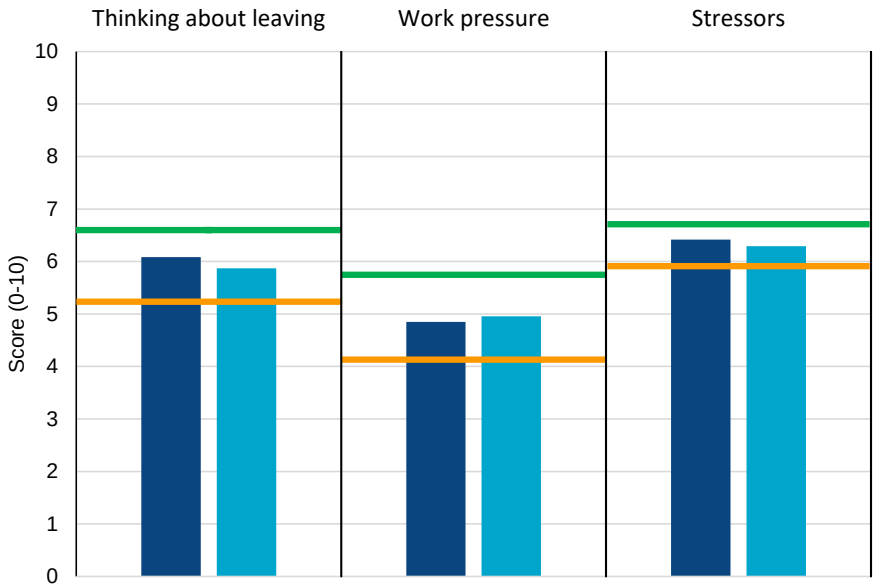
All of the People Promise elements, themes and sub-scores are scored on a 0-10 scale, **where a higher score is more positive than a lower score**.

Theme: Staff engagement



	Motivation	Involvement	Advocacy
Your org	7.0	7.0	6.8
Best	7.4	7.3	7.7
Average	7.0	6.8	6.6
Worst	6.5	6.3	5.6
Responses	1386	1400	1399

Theme: Morale



	Thinking about leaving	Work pressure	Stressors
Your org	6.1	4.8	6.4
Best	6.6	5.7	6.7
Average	5.9	5.0	6.3
Worst	5.2	4.1	5.9
Responses	1398	1399	1399

Survey Coordination Centre

NHS

People Promise Elements, Themes and Sub-scores: Trends

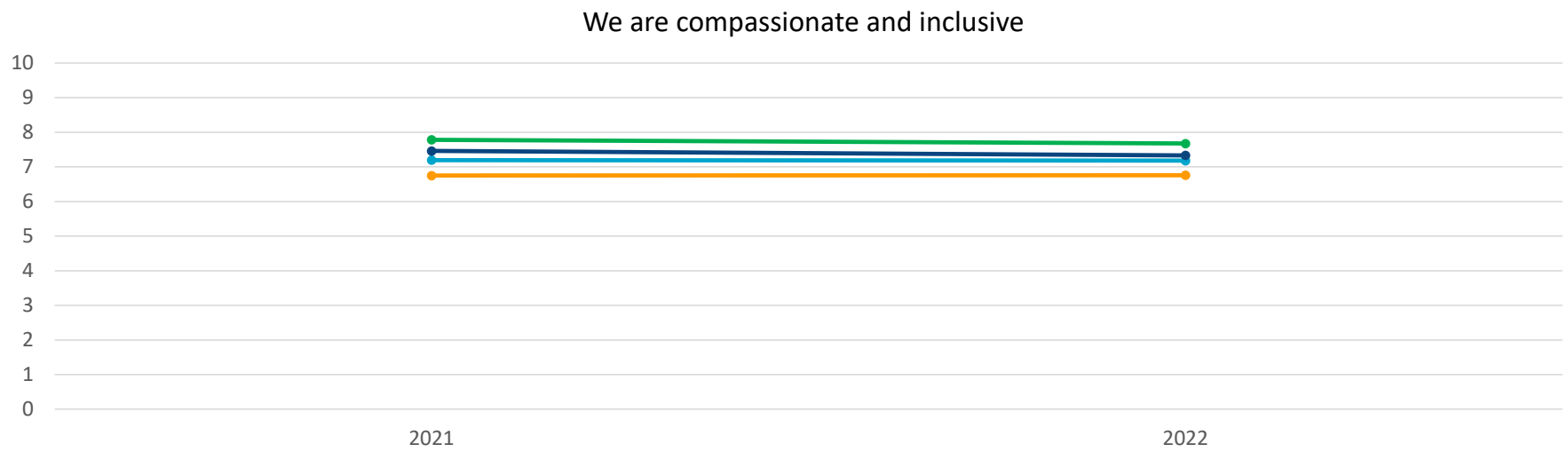
Please note, where there are less than 11 responses for a question this data is not shown in the chart to protect the confidentiality of staff and reliability of results.

People Promise Elements and Themes: Trends

Survey Coordination Centre NHS

All of the People Promise elements, themes and sub-scores are scored on a 0-10 scale, **where a higher score is more positive than a lower score**.

Promise element 1: We are compassionate and inclusive



	2021	2022
Your org	7.5	7.3
Best	7.8	7.7
Average	7.2	7.2
Worst	6.7	6.8
Responses	1515	1403

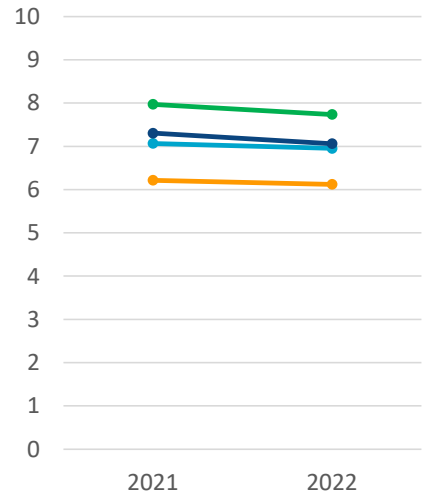
People Promise Elements, Themes and Sub-scores: Sub-score trends

Survey Coordination Centre NHS

All of the People Promise elements, themes and sub-scores are scored on a 0-10 scale, **where a higher score is more positive than a lower score**.

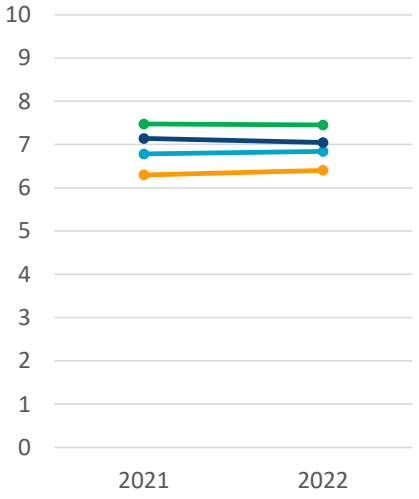
Promise element 1: We are compassionate and inclusive

Compassionate culture



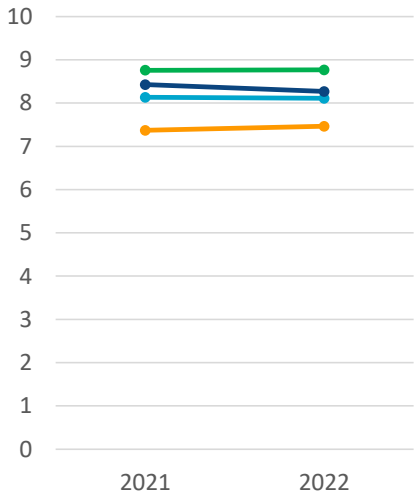
	2021	2022
Your org	7.3	7.1
Best	8.0	7.7
Average	7.1	7.0
Worst	6.2	6.1
Responses	1508	1399

Compassionate leadership



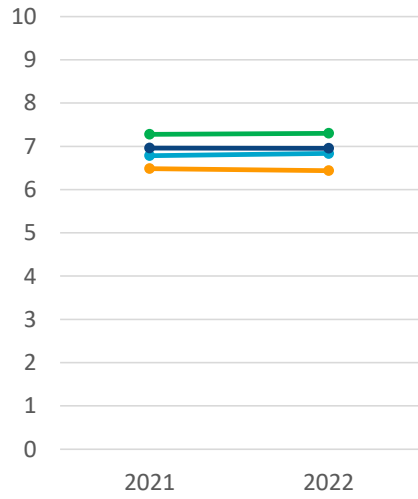
	2021	2022
Your org	7.1	7.0
Best	7.5	7.4
Average	6.8	6.8
Worst	6.3	6.4
Responses	1513	1398

Diversity and equality



	2021	2022
Your org	8.4	8.3
Best	8.8	8.8
Average	8.1	8.1
Worst	7.4	7.5
Responses	1510	1402

Inclusion



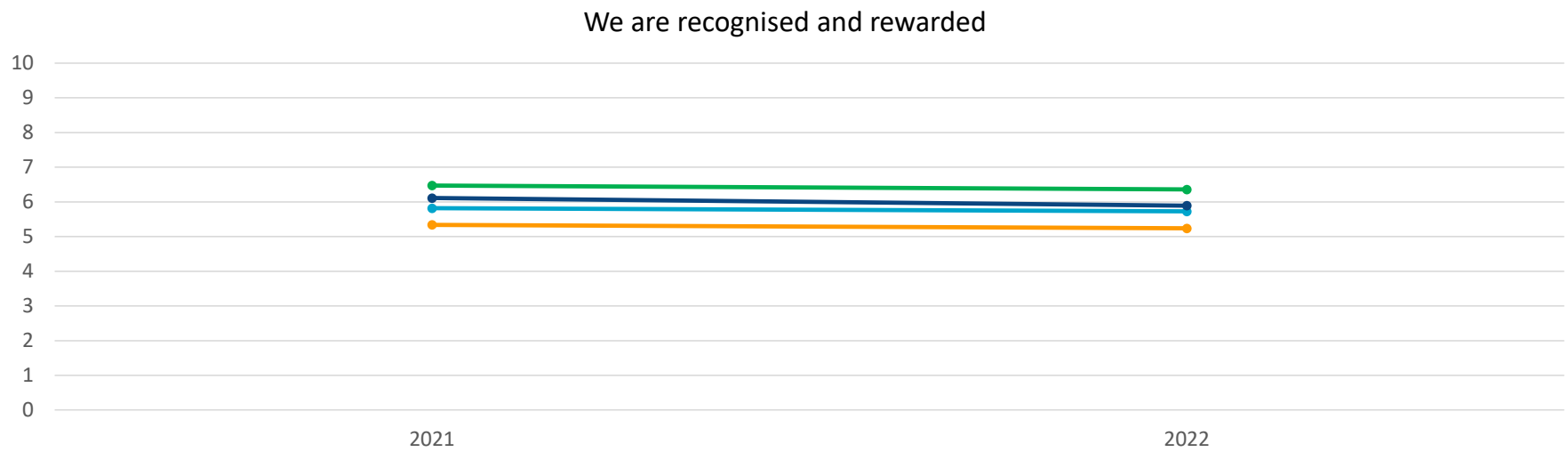
	2021	2022
Your org	7.0	7.0
Best	7.3	7.3
Average	6.8	6.8
Worst	6.5	6.4
Responses	1511	1397

People Promise Elements and Themes: Trends

Survey Coordination Centre NHS

All of the People Promise elements, themes and sub-scores are scored on a 0-10 scale, **where a higher score is more positive than a lower score**.

Promise element 2: We are recognised and rewarded



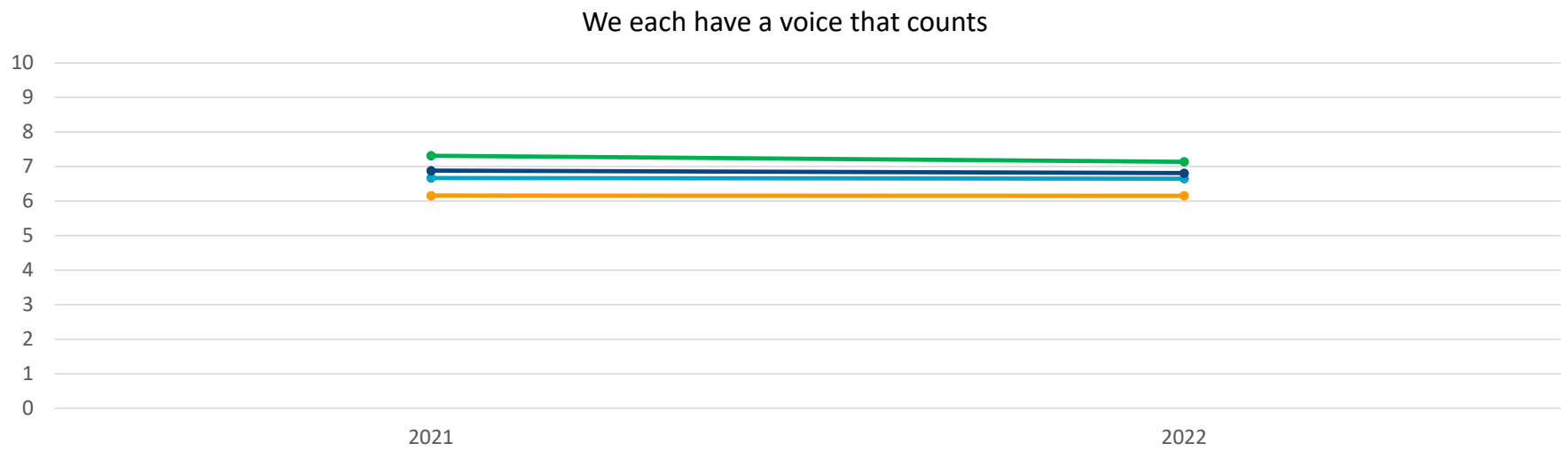
	2021	2022
Your org	6.1	5.9
Best	6.5	6.4
Average	5.8	5.7
Worst	5.3	5.2
Responses	1514	1396

People Promise Elements and Themes: Trends

Survey Coordination Centre NHS

All of the People Promise elements, themes and sub-scores are scored on a 0-10 scale, **where a higher score is more positive than a lower score**.

Promise element 3: We each have a voice that counts



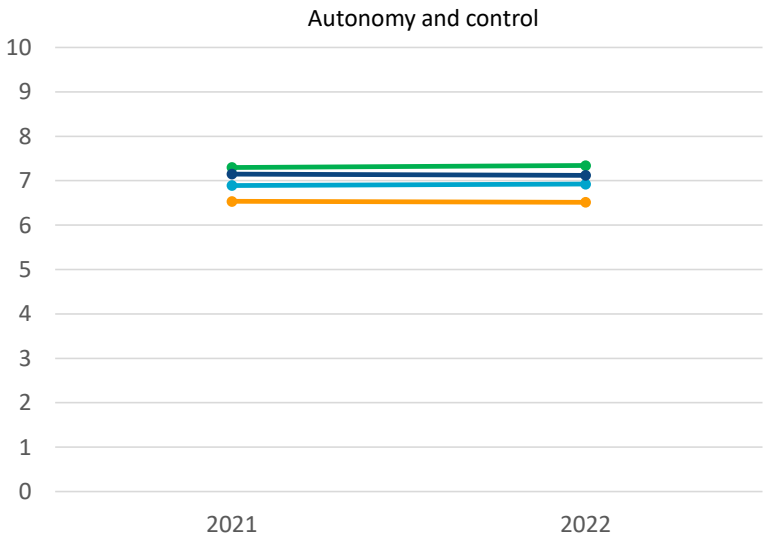
	2021	2022
Your org	6.9	6.8
Best	7.3	7.1
Average	6.7	6.6
Worst	6.2	6.2
Responses	1497	1391

People Promise Elements, Themes and Sub-scores: Sub-score trends

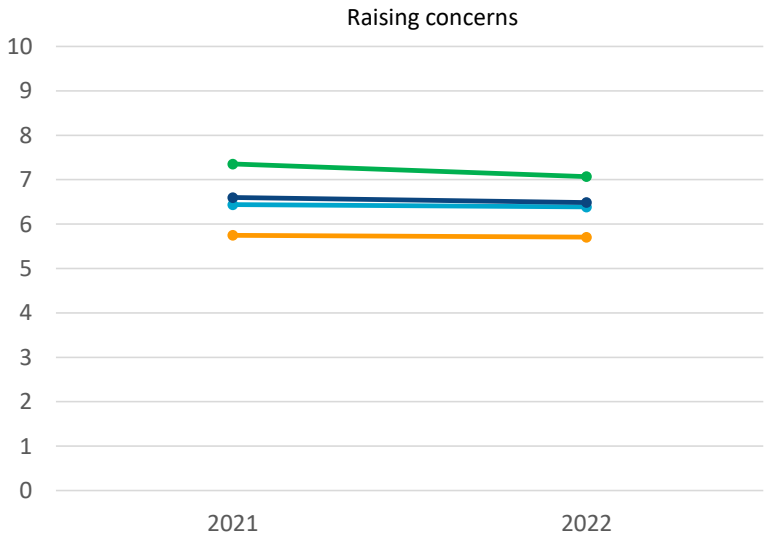
Survey Coordination Centre NHS

All of the People Promise elements, themes and sub-scores are scored on a 0-10 scale, **where a higher score is more positive than a lower score**.

Promise element 3: We each have a voice that counts



	2021	2022
Your org	7.2	7.1
Best	7.3	7.3
Average	6.9	6.9
Worst	6.5	6.5
Responses	1514	1400



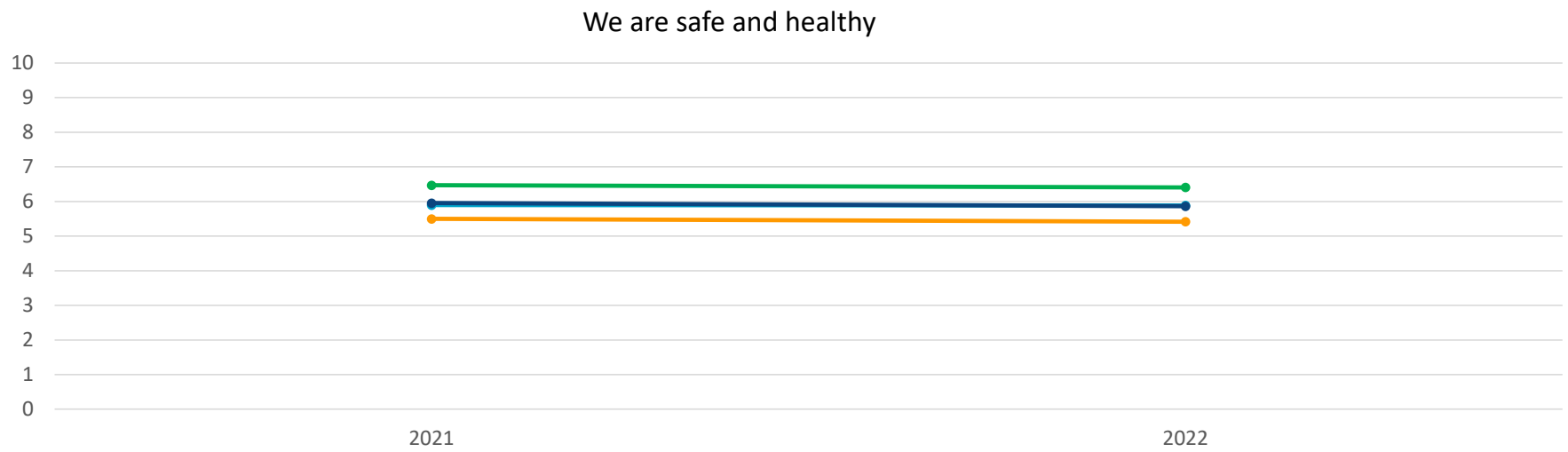
	2021	2022
Your org	6.6	6.5
Best	7.4	7.1
Average	6.4	6.4
Worst	5.7	5.7
Responses	1499	1395

People Promise Elements and Themes: Trends

Survey Coordination Centre NHS

All of the People Promise elements, themes and sub-scores are scored on a 0-10 scale, **where a higher score is more positive than a lower score**.

Promise element 4: We are safe and healthy



	2021	2022
Your org	6.0	5.9
Best	6.5	6.4
Average	5.9	5.9
Worst	5.5	5.4
Responses	1501	1399

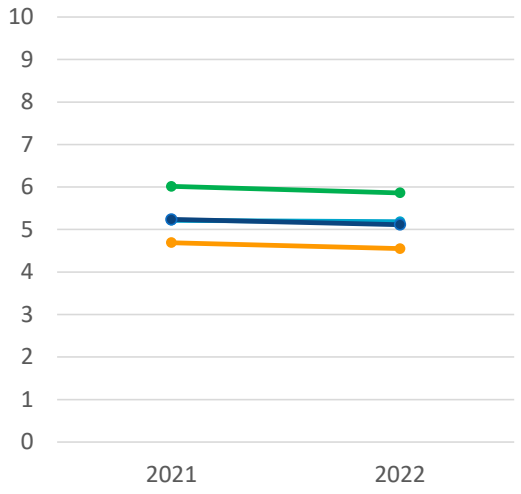
People Promise Elements, Themes and Sub-scores: Sub-score trends

Survey Coordination Centre NHS

All of the People Promise elements, themes and sub-scores are scored on a 0-10 scale, **where a higher score is more positive than a lower score**.

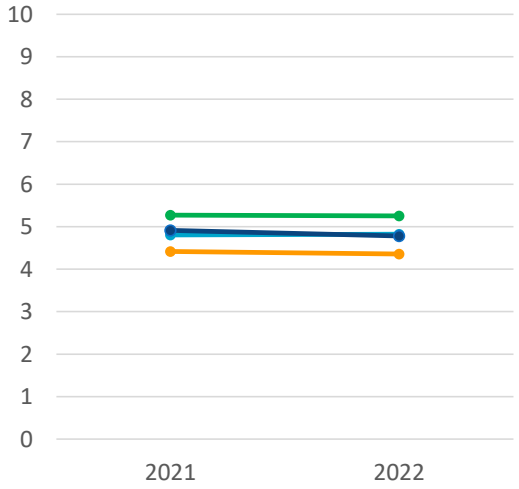
Promise element 4: We are safe and healthy

Health and safety climate



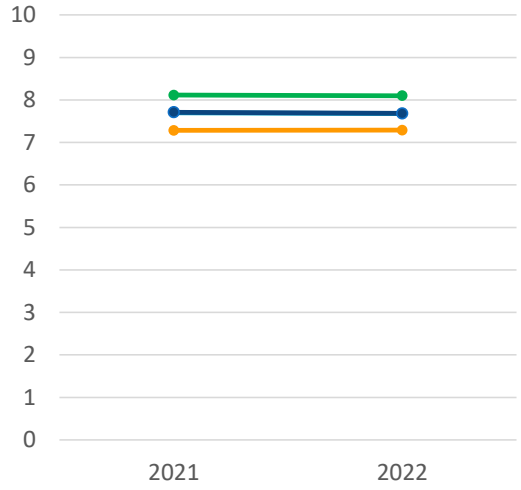
	2021	2022
Your org	5.2	5.1
Best	6.0	5.9
Average	5.2	5.2
Worst	4.7	4.6
Responses	1514	1400

Burnout



	2021	2022
Your org	4.9	4.8
Best	5.3	5.3
Average	4.8	4.8
Worst	4.4	4.4
Responses	1512	1404

Negative experiences



	2021	2022
Your org	7.7	7.7
Best	8.1	8.1
Average	7.7	7.7
Worst	7.3	7.3
Responses	1504	1403

People Promise Elements and Themes: Trends

Survey Coordination Centre NHS

All of the People Promise elements, themes and sub-scores are scored on a 0-10 scale, **where a higher score is more positive than a lower score**.

Promise element 5: We are always learning

	2021	2022
Your org	5.6	5.5
Best	6.0	5.9
Average	5.2	5.4
Worst	4.3	4.4
Responses	1431	1336

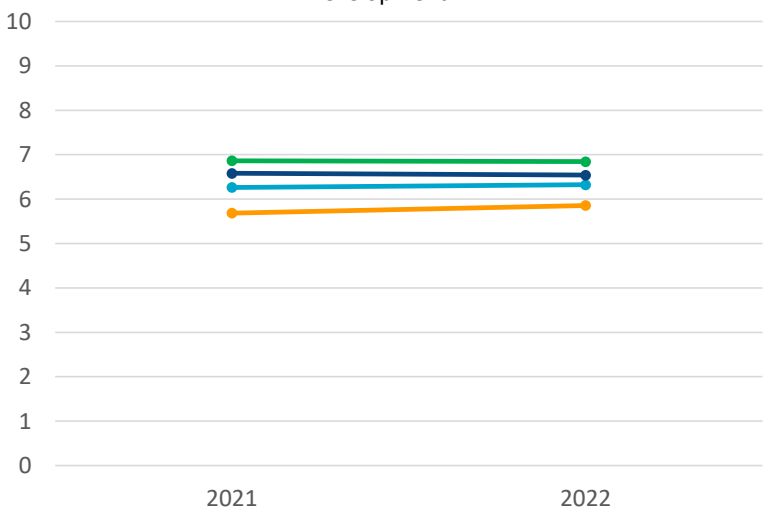
People Promise Elements, Themes and Sub-scores: Sub-score trends

Survey Coordination Centre NHS

All of the People Promise elements, themes and sub-scores are scored on a 0-10 scale, **where a higher score is more positive than a lower score**.

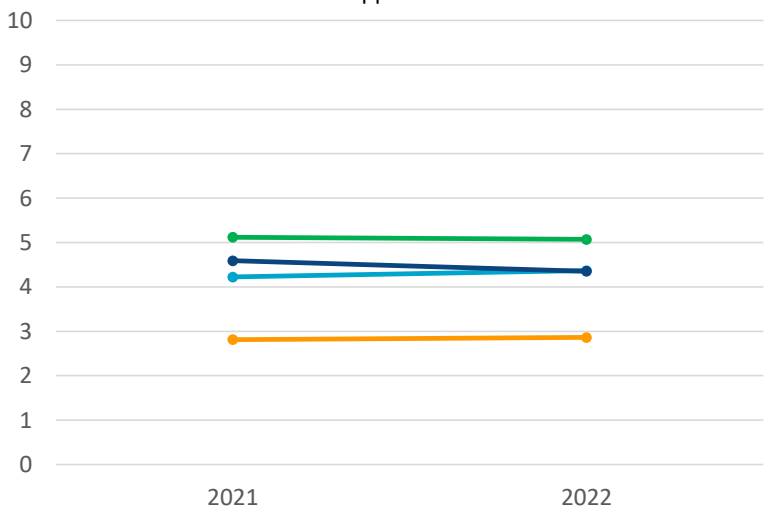
Promise element 5: We are always learning

Development



	2021	2022
Your org	6.6	6.5
Best	6.9	6.8
Average	6.3	6.3
Worst	5.7	5.9
Responses	1500	1396

Appraisals



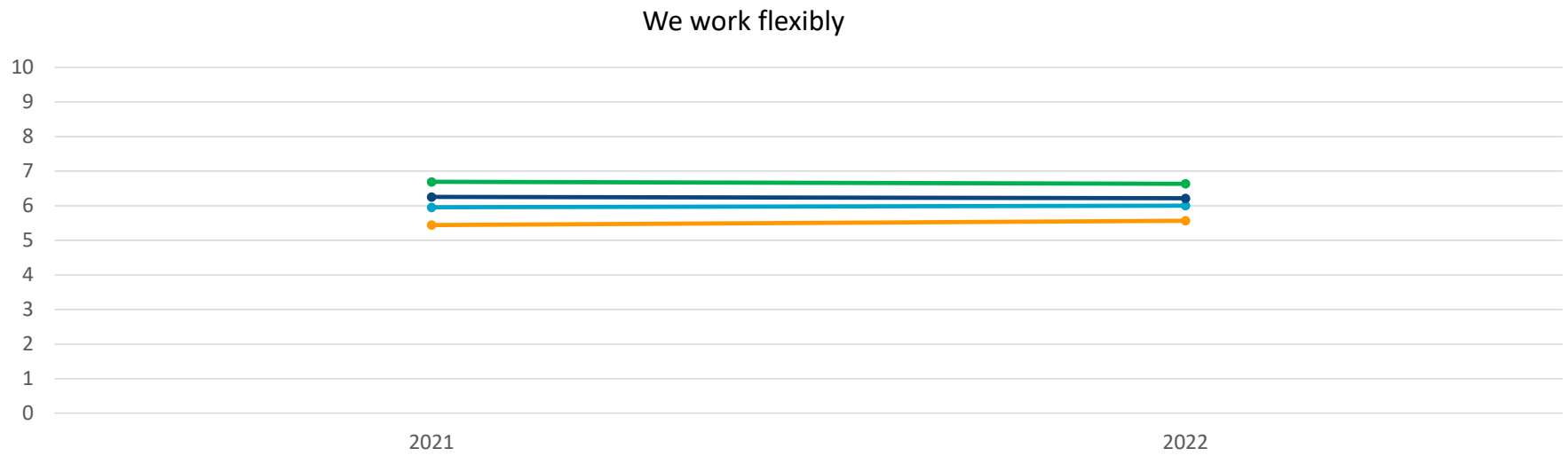
	2021	2022
Your org	4.6	4.4
Best	5.1	5.1
Average	4.2	4.4
Worst	2.8	2.9
Responses	1437	1341

People Promise Elements and Themes: Trends

Survey Coordination Centre NHS

All of the People Promise elements, themes and sub-scores are scored on a 0-10 scale, **where a higher score is more positive than a lower score**.

Promise element 6: We work flexibly



	2021	2022
Your org	6.3	6.2
Best	6.7	6.6
Average	6.0	6.0
Worst	5.4	5.6
Responses	1508	1392

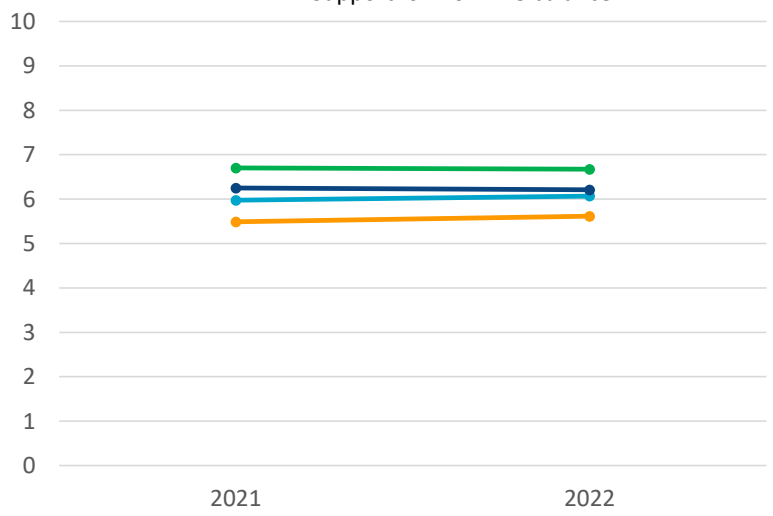
People Promise Elements, Themes and Sub-scores: Sub-score trends

Survey Coordination Centre NHS

All of the People Promise elements, themes and sub-scores are scored on a 0-10 scale, **where a higher score is more positive than a lower score**.

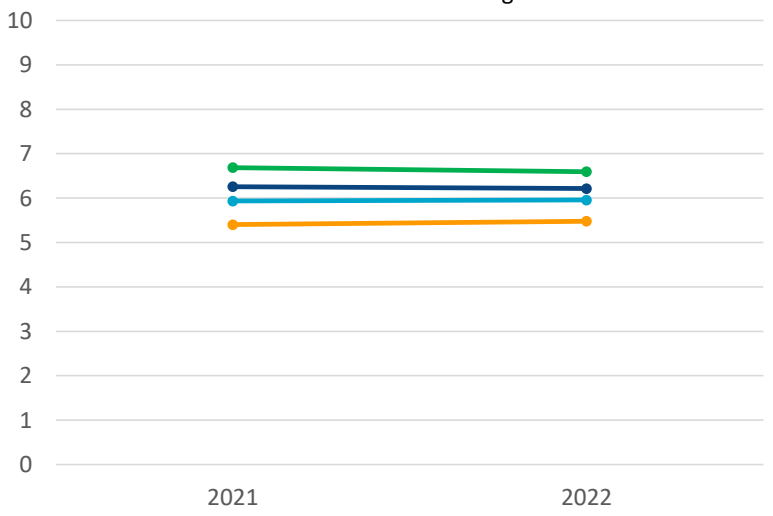
Promise element 6: We work flexibly

Support for work-life balance



	2021	2022
Your org	6.2	6.2
Best	6.7	6.7
Average	6.0	6.1
Worst	5.5	5.6
Responses	1514	1401

Flexible working



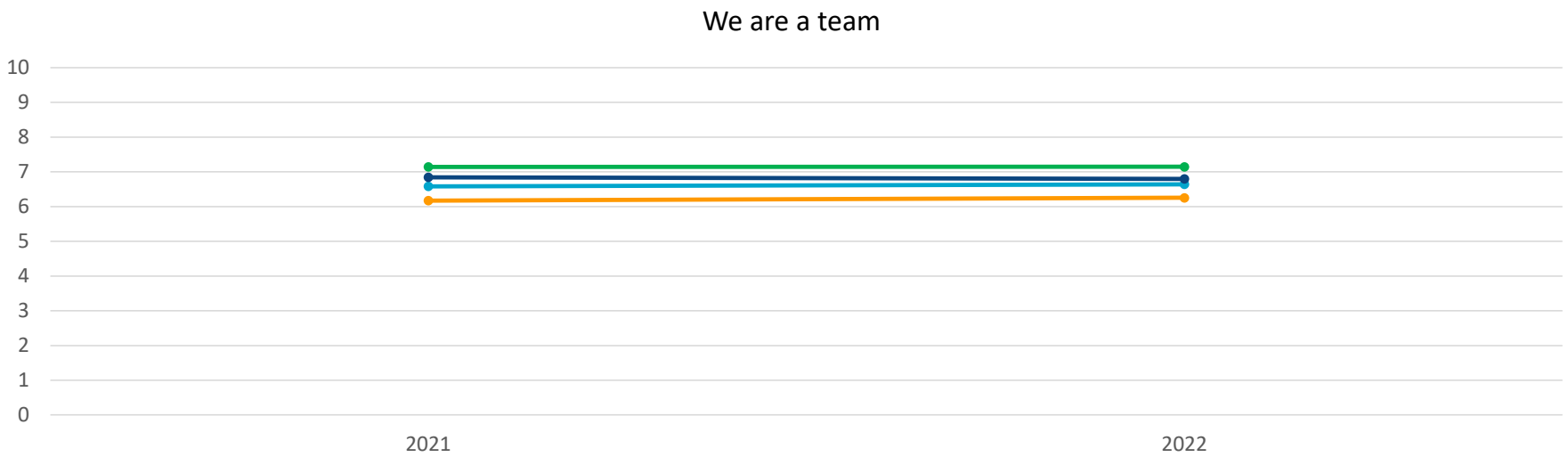
	2021	2022
Your org	6.3	6.2
Best	6.7	6.6
Average	5.9	6.0
Worst	5.4	5.5
Responses	1510	1394

People Promise Elements and Themes: Trends

Survey Coordination Centre NHS

All of the People Promise elements, themes and sub-scores are scored on a 0-10 scale, **where a higher score is more positive than a lower score**.

Promise element 7: We are a team



	2021	2022
Your org	6.8	6.8
Best	7.1	7.1
Average	6.6	6.6
Worst	6.2	6.3
Responses	1511	1397

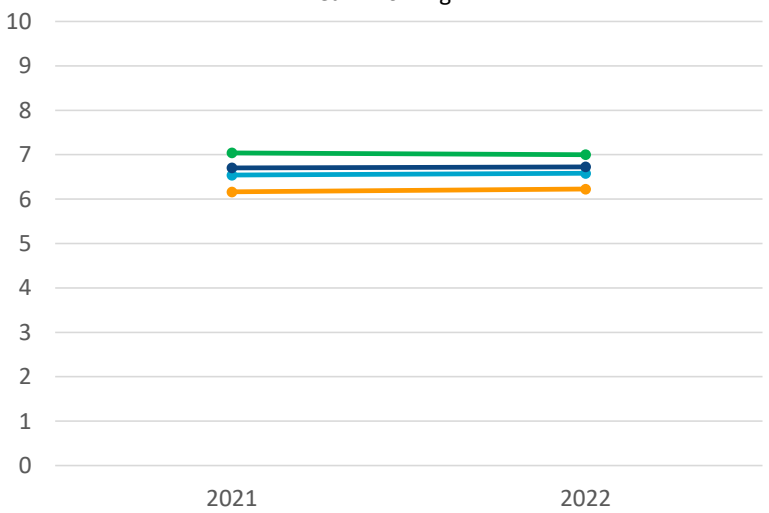
People Promise Elements, Themes and Sub-scores: Sub-score trends

Survey Coordination Centre NHS

All of the People Promise elements, themes and sub-scores are scored on a 0-10 scale, **where a higher score is more positive than a lower score**.

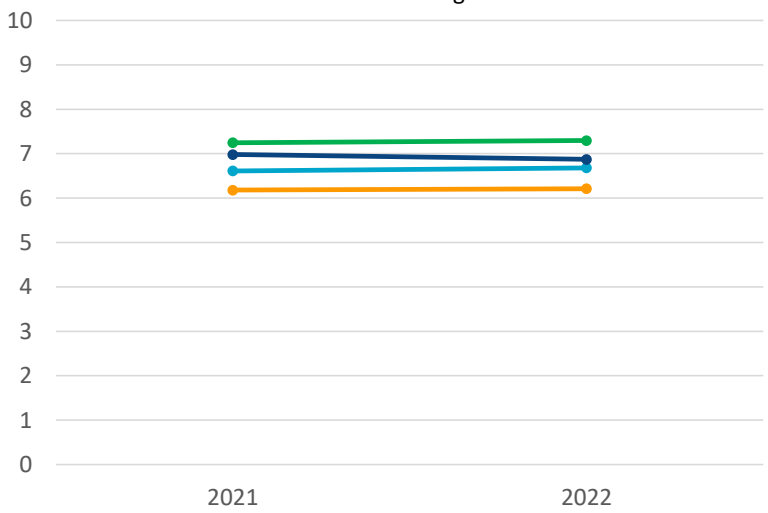
Promise element 7: We are a team

Team working



	2021	2022
Your org	6.7	6.7
Best	7.0	7.0
Average	6.5	6.6
Worst	6.2	6.2
Responses	1515	1401

Line management



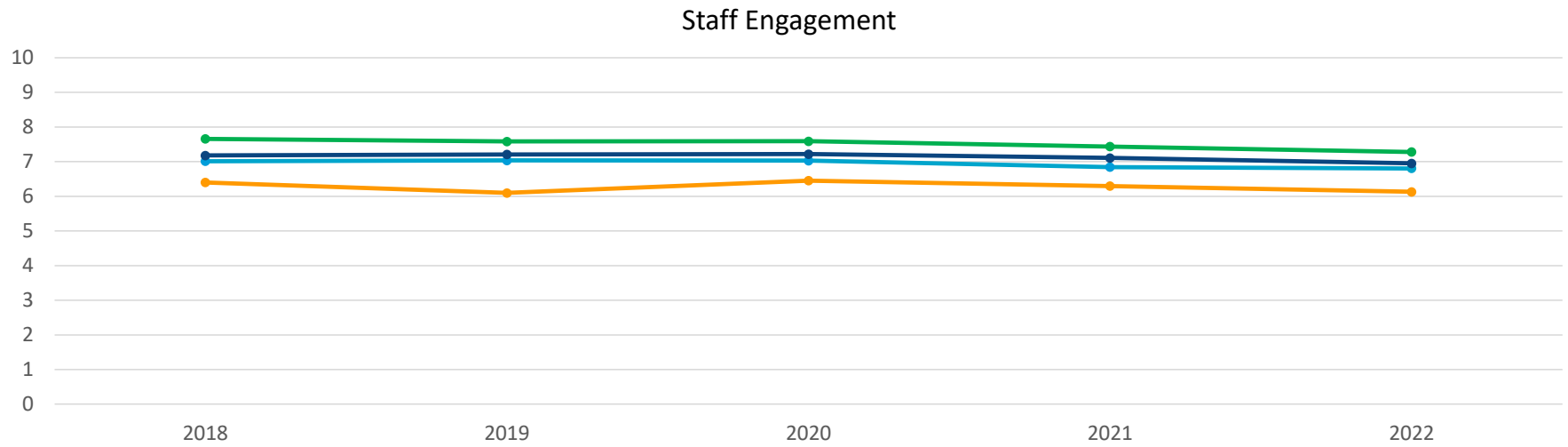
	2021	2022
Your org	7.0	6.9
Best	7.2	7.3
Average	6.6	6.7
Worst	6.2	6.2
Responses	1512	1399

People Promise Elements and Themes: Trends

Survey Coordination Centre NHS

All of the People Promise elements, themes and sub-scores are scored on a 0-10 scale, **where a higher score is more positive than a lower score**.

Theme: Staff Engagement



	2018	2019	2020	2021	2022
Your org	7.2	7.2	7.2	7.1	6.9
Best	7.7	7.6	7.6	7.4	7.3
Average	7.0	7.0	7.0	6.8	6.8
Worst	6.4	6.1	6.5	6.3	6.1
Responses	1316	1232	1356	1515	1402

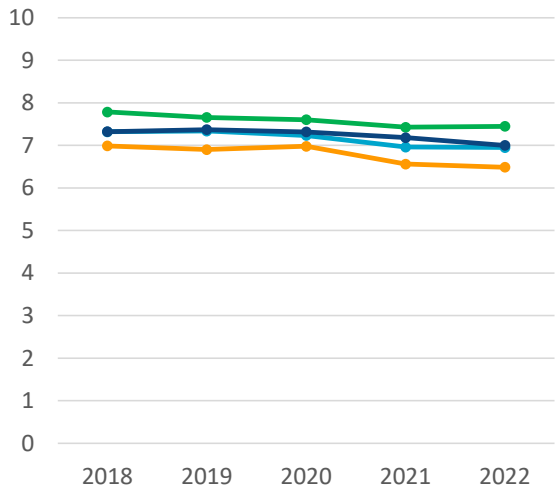
People Promise Elements, Themes and Sub-scores: Sub-score trends

Survey Coordination Centre NHS

All of the People Promise elements, themes and sub-scores are scored on a 0-10 scale, **where a higher score is more positive than a lower score**.

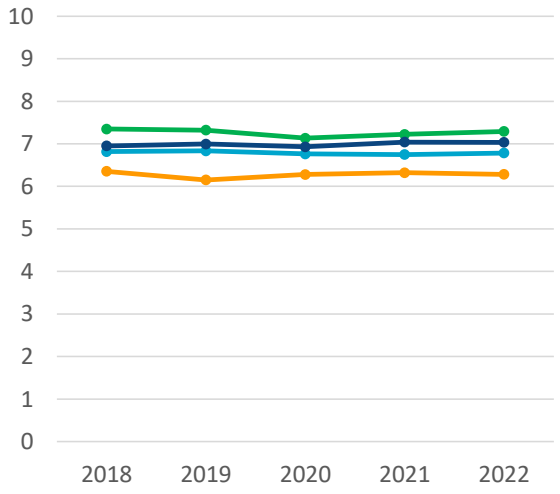
Theme: Staff Engagement

Motivation



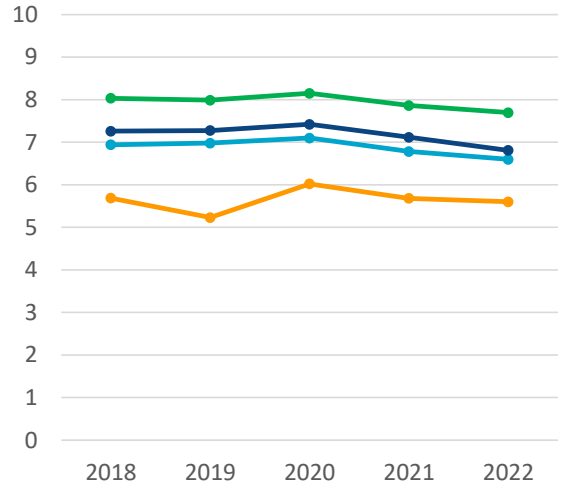
	2018	2019	2020	2021	2022
Your org	7.3	7.4	7.3	7.2	7.0
Best	7.8	7.7	7.6	7.4	7.4
Average	7.3	7.3	7.2	7.0	7.0
Worst	7.0	6.9	7.0	6.6	6.5
Responses	1297	1219	1341	1504	1386

Involvement



	2018	2019	2020	2021	2022
Your org	7.0	7.0	6.9	7.0	7.0
Best	7.3	7.3	7.1	7.2	7.3
Average	6.8	6.8	6.8	6.7	6.8
Worst	6.4	6.2	6.3	6.3	6.3
Responses	1315	1231	1355	1515	1400

Advocacy



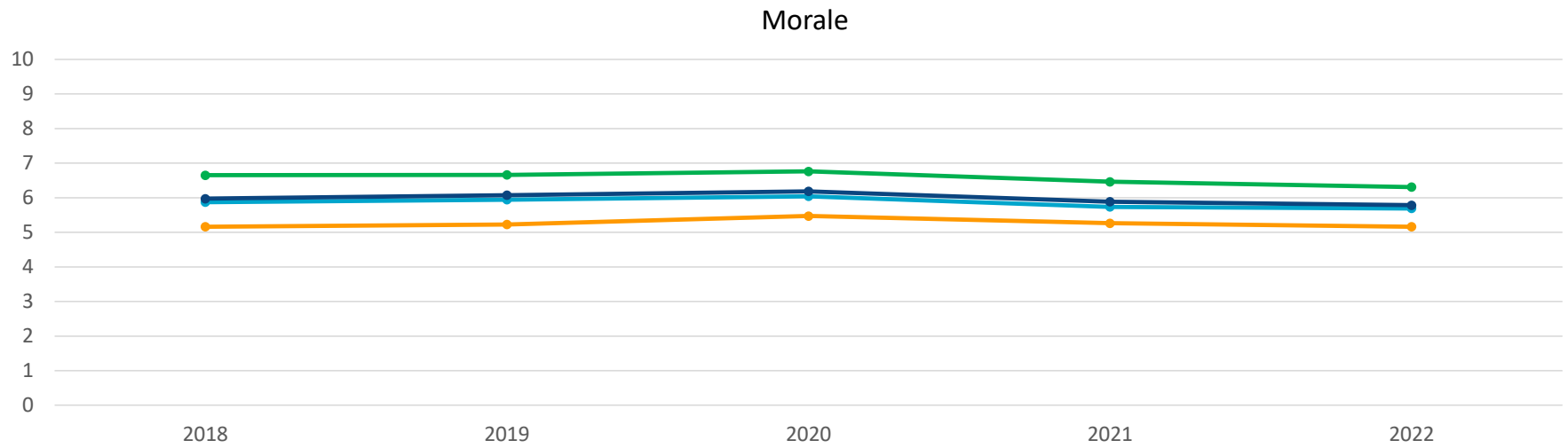
	2018	2019	2020	2021	2022
Your org	7.3	7.3	7.4	7.1	6.8
Best	8.0	8.0	8.2	7.9	7.7
Average	6.9	7.0	7.1	6.8	6.6
Worst	5.7	5.2	6.0	5.7	5.6
Responses	1309	1208	1348	1510	1399

People Promise Elements and Themes: Trends

Survey Coordination Centre NHS

All of the People Promise elements, themes and sub-scores are scored on a 0-10 scale, **where a higher score is more positive than a lower score**.

Theme: Morale



	2018	2019	2020	2021	2022
Your org	6.0	6.1	6.2	5.9	5.8
Best	6.6	6.7	6.8	6.5	6.3
Average	5.9	5.9	6.0	5.7	5.7
Worst	5.2	5.2	5.5	5.3	5.2
Responses	1317	1227	1355	1516	1402

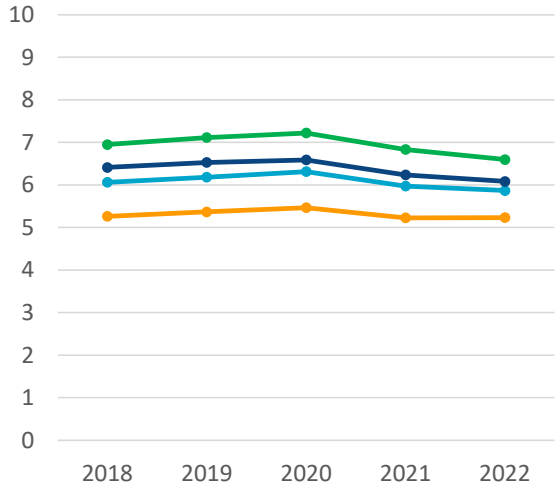
People Promise Elements, Themes and Sub-scores: Sub-score trends

Survey Coordination Centre NHS

All of the People Promise elements, themes and sub-scores are scored on a 0-10 scale, **where a higher score is more positive than a lower score**.

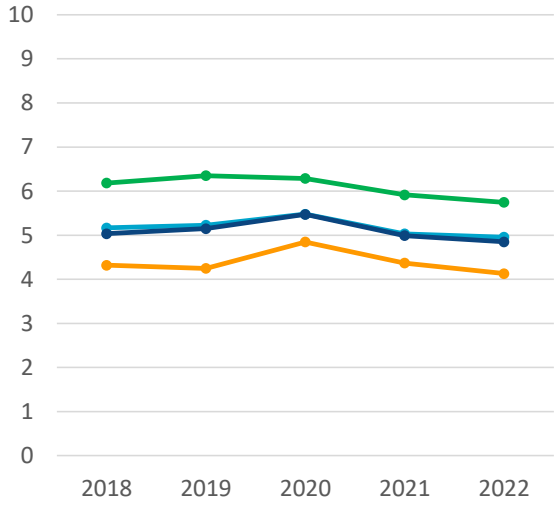
Theme: Morale

Thinking about leaving



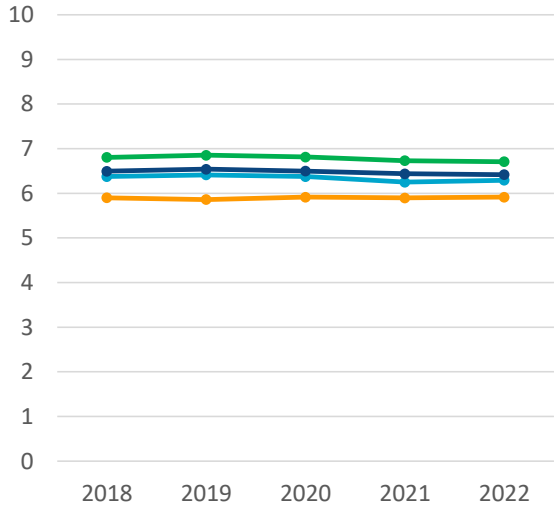
	2018	2019	2020	2021	2022
Your org	6.4	6.5	6.6	6.2	6.1
Best	6.9	7.1	7.2	6.8	6.6
Average	6.1	6.2	6.3	6.0	5.9
Worst	5.3	5.4	5.5	5.2	5.2
Responses	1304	1210	1347	1513	1398

Work pressure



	2018	2019	2020	2021	2022
Your org	5.0	5.1	5.5	5.0	4.8
Best	6.2	6.4	6.3	5.9	5.7
Average	5.2	5.2	5.5	5.0	5.0
Worst	4.3	4.2	4.8	4.4	4.1
Responses	1313	1230	1355	1512	1399

Stressors



	2018	2019	2020	2021	2022
Your org	6.5	6.5	6.5	6.4	6.4
Best	6.8	6.9	6.8	6.7	6.7
Average	6.4	6.4	6.4	6.3	6.3
Worst	5.9	5.9	5.9	5.9	5.9
Responses	1316	1221	1341	1509	1399

Survey Coordination Centre

NHS

Covid-19 Classification breakdowns

Please note, where there are less than 11 responses for a question this data is not shown in the chart to protect the confidentiality of staff and reliability of results.

Covid-19 classification breakdowns

Survey Coordination Centre NHS

Covid-19 questions

In the 2022 survey, staff were asked three classification questions relating to their experience during the Covid-19 pandemic:

a. In the past 12 months, have you worked on a Covid-19 specific ward or area at any time?	1 ☐ Yes	2 ☐ No
b. In the past 12 months, have you been redeployed due to the Covid-19 pandemic at any time?	1 ☐ Yes	2 ☐ No
c. In the past 12 months, have you been required to work remotely/from home due to the Covid-19 pandemic?	1 ☐ Yes	2 ☐ No

The charts on the following pages show the breakdown of People Promise elements scores for staff answering 'yes' to each of these questions, compared with the results for all staff at your organisation. Results are presented in the context of highest, average and lowest scores for similar organisations.

Comparing your data

To improve overall comparability, the data have been weighted to match the occupation group profile of staff at your organisation to that of the benchmarking group, as in previous charts. However, there may be differences in the occupation group profiles of the individual COVID-19 subgroups. For example, the mix of occupational groups across redeployed staff at your organisation may differ from similar organisations. This difference would not be accounted for by the weighting and therefore may affect the comparability of trend results. As such, a degree of caution is advised when interpreting your results.

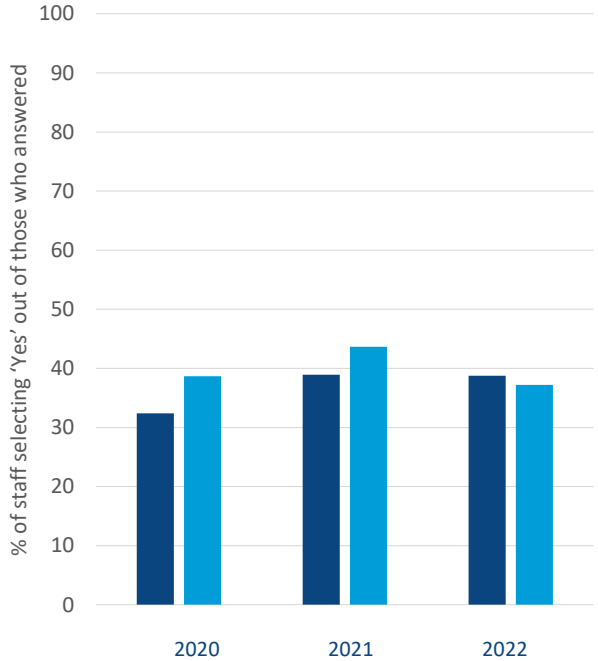
Further information

Results for these groups of staff, including data for individual questions, are also available via the online dashboards. Please note that results presented in these dashboards have not been weighted where no benchmarking takes place and so may vary slightly from those shown in this report.

The Covid-19 pandemic – Your experience during the Covid-19 pandemic

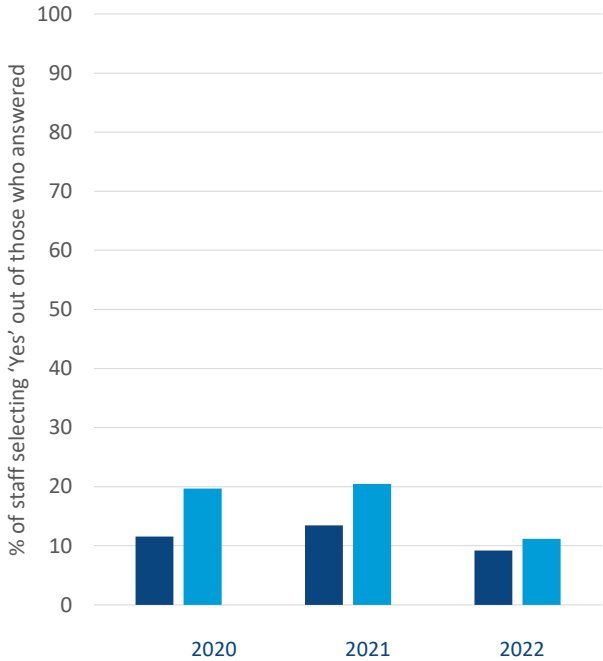
Survey Coordination Centre NHS

Q25a In the past 12 months, have you worked on a Covid-19 specific ward or area at any time?



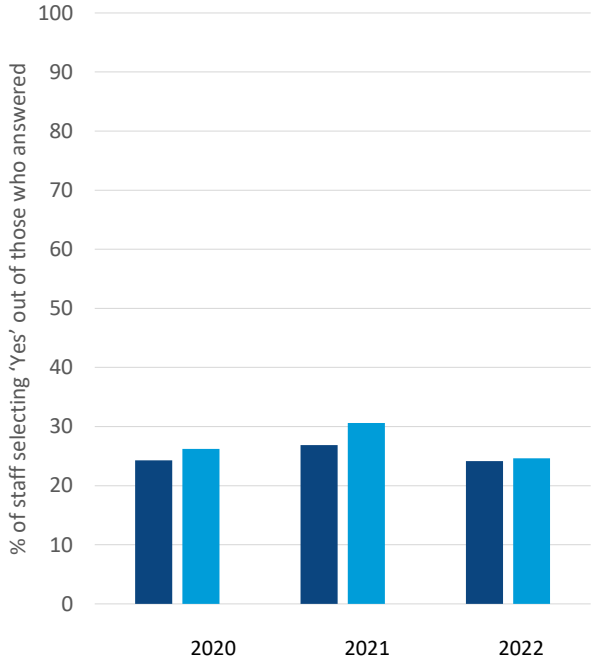
	2020	2021	2022
Your org	32.4%	38.9%	38.8%
Average	38.7%	43.6%	37.2%
Responses	1347	1511	1396

Q25b In the past 12 months, have you been redeployed due to the Covid-19 pandemic at any time?



	2020	2021	2022
Your org	11.6%	13.4%	9.2%
Average	19.7%	20.4%	11.2%
Responses	1341	1503	1389

Q25c In the past 12 months, have you been required to work remotely/from home due to the Covid-19 pandemic?



	2020	2021	2022
Your org	24.3%	26.9%	24.1%
Average	26.2%	30.6%	24.6%
Responses	1330	1504	1392

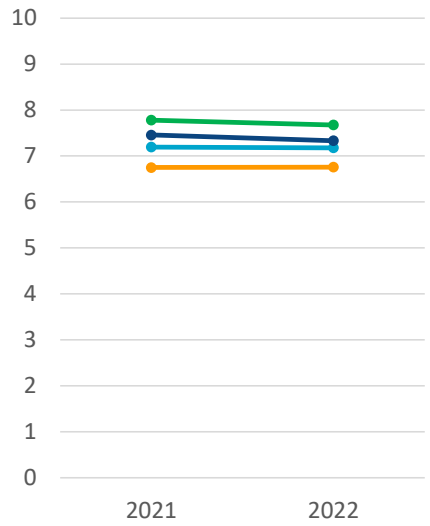
The Covid-19 pandemic – Your experience during the Covid-19 pandemic

Survey Coordination Centre NHS

All of the People Promise elements, themes and sub-scores are scored on a 0-10 scale, **where a higher score is more positive than a lower score**.

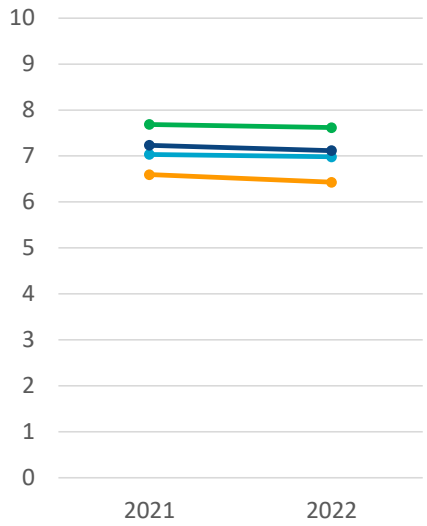
Promise element 1: We are compassionate and inclusive

All staff



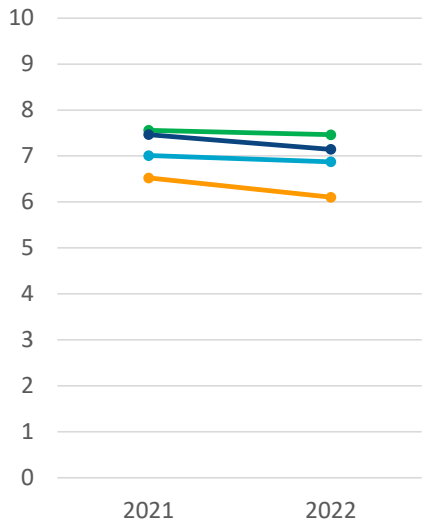
	2021	2022
Your org	7.5	7.3
Highest	7.8	7.7
Average	7.2	7.2
Lowest	6.7	6.8
Responses	1515	1403

Worked on a Covid-19 ward or specific area



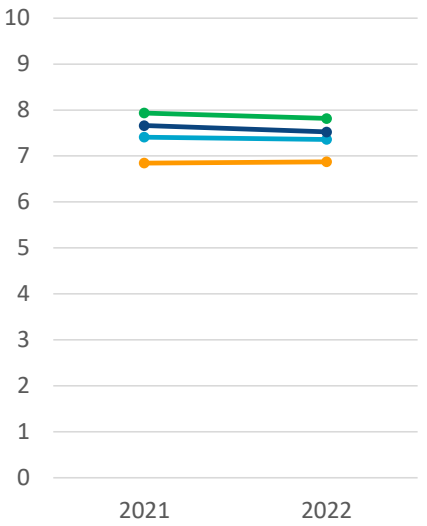
	2021	2022
Your org	7.2	7.1
Highest	7.7	7.6
Average	7.0	7.0
Lowest	6.6	6.4
Responses	586	540

Redeployed



	2021	2022
Your org	7.5	7.1
Highest	7.6	7.5
Average	7.0	6.9
Lowest	6.5	6.1
Responses	202	128

Required to work remotely / from home



	2021	2022
Your org	7.7	7.5
Highest	7.9	7.8
Average	7.4	7.4
Lowest	6.8	6.9
Responses	404	336

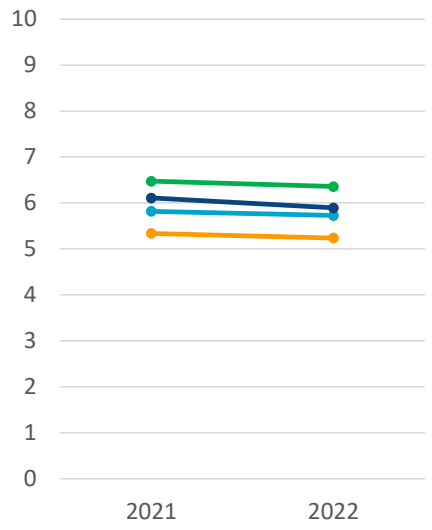
The Covid-19 pandemic – Your experience during the Covid-19 pandemic

Survey Coordination Centre NHS

All of the People Promise elements, themes and sub-scores are scored on a 0-10 scale, **where a higher score is more positive than a lower score**.

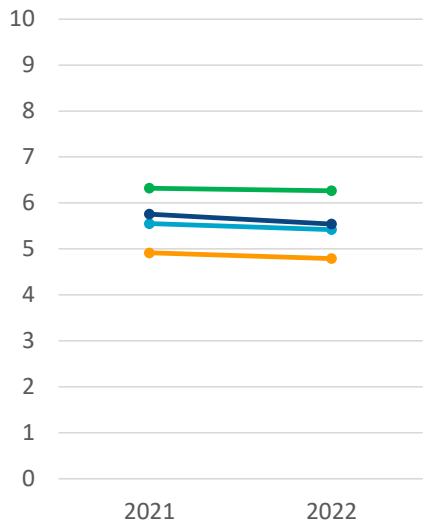
Promise element 2: We are recognised and rewarded

All staff



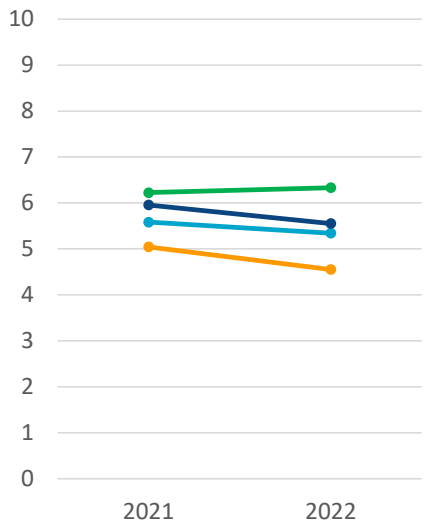
	2021	2022
Your org	6.1	5.9
Highest	6.5	6.4
Average	5.8	5.7
Lowest	5.3	5.2
Responses	1514	1396

Worked on a Covid-19 ward or specific area



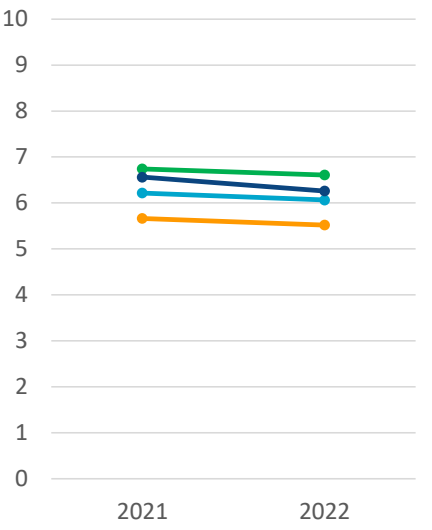
	2021	2022
Your org	5.8	5.5
Highest	6.3	6.3
Average	5.6	5.4
Lowest	4.9	4.8
Responses	587	536

Redeployed



	2021	2022
Your org	6.0	5.6
Highest	6.2	6.3
Average	5.6	5.3
Lowest	5.0	4.6
Responses	202	128

Required to work remotely / from home



	2021	2022
Your org	6.6	6.3
Highest	6.7	6.6
Average	6.2	6.1
Lowest	5.7	5.5
Responses	402	336

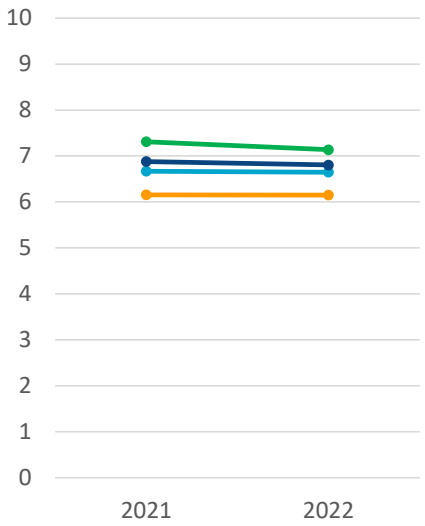
The Covid-19 pandemic – Your experience during the Covid-19 pandemic

Survey Coordination Centre NHS

All of the People Promise elements, themes and sub-scores are scored on a 0-10 scale, **where a higher score is more positive than a lower score**.

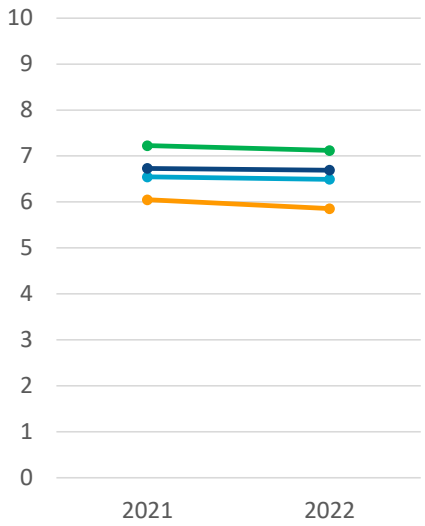
Promise element 3: We each have a voice that counts

All staff



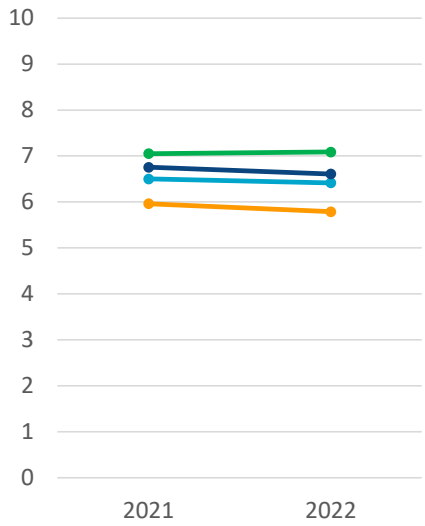
	2021	2022
Your org	6.9	6.8
Highest	7.3	7.1
Average	6.7	6.6
Lowest	6.2	6.2
Responses	1497	1391

Worked on a Covid-19 ward or specific area



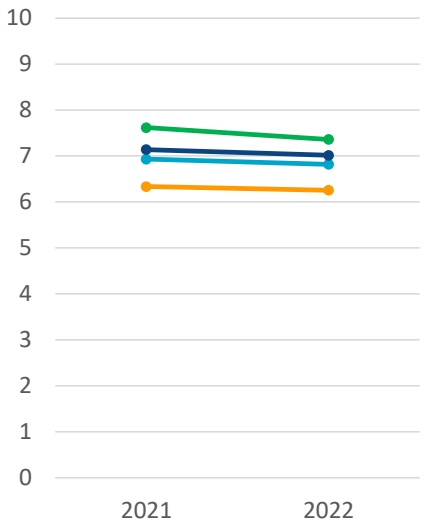
	2021	2022
Your org	6.7	6.7
Highest	7.2	7.1
Average	6.5	6.5
Lowest	6.0	5.9
Responses	578	538

Redeployed



	2021	2022
Your org	6.8	6.6
Highest	7.1	7.1
Average	6.5	6.4
Lowest	6.0	5.8
Responses	201	127

Required to work remotely / from home



	2021	2022
Your org	7.1	7.0
Highest	7.6	7.4
Average	6.9	6.8
Lowest	6.3	6.3
Responses	402	334

The Covid-19 pandemic – Your experience during the Covid-19 pandemic

Survey Coordination Centre NHS

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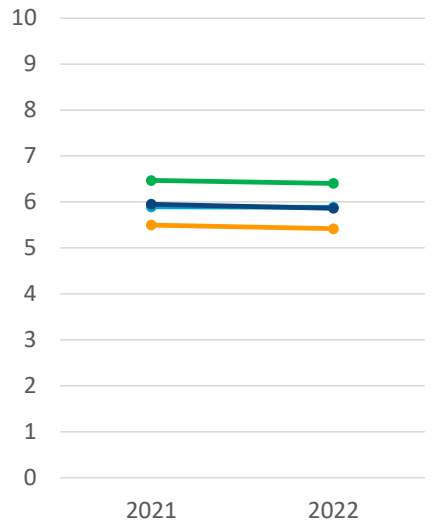
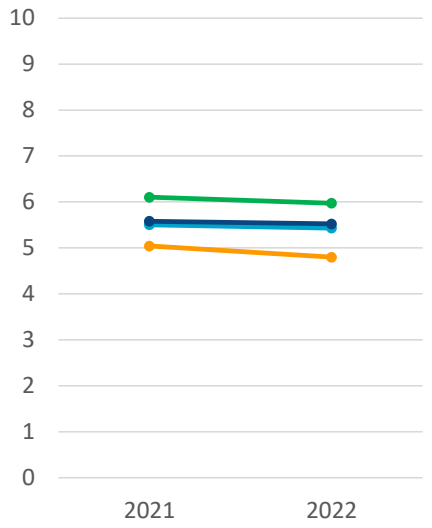
Promise element 4: We are safe and healthy

All staff



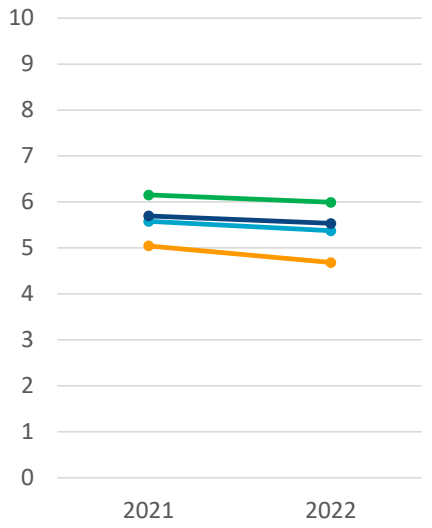
	2021	2022
Your org	6.0	5.9
Highest	6.5	6.4
Average	5.9	5.9
Lowest	5.5	5.4
Responses	1501	1399

Worked on a Covid-19 ward or specific area



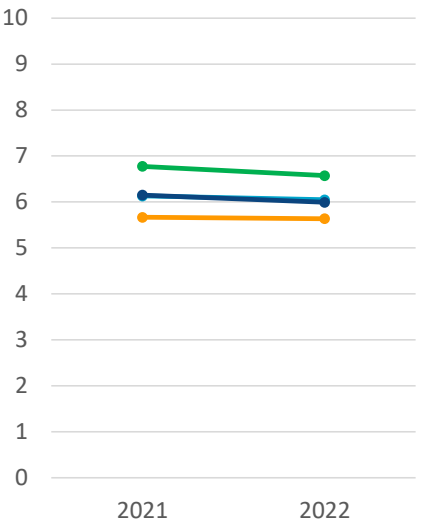
	2021	2022
Your org	5.6	5.5
Highest	6.1	6.0
Average	5.5	5.4
Lowest	5.0	4.8
Responses	581	539

Redeployed



	2021	2022
Your org	5.7	5.5
Highest	6.2	6.0
Average	5.6	5.4
Lowest	5.0	4.7
Responses	199	127

Required to work remotely / from home



	2021	2022
Your org	6.2	6.0
Highest	6.8	6.6
Average	6.1	6.0
Lowest	5.7	5.6
Responses	403	336

The Covid-19 pandemic – Your experience during the Covid-19 pandemic

Survey Coordination Centre NHS

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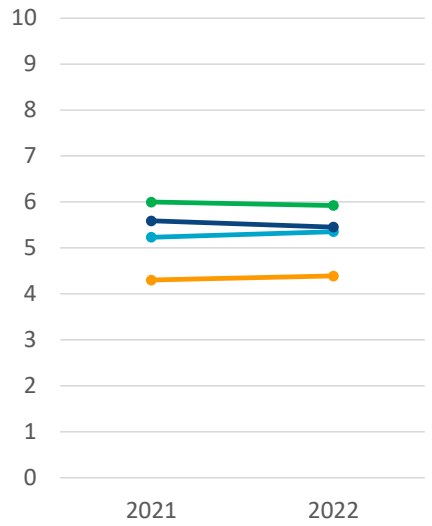
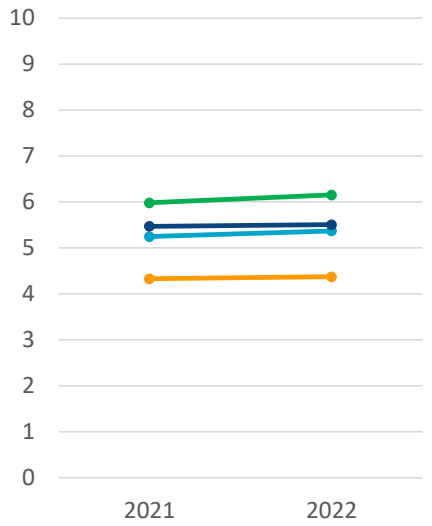
Promise element 5: We are always learning

All staff



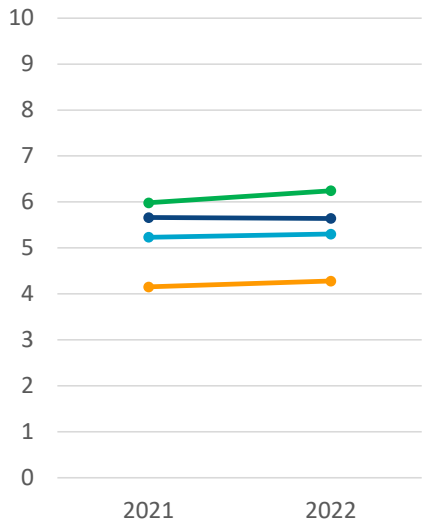
	2021	2022
Your org	5.6	5.5
Highest	6.0	5.9
Average	5.2	5.4
Lowest	4.3	4.4
Responses	1431	1336

Worked on a Covid-19 ward or specific area



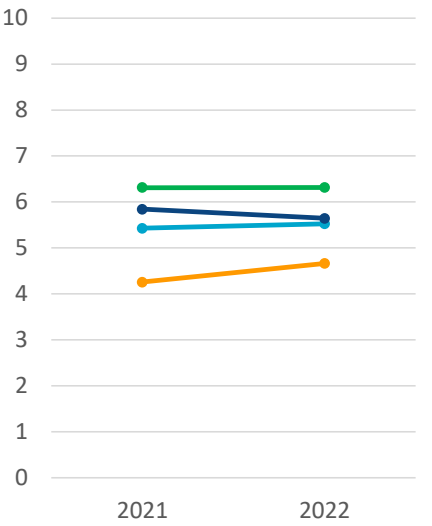
	2021	2022
Your org	5.5	5.5
Highest	6.0	6.2
Average	5.2	5.4
Lowest	4.3	4.4
Responses	552	514

Redeployed



	2021	2022
Your org	5.7	5.6
Highest	6.0	6.2
Average	5.2	5.3
Lowest	4.2	4.3
Responses	191	121

Required to work remotely / from home



	2021	2022
Your org	5.8	5.6
Highest	6.3	6.3
Average	5.4	5.5
Lowest	4.3	4.7
Responses	388	324

The Covid-19 pandemic – Your experience during the Covid-19 pandemic

Survey Coordination Centre NHS

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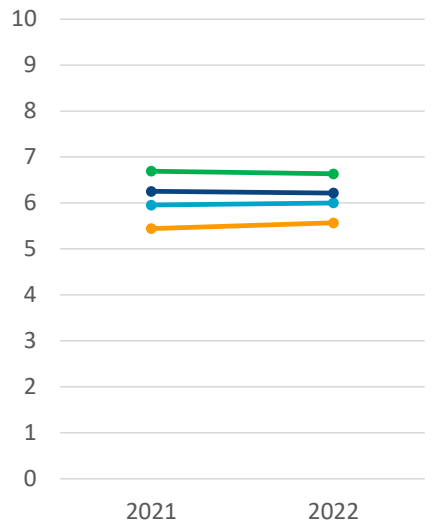
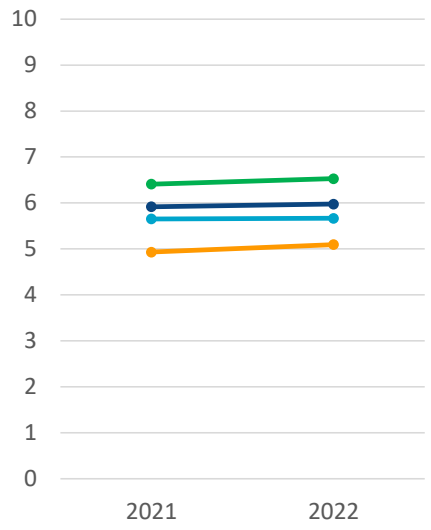
Promise element 6: We work flexibly

All staff



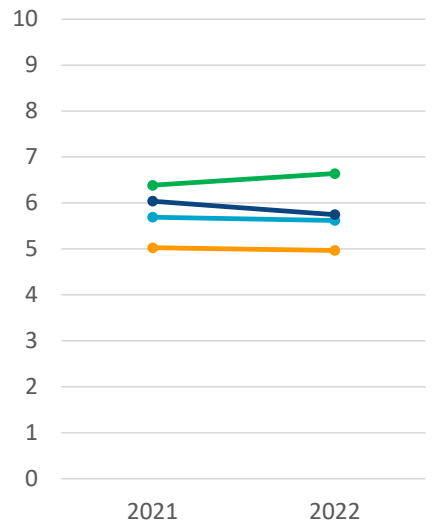
	2021	2022
Your org	6.3	6.2
Highest	6.7	6.6
Average	6.0	6.0
Lowest	5.4	5.6
Responses	1508	1392

Worked on a Covid-19 ward or specific area



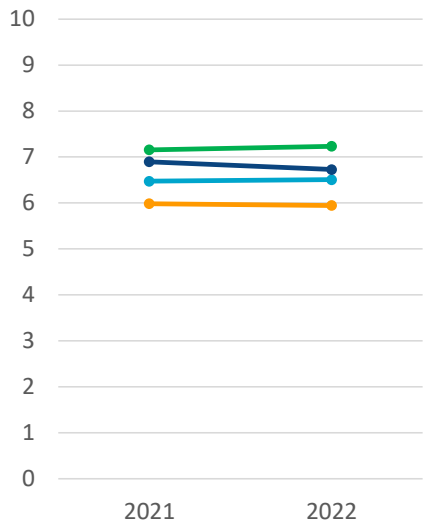
	2021	2022
Your org	5.9	6.0
Highest	6.4	6.5
Average	5.7	5.7
Lowest	4.9	5.1
Responses	585	534

Redeployed



	2021	2022
Your org	6.0	5.7
Highest	6.4	6.6
Average	5.7	5.6
Lowest	5.0	5.0
Responses	202	128

Required to work remotely / from home



	2021	2022
Your org	6.9	6.7
Highest	7.2	7.2
Average	6.5	6.5
Lowest	6.0	5.9
Responses	402	335

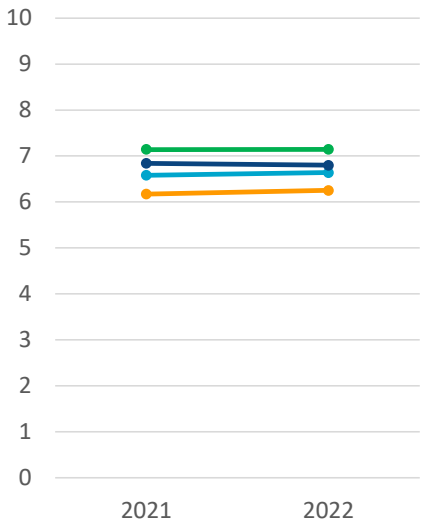
The Covid-19 pandemic – Your experience during the Covid-19 pandemic

Survey Coordination Centre NHS

All of the People Promise elements, themes and sub-scores are scored on a 0-10 scale, **where a higher score is more positive than a lower score**.

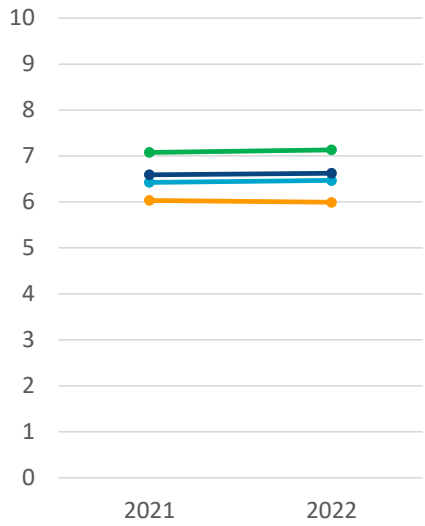
Promise element 7: We are a team

All staff



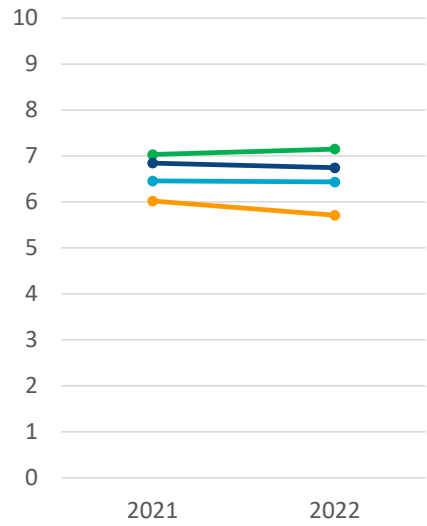
	2021	2022
Your org	6.8	6.8
Highest	7.1	7.1
Average	6.6	6.6
Lowest	6.2	6.3
Responses	1511	1397

Worked on a Covid-19 ward or specific area



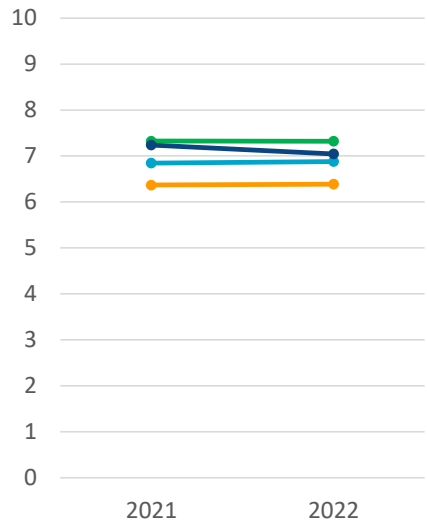
	2021	2022
Your org	6.6	6.6
Highest	7.1	7.1
Average	6.4	6.5
Lowest	6.0	6.0
Responses	587	540

Redeployed



	2021	2022
Your org	6.8	6.7
Highest	7.0	7.2
Average	6.5	6.4
Lowest	6.0	5.7
Responses	201	127

Required to work remotely / from home



	2021	2022
Your org	7.2	7.0
Highest	7.3	7.3
Average	6.8	6.9
Lowest	6.4	6.4
Responses	403	334

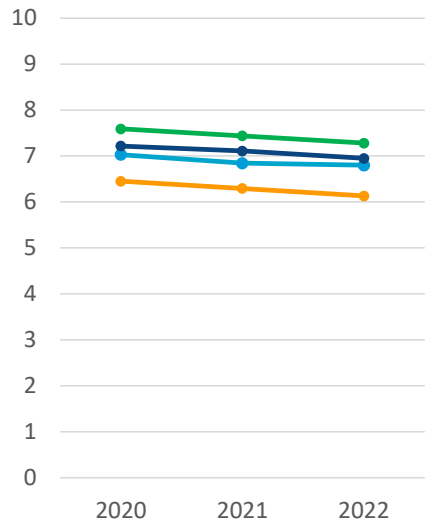
The Covid-19 pandemic – Your experience during the Covid-19 pandemic

Survey Coordination Centre NHS

All of the People Promise elements, themes and sub-scores are scored on a 0-10 scale, **where a higher score is more positive than a lower score**.

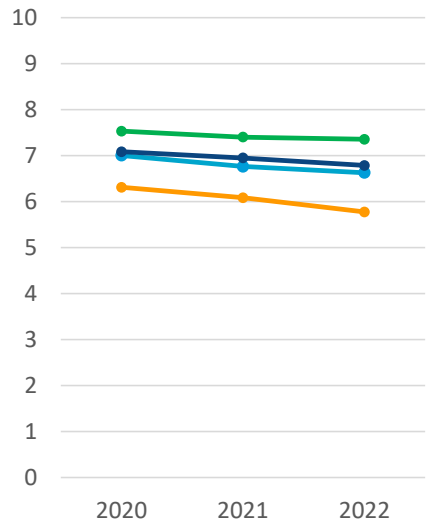
Theme: Staff Engagement

All staff



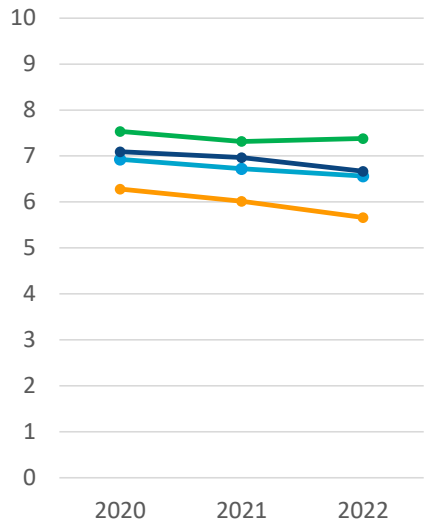
	2020	2021	2022
Your org	7.2	7.1	6.9
Highest	7.6	7.4	7.3
Average	7.0	6.8	6.8
Lowest	6.5	6.3	6.1
Responses	1356	1515	1402

Worked on Covid-19 specific ward or area



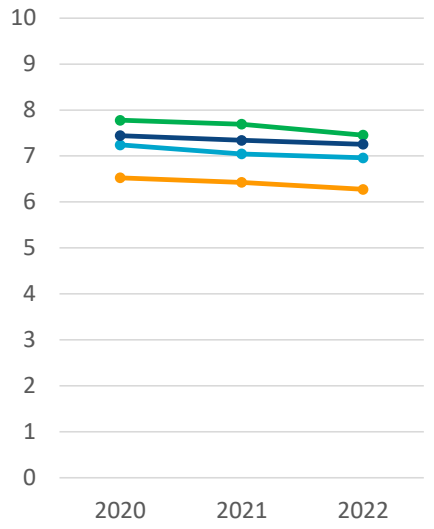
	2020	2021	2022
Your org	7.1	6.9	6.8
Highest	7.5	7.4	7.4
Average	7.0	6.8	6.6
Lowest	6.3	6.1	5.8
Responses	436	587	540

Redeployed



	2020	2021	2022
Your org	7.1	7.0	6.7
Highest	7.5	7.3	7.4
Average	6.9	6.7	6.6
Lowest	6.3	6.0	5.7
Responses	155	202	128

Required to work remotely / from home



	2020	2021	2022
Your org	7.4	7.3	7.3
Highest	7.8	7.7	7.5
Average	7.2	7.0	7.0
Lowest	6.5	6.4	6.3
Responses	323	404	336

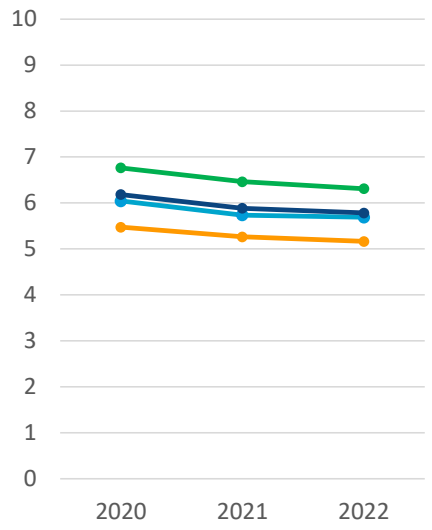
The Covid-19 pandemic – Your experience during the Covid-19 pandemic

Survey Coordination Centre NHS

All of the People Promise elements, themes and sub-scores are scored on a 0-10 scale, **where a higher score is more positive than a lower score**.

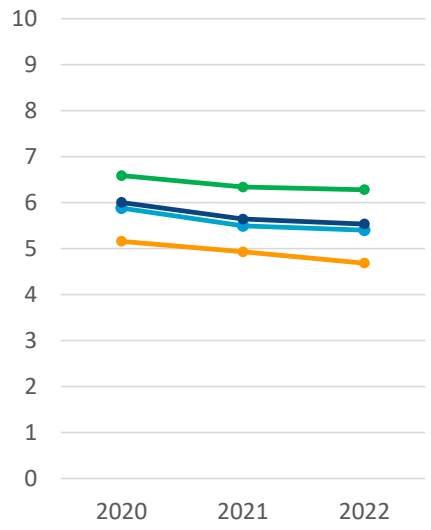
Theme: Morale

All staff



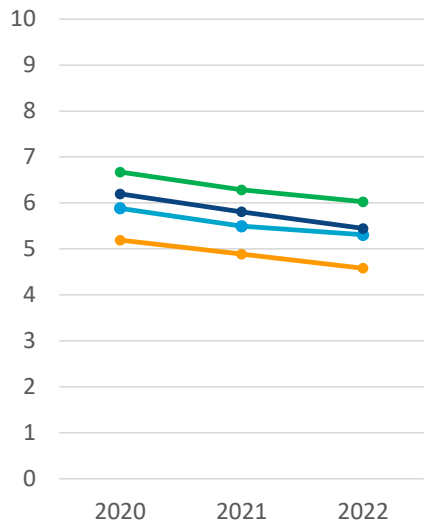
	2020	2021	2022
Your org	6.2	5.9	5.8
Highest	6.8	6.5	6.3
Average	6.0	5.7	5.7
Lowest	5.5	5.3	5.2
Responses	1355	1516	1402

Worked on Covid-19 specific ward or area



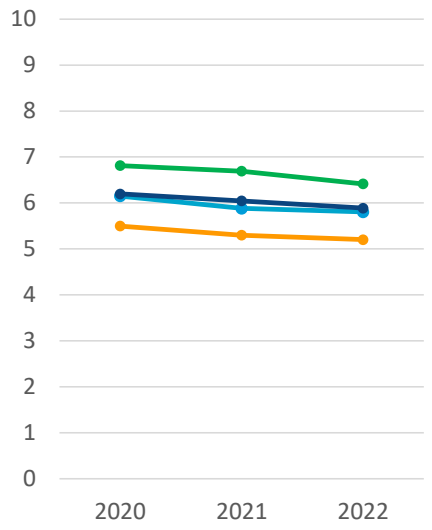
	2020	2021	2022
Your org	6.0	5.6	5.5
Highest	6.6	6.3	6.3
Average	5.9	5.5	5.4
Lowest	5.2	4.9	4.7
Responses	435	587	540

Redeployed



	2020	2021	2022
Your org	6.2	5.8	5.4
Highest	6.7	6.3	6.0
Average	5.9	5.5	5.3
Lowest	5.2	4.9	4.6
Responses	155	202	127

Required to work remotely / from home



	2020	2021	2022
Your org	6.2	6.0	5.9
Highest	6.8	6.7	6.4
Average	6.1	5.9	5.8
Lowest	5.5	5.3	5.2
Responses	323	404	336

Survey Coordination Centre

NHS

People Promise element – We are compassionate and inclusive

Questions included:

Compassionate culture – Q6a, Q23a, Q23b, Q23c, Q23d

Compassionate leadership – Q9f, Q9g, Q9h, Q9i

Diversity and equality – Q15, Q16a, Q16b, Q20

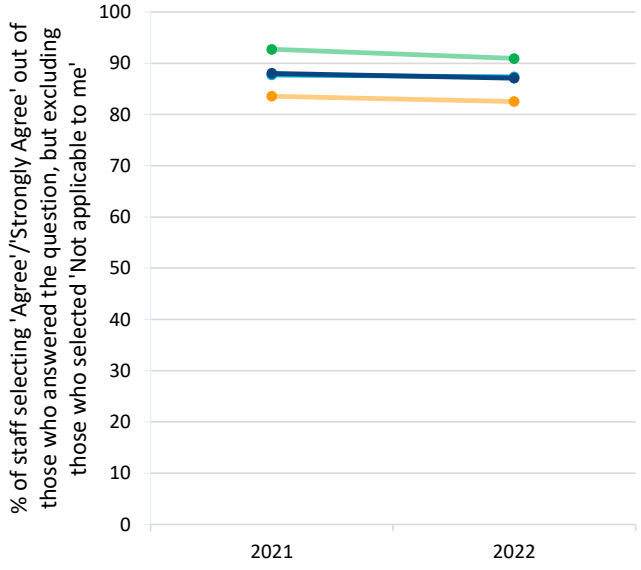
Inclusion – Q7h, Q7i, Q8b, Q8c

Please note, where there are less than 11 responses for a question this data is not shown in the chart to protect the confidentiality of staff and reliability of results.

People Promise elements and theme results – We are compassionate and inclusive: Compassionate culture

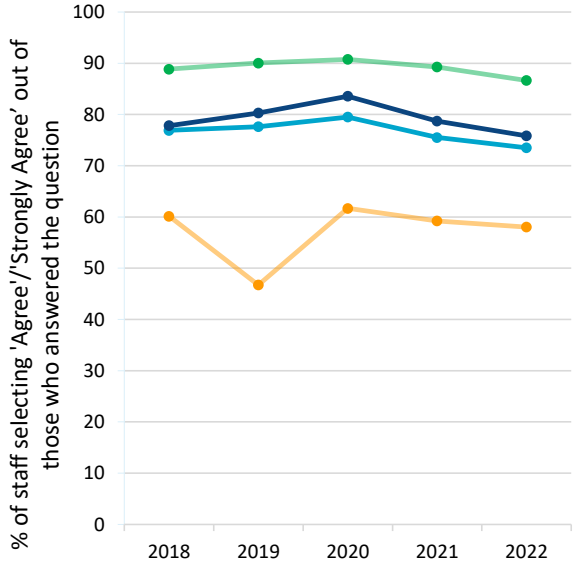
Survey Coordination Centre

Q6a I feel that my role makes a difference to patients / service users.



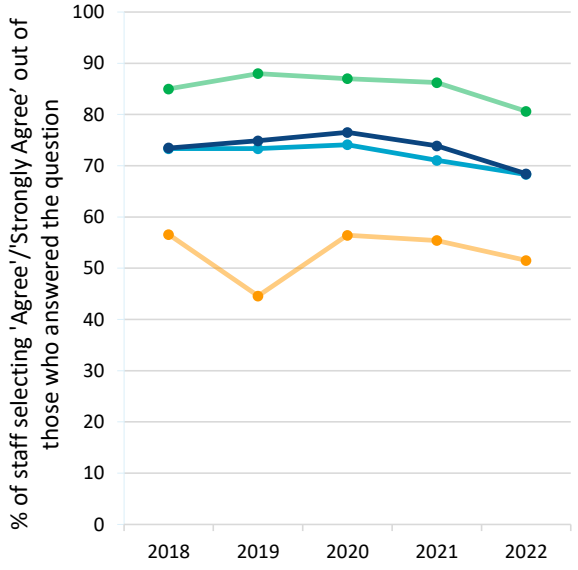
	2021	2022
Your org	88.0%	87.1%
Best	92.7%	90.9%
Average	87.7%	87.3%
Worst	83.6%	82.5%
Responses	1458	1361

Q23a Care of patients / service users is my organisation's top priority.



	2018	2019	2020	2021	2022
Your org	77.8%	80.3%	83.6%	78.7%	75.8%
Best	88.8%	90.0%	90.8%	89.3%	86.6%
Average	76.9%	77.6%	79.5%	75.5%	73.5%
Worst	60.1%	46.7%	61.7%	59.2%	58.0%
Responses	1306	1208	1347	1509	1398

Q23b My organisation acts on concerns raised by patients / service users.



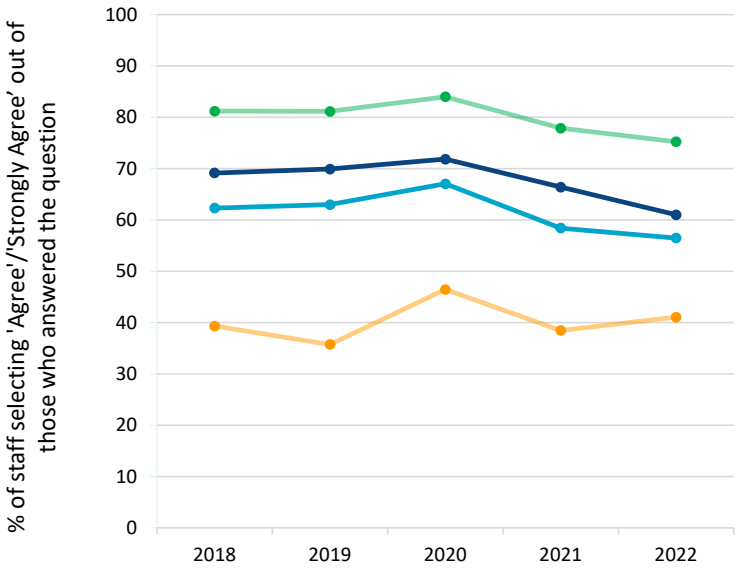
	2018	2019	2020	2021	2022
Your org	73.5%	74.9%	76.5%	73.9%	68.4%
Best	85.0%	88.0%	87.0%	86.2%	80.6%
Average	73.3%	73.3%	74.1%	71.0%	68.3%
Worst	56.6%	44.6%	56.4%	55.4%	51.5%
Responses	1303	1206	1343	1504	1393

People Promise elements and theme results – We are compassionate and inclusive: Compassionate culture

Survey Coordination Centre

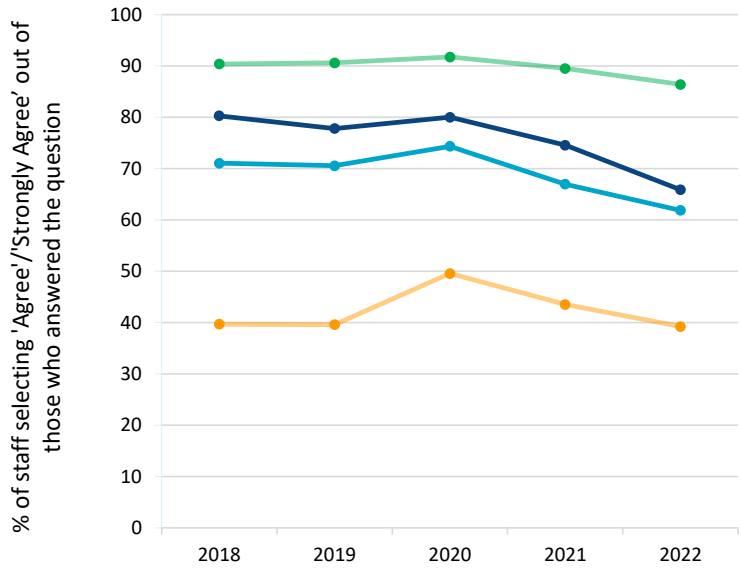
NHS

Q23c I would recommend my organisation as a place to work.



	2018	2019	2020	2021	2022
Your org	69.1%	69.9%	71.9%	66.4%	61.0%
Best	81.2%	81.2%	84.0%	77.9%	75.2%
Average	62.3%	63.0%	67.1%	58.4%	56.5%
Worst	39.3%	35.7%	46.5%	38.5%	41.0%
Responses	1308	1204	1344	1508	1399

Q23d If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation.



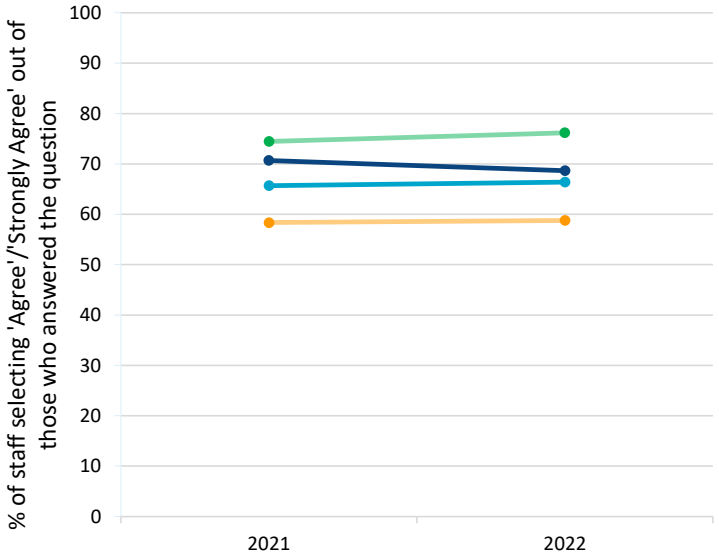
	2018	2019	2020	2021	2022
Your org	80.3%	77.8%	80.0%	74.6%	65.9%
Best	90.4%	90.6%	91.8%	89.5%	86.4%
Average	71.1%	70.6%	74.3%	67.0%	61.9%
Worst	39.7%	39.6%	49.6%	43.5%	39.2%
Responses	1307	1206	1346	1506	1397

People Promise elements and theme results – We are compassionate and inclusive: Compassionate leadership

Survey Coordination Centre

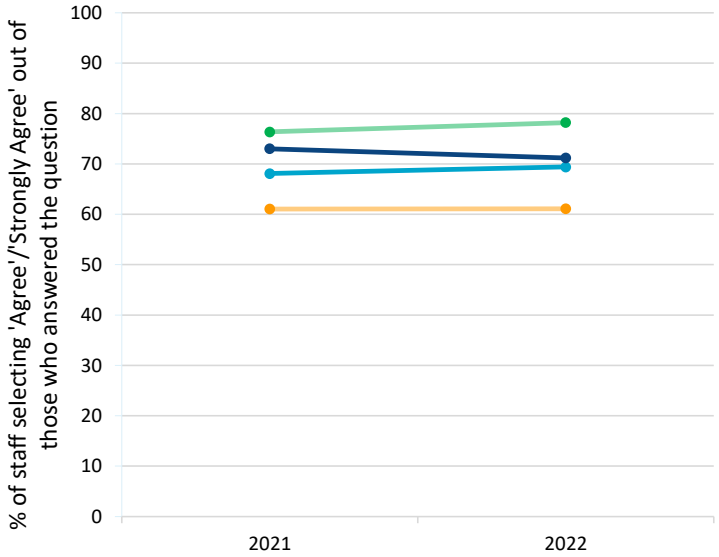
NHS

Q9f My immediate manager works together with me to come to an understanding of problems.



	2021	2022
Your org	70.7%	68.7%
Best	74.5%	76.2%
Average	65.7%	66.4%
Worst	58.4%	58.8%
Responses	1508	1398

Q9g My immediate manager is interested in listening to me when I describe challenges I face.



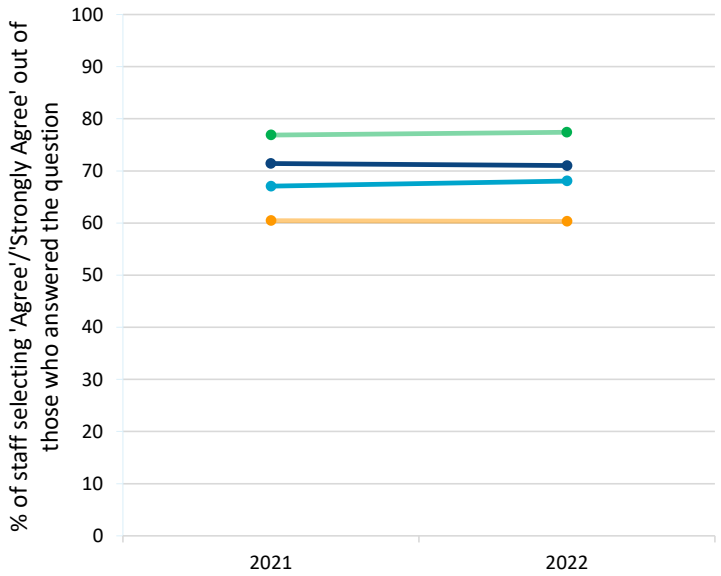
	2021	2022
Your org	73.0%	71.2%
Best	76.4%	78.2%
Average	68.1%	69.4%
Worst	61.1%	61.1%
Responses	1510	1397

People Promise elements and theme results – We are compassionate and inclusive: Compassionate leadership

Survey Coordination Centre

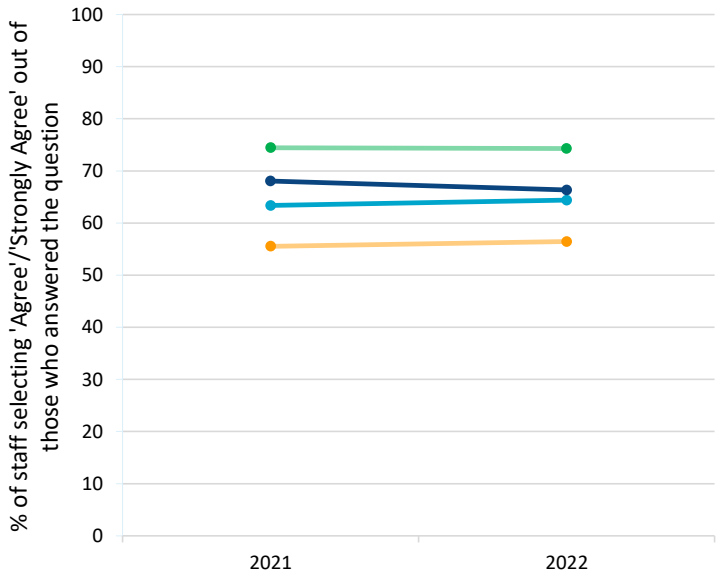
NHS

Q9h My immediate manager cares about my concerns.



	2021	2022
Your org	71.4%	71.0%
Best	76.9%	77.4%
Average	67.1%	68.1%
Worst	60.5%	60.3%
Responses	1506	1396

Q9i My immediate manager takes effective action to help me with any problems I face.

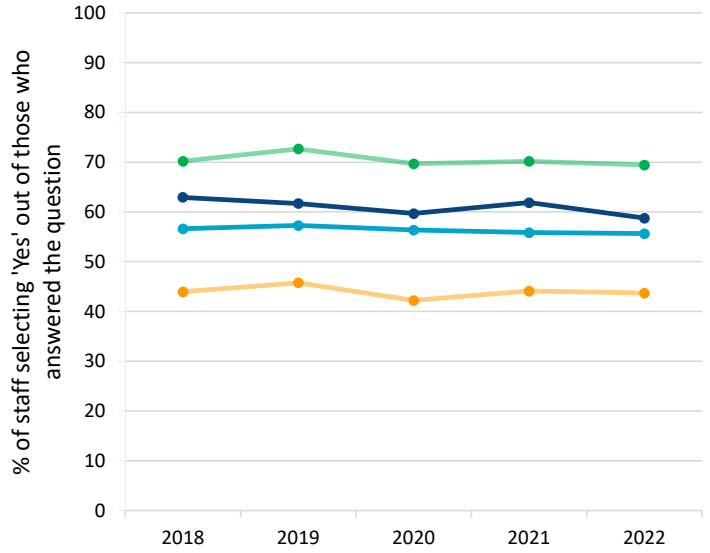


	2021	2022
Your org	68.0%	66.3%
Best	74.5%	74.3%
Average	63.4%	64.4%
Worst	55.6%	56.4%
Responses	1508	1398

People Promise elements and theme results – We are compassionate and inclusive: Diversity and equality

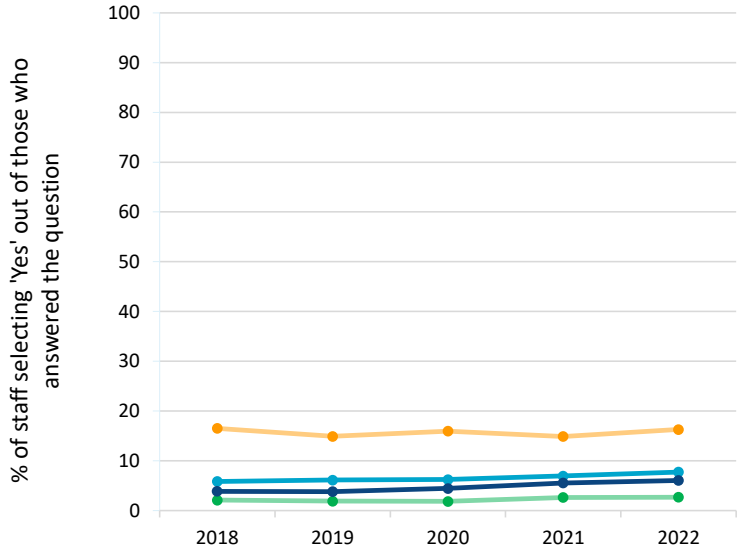
Survey Coordination Centre

Q15 Does your organisation act fairly with regard to career progression / promotion, regardless of ethnic background, gender, religion, sexual orientation, disability or age?



	2018	2019	2020	2021	2022
Your org	62.9%	61.7%	59.7%	61.9%	58.8%
Best	70.2%	72.7%	69.7%	70.2%	69.4%
Average	56.6%	57.3%	56.4%	55.8%	55.6%
Worst	44.0%	45.8%	42.2%	44.1%	43.7%
Responses	1305	1217	1351	1496	1394

Q16a In the last 12 months have you personally experienced discrimination at work from patients / service users, their relatives or other members of the public?



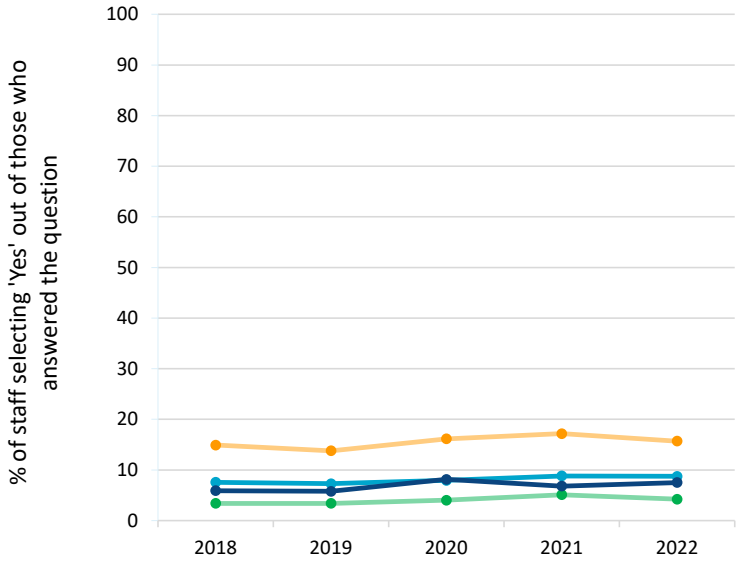
	2018	2019	2020	2021	2022
Your org	3.9%	3.8%	4.5%	5.6%	6.1%
Best	2.1%	1.9%	1.9%	2.7%	2.7%
Average	5.9%	6.2%	6.3%	7.0%	7.8%
Worst	16.5%	14.9%	16.0%	14.9%	16.3%
Responses	1309	1217	1347	1501	1400

People Promise elements and theme results – We are compassionate and inclusive: Diversity and equality

Survey Coordination Centre

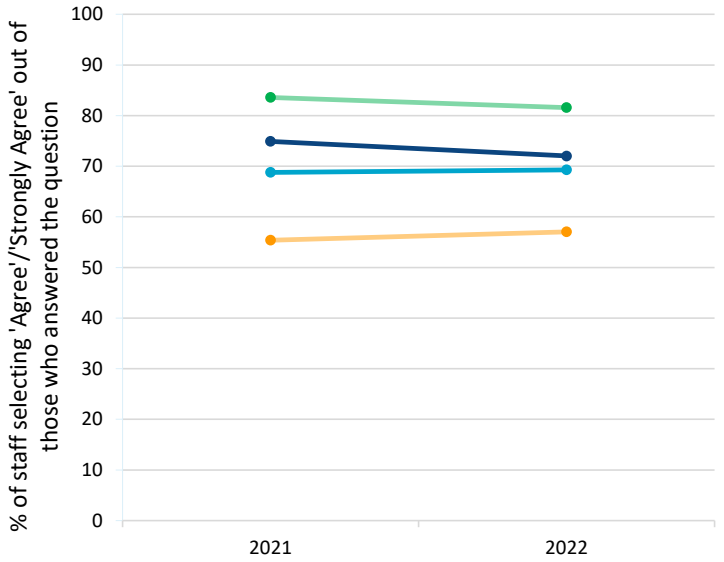
NHS

Q16b In the last 12 months have you personally experienced discrimination at work from manager / team leader or other colleagues?



	2018	2019	2020	2021	2022
Your org	5.9%	5.8%	8.1%	6.8%	7.5%
Best	3.4%	3.4%	4.0%	5.1%	4.2%
Average	7.5%	7.3%	7.9%	8.8%	8.7%
Worst	14.9%	13.8%	16.1%	17.2%	15.7%
Responses	1310	1210	1339	1505	1393

Q20 I think that my organisation respects individual differences (e.g. cultures, working styles, backgrounds, ideas, etc).

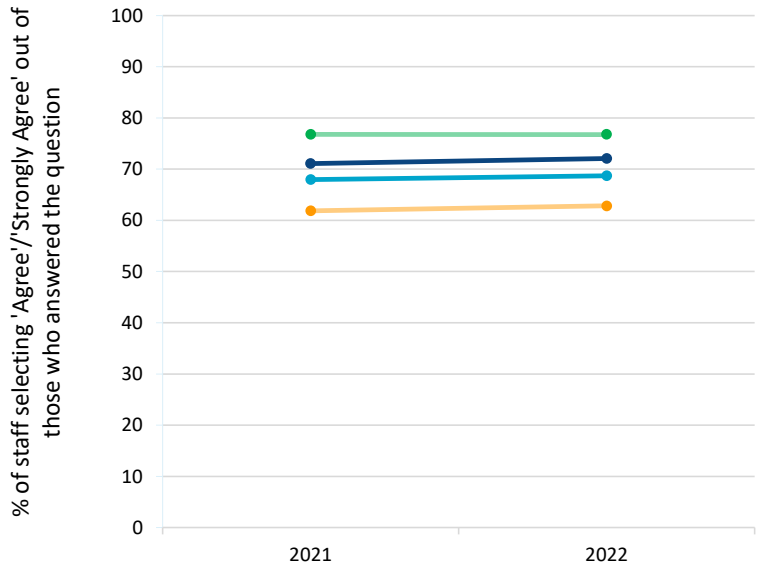


	2021	2022
Your org	74.9%	72.0%
Best	83.6%	81.6%
Average	68.8%	69.3%
Worst	55.4%	57.1%
Responses	1505	1401

People Promise elements and theme results – We are compassionate and inclusive: Inclusion

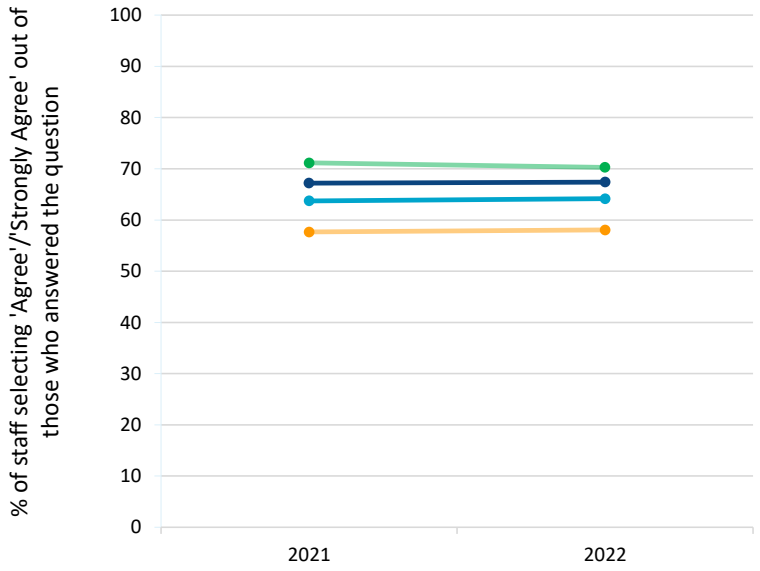
Survey Coordination Centre NHS

Q7h I feel valued by my team.



	2021	2022
Your org	71.1%	72.1%
Best	76.8%	76.8%
Average	68.0%	68.7%
Worst	61.9%	62.8%
Responses	1510	1399

Q7i I feel a strong personal attachment to my team.

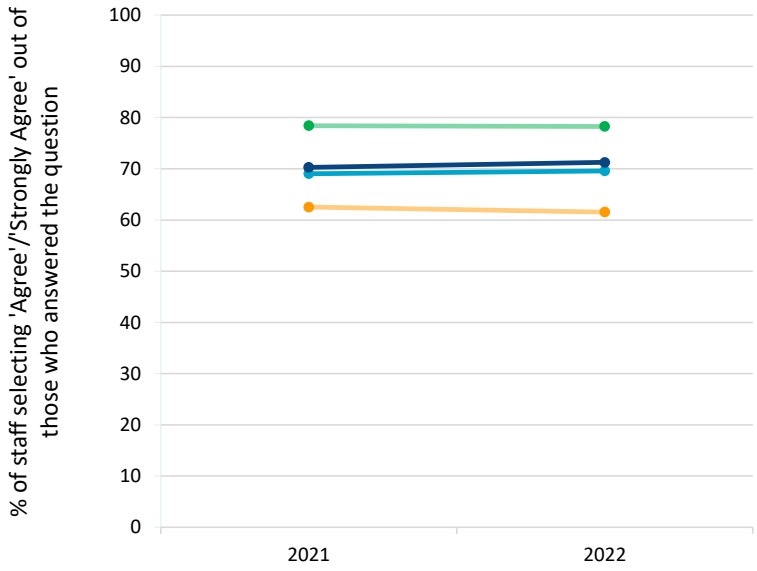


	2021	2022
Your org	67.2%	67.4%
Best	71.2%	70.3%
Average	63.7%	64.2%
Worst	57.7%	58.1%
Responses	1510	1396

People Promise elements and theme results – We are compassionate and inclusive: Inclusion

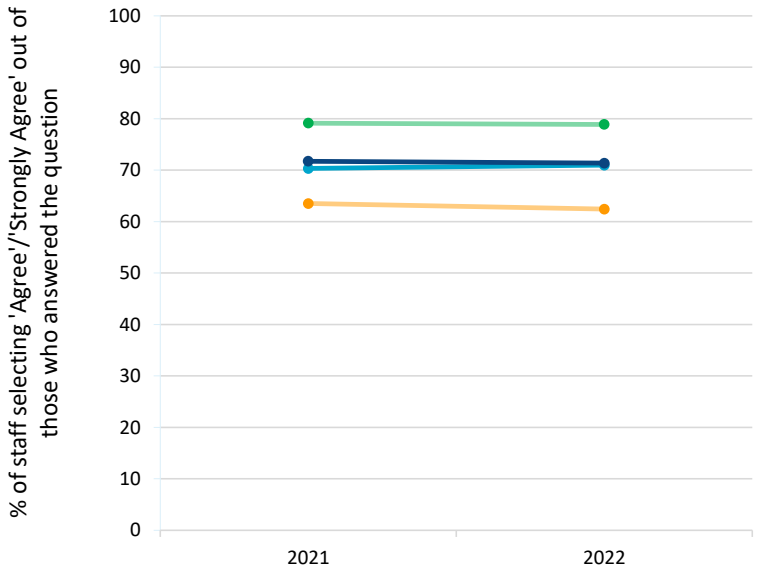
Survey Coordination Centre NHS

Q8b The people I work with are understanding and kind to one another.



	2021	2022
Your org	70.3%	71.3%
Best	78.4%	78.3%
Average	69.0%	69.6%
Worst	62.5%	61.6%
Responses	1509	1400

Q8c The people I work with are polite and treat each other with respect.



	2021	2022
Your org	71.7%	71.4%
Best	79.1%	78.9%
Average	70.3%	71.0%
Worst	63.5%	62.4%
Responses	1510	1399

Survey Coordination Centre

NHS

People Promise element – We are recognised and rewarded

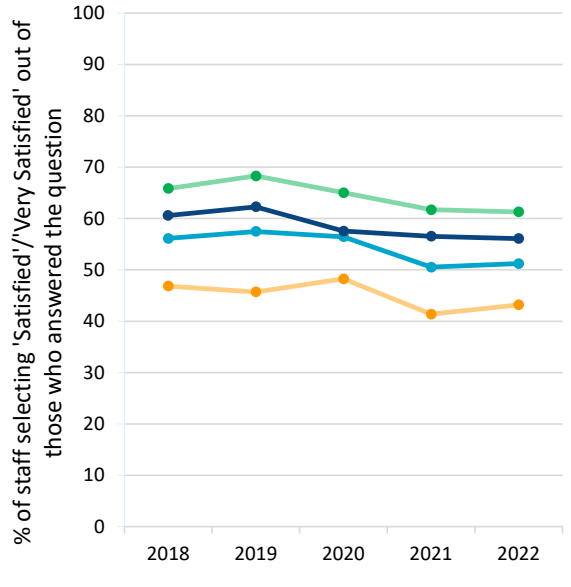
Questions included:
Q4a, Q4b, Q4c, Q8d, Q9e

Please note, where there are less than 11 responses for a question this data is not shown in the chart to protect the confidentiality of staff and reliability of results.

People Promise elements and theme results – We are recognised and rewarded

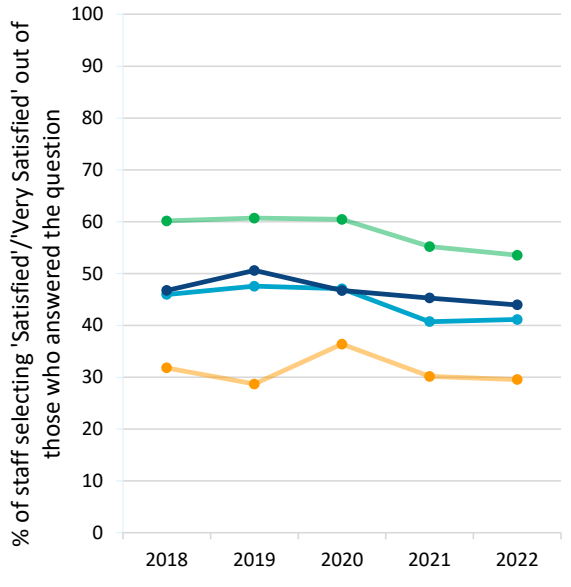
Survey Coordination Centre NHS

Q4a How satisfied are you with each of the following aspects of your job? The recognition I get for good work.



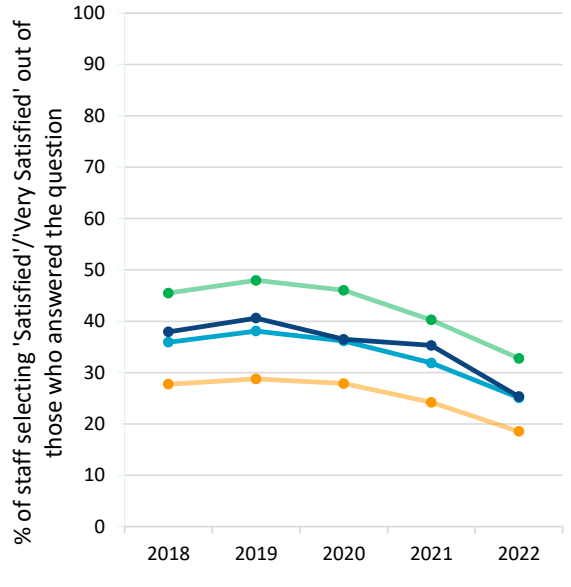
	2018	2019	2020	2021	2022
Your org	60.6%	62.3%	57.5%	56.5%	56.1%
Best	65.8%	68.3%	65.0%	61.7%	61.3%
Average	56.1%	57.5%	56.4%	50.5%	51.2%
Worst	46.8%	45.7%	48.2%	41.4%	43.2%
Responses	1312	1228	1352	1512	1396

Q4b How satisfied are you with each of the following aspects of your job? The extent to which my organisation values my work.



	2018	2019	2020	2021	2022
Your org	46.7%	50.6%	46.7%	45.3%	44.0%
Best	60.1%	60.7%	60.4%	55.2%	53.5%
Average	45.9%	47.5%	47.1%	40.7%	41.1%
Worst	31.8%	28.7%	36.4%	30.1%	29.5%
Responses	1309	1228	1349	1510	1393

Q4c How satisfied are you with each of the following aspects of your job? My level of pay.

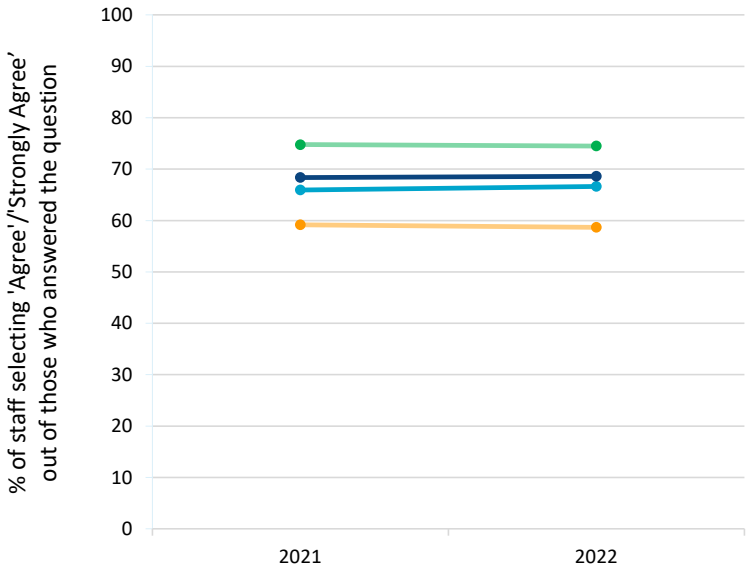


	2018	2019	2020	2021	2022
Your org	37.9%	40.6%	36.5%	35.3%	25.3%
Best	45.5%	47.9%	46.0%	40.3%	32.8%
Average	35.9%	38.1%	36.2%	31.9%	25.1%
Worst	27.7%	28.7%	27.9%	24.2%	18.5%
Responses	1309	1225	1350	1513	1394

People Promise elements and theme results – We are recognised and rewarded

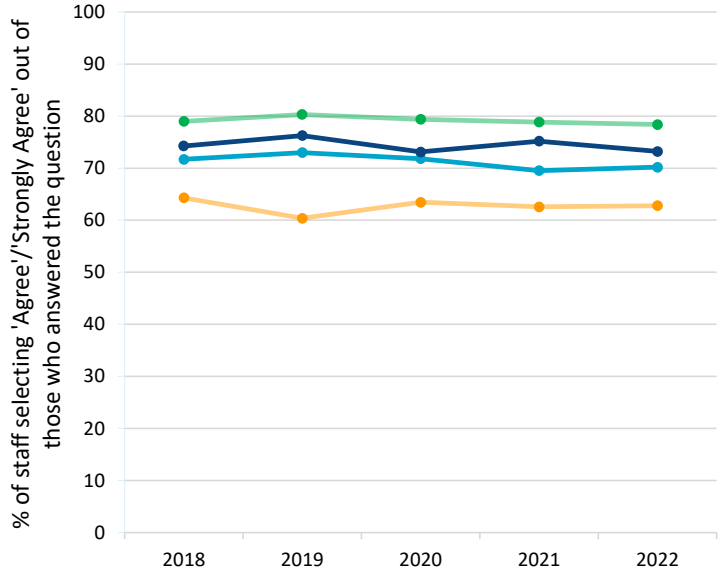
Survey Coordination Centre

Q8d The people I work with show appreciation to one another.



	2021	2022
Your org	68.3%	68.6%
Best	74.8%	74.5%
Average	66.0%	66.6%
Worst	59.2%	58.7%
Responses	1508	1395

Q9e My immediate manager values my work.



	2018	2019	2020	2021	2022
Your org	74.2%	76.3%	73.1%	75.2%	73.2%
Best	79.0%	80.3%	79.4%	78.8%	78.4%
Average	71.7%	73.0%	71.8%	69.5%	70.2%
Worst	64.3%	60.4%	63.4%	62.6%	62.8%
Responses	1313	1220	1347	1511	1399

Survey Coordination Centre

NHS

People Promise element – We each have a voice that counts

Questions included:

Autonomy and control – Q3a, Q3b, Q3c, Q3d, Q3e, Q3f, Q5b

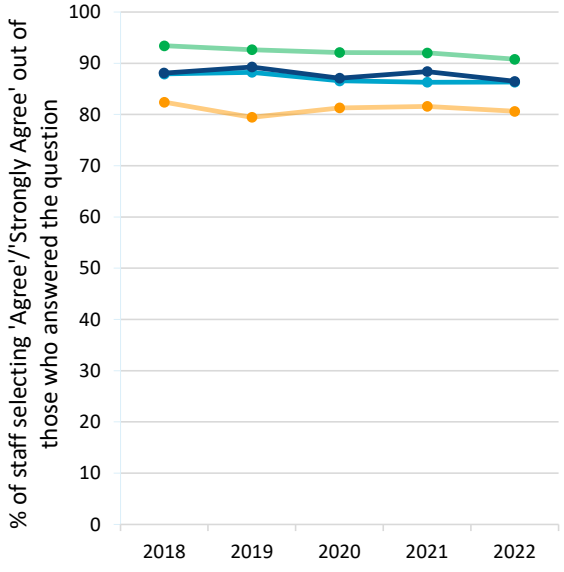
Raising concerns – Q19a, Q19b, Q23e, Q23f

Please note, where there are less than 11 responses for a question this data is not shown in the chart to protect the confidentiality of staff and reliability of results.

People Promise elements and theme results – We each have a voice that counts: Autonomy and control

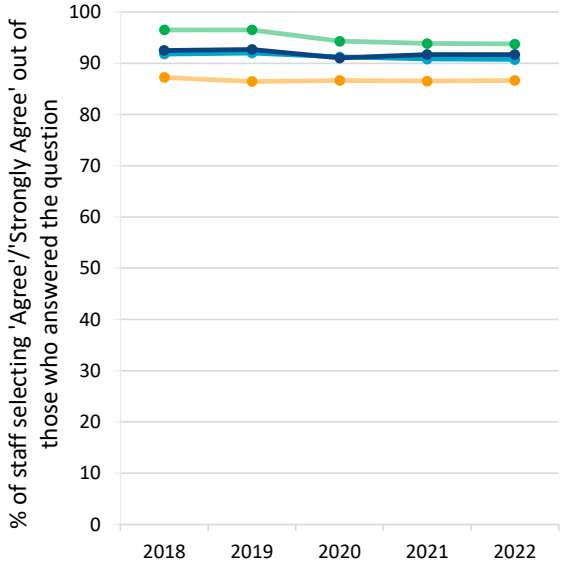
Survey Coordination Centre

Q3a I always know what my work responsibilities are.



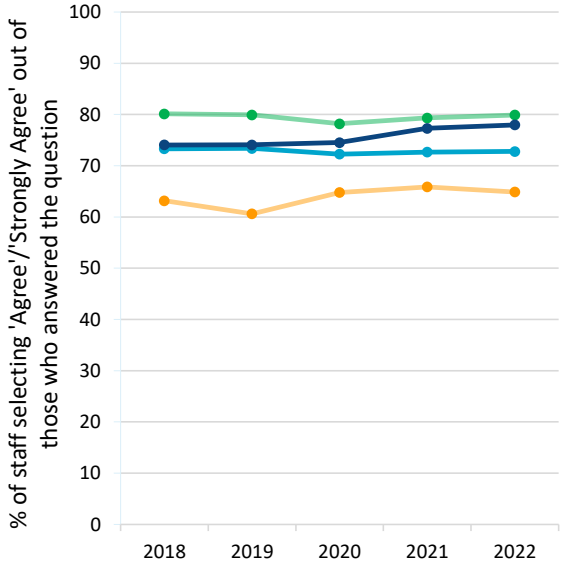
	2018	2019	2020	2021	2022
Your org	88.1%	89.3%	87.1%	88.4%	86.5%
Best	93.4%	92.7%	92.1%	92.0%	90.8%
Average	87.9%	88.2%	86.6%	86.3%	86.3%
Worst	82.4%	79.5%	81.3%	81.6%	80.6%
Responses	1315	1230	1345	1513	1398

Q3b I am trusted to do my job.



	2018	2019	2020	2021	2022
Your org	92.5%	92.7%	91.0%	91.7%	91.7%
Best	96.5%	96.5%	94.3%	93.9%	93.8%
Average	91.8%	92.0%	91.2%	90.8%	90.7%
Worst	87.3%	86.5%	86.7%	86.5%	86.7%
Responses	1310	1225	1341	1513	1399

Q3c There are frequent opportunities for me to show initiative in my role.

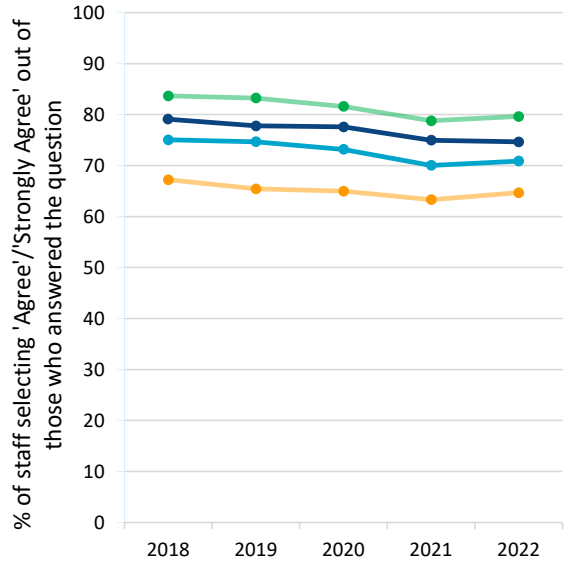


	2018	2019	2020	2021	2022
Your org	74.0%	74.1%	74.5%	77.3%	78.0%
Best	80.1%	79.9%	78.2%	79.3%	79.9%
Average	73.3%	73.4%	72.3%	72.7%	72.8%
Worst	63.2%	60.6%	64.8%	65.9%	64.9%
Responses	1314	1231	1352	1511	1398

People Promise elements and theme results – We each have a voice that counts: Autonomy and control

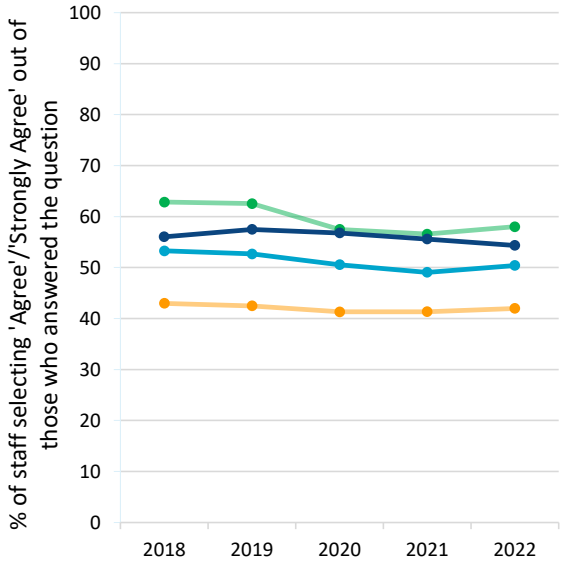
Survey Coordination Centre

Q3d I am able to make suggestions to improve the work of my team / department.



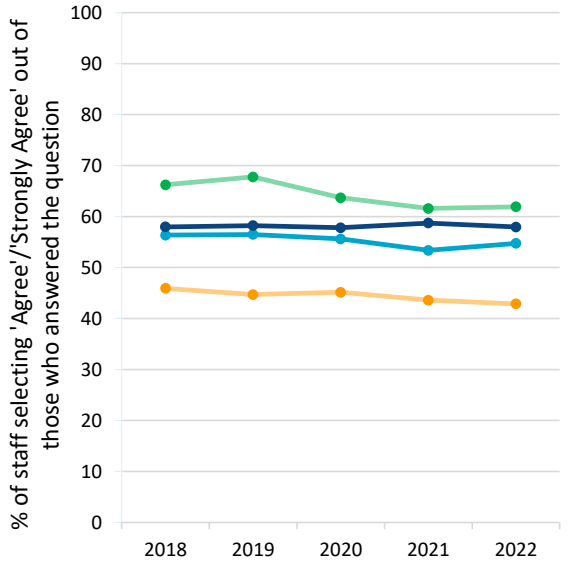
	2018	2019	2020	2021	2022
Your org	79.1%	77.8%	77.6%	75.0%	74.6%
Best	83.7%	83.3%	81.6%	78.8%	79.6%
Average	75.0%	74.7%	73.2%	70.0%	70.9%
Worst	67.2%	65.4%	65.0%	63.3%	64.7%
Responses	1314	1229	1351	1508	1397

Q3e I am involved in deciding on changes introduced that affect my work area / team / department.



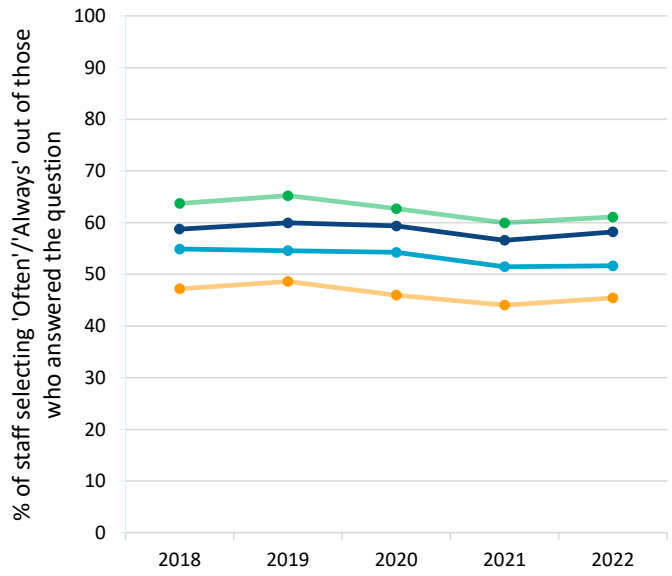
	2018	2019	2020	2021	2022
Your org	56.0%	57.5%	56.8%	55.6%	54.3%
Best	62.8%	62.5%	57.5%	56.5%	58.0%
Average	53.3%	52.7%	50.6%	49.1%	50.4%
Worst	43.0%	42.5%	41.3%	41.3%	42.0%
Responses	1313	1228	1349	1511	1391

Q3f I am able to make improvements happen in my area of work.



	2018	2019	2020	2021	2022
Your org	57.9%	58.2%	57.8%	58.7%	58.0%
Best	66.2%	67.8%	63.7%	61.6%	61.9%
Average	56.4%	56.5%	55.6%	53.4%	54.7%
Worst	45.9%	44.7%	45.1%	43.6%	42.9%
Responses	1306	1226	1346	1510	1393

Q5b I have a choice in deciding how to do my work.

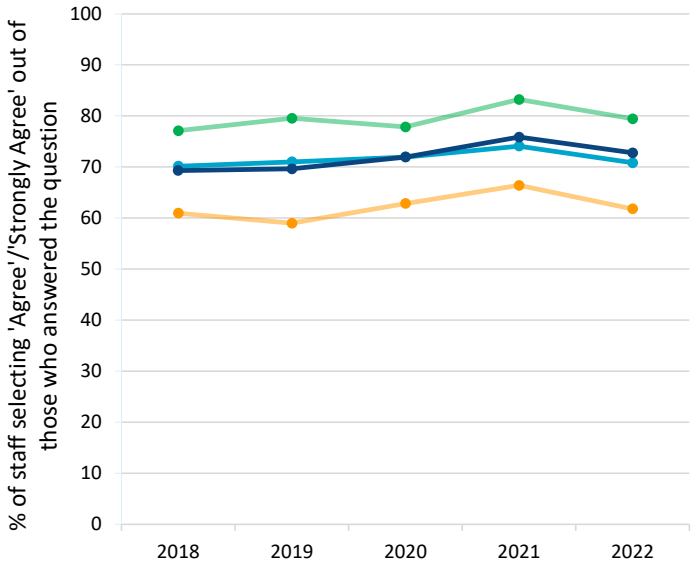


	2018	2019	2020	2021	2022
Your org	58.8%	60.0%	59.4%	56.6%	58.2%
Best	63.7%	65.2%	62.7%	60.0%	61.1%
Average	54.9%	54.6%	54.3%	51.5%	51.7%
Worst	47.2%	48.6%	46.0%	44.1%	45.4%
Responses	1308	1217	1339	1502	1396

People Promise elements and theme results – We each have a voice that counts: Raising concerns

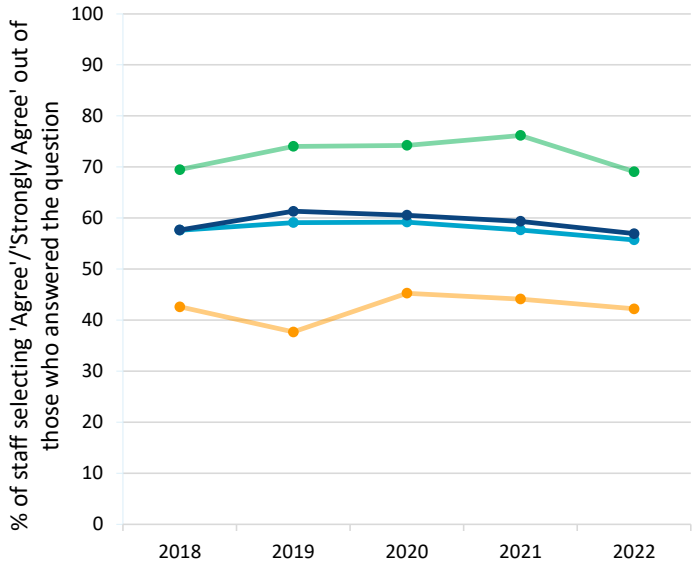
Survey Coordination Centre

Q19a I would feel secure raising concerns about unsafe clinical practice.



	2018	2019	2020	2021	2022
Your org	69.3%	69.6%	72.0%	75.9%	72.8%
Best	77.1%	79.5%	77.9%	83.2%	79.4%
Average	70.1%	71.0%	71.9%	74.1%	70.8%
Worst	60.9%	59.0%	62.8%	66.4%	61.8%
Responses	1295	1203	1339	1499	1399

Q19b I am confident that my organisation would address my concern.

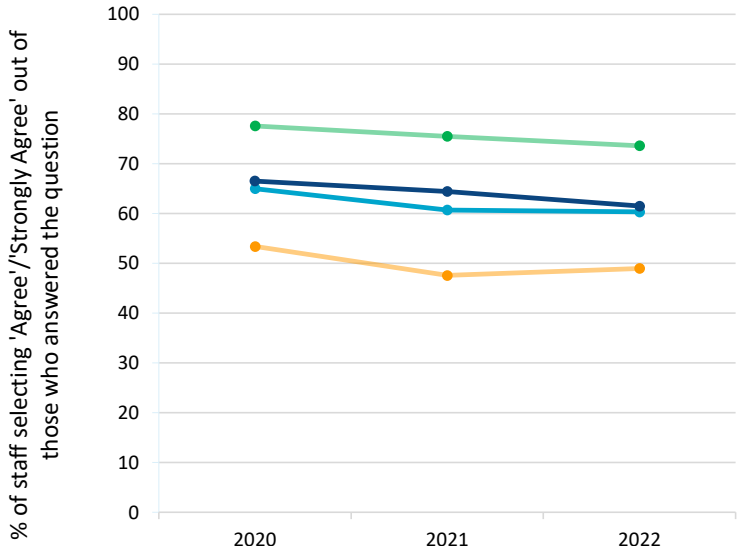


	2018	2019	2020	2021	2022
Your org	57.6%	61.3%	60.5%	59.4%	56.9%
Best	69.5%	74.0%	74.2%	76.2%	69.1%
Average	57.6%	59.1%	59.2%	57.7%	55.7%
Worst	42.6%	37.7%	45.3%	44.1%	42.2%
Responses	1294	1202	1334	1496	1398

People Promise elements and theme results – We each have a voice that counts: Raising concerns

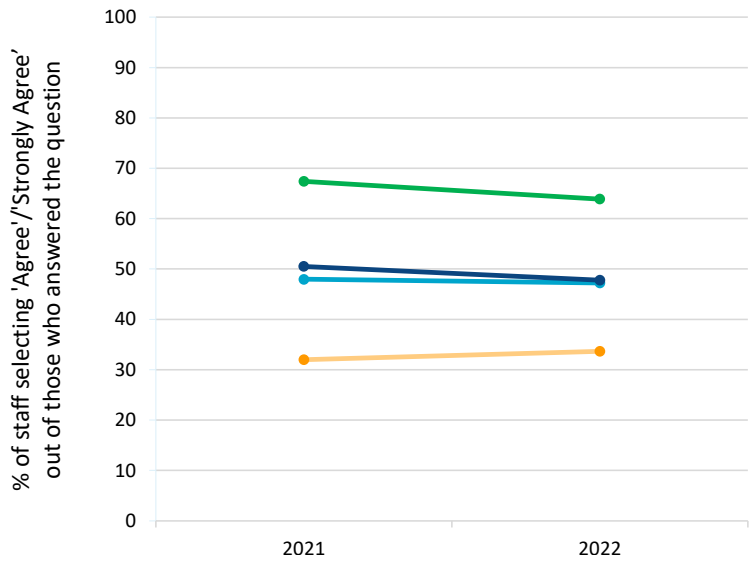
Survey Coordination Centre NHS

Q23e I feel safe to speak up about anything that concerns me in this organisation.



	2020	2021	2022
Your org	66.5%	64.5%	61.5%
Best	77.6%	75.5%	73.6%
Average	65.0%	60.7%	60.3%
Worst	53.4%	47.6%	49.0%
Responses	1349	1505	1396

Q23f If I spoke up about something that concerned me I am confident my organisation would address my concern.



	2021	2022
Your org	50.5%	47.8%
Best	67.4%	63.9%
Average	48.0%	47.2%
Worst	32.0%	33.7%
Responses	1508	1393

Survey Coordination Centre

NHS

People Promise element – We are safe and healthy

Questions included:

Health and safety climate: Q3g, Q3h, Q3i, Q5a, Q11a, Q13d, Q14d

Burnout: Q12a, Q12b, Q12c, Q12d, Q12e, Q12f, Q12g

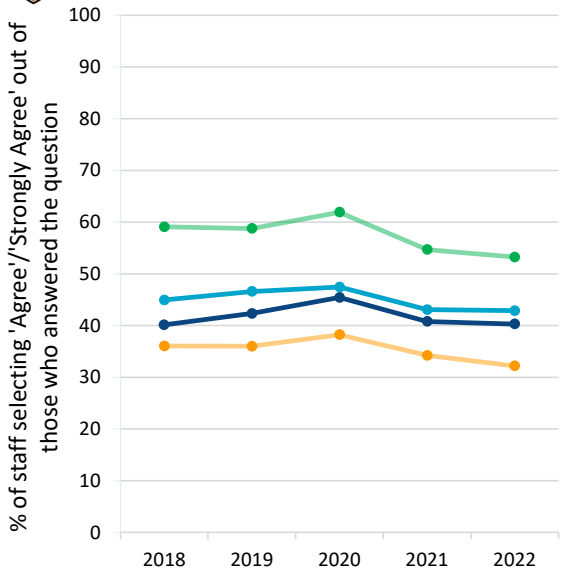
Negative experiences: Q11b, Q11c, Q11d, Q13a, Q13b, Q13c, Q14a, Q14b, Q14c

Please note, where there are less than 11 responses for a question this data is not shown in the chart to protect the confidentiality of staff and reliability of results.

People Promise elements and theme results – We are safe and healthy: Health and safety climate

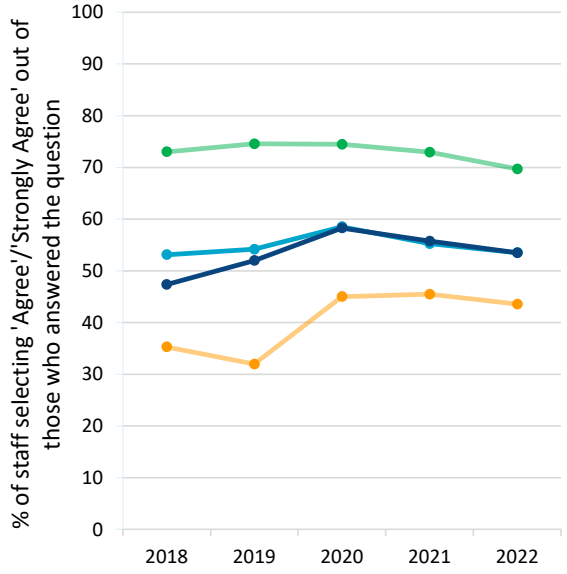
Survey Coordination Centre NHS

Q3g I am able to meet all the conflicting demands on my time at work.



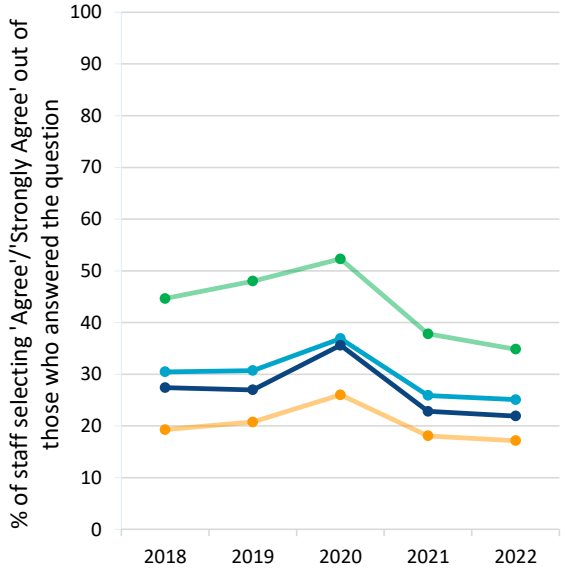
	2018	2019	2020	2021	2022
Your org	40.1%	42.3%	45.4%	40.8%	40.3%
Best	59.1%	58.8%	61.9%	54.7%	53.2%
Average	44.9%	46.6%	47.4%	43.1%	42.9%
Worst	36.0%	36.0%	38.2%	34.2%	32.2%
Responses	1304	1227	1350	1506	1398

Q3h I have adequate materials, supplies and equipment to do my work.



	2018	2019	2020	2021	2022
Your org	47.4%	52.0%	58.3%	55.7%	53.5%
Best	73.0%	74.6%	74.5%	72.9%	69.7%
Average	53.1%	54.2%	58.5%	55.3%	53.5%
Worst	35.3%	32.0%	45.0%	45.5%	43.6%
Responses	1312	1226	1346	1500	1397

Q3i There are enough staff at this organisation for me to do my job properly.

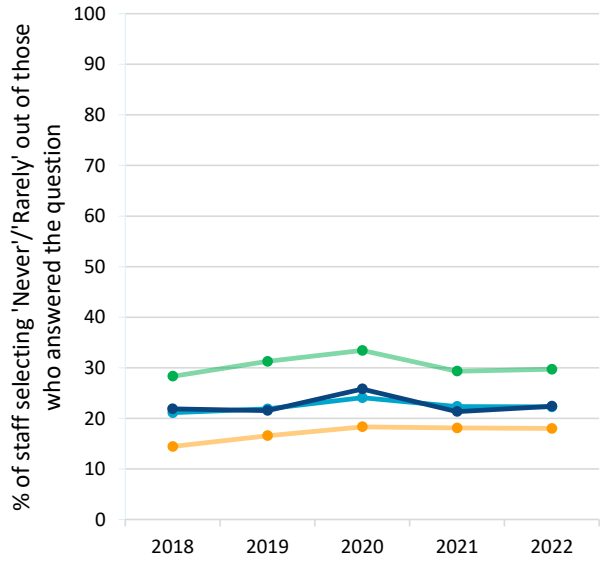


	2018	2019	2020	2021	2022
Your org	27.4%	27.0%	35.6%	22.8%	21.9%
Best	44.6%	48.0%	52.3%	37.8%	34.8%
Average	30.5%	30.7%	36.9%	25.9%	25.1%
Worst	19.3%	20.8%	26.0%	18.1%	17.2%
Responses	1310	1228	1349	1508	1395

People Promise elements and theme results – We are safe and healthy: Health and safety climate

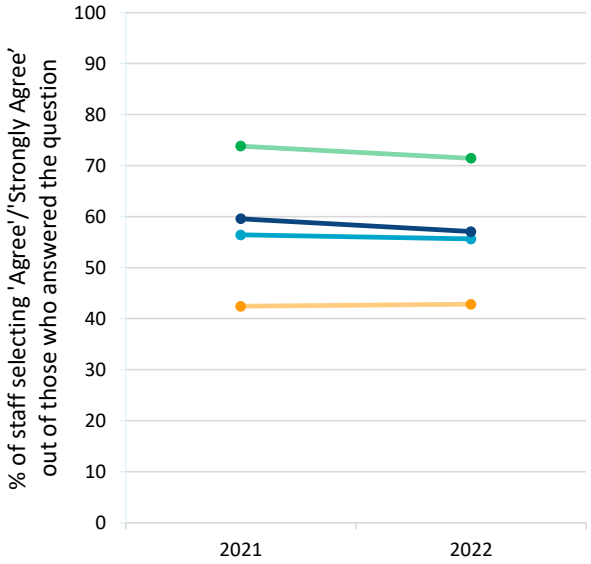
Survey Coordination Centre NHS

Q5a I have unrealistic time pressures.



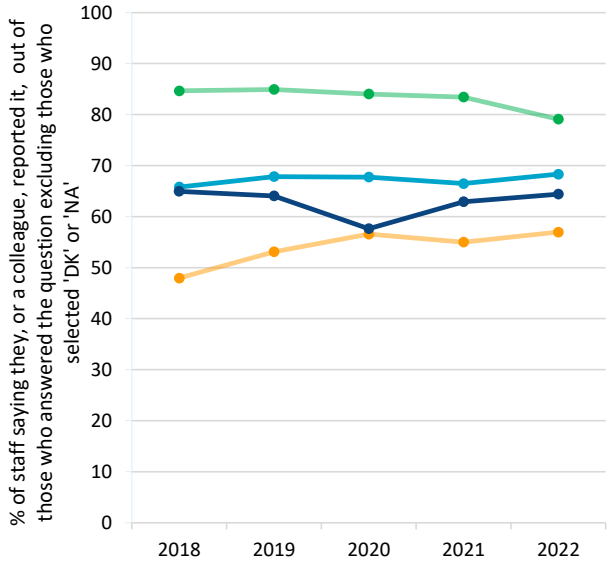
	2018	2019	2020	2021	2022
Your org	21.9%	21.6%	25.8%	21.3%	22.4%
Best	28.3%	31.3%	33.4%	29.3%	29.7%
Average	21.1%	21.9%	24.1%	22.4%	22.3%
Worst	14.4%	16.6%	18.3%	18.1%	18.0%
Responses	1310	1219	1341	1507	1398

Q11a My organisation take positive action on health and well-being.



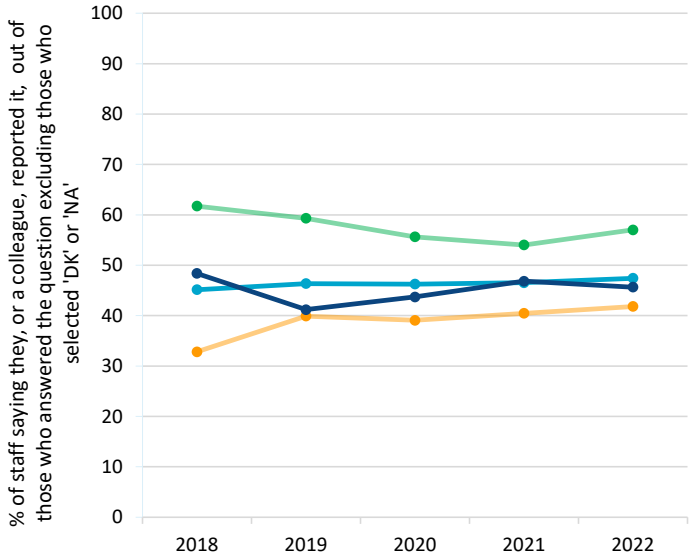
	2021	2022
Your org	59.6%	57.1%
Best	73.8%	71.4%
Average	56.4%	55.6%
Worst	42.4%	42.8%
Responses	1495	1391

Q13d The last time you experienced physical violence at work, did you or a colleague report it?



	2018	2019	2020	2021	2022
Your org	65.0%	64.0%	57.6%	62.9%	64.4%
Best	84.6%	84.9%	84.0%	83.4%	79.1%
Average	65.8%	67.8%	67.8%	66.5%	68.3%
Worst	47.9%	53.1%	56.6%	55.0%	57.0%
Responses	145	120	146	155	149

Q14d The last time you experienced harassment, bullying or abuse at work, did you or a colleague report it?

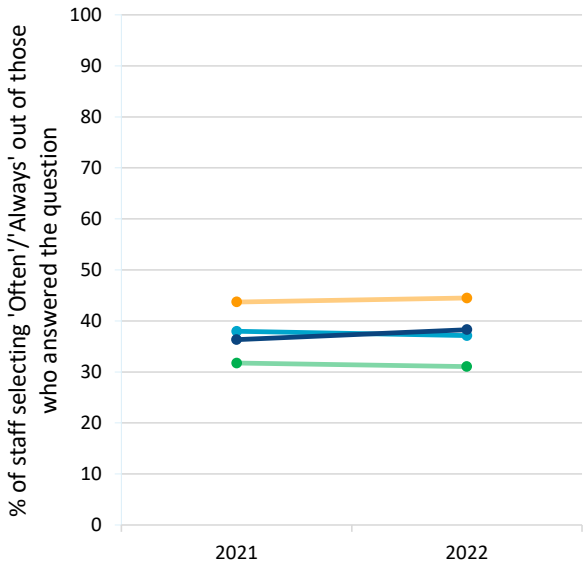


	2018	2019	2020	2021	2022
Your org	48.4%	41.2%	43.7%	46.8%	45.6%
Best	61.7%	59.3%	55.6%	54.0%	57.0%
Average	45.1%	46.4%	46.3%	46.5%	47.4%
Worst	32.8%	39.9%	39.1%	40.5%	41.8%
Responses	424	403	464	542	491

People Promise elements and theme results – We are safe and healthy: Burnout

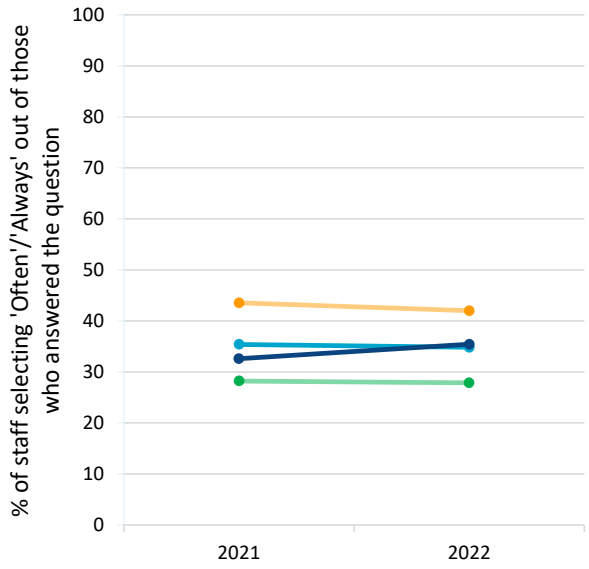
Survey Coordination Centre NHS

Q12a How often, if at all, do you find your work emotionally exhausting?



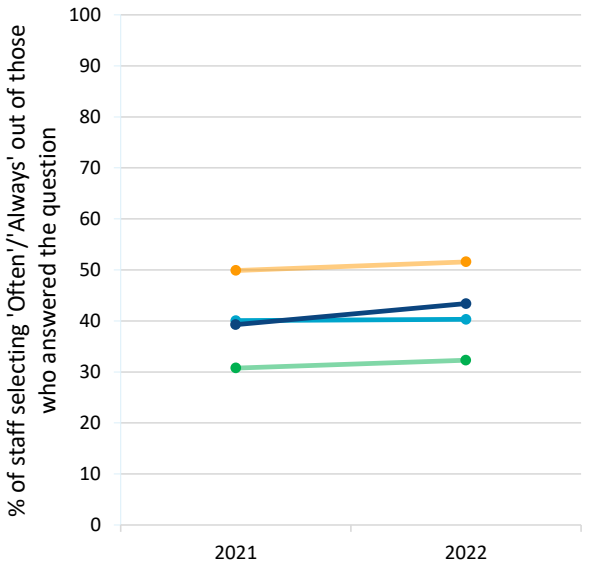
	2021	2022
Your org	36.3%	38.3%
Best	31.7%	31.0%
Average	38.0%	37.1%
Worst	43.7%	44.5%
Responses	1513	1404

Q12b How often, if at all, do you feel burnt out because of your work?



	2021	2022
Your org	32.6%	35.4%
Best	28.2%	27.9%
Average	35.4%	34.8%
Worst	43.5%	42.0%
Responses	1508	1402

Q12c How often, if at all, does your work frustrate you?

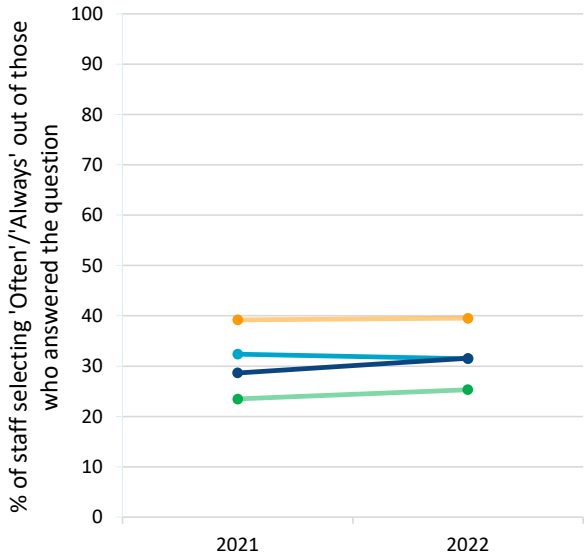


	2021	2022
Your org	39.3%	43.4%
Best	30.8%	32.3%
Average	40.1%	40.3%
Worst	49.9%	51.6%
Responses	1509	1403

People Promise elements and theme results – We are safe and healthy: Burnout

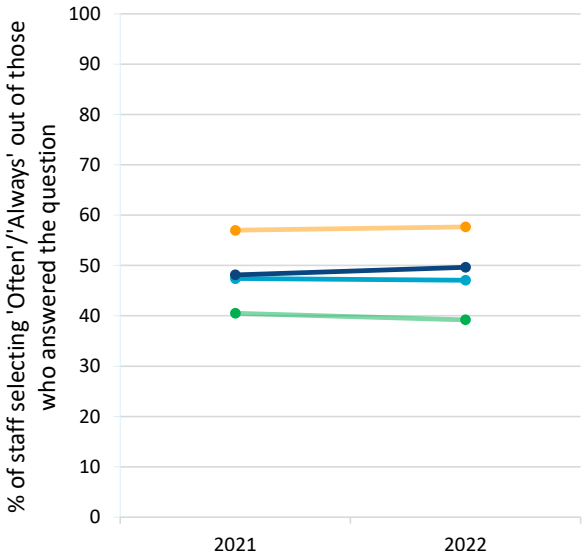
Survey Coordination Centre NHS

Q12d How often, if at all, are you exhausted at the thought of another day/shift at work?



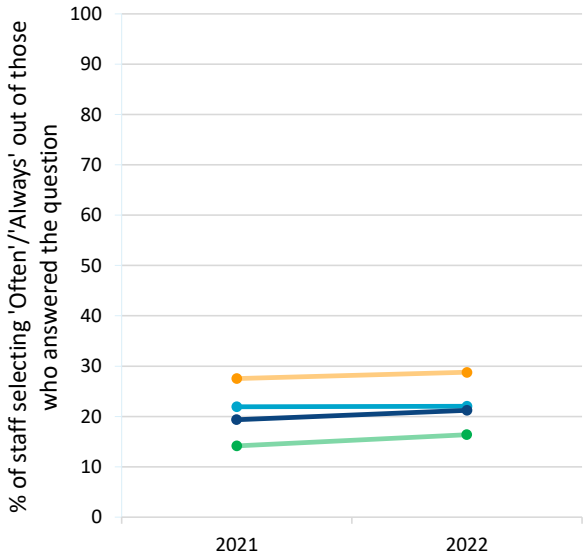
	2021	2022
Your org	28.6%	31.6%
Best	23.5%	25.3%
Average	32.4%	31.5%
Worst	39.2%	39.5%
Responses	1506	1396

Q12e How often, if at all, do you feel worn out at the end of your working day/shift?

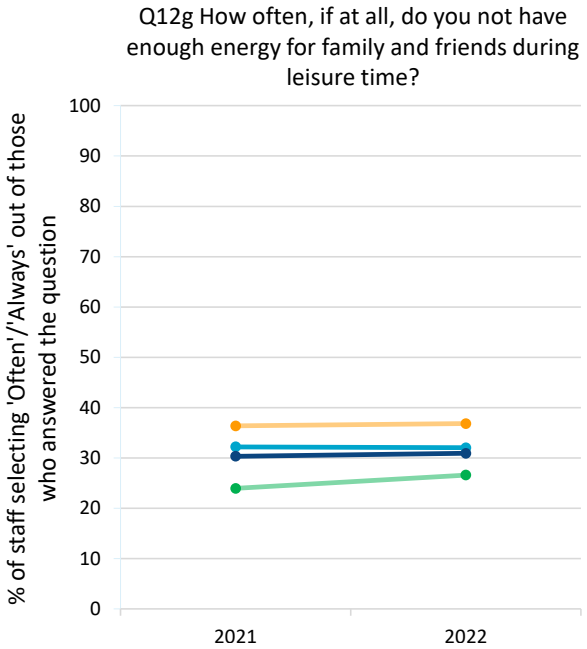


	2021	2022
Your org	48.1%	49.7%
Best	40.5%	39.2%
Average	47.4%	47.1%
Worst	57.0%	57.7%
Responses	1507	1399

Q12f How often, if at all, do you feel that every working hour is tiring for you?



	2021	2022
Your org	19.4%	21.2%
Best	14.2%	16.4%
Average	21.9%	22.0%
Worst	27.5%	28.8%
Responses	1503	1397

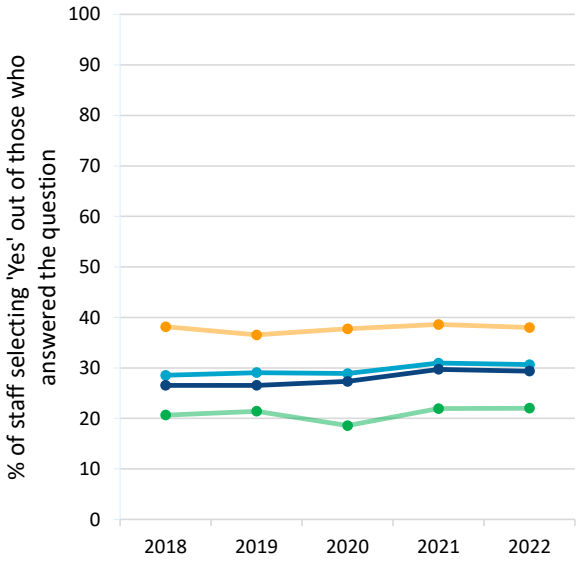


	2021	2022
Your org	30.3%	30.9%
Best	23.9%	26.6%
Average	32.2%	32.0%
Worst	36.4%	36.8%
Responses	1509	1403

People Promise elements and theme results – We are safe and healthy: Negative experiences

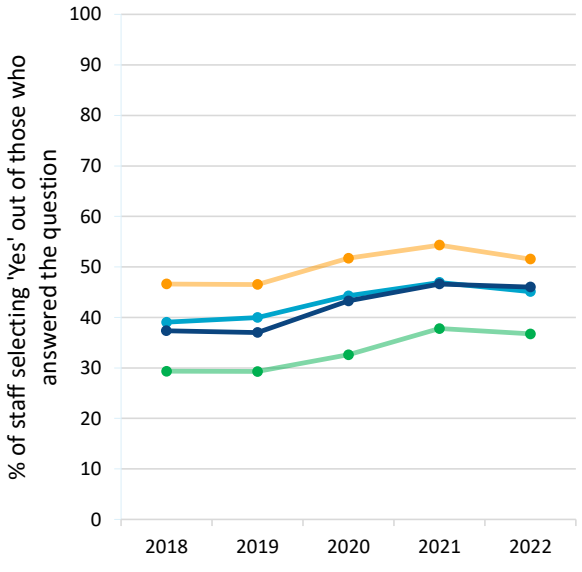
Survey Coordination Centre NHS

Q11b In the last 12 months have you experienced musculoskeletal problems (MSK) as a result of work activities?



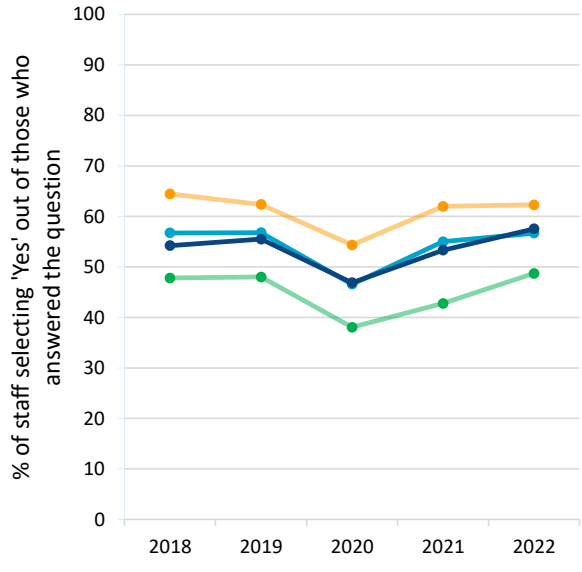
	2018	2019	2020	2021	2022
Your org	26.5%	26.6%	27.3%	29.7%	29.4%
Best	20.7%	21.4%	18.6%	21.9%	22.0%
Average	28.5%	29.1%	28.9%	31.0%	30.6%
Worst	38.1%	36.5%	37.7%	38.6%	38.0%
Responses	1308	1215	1347	1497	1398

Q11c During the last 12 months have you felt unwell as a result of work related stress?



	2018	2019	2020	2021	2022
Your org	37.4%	37.0%	43.3%	46.6%	46.0%
Best	29.3%	29.3%	32.6%	37.8%	36.7%
Average	39.1%	40.0%	44.3%	46.9%	45.1%
Worst	46.6%	46.5%	51.7%	54.3%	51.5%
Responses	1311	1218	1350	1500	1401

Q11d In the last three months have you ever come to work despite not feeling well enough to perform your duties?

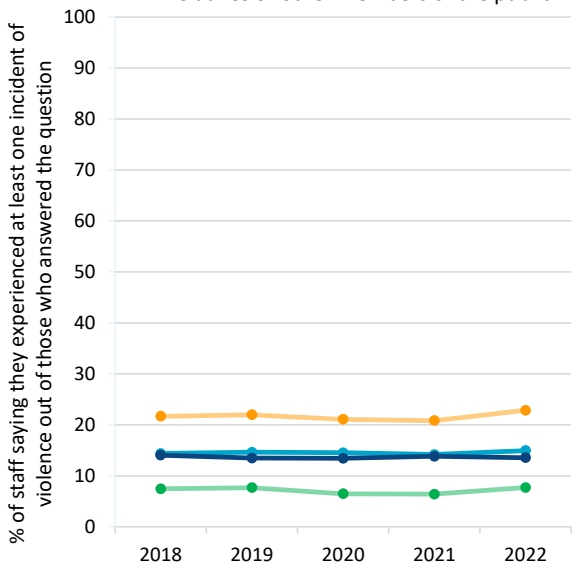


	2018	2019	2020	2021	2022
Your org	54.2%	55.5%	46.9%	53.3%	57.5%
Best	47.8%	48.0%	38.0%	42.8%	48.7%
Average	56.7%	56.8%	46.6%	55.0%	56.7%
Worst	64.5%	62.4%	54.3%	62.0%	62.3%
Responses	1305	1213	1347	1492	1399

People Promise elements and theme results – We are safe and healthy: Negative experiences

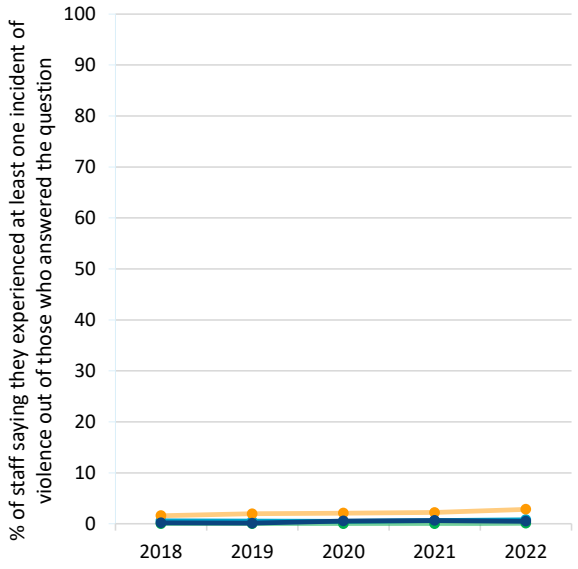
Survey Coordination Centre NHS

Q13a In the last 12 months how many times have you personally experienced physical violence at work from...? Patients / service users, their relatives or other members of the public.



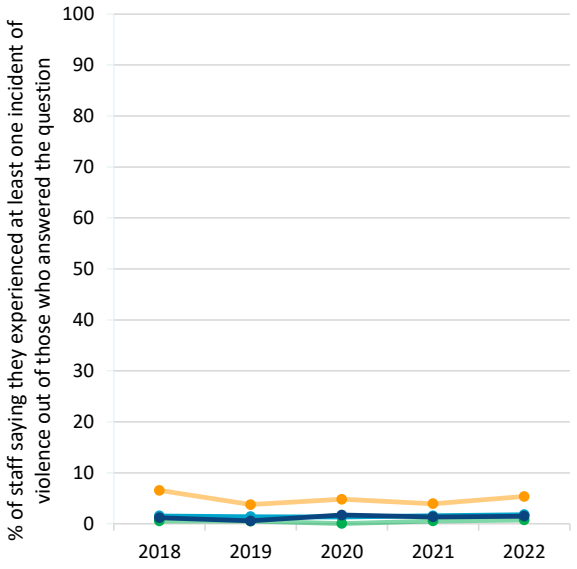
	2018	2019	2020	2021	2022
Your org	14.0%	13.5%	13.4%	13.8%	13.6%
Best	7.5%	7.7%	6.5%	6.4%	7.7%
Average	14.4%	14.6%	14.5%	14.2%	15.0%
Worst	21.7%	22.0%	21.1%	20.8%	22.8%
Responses	1311	1215	1348	1507	1401

Q13b In the last 12 months how many times have you personally experienced physical violence at work from...? Managers.



	2018	2019	2020	2021	2022
Your org	0.2%	0.1%	0.5%	0.6%	0.5%
Best	0.0%	0.0%	0.0%	0.0%	0.1%
Average	0.6%	0.5%	0.5%	0.6%	0.8%
Worst	1.6%	2.0%	2.1%	2.2%	2.9%
Responses	1303	1212	1344	1500	1397

Q13c In the last 12 months how many times have you personally experienced physical violence at work from...? Other colleagues.

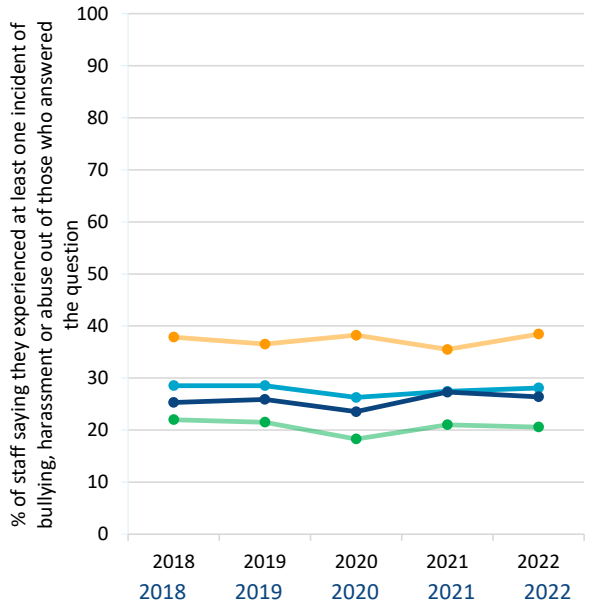


	2018	2019	2020	2021	2022
Your org	1.2%	0.6%	1.7%	1.3%	1.5%
Best	0.6%	0.5%	0.1%	0.6%	0.7%
Average	1.5%	1.4%	1.4%	1.6%	1.8%
Worst	6.6%	3.8%	4.8%	4.0%	5.4%
Responses	1305	1204	1334	1482	1388

People Promise elements and theme results – We are safe and healthy: Negative experiences

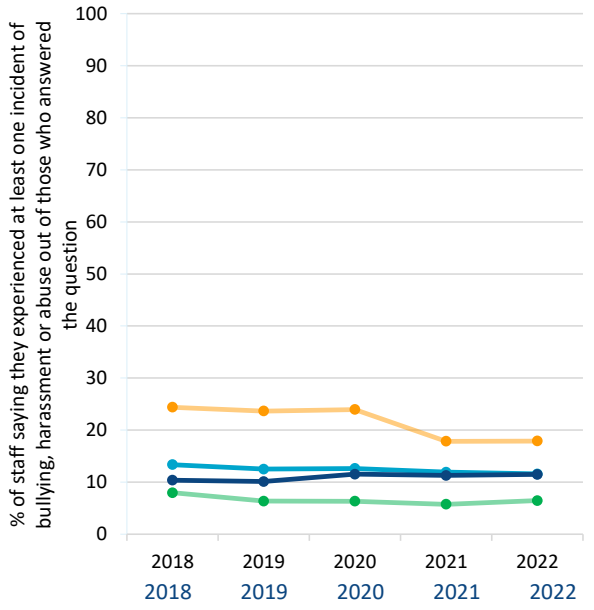
Survey Coordination Centre NHS

Q14a In the last 12 months how many times have you personally experienced harassment, bullying or abuse at work from...? Patients / service users, their relatives or other members of the public.



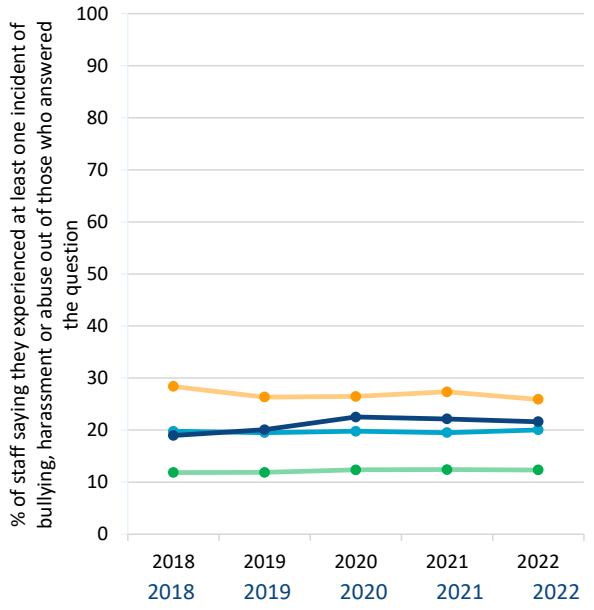
	2018	2019	2020	2021	2022
Your org	25.3%	25.9%	23.5%	27.3%	26.4%
Best	22.0%	21.5%	18.3%	21.0%	20.6%
Average	28.5%	28.5%	26.3%	27.4%	28.1%
Worst	37.9%	36.5%	38.2%	35.5%	38.5%
Responses	1306	1217	1341	1504	1395

Q14b In the last 12 months how many times have you personally experienced harassment, bullying or abuse at work from...? Managers.



	2018	2019	2020	2021	2022
Your org	10.4%	10.1%	11.5%	11.3%	11.5%
Best	8.0%	6.4%	6.3%	5.7%	6.4%
Average	13.3%	12.5%	12.6%	11.9%	11.6%
Worst	24.4%	23.7%	23.9%	17.8%	17.9%
Responses	1300	1209	1336	1495	1390

Q14c In the last 12 months how many times have you personally experienced harassment, bullying or abuse at work from...? Other colleagues.



	2018	2019	2020	2021	2022
Your org	18.9%	20.1%	22.5%	22.1%	21.6%
Best	11.8%	11.9%	12.4%	12.4%	12.3%
Average	19.8%	19.5%	19.8%	19.5%	20.0%
Worst	28.4%	26.3%	26.5%	27.3%	25.9%
Responses	1299	1206	1330	1479	1388

Survey Coordination Centre

NHS

People Promise element – We are always learning

Questions included:

Development – Q22a, Q22b, Q22c, Q22d, Q22e

Appraisals – Q21b, Q21c, Q21d

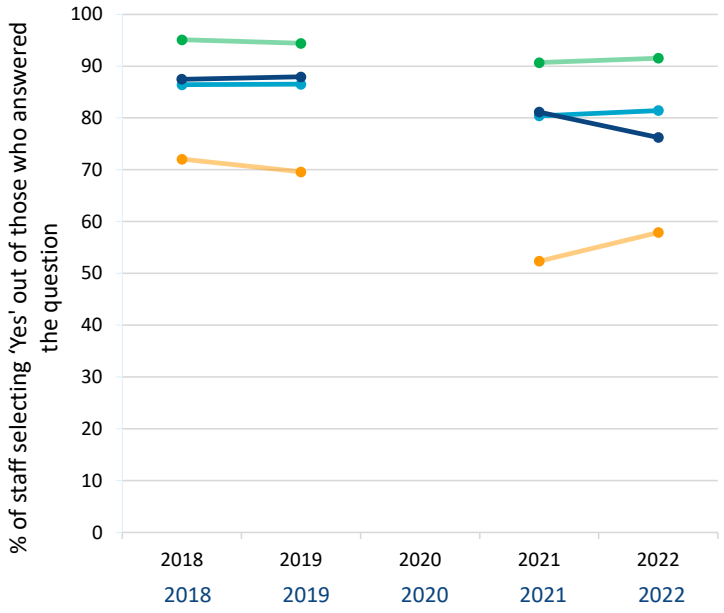
Please note, where there are less than 11 responses for a question this data is not shown in the chart to protect the confidentiality of staff and reliability of results.

People Promise elements and theme results – We are always learning: Development

Survey Coordination Centre

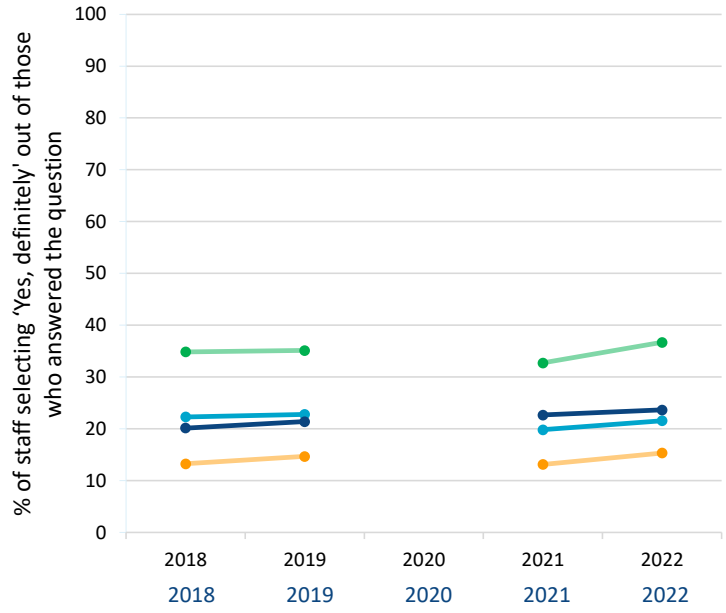
*Q21a is a filter question and therefore influences the sub-score without being a directly scored question.

Q21a In the last 12 months, have you had an appraisal, annual review, development review, or Knowledge and Skills Framework (KSF) development review?



	2018	2019	2020	2021	2022
Your org	87.5%	87.9%	-	81.1%	76.2%
Best	95.1%	94.4%	-	90.7%	91.5%
Average	86.4%	86.5%	-	80.4%	81.4%
Worst	72.1%	69.6%	-	52.4%	57.9%
Responses	1305	1212	-	1492	1392

Q21b It helped me to improve how I do my job.



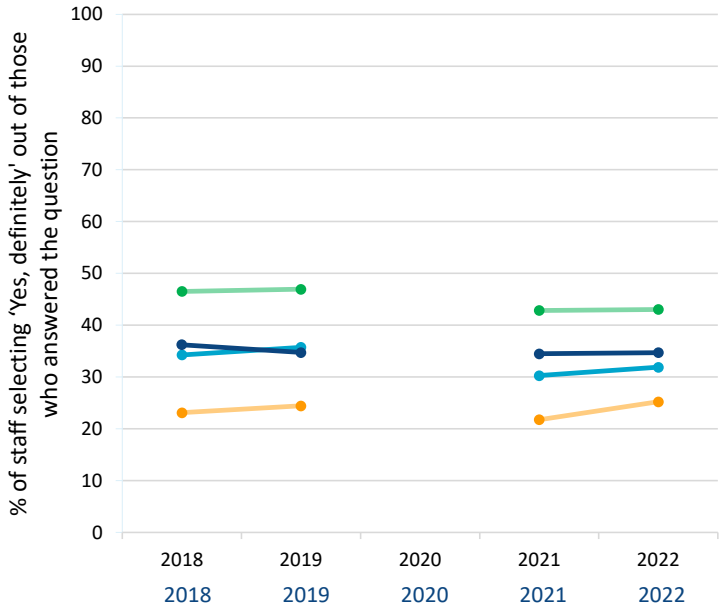
	2018	2019	2020	2021	2022
Your org	20.1%	21.4%	-	22.6%	23.6%
Best	34.8%	35.1%	-	32.7%	36.7%
Average	22.3%	22.8%	-	19.8%	21.5%
Worst	13.2%	14.7%	-	13.1%	15.3%
Responses	1130	1050	-	1191	1050

People Promise elements and theme results – We are always learning: Development

Survey Coordination Centre

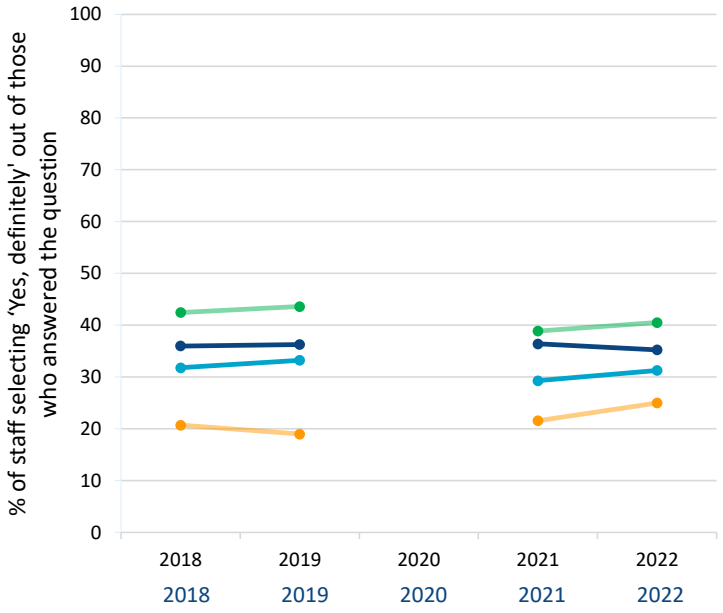
NHS

Q21c It helped me agree clear objectives for my work.



	2018	2019	2020	2021	2022
Your org	36.2%	34.7%	-	34.5%	34.7%
Best	46.5%	46.9%	-	42.8%	43.0%
Average	34.3%	35.7%	-	30.2%	31.9%
Worst	23.1%	24.4%	-	21.8%	25.2%
Responses	1131	1048	-	1190	1049

Q21d It left me feeling that my work is valued by my organisation.

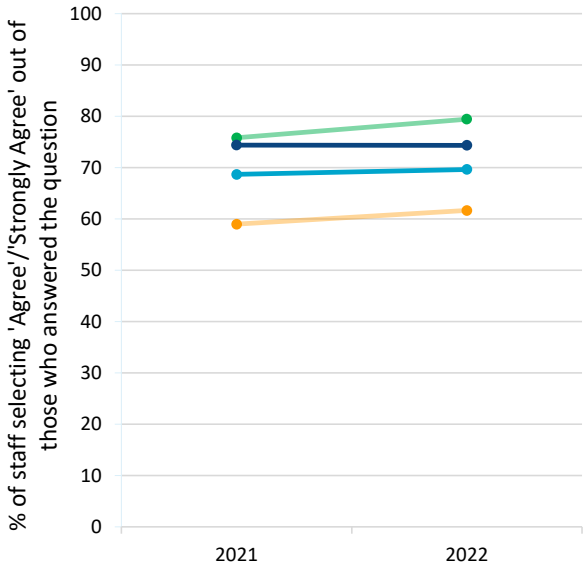


	2018	2019	2020	2021	2022
Your org	36.0%	36.3%	-	36.4%	35.2%
Best	42.4%	43.6%	-	38.9%	40.5%
Average	31.8%	33.2%	-	29.3%	31.3%
Worst	20.7%	19.0%	-	21.5%	25.0%
Responses	1128	1048	-	1193	1049

People Promise elements and theme results – We are always learning: Development

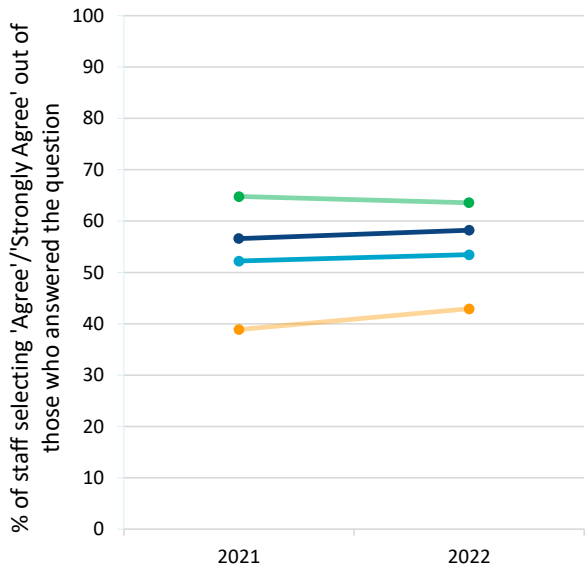
Survey Coordination Centre NHS

Q22a This organisation offers me challenging work.



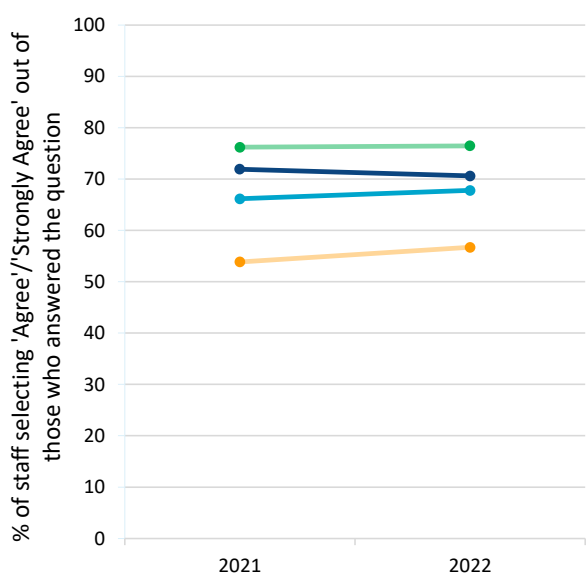
	2021	2022
Your org	74.4%	74.3%
Best	75.8%	79.4%
Average	68.7%	69.6%
Worst	59.0%	61.7%
Responses	1502	1394

Q22b There are opportunities for me to develop my career in this organisation.



	2021	2022
Your org	56.6%	58.2%
Best	64.8%	63.6%
Average	52.2%	53.4%
Worst	38.9%	42.9%
Responses	1498	1396

Q22c I have opportunities to improve my knowledge and skills.

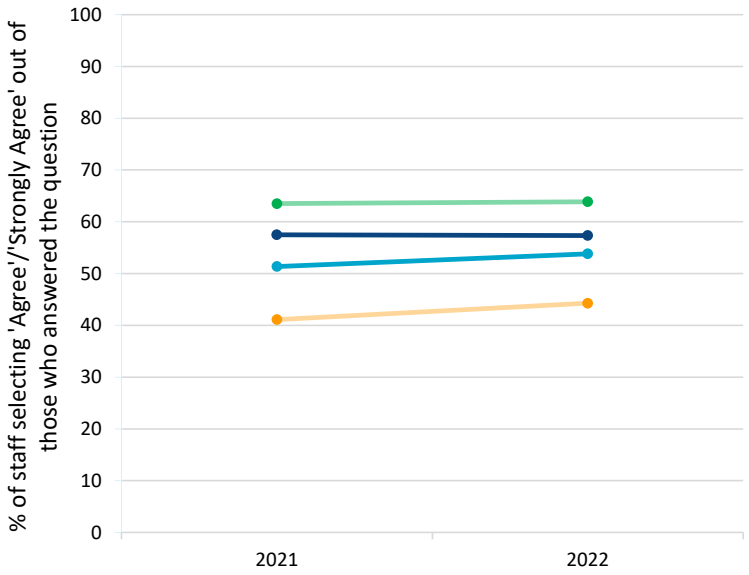


	2021	2022
Your org	71.9%	70.6%
Best	76.2%	76.5%
Average	66.2%	67.8%
Worst	53.9%	56.7%
Responses	1501	1393

People Promise elements and theme results – We are always learning: Development

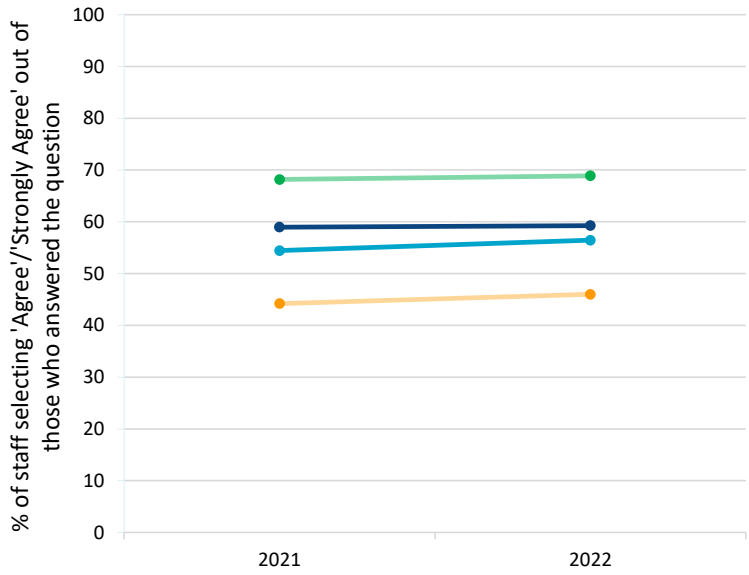
Survey Coordination Centre

Q22d I feel supported to develop my potential.



	2021	2022
Your org	57.5%	57.4%
Best	63.5%	63.9%
Average	51.4%	53.8%
Worst	41.1%	44.3%
Responses	1499	1394

Q22e I am able to access the right learning and development opportunities when I need to.



	2021	2022
Your org	58.9%	59.3%
Best	68.2%	68.9%
Average	54.4%	56.4%
Worst	44.2%	46.0%
Responses	1501	1392

Survey Coordination Centre

NHS

People Promise element – We work flexibly

Questions included:

Support for work-life balance – Q6b, Q6c, Q6d

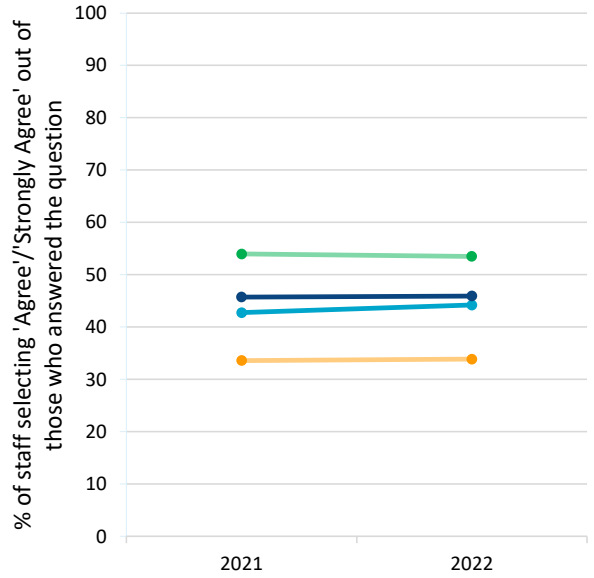
Flexible working – Q4d

Please note, where there are less than 11 responses for a question this data is not shown in the chart to protect the confidentiality of staff and reliability of results.

People Promise elements and theme results – We work flexibly: Support for work-life balance

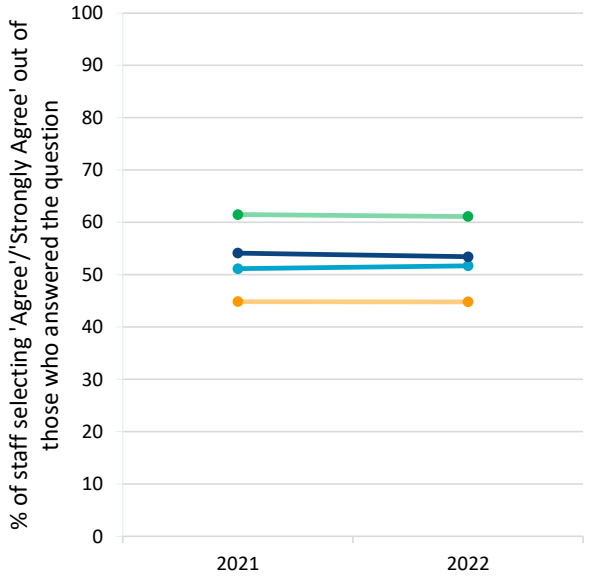
Survey Coordination Centre NHS

Q6b My organisation is committed to helping me balance my work and home life.



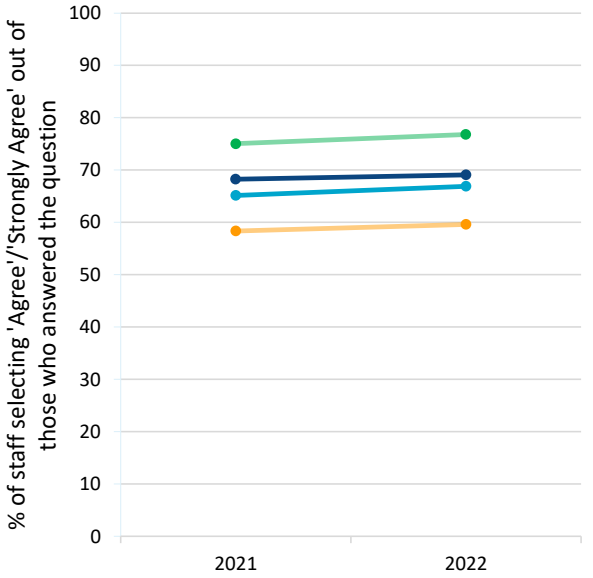
	2021	2022
Your org	45.7%	45.9%
Best	54.0%	53.5%
Average	42.7%	44.2%
Worst	33.6%	33.9%
Responses	1513	1401

Q6c I achieve a good balance between my work life and my home life.



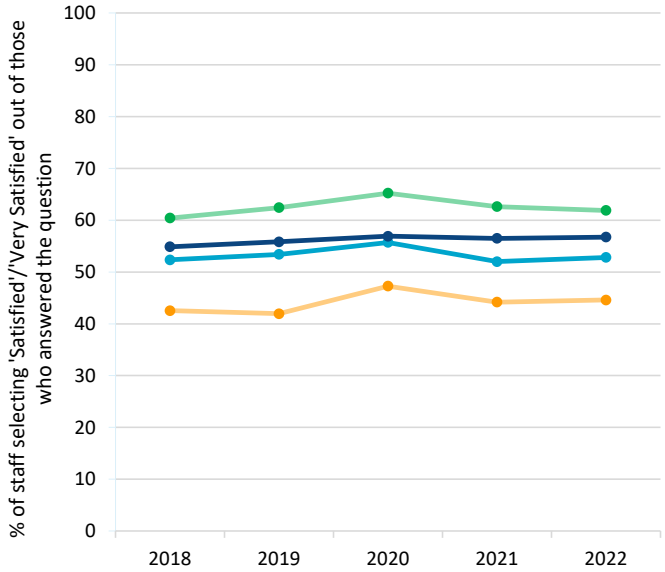
	2021	2022
Your org	54.1%	53.4%
Best	61.5%	61.1%
Average	51.1%	51.7%
Worst	44.9%	44.8%
Responses	1510	1399

Q6d I can approach my immediate manager to talk openly about flexible working.



	2021	2022
Your org	68.3%	69.1%
Best	75.0%	76.8%
Average	65.2%	66.9%
Worst	58.4%	59.6%
Responses	1508	1401

Q4d How satisfied are you with each of the following aspects of your job? The opportunities for flexible working patterns.

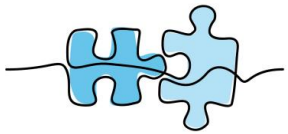


	2018	2019	2020	2021	2022
Your org	54.8%	55.8%	56.9%	56.5%	56.7%
Best	60.4%	62.4%	65.2%	62.6%	61.9%
Average	52.3%	53.4%	55.7%	52.0%	52.8%
Worst	42.5%	42.0%	47.3%	44.2%	44.6%
Responses	1315	1229	1351	1510	1394

Survey Coordination Centre

NHS

People Promise element – We are a team



Questions included:

Teamworking – Q7a, Q7b, Q7c, Q7d, Q7e, Q7f, Q7g, Q8a

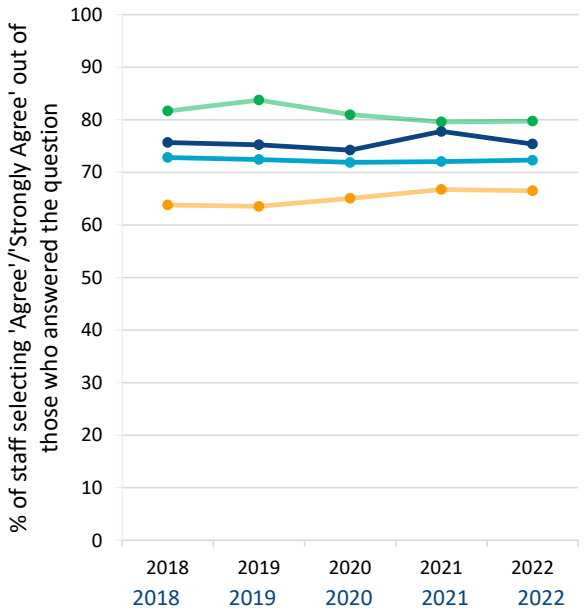
Line management – Q9a, Q9b, Q9c, Q9d

Please note, where there are less than 11 responses for a question this data is not shown in the chart to protect the confidentiality of staff and reliability of results.

People Promise elements and theme results – We are a team: Teamworking

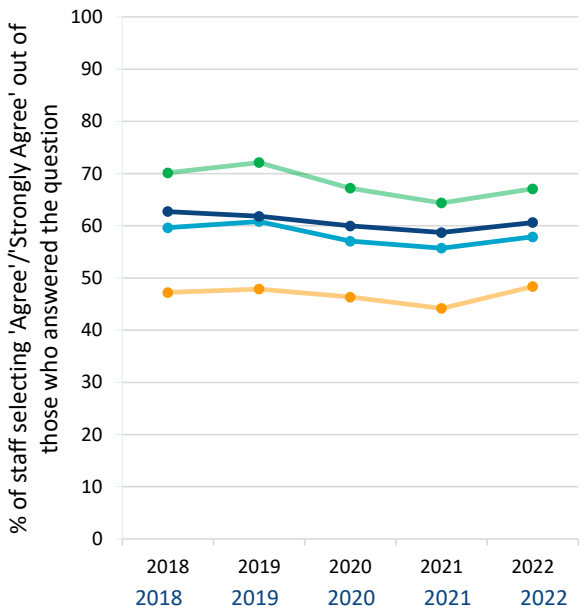
Survey Coordination Centre NHS

Q7a The team I work in has a set of shared objectives.



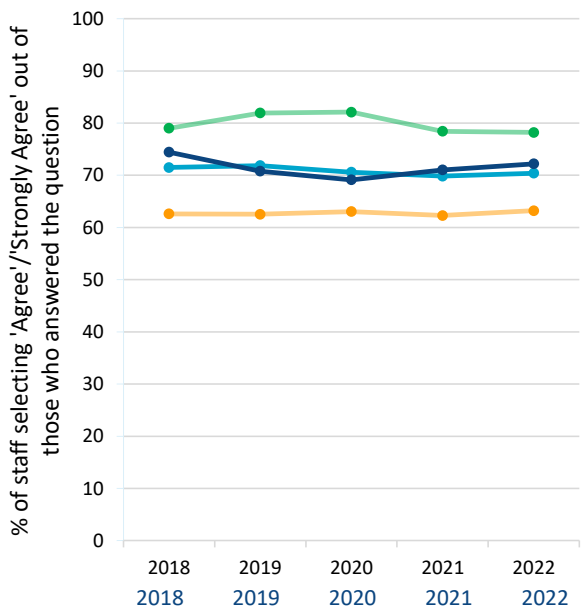
	2018	2019	2020	2021	2022
Your org	75.7%	75.3%	74.2%	77.8%	75.4%
Best	81.7%	83.8%	81.0%	79.6%	79.8%
Average	72.8%	72.5%	71.9%	72.1%	72.3%
Worst	63.8%	63.5%	65.0%	66.8%	66.5%
Responses	1308	1221	1348	1511	1399

Q7b The team I work in often meets to discuss the team's effectiveness.



	2018	2019	2020	2021	2022
Your org	62.7%	61.8%	60.0%	58.7%	60.6%
Best	70.1%	72.1%	67.2%	64.4%	67.1%
Average	59.6%	60.8%	57.0%	55.7%	57.9%
Worst	47.2%	47.9%	46.4%	44.2%	48.4%
Responses	1312	1226	1344	1510	1400

Q7c I receive the respect I deserve from my colleagues at work.

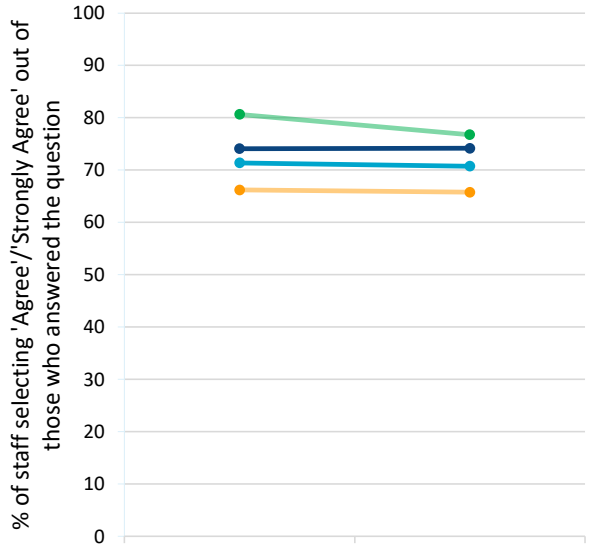


	2018	2019	2020	2021	2022
Your org	74.4%	70.8%	69.1%	71.0%	72.2%
Best	79.0%	81.9%	82.1%	78.4%	78.2%
Average	71.5%	71.8%	70.6%	69.9%	70.4%
Worst	62.6%	62.5%	63.0%	62.3%	63.2%
Responses	1311	1232	1347	1511	1401

People Promise elements and theme results – We are a team: Teamworking

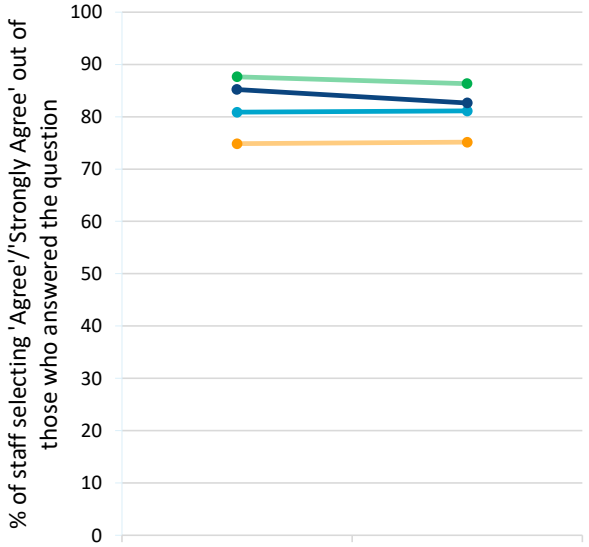
Survey Coordination Centre NHS

Q7d Team members understand each other's roles.



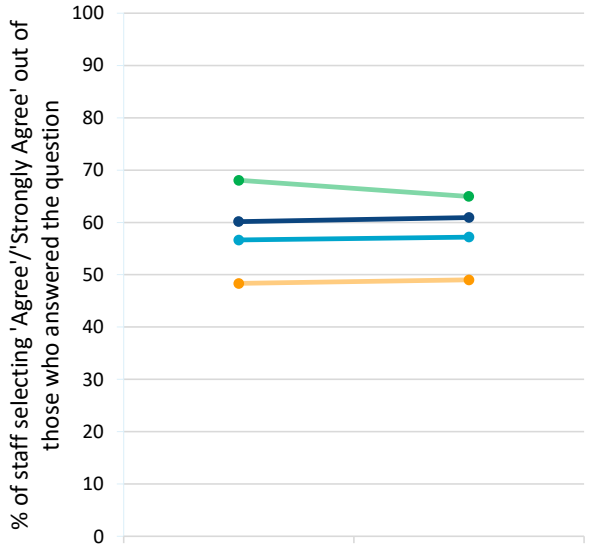
	2021	2022
Your org	74.1%	74.2%
Best	80.6%	76.8%
Average	71.4%	70.7%
Worst	66.2%	65.8%
Responses	1511	1399

Q7e I enjoy working with the colleagues in my team.



	2021	2022
Your org	85.2%	82.6%
Best	87.6%	86.3%
Average	80.9%	81.1%
Worst	74.8%	75.1%
Responses	1513	1397

Q7f My team has enough freedom in how to do its work.

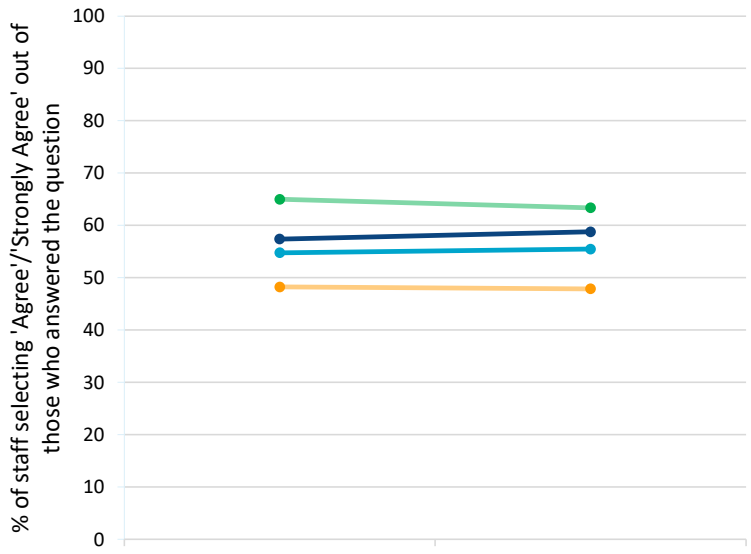


	2021	2022
Your org	60.2%	60.9%
Best	68.0%	64.9%
Average	56.6%	57.2%
Worst	48.3%	49.0%
Responses	1510	1400

People Promise elements and theme results – We are a team: Teamworking

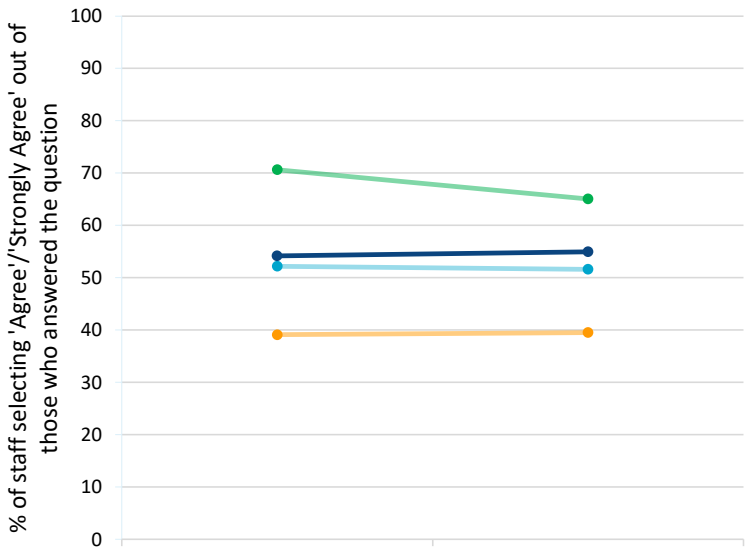
Survey Coordination Centre NHS

Q7g In my team disagreements are dealt with constructively.



	2021	2022
Your org	57.4%	58.8%
Best	65.0%	63.3%
Average	54.8%	55.5%
Worst	48.2%	47.9%
Responses	1508	1396

Q8a Teams within this organisation work well together to achieve their objectives.

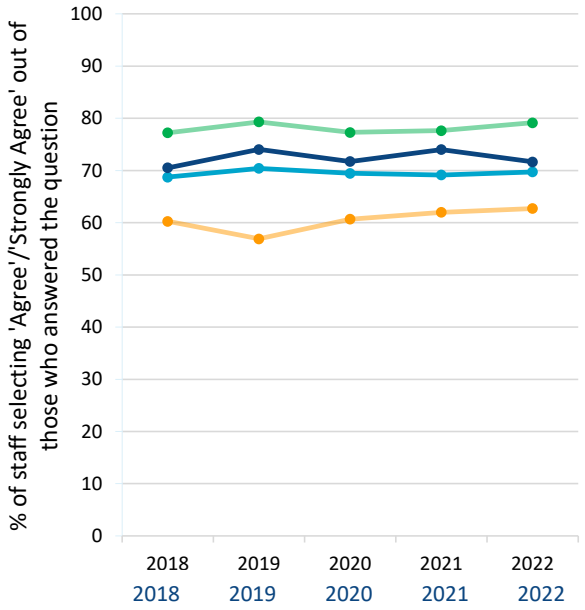


	2021	2022
Your org	54.2%	55.0%
Best	70.6%	65.1%
Average	52.2%	51.6%
Worst	39.1%	39.5%
Responses	1509	1397

People Promise elements and theme results – We are a team: Line management

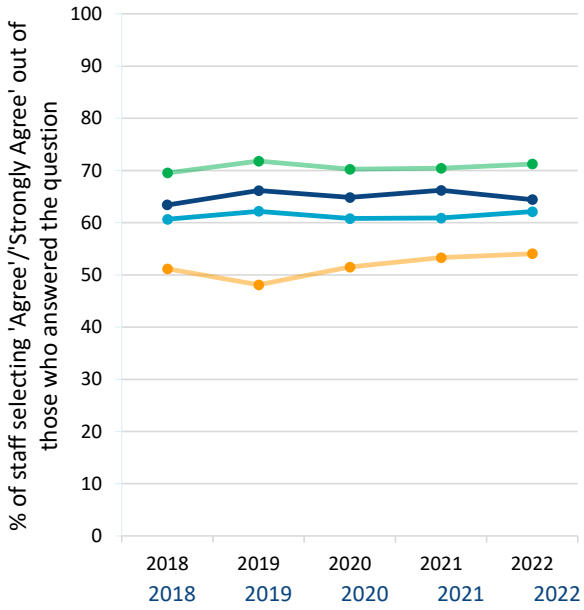
Survey Coordination Centre NHS

Q9a My immediate manager encourages me at work.



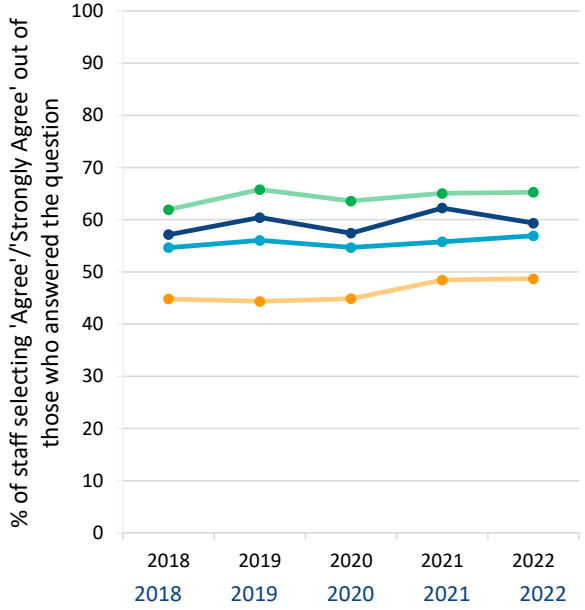
	2018	2019	2020	2021	2022
Your org	70.5%	74.0%	71.7%	74.0%	71.7%
Best	77.2%	79.3%	77.3%	77.6%	79.2%
Average	68.7%	70.4%	69.5%	69.1%	69.7%
Worst	60.3%	56.9%	60.7%	62.0%	62.7%
Responses	1311	1222	1351	1513	1397

Q9b My immediate manager gives me clear feedback on my work.



	2018	2019	2020	2021	2022
Your org	63.4%	66.2%	64.8%	66.2%	64.4%
Best	69.5%	71.8%	70.3%	70.4%	71.3%
Average	60.7%	62.2%	60.8%	60.9%	62.1%
Worst	51.2%	48.1%	51.5%	53.3%	54.1%
Responses	1314	1222	1348	1507	1398

Q9c My immediate manager asks for my opinion before making decisions that affect my work.

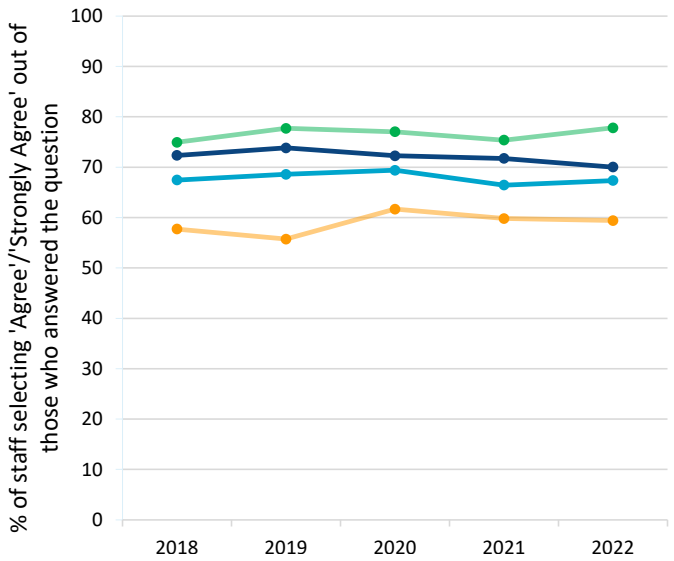


	2018	2019	2020	2021	2022
Your org	57.1%	60.4%	57.4%	62.2%	59.4%
Best	61.9%	65.8%	63.6%	65.1%	65.3%
Average	54.7%	56.0%	54.7%	55.8%	56.9%
Worst	44.8%	44.4%	44.9%	48.4%	48.7%
Responses	1313	1220	1352	1511	1398

People Promise elements and theme results – We are a team: Line management

Survey Coordination Centre NHS

Q9d My immediate manager takes a positive interest in my health and well-being.



	2018	2019	2020	2021	2022
Your org	72.3%	73.8%	72.3%	71.7%	70.0%
Best	74.9%	77.7%	77.0%	75.4%	77.8%
Average	67.5%	68.6%	69.4%	66.4%	67.4%
Worst	57.7%	55.7%	61.7%	59.8%	59.4%
Responses	1313	1223	1351	1512	1401

Survey Coordination Centre

NHS

Theme – Staff engagement

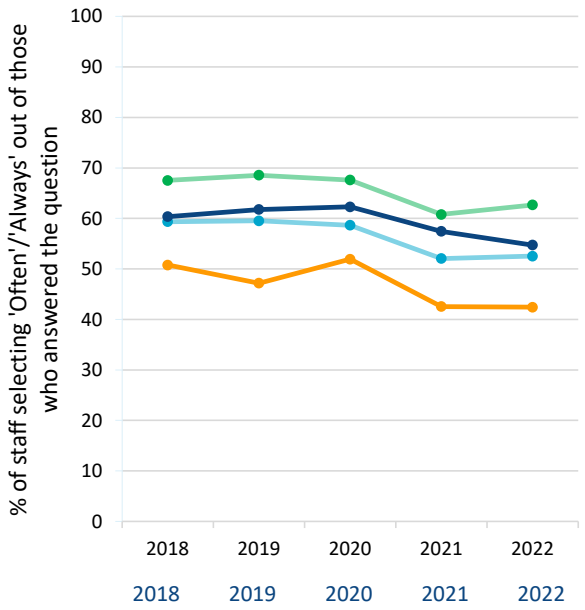
Questions included:
Motivation – Q2a, Q2b, Q2c
Involvement – Q3c, Q3d, Q3f
Advocacy – Q23a, Q23c, Q23d

Please note, where there are less than 11 responses for a question this data is not shown in the chart to protect the confidentiality of staff and reliability of results.

People Promise elements and theme results – Staff engagement: Motivation

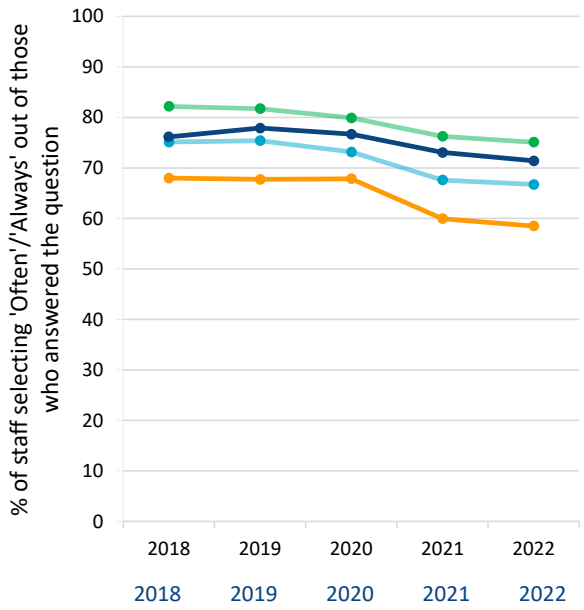
Survey Coordination Centre NHS

Q2a I look forward to going to work.



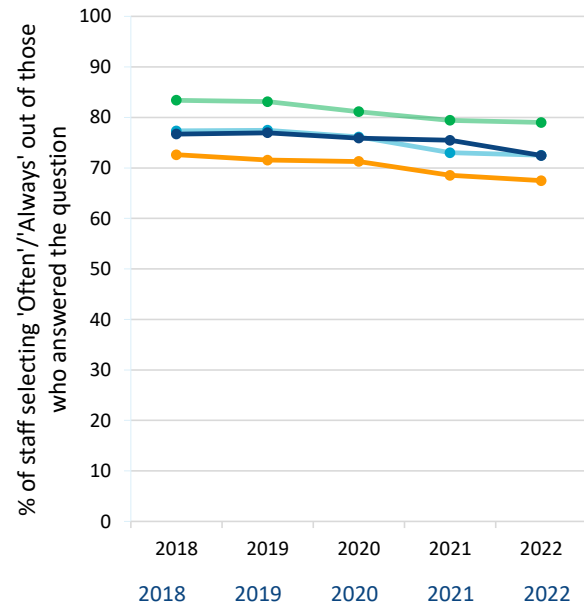
	2018	2019	2020	2021	2022
Your org	60.4%	61.8%	62.3%	57.4%	54.7%
Best	67.5%	68.6%	67.6%	60.8%	62.7%
Average	59.4%	59.5%	58.6%	52.0%	52.5%
Worst	50.8%	47.2%	51.9%	42.5%	42.4%
Responses	1309	1229	1346	1508	1395

Q2b I am enthusiastic about my job.



	2018	2019	2020	2021	2022
Your org	76.1%	77.9%	76.7%	73.1%	71.4%
Best	82.2%	81.7%	79.9%	76.2%	75.1%
Average	75.1%	75.4%	73.2%	67.6%	66.7%
Worst	68.0%	67.7%	67.9%	60.0%	58.5%
Responses	1299	1217	1341	1505	1387

Q2c Time passes quickly when I am working.

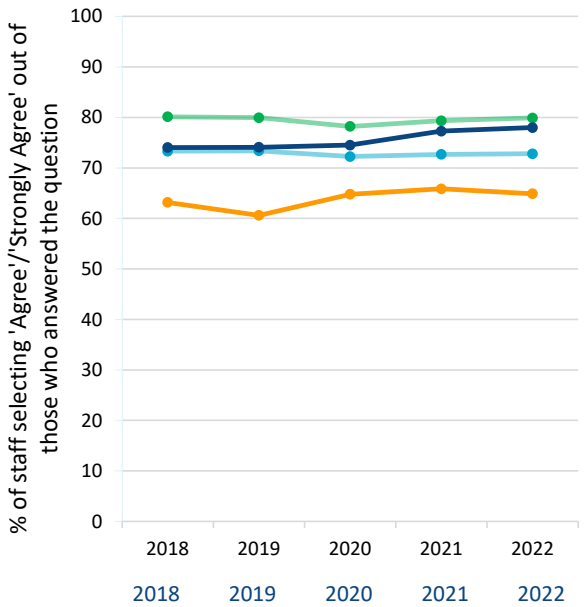


	2018	2019	2020	2021	2022
Your org	76.7%	76.9%	75.9%	75.5%	72.5%
Best	83.4%	83.1%	81.1%	79.4%	79.0%
Average	77.3%	77.4%	76.1%	73.0%	72.5%
Worst	72.6%	71.6%	71.3%	68.5%	67.5%
Responses	1301	1218	1341	1507	1386

People Promise elements and theme results – Staff engagement: Involvement

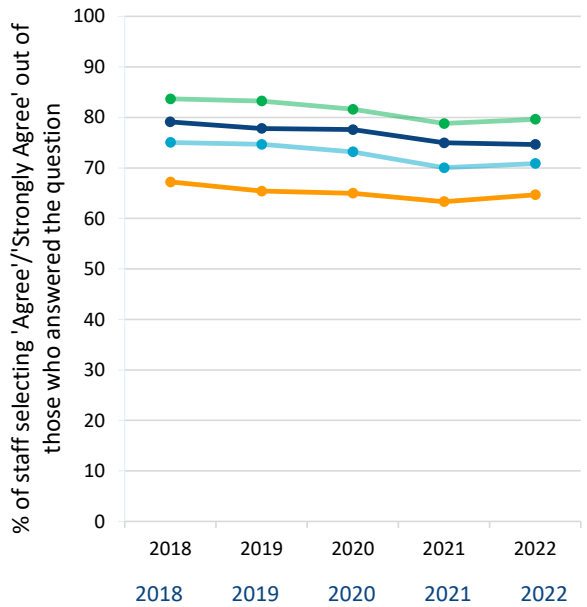
Survey Coordination Centre NHS

Q3c There are frequent opportunities for me to show initiative in my role.



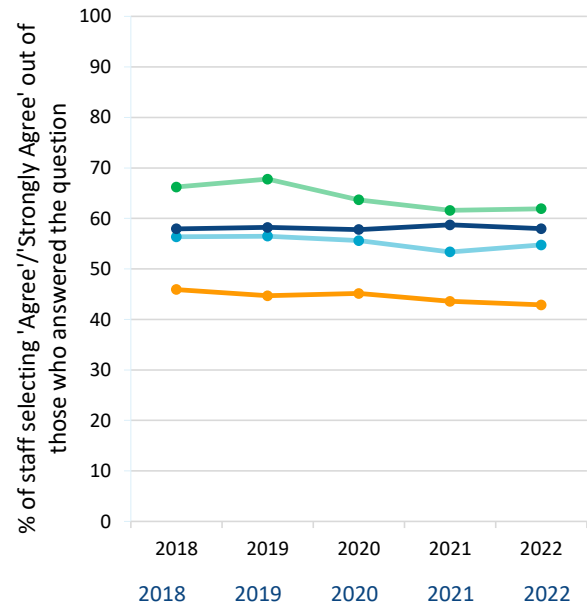
	2018	2019	2020	2021	2022
Your org	74.0%	74.1%	74.5%	77.3%	78.0%
Best	80.1%	79.9%	78.2%	79.3%	79.9%
Average	73.3%	73.4%	72.3%	72.7%	72.8%
Worst	63.2%	60.6%	64.8%	65.9%	64.9%
Responses	1314	1231	1352	1511	1398

Q3d I am able to make suggestions to improve the work of my team / department.



	2018	2019	2020	2021	2022
Your org	79.1%	77.8%	77.6%	75.0%	74.6%
Best	83.7%	83.3%	81.6%	78.8%	79.6%
Average	75.0%	74.7%	73.2%	70.0%	70.9%
Worst	67.2%	65.4%	65.0%	63.3%	64.7%
Responses	1314	1229	1351	1508	1397

Q3f I am able to make improvements happen in my area of work.

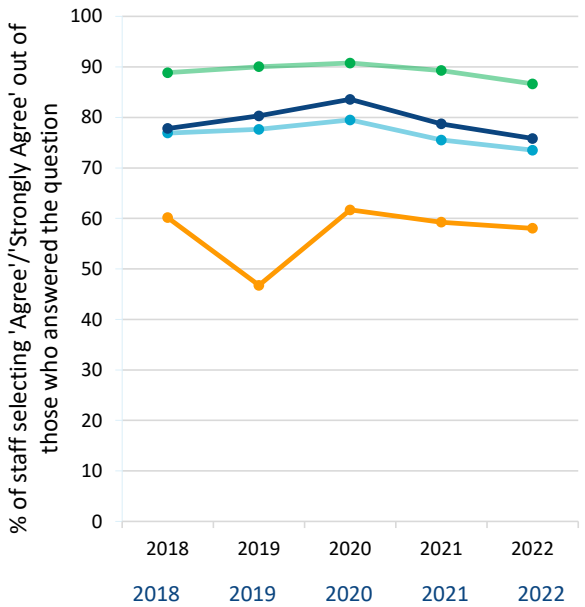


	2018	2019	2020	2021	2022
Your org	57.9%	58.2%	57.8%	58.7%	58.0%
Best	66.2%	67.8%	63.7%	61.6%	61.9%
Average	56.4%	56.5%	55.6%	53.4%	54.7%
Worst	45.9%	44.7%	45.1%	43.6%	42.9%
Responses	1306	1226	1346	1510	1393

People Promise elements and theme results – Staff engagement: Advocacy

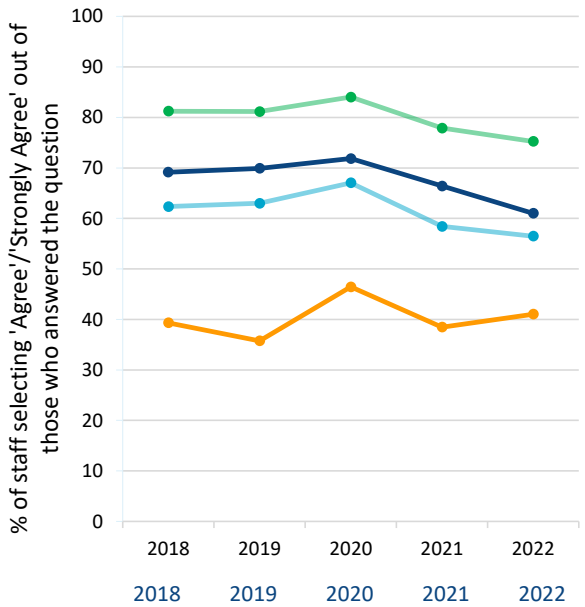
Survey Coordination Centre NHS

Q23a Care of patients / service users is my organisation's top priority.



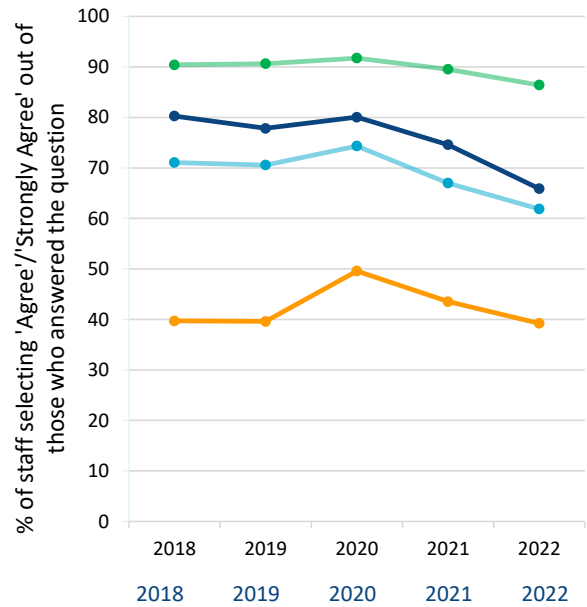
	2018	2019	2020	2021	2022
Your org	77.8%	80.3%	83.6%	78.7%	75.8%
Best	88.8%	90.0%	90.8%	89.3%	86.6%
Average	76.9%	77.6%	79.5%	75.5%	73.5%
Worst	60.1%	46.7%	61.7%	59.2%	58.0%
Responses	1306	1208	1347	1509	1398

Q23c I would recommend my organisation as a place to work.



	2018	2019	2020	2021	2022
Your org	69.1%	69.9%	71.9%	66.4%	61.0%
Best	81.2%	81.2%	84.0%	77.9%	75.2%
Average	62.3%	63.0%	67.1%	58.4%	56.5%
Worst	39.3%	35.7%	46.5%	38.5%	41.0%
Responses	1308	1204	1344	1508	1399

Q23d If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation.



	2018	2019	2020	2021	2022
Your org	80.3%	77.8%	80.0%	74.6%	65.9%
Best	90.4%	90.6%	91.8%	89.5%	86.4%
Average	71.1%	70.6%	74.3%	67.0%	61.9%
Worst	39.7%	39.6%	49.6%	43.5%	39.2%
Responses	1307	1206	1346	1506	1397

Survey Coordination Centre

NHS

Theme - Morale

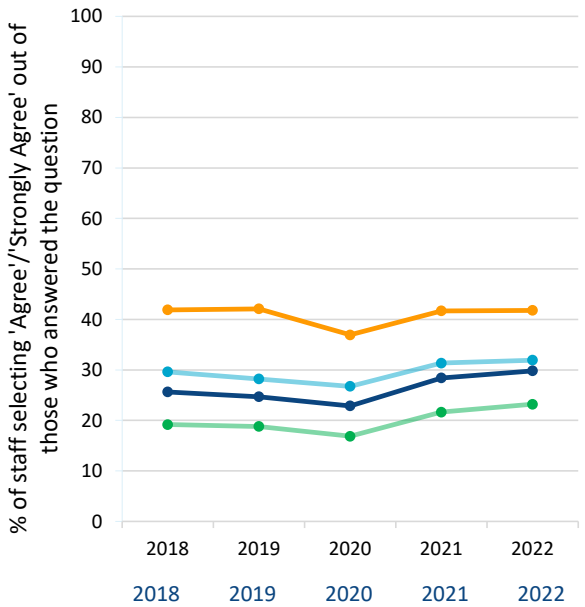
Questions included:
Thinking about leaving – Q24a, Q24b, Q24c
Work pressure – Q3g, Q3h, Q3i
Stressors – Q3a, Q3e, Q5a, Q5b, Q5c, Q7c, Q9a

Please note, where there are less than 11 responses for a question this data is not shown in the chart to protect the confidentiality of staff and reliability of results.

People Promise elements and theme results – Morale: Thinking about leaving

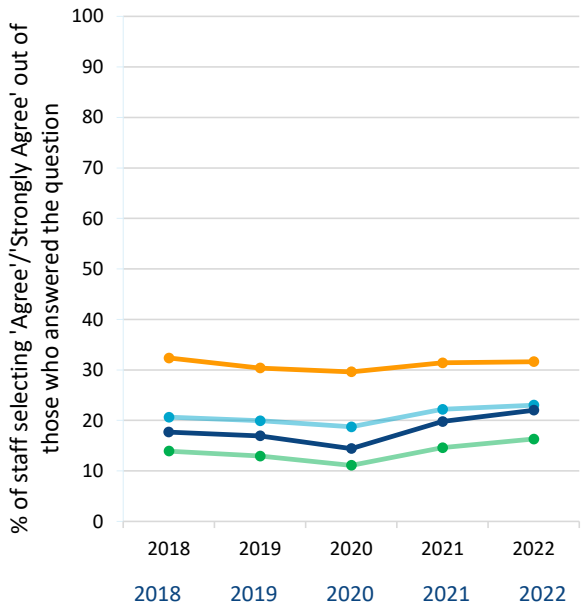
Survey Coordination Centre NHS

Q24a I often think about leaving this organisation.



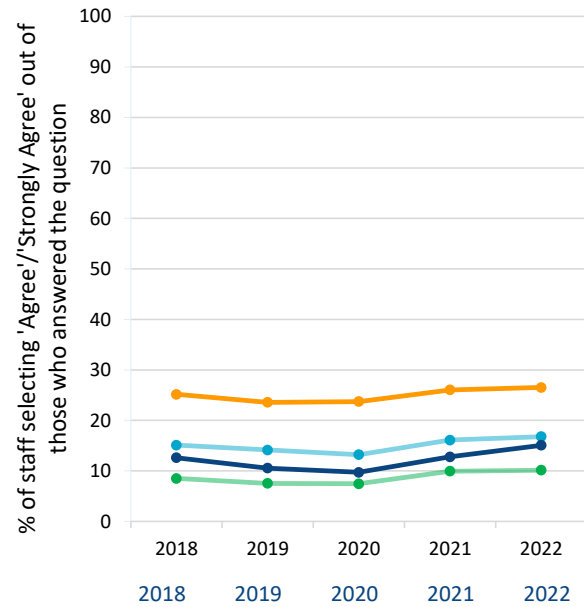
	2018	2019	2020	2021	2022
Your org	25.6%	24.7%	22.9%	28.4%	29.8%
Best	19.2%	18.8%	16.9%	21.6%	23.2%
Average	29.6%	28.2%	26.8%	31.3%	31.9%
Worst	41.9%	42.1%	36.9%	41.7%	41.8%
Responses	1305	1213	1348	1515	1398

Q24b I will probably look for a job at a new organisation in the next 12 months.



	2018	2019	2020	2021	2022
Your org	17.7%	16.9%	14.4%	19.8%	22.0%
Best	13.9%	12.9%	11.1%	14.6%	16.3%
Average	20.6%	19.9%	18.7%	22.2%	23.0%
Worst	32.3%	30.4%	29.6%	31.4%	31.6%
Responses	1303	1208	1343	1511	1395

Q24c As soon as I can find another job, I will leave this organisation.

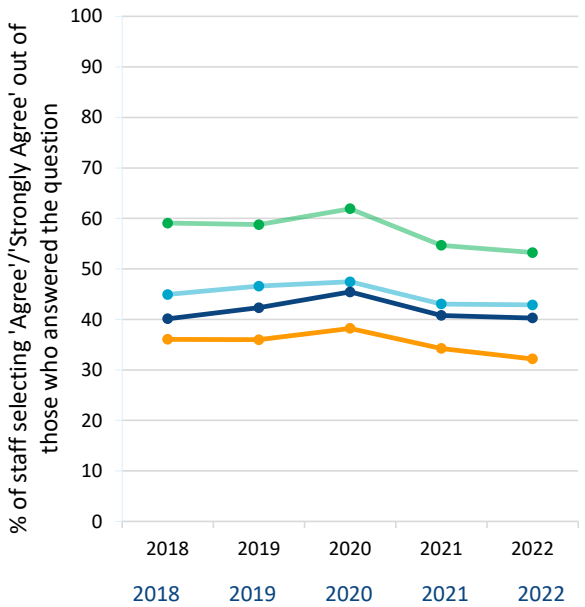


	2018	2019	2020	2021	2022
Your org	12.6%	10.6%	9.7%	12.8%	15.1%
Best	8.5%	7.5%	7.5%	9.9%	10.2%
Average	15.1%	14.1%	13.2%	16.1%	16.8%
Worst	25.2%	23.6%	23.7%	26.0%	26.5%
Responses	1301	1202	1345	1508	1389

People Promise elements and theme results – Morale: Work pressure

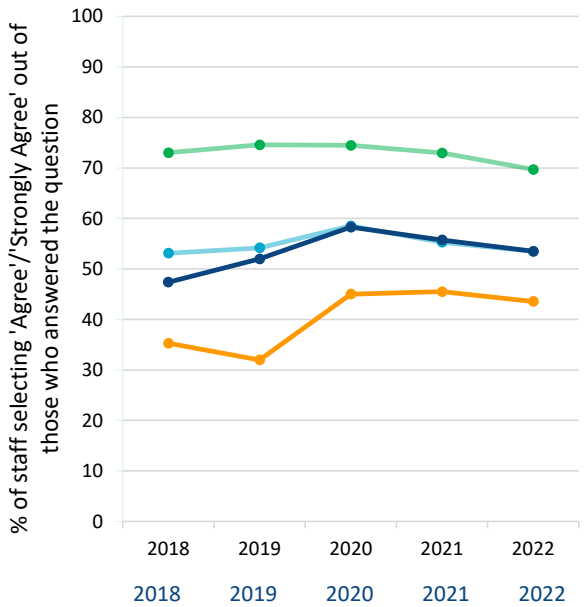
Survey Coordination Centre NHS

Q3g I am able to meet all the conflicting demands on my time at work.



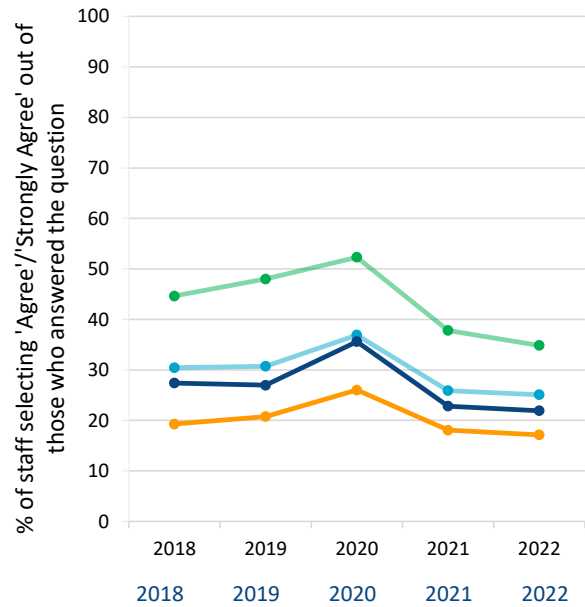
	2018	2019	2020	2021	2022
Your org	40.1%	42.3%	45.4%	40.8%	40.3%
Best	59.1%	58.8%	61.9%	54.7%	53.2%
Average	44.9%	46.6%	47.4%	43.1%	42.9%
Worst	36.0%	36.0%	38.2%	34.2%	32.2%
Responses	1304	1227	1350	1506	1398

Q3h I have adequate materials, supplies and equipment to do my work.



	2018	2019	2020	2021	2022
Your org	47.4%	52.0%	58.3%	55.7%	53.5%
Best	73.0%	74.6%	74.5%	72.9%	69.7%
Average	53.1%	54.2%	58.5%	55.3%	53.5%
Worst	35.3%	32.0%	45.0%	45.5%	43.6%
Responses	1312	1226	1346	1500	1397

Q3i There are enough staff at this organisation for me to do my job properly.

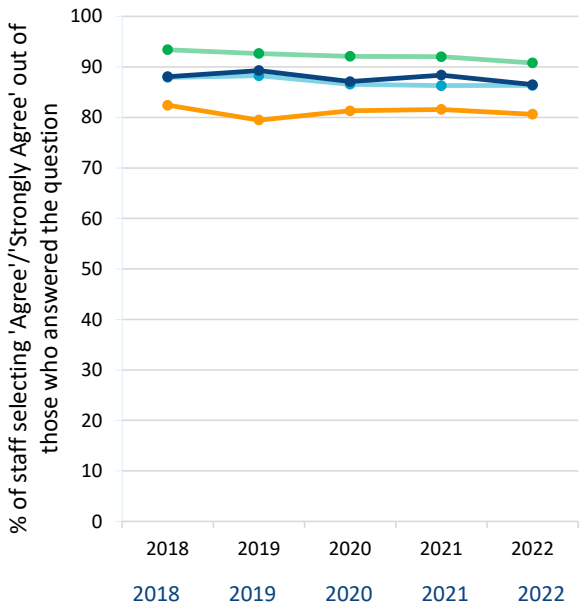


	2018	2019	2020	2021	2022
Your org	27.4%	27.0%	35.6%	22.8%	21.9%
Best	44.6%	48.0%	52.3%	37.8%	34.8%
Average	30.5%	30.7%	36.9%	25.9%	25.1%
Worst	19.3%	20.8%	26.0%	18.1%	17.2%
Responses	1310	1228	1349	1508	1395

People Promise elements and theme results – Morale: Stressors

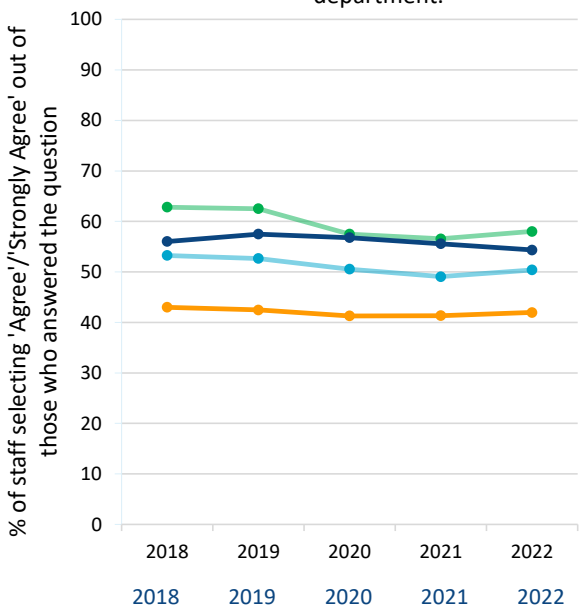
Survey Coordination Centre NHS

Q3a I always know what my work responsibilities are.



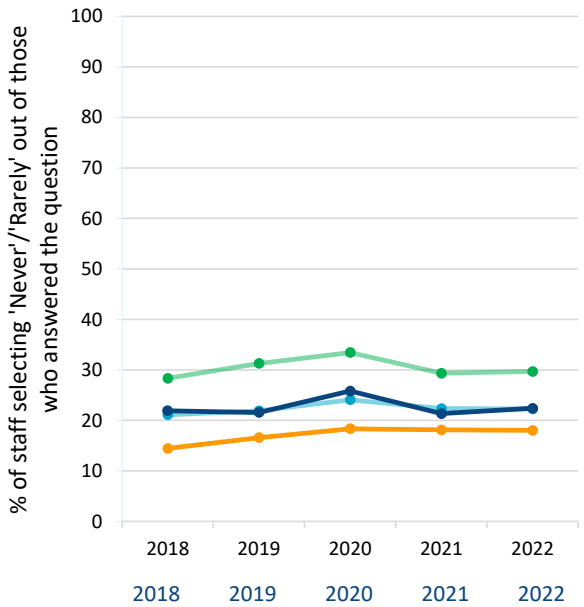
	2018	2019	2020	2021	2022
Your org	88.1%	89.3%	87.1%	88.4%	86.5%
Best	93.4%	92.7%	92.1%	92.0%	90.8%
Average	87.9%	88.2%	86.6%	86.3%	86.3%
Worst	82.4%	79.5%	81.3%	81.6%	80.6%
Responses	1315	1230	1345	1513	1398

Q3e I am involved in deciding on changes introduced that affect my work area / team / department.



	2018	2019	2020	2021	2022
Your org	56.0%	57.5%	56.8%	55.6%	54.3%
Best	62.8%	62.5%	57.5%	56.5%	58.0%
Average	53.3%	52.7%	50.6%	49.1%	50.4%
Worst	43.0%	42.5%	41.3%	41.3%	42.0%
Responses	1313	1228	1349	1511	1391

Q5a I have unrealistic time pressures.

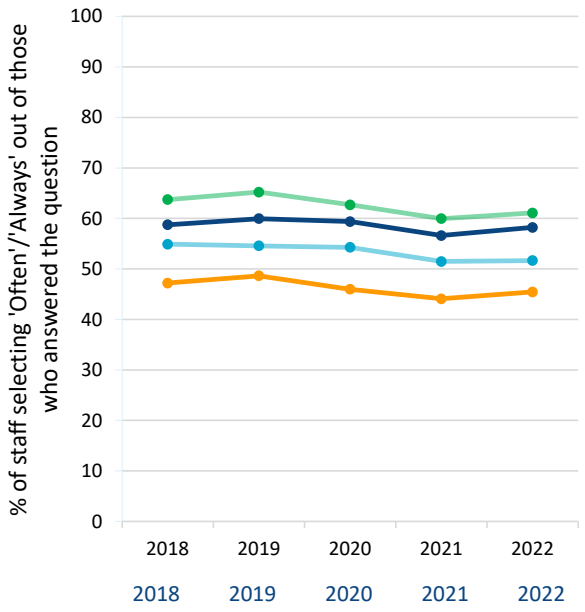


	2018	2019	2020	2021	2022
Your org	21.9%	21.6%	25.8%	21.3%	22.4%
Best	28.3%	31.3%	33.4%	29.3%	29.7%
Average	21.1%	21.9%	24.1%	22.4%	22.3%
Worst	14.4%	16.6%	18.3%	18.1%	18.0%
Responses	1310	1219	1341	1507	1398

People Promise elements and theme results – Morale: Stressors

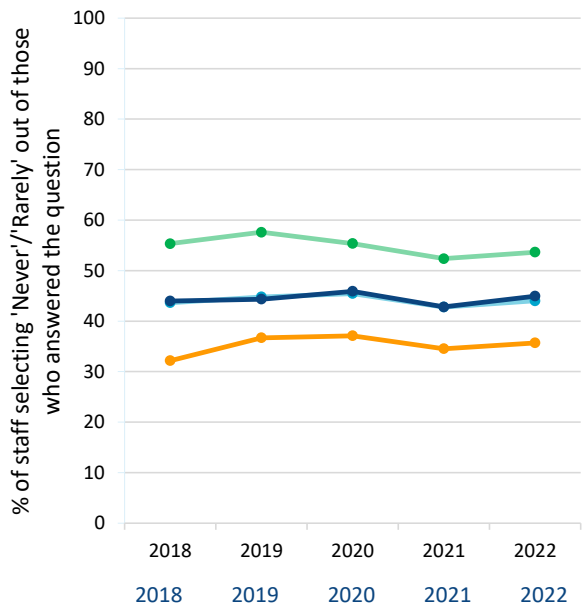
Survey Coordination Centre NHS

Q5b I have a choice in deciding how to do my work.



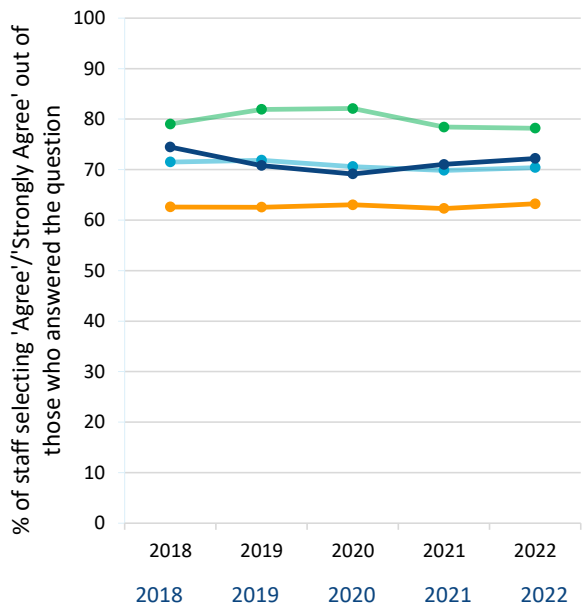
	2018	2019	2020	2021	2022
Your org	58.8%	60.0%	59.4%	56.6%	58.2%
Best	63.7%	65.2%	62.7%	60.0%	61.1%
Average	54.9%	54.6%	54.3%	51.5%	51.7%
Worst	47.2%	48.6%	46.0%	44.1%	45.4%
Responses	1308	1217	1339	1502	1396

Q5c Relationships at work are strained.



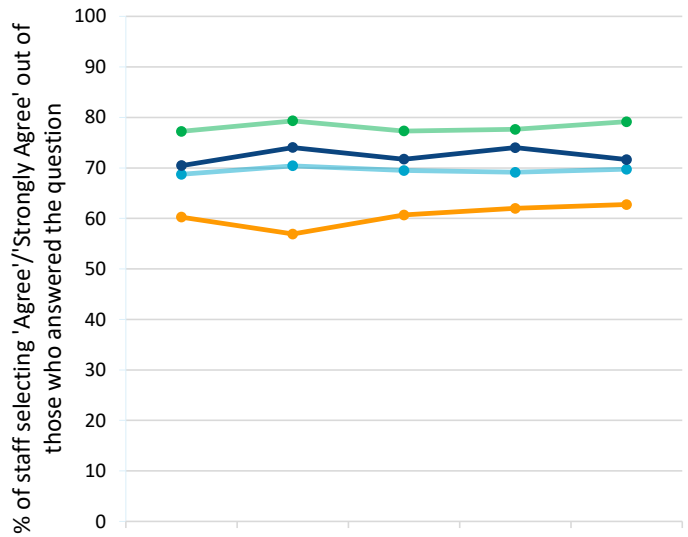
	2018	2019	2020	2021	2022
Your org	44.0%	44.3%	45.9%	42.8%	45.0%
Best	55.3%	57.6%	55.4%	52.4%	53.6%
Average	43.6%	44.8%	45.4%	42.8%	44.0%
Worst	32.2%	36.7%	37.1%	34.5%	35.7%
Responses	1307	1217	1340	1508	1393

Q7c I receive the respect I deserve from my colleagues at work.



	2018	2019	2020	2021	2022
Your org	74.4%	70.8%	69.1%	71.0%	72.2%
Best	79.0%	81.9%	82.1%	78.4%	78.2%
Average	71.5%	71.8%	70.6%	69.9%	70.4%
Worst	62.6%	62.5%	63.0%	62.3%	63.2%
Responses	1311	1232	1347	1511	1401

Q9a My immediate manager encourages me at work.



	2018	2019	2020	2021	2022
Your org	70.5%	74.0%	71.7%	74.0%	71.7%
Best	77.2%	79.3%	77.3%	77.6%	79.2%
Average	68.7%	70.4%	69.5%	69.1%	69.7%
Worst	60.3%	56.9%	60.7%	62.0%	62.7%
Responses	1311	1222	1351	1513	1397

Survey Coordination Centre

NHS England

Question not linked to People Promise elements or themes

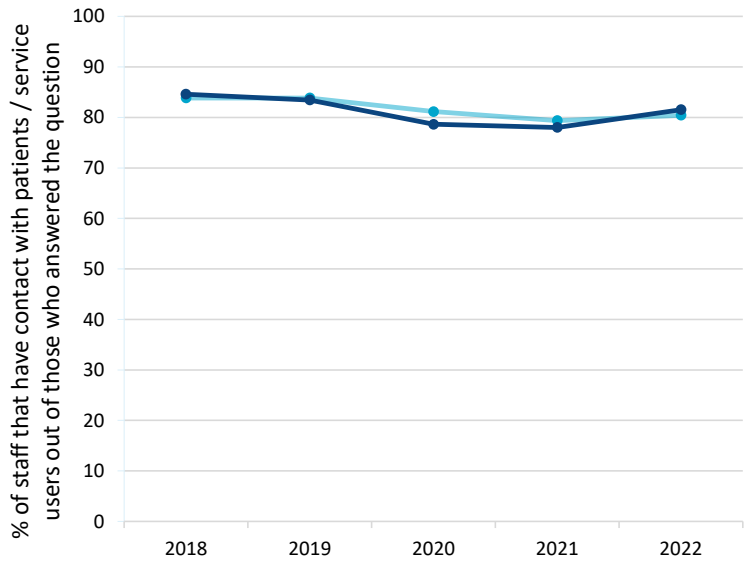
Questions included:
Q1, Q10a, Q10b, Q10c, Q11e, Q16c, Q17, Q18a, Q18b, Q18c, Q18d, Q24d, Q30b

Please note, where there are less than 11 responses for a question this data is not shown in the chart to protect the confidentiality of staff and reliability of results.

People Promise elements and theme results – Questions not linked to People Promise elements or themes

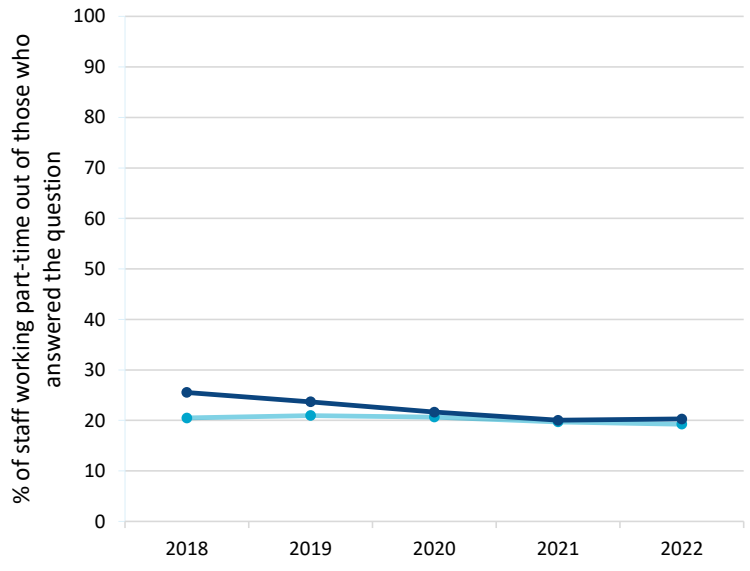
Survey Coordination Centre NHS

Q1 Do you have face-to-face, video or telephone contact with patients / service users as part of your job?



	2018	2019	2020	2021	2022
Your org	84.6%	83.5%	78.7%	78.0%	81.5%
Average	83.8%	83.9%	81.2%	79.4%	80.4%
Responses	1304	1227	1349	1501	1392

Q10a How many hours a week are you contracted to work?

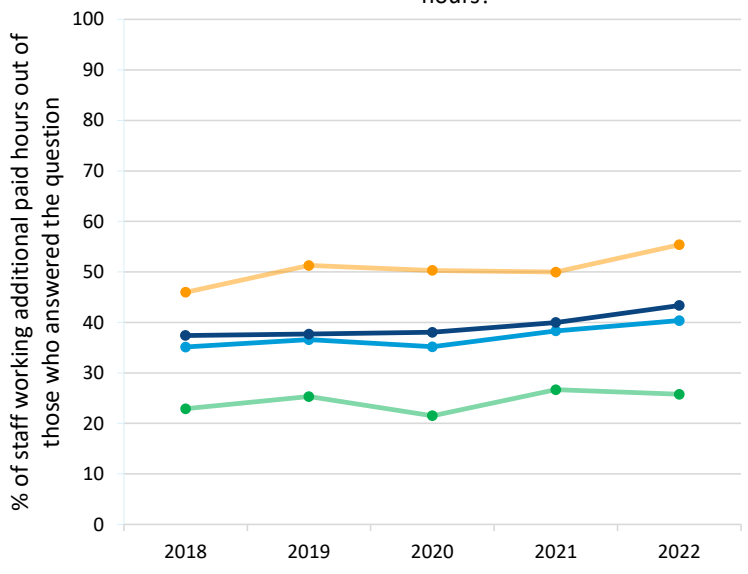


	2018	2019	2020	2021	2022
Your org	25.5%	23.7%	21.6%	20.0%	20.3%
Average	20.5%	21.0%	20.7%	19.7%	19.2%
Responses	1309	1178	1280	1417	1306

People Promise elements and theme results – Questions not linked to People Promise elements or themes

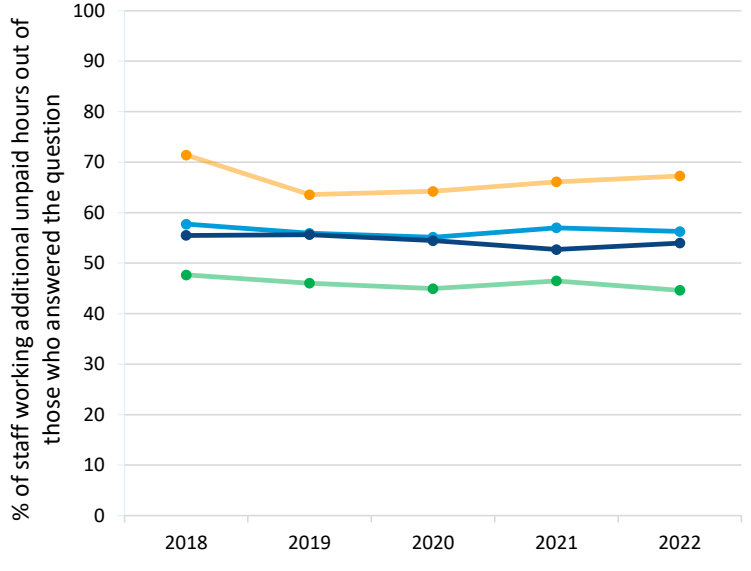
Survey Coordination Centre NHS

Q10b On average, how many additional PAID hours do you work per week for this organisation, over and above your contracted hours?



	2018	2019	2020	2021	2022
Your org	37.4%	37.7%	38.0%	40.0%	43.3%
Lowest	22.9%	25.3%	21.5%	26.7%	25.8%
Average	35.1%	36.6%	35.2%	38.3%	40.4%
Highest	46.0%	51.3%	50.3%	50.0%	55.4%
Responses	1275	1184	1305	1450	1336

Q10c On average, how many additional UNPAID hours do you work per week for this organisation, over and above your contracted hours?



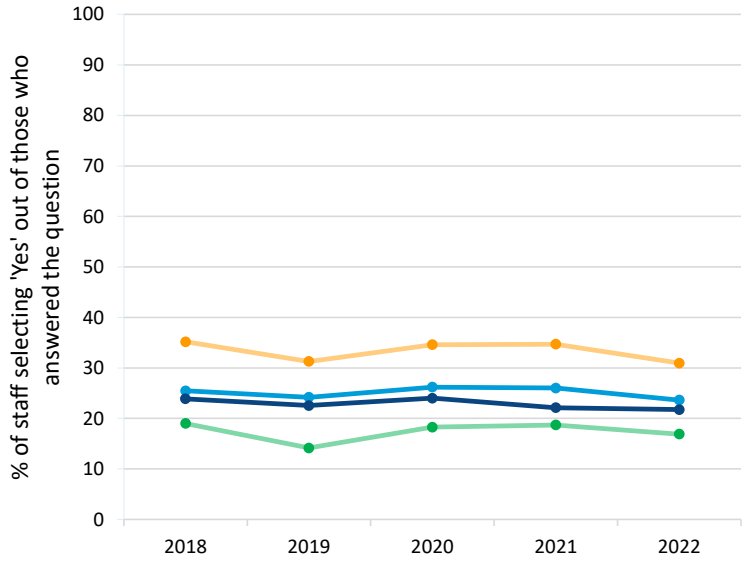
	2018	2019	2020	2021	2022
Your org	55.5%	55.6%	54.5%	52.7%	54.0%
Lowest	47.7%	46.0%	45.0%	46.5%	44.6%
Average	57.7%	55.9%	55.1%	57.0%	56.3%
Highest	71.4%	63.6%	64.2%	66.1%	67.3%
Responses	1278	1181	1314	1449	1338

People Promise elements and theme results – Questions not linked to People Promise elements or themes

Survey Coordination Centre NHS

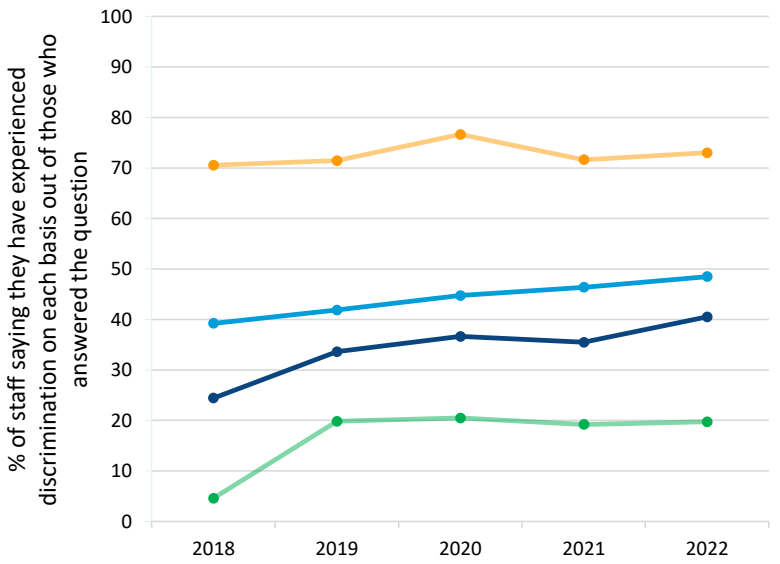
*Q11e is only answered by staff who responded 'Yes' to Q11d.

Q11e Have you felt pressure from your manager to come to work?



	2018	2019	2020	2021	2022
Your org	23.8%	22.5%	24.0%	22.1%	21.7%
Best	19.0%	14.1%	18.3%	18.7%	16.9%
Average	25.5%	24.2%	26.2%	26.0%	23.6%
Worst	35.2%	31.3%	34.6%	34.7%	30.9%
Responses	682	657	622	766	786

Q16c.1 On what grounds have you experienced discrimination? - Ethnic background.

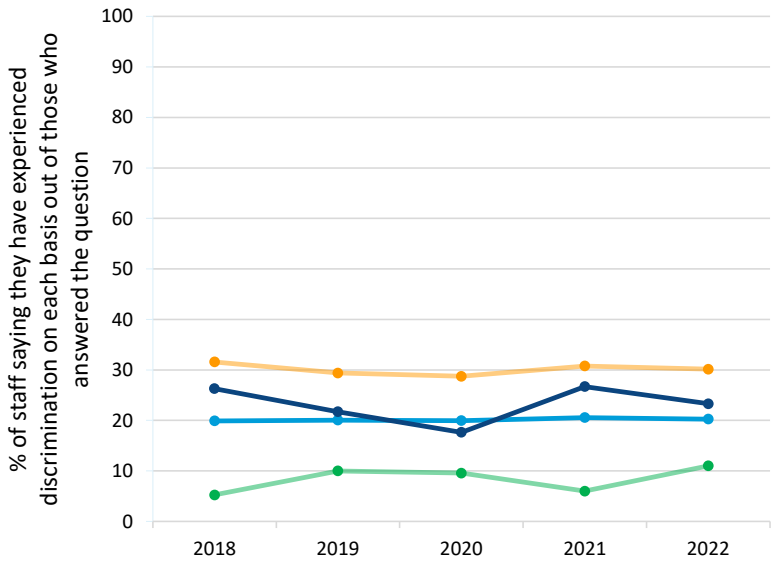


	2018	2019	2020	2021	2022
Your org	24.4%	33.6%	36.6%	35.5%	40.5%
Best	4.6%	19.8%	20.5%	19.2%	19.7%
Average	39.2%	41.9%	44.7%	46.4%	48.5%
Worst	70.5%	71.4%	76.6%	71.6%	73.0%
Responses	111	94	139	155	151

People Promise elements and theme results – Questions not linked to People Promise elements or themes

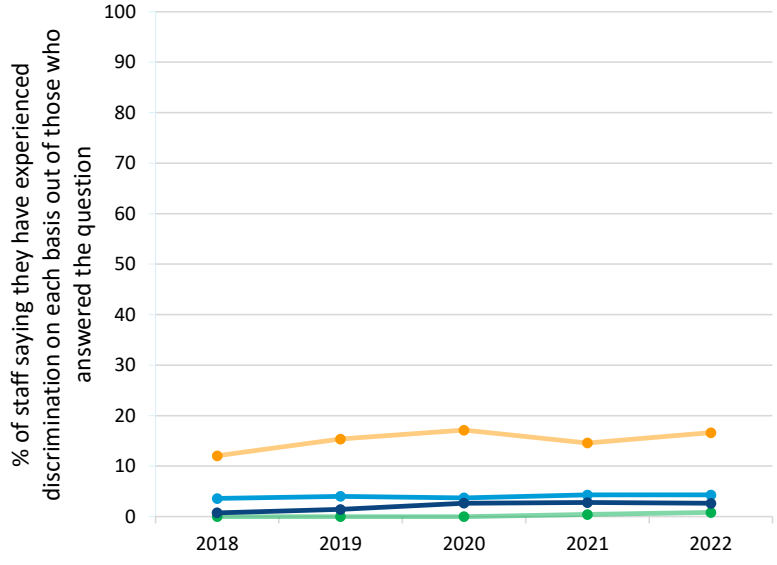
Survey Coordination Centre NHS

Q16c.2 On what grounds have you experienced discrimination? – Gender.



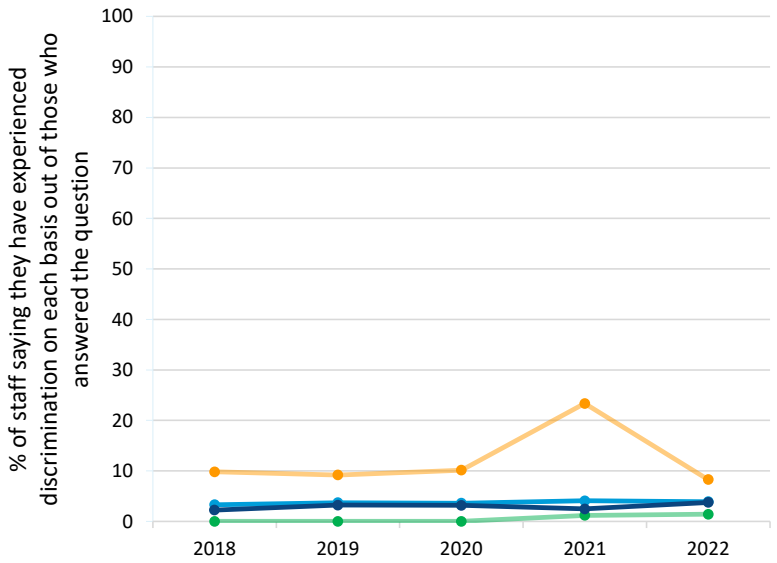
	2018	2019	2020	2021	2022
Your org	26.3%	21.7%	17.6%	26.7%	23.3%
Best	5.2%	10.0%	9.6%	6.0%	11.0%
Average	19.9%	20.1%	20.0%	20.6%	20.3%
Worst	31.6%	29.4%	28.7%	30.8%	30.1%
Responses	111	94	139	155	151

Q16c.3 On what grounds have you experienced discrimination? – Religion.



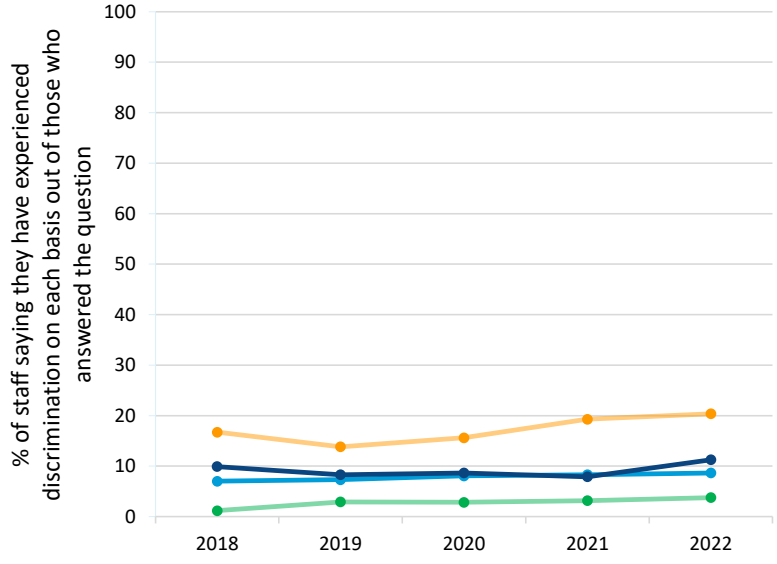
	2018	2019	2020	2021	2022
Your org	0.7%	1.4%	2.7%	2.8%	2.6%
Best	0.0%	0.0%	0.0%	0.4%	0.8%
Average	3.6%	4.0%	3.7%	4.3%	4.3%
Worst	12.0%	15.4%	17.1%	14.6%	16.6%
Responses	111	94	139	155	151

Q16c.4 On what grounds have you experienced discrimination? – Sexual orientation.



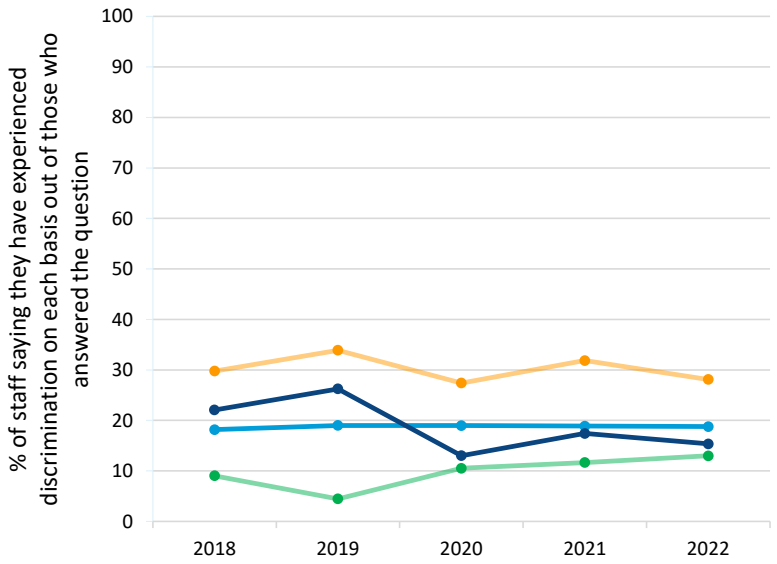
	2018	2019	2020	2021	2022
Your org	2.2%	3.2%	3.2%	2.5%	3.7%
Best	0.0%	0.0%	0.0%	1.2%	1.4%
Average	3.3%	3.7%	3.6%	4.1%	3.9%
Worst	9.8%	9.2%	10.1%	23.4%	8.3%
Responses	111	94	139	155	151

Q16c.5 On what grounds have you experienced discrimination? – Disability.



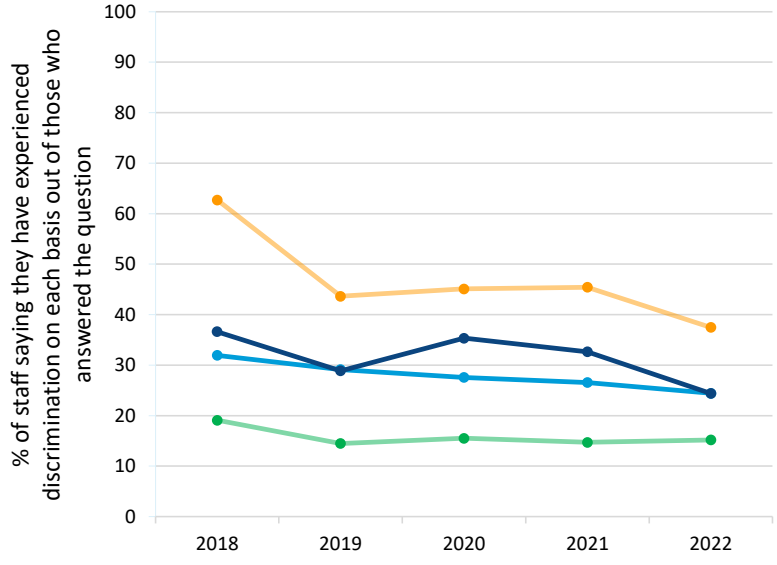
	2018	2019	2020	2021	2022
Your org	9.9%	8.3%	8.6%	7.9%	11.3%
Best	1.2%	2.9%	2.8%	3.2%	3.8%
Average	7.0%	7.3%	8.1%	8.3%	8.7%
Worst	16.7%	13.8%	15.6%	19.3%	20.4%
Responses	111	94	139	155	151

Q16c.6 On what grounds have you experienced discrimination? – Age.



	2018	2019	2020	2021	2022
Your org	22.1%	26.2%	13.0%	17.4%	15.4%
Best	9.0%	4.5%	10.5%	11.7%	13.0%
Average	18.2%	19.0%	19.0%	18.9%	18.8%
Worst	29.8%	33.9%	27.4%	31.8%	28.1%
Responses	111	94	139	155	151

Q16c.7 On what grounds have you experienced discrimination? – Other.

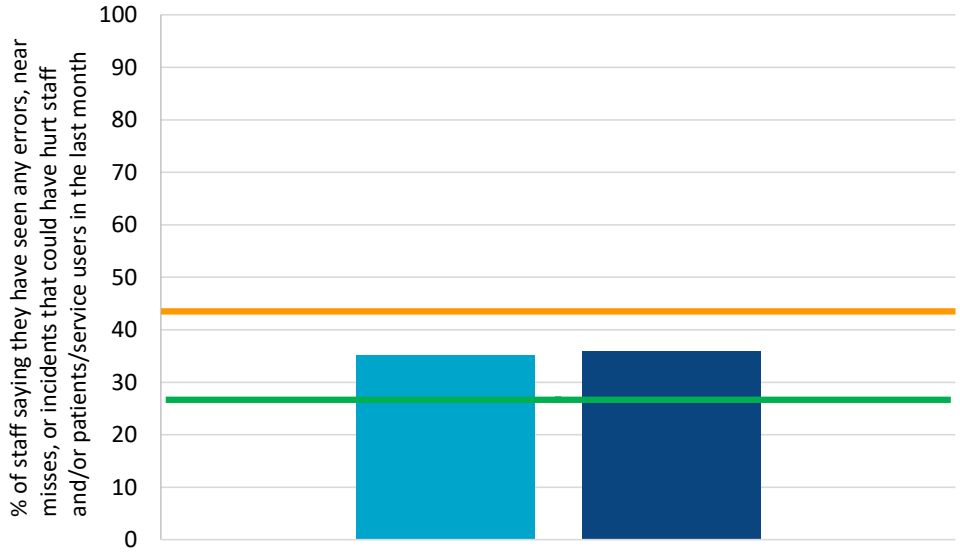


	2018	2019	2020	2021	2022
Your org	36.6%	28.9%	35.4%	32.6%	24.4%
Best	19.1%	14.5%	15.5%	14.7%	15.2%
Average	31.9%	29.1%	27.6%	26.6%	24.4%
Worst	62.7%	43.6%	45.1%	45.4%	37.5%
Responses	111	94	139	155	151

People Promise elements and theme results – Questions not linked to People Promise elements or themes

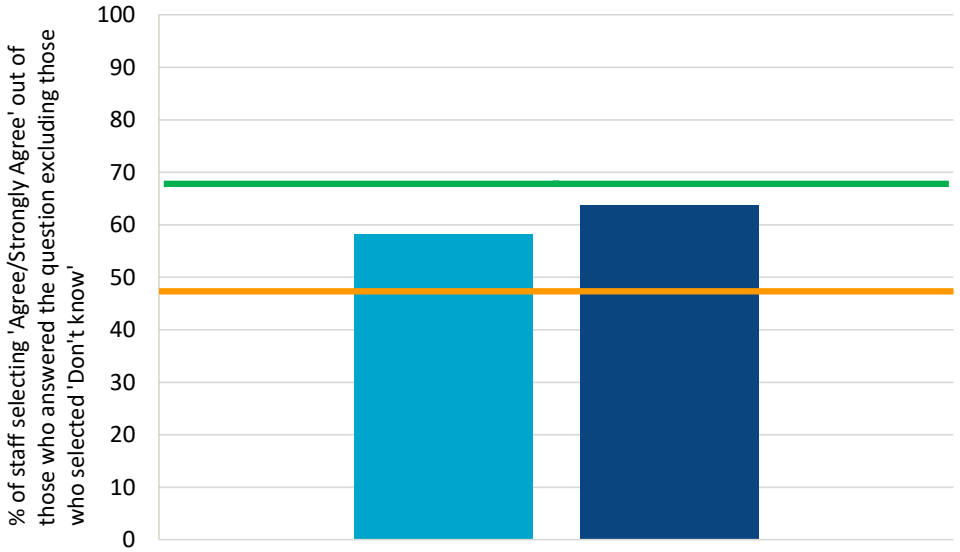
Survey Coordination Centre NHS

Q17 In the last month have you seen any errors, near misses, or incidents that could have hurt staff and/or patients/service users?



	2022
Your org	36.0%
Best	26.7%
Average	35.2%
Worst	43.5%
Responses	1395

Q18a My organisation treats staff who are involved in an error, near miss or incident fairly.

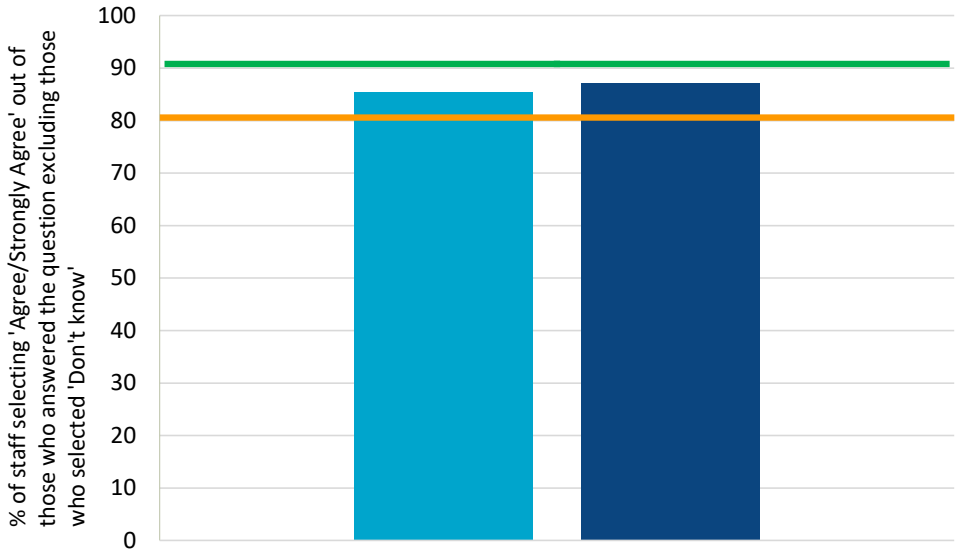


	2022
Your org	63.7%
Best	67.8%
Average	58.2%
Worst	47.3%
Responses	1067

People Promise elements and theme results – Questions not linked to People Promise elements or themes

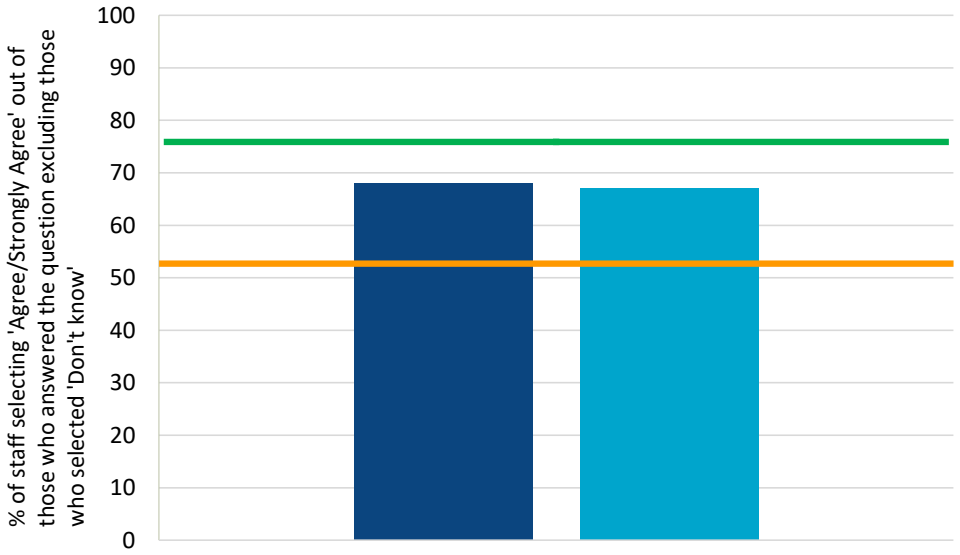
Survey Coordination Centre NHS

Q18b My organisation encourages us to report errors, near misses or incidents.



	2022
Your org	87.2%
Best	90.8%
Average	85.5%
Worst	80.6%
Responses	1333

Q18c When errors, near misses or incidents are reported, my organisation takes action to ensure that they do not happen again.

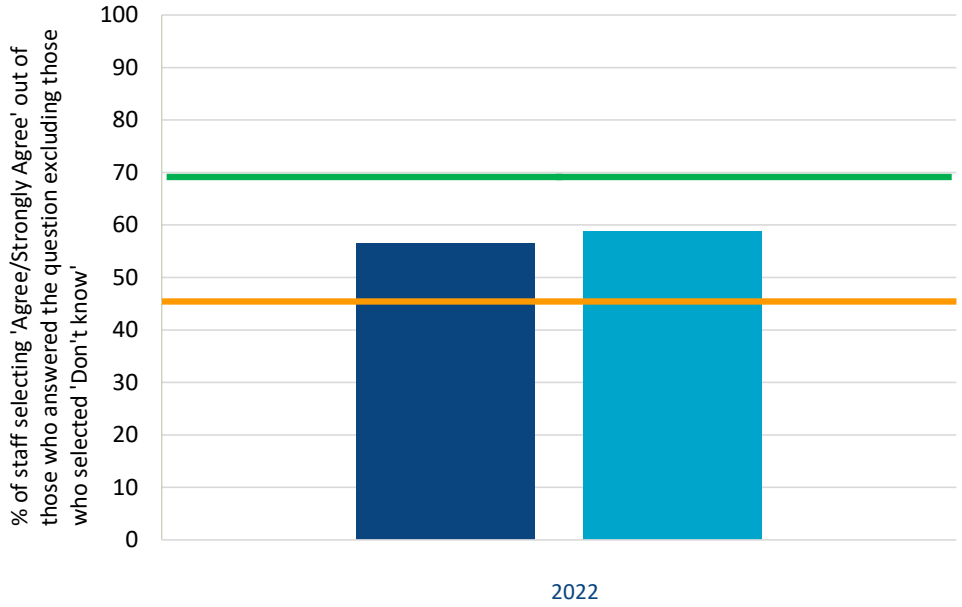


	2022
Your org	68.0%
Best	75.9%
Average	67.0%
Worst	52.7%
Responses	1221

People Promise elements and theme results – Questions not linked to People Promise elements or themes

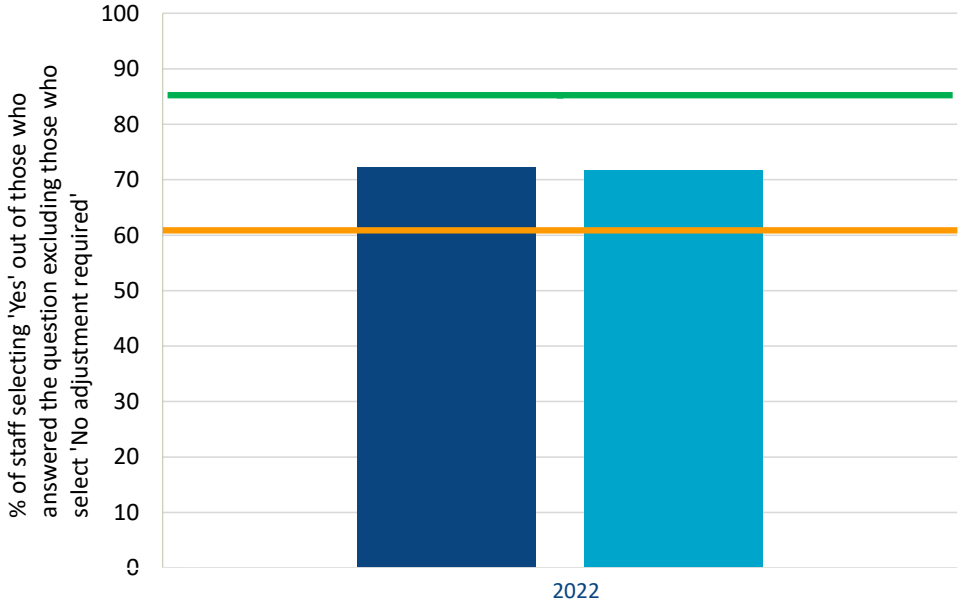
Survey Coordination Centre NHS

Q18d We are given feedback about changes made in response to reported errors, near misses and incidents.



Your org	56.5%
Best	69.1%
Average	58.8%
Worst	45.4%
Responses	1214

Q30b Has your employer made reasonable adjustment(s) to enable you to carry out your work?

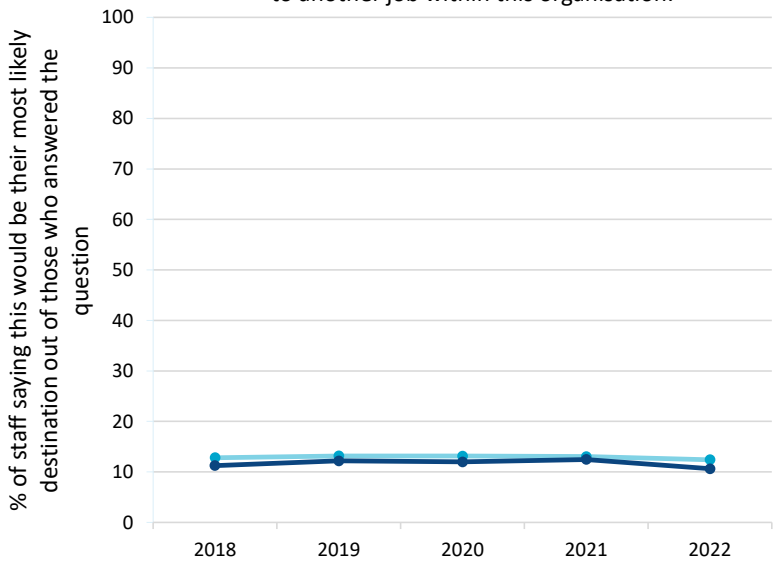


Your org	72.2%
Best	85.3%
Average	71.7%
Worst	60.9%
Responses	203

People Promise elements and theme results – Questions not linked to People Promise elements or themes

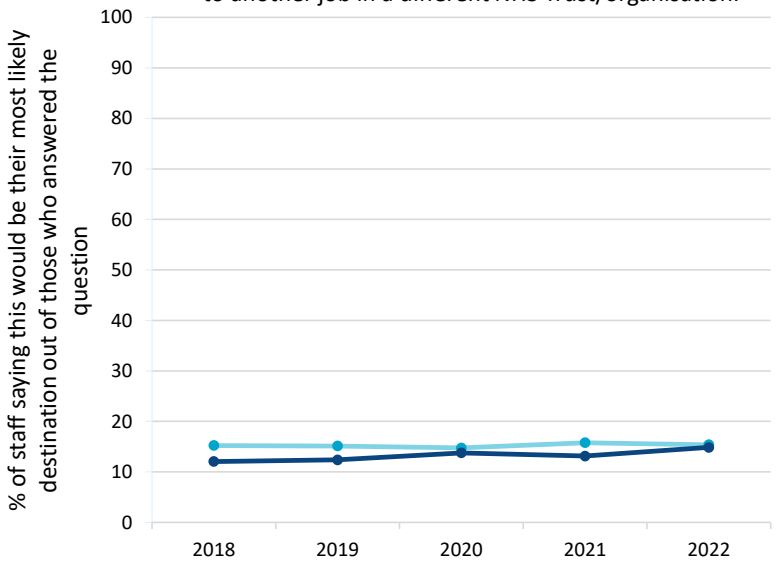
Survey Coordination Centre NHS

Q24d.1 If you are considering leaving your current job, what would be your most likely destination? - I would want to move to another job within this organisation.



	2018	2019	2020	2021	2022
Your org	11.2%	12.2%	12.0%	12.5%	10.6%
Average	12.8%	13.2%	13.1%	13.0%	12.4%
Responses	1104	1026	1184	1340	1233

Q24d.2 If you are considering leaving your current job, what would be your most likely destination? - I would want to move to another job in a different NHS Trust/organisation.

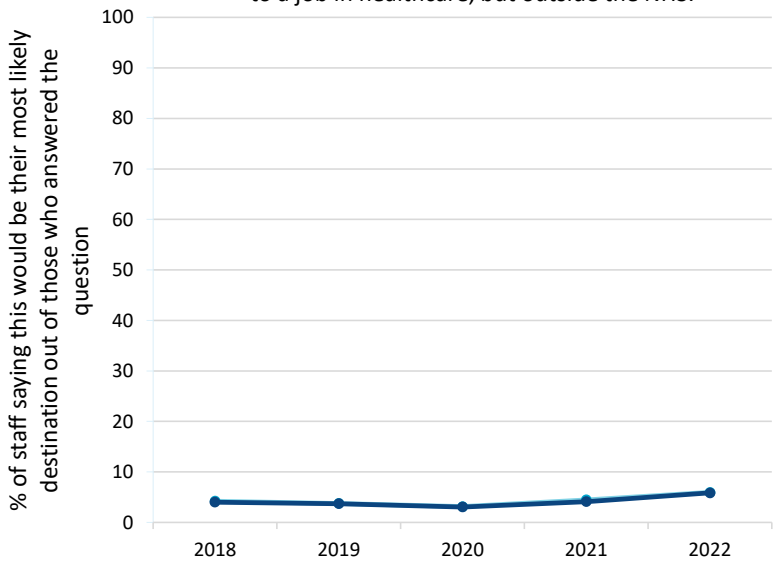


	2018	2019	2020	2021	2022
Your org	12.0%	12.4%	13.8%	13.1%	14.8%
Average	15.2%	15.1%	14.8%	15.8%	15.4%
Responses	1104	1026	1184	1340	1233

People Promise elements and theme results – Questions not linked to People Promise elements or themes

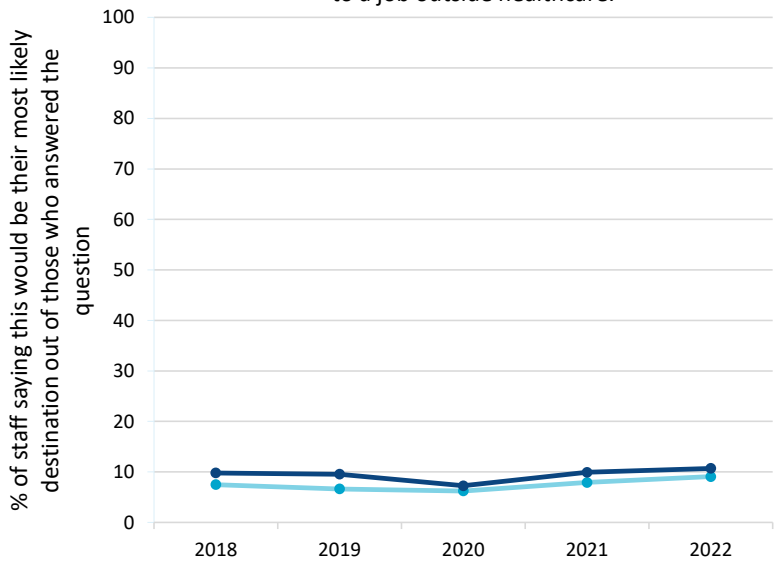
Survey Coordination Centre NHS

Q24d.3 If you are considering leaving your current job, what would be your most likely destination? - I would want to move to a job in healthcare, but outside the NHS.



	2018	2019	2020	2021	2022
Your org	4.0%	3.7%	3.0%	4.1%	5.8%
Average	4.2%	3.8%	3.1%	4.5%	6.0%
Responses	1104	1026	1184	1340	1233

Q24d.4 If you are considering leaving your current job, what would be your most likely destination? - I would want to move to a job outside healthcare.

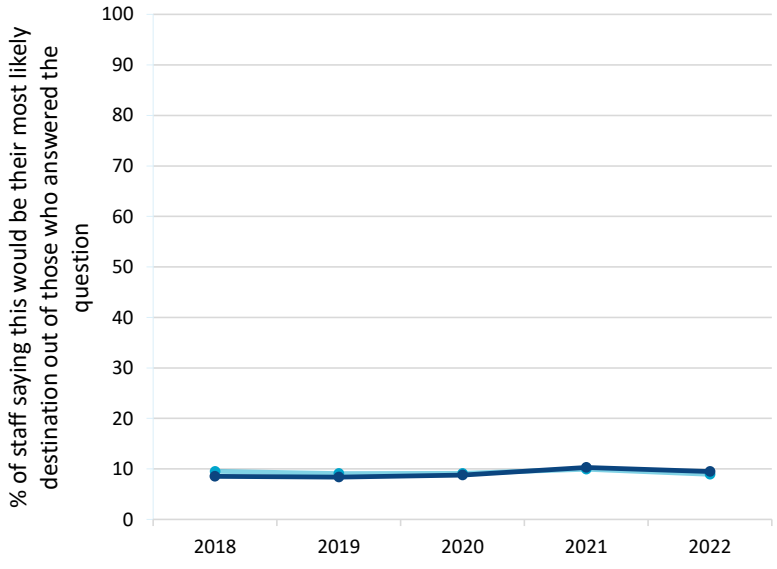


	2018	2019	2020	2021	2022
Your org	9.8%	9.6%	7.3%	9.9%	10.7%
Average	7.5%	6.6%	6.2%	7.9%	9.1%
Responses	1104	1026	1184	1340	1233

People Promise elements and theme results – Questions not linked to People Promise elements or themes

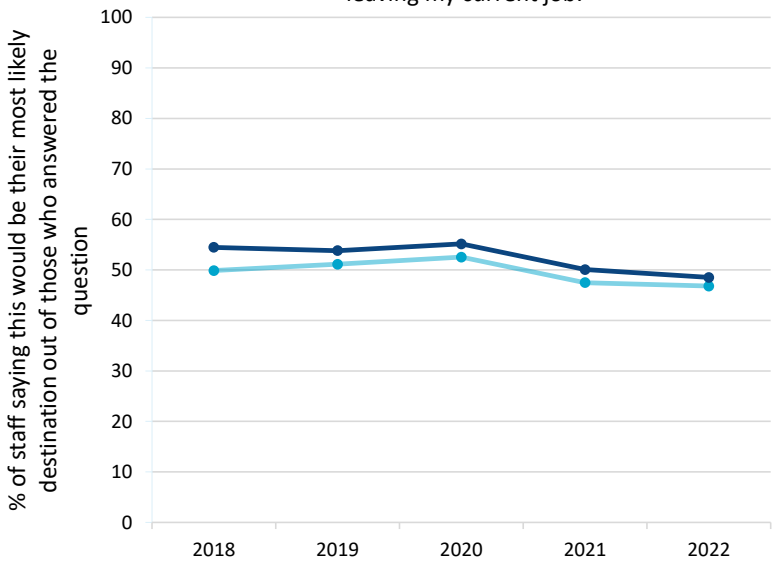
Survey Coordination Centre NHS

Q24d.5 If you are considering leaving your current job, what would be your most likely destination? - I would retire or take a career break.



	2018	2019	2020	2021	2022
Your org	8.5%	8.4%	8.8%	10.3%	9.5%
Average	9.5%	9.1%	9.1%	10.0%	8.9%
Responses	1104	1026	1184	1340	1233

Q24d.9 If you are considering leaving your current job, what would be your most likely destination? - I am not considering leaving my current job.



	2018	2019	2020	2021	2022
Your org	54.4%	53.8%	55.2%	50.1%	48.5%
Average	49.9%	51.1%	52.5%	47.5%	46.8%
Responses	1104	1026	1184	1340	1233

Survey Coordination Centre

NHS

Workforce Equality Standards

Please note, when there are less than 11 responses for a question, results are suppressed to protect staff confidentiality and reliability of data.

Workforce Equality Standards

Survey Coordination Centre NHS

Workforce Race Equality Standards (WRES)

This section contains data for the organisation required for the NHS Staff Survey indicators used in the Workforce Race Equality Standard (WRES). It includes the 2018-2022 organisation and benchmarking group median results for q13a, q13b&c combined, q15, and q16b split by ethnicity (by white staff / staff from all other ethnic groups combined).

Workforce Disability Equality Standards (WDES)

This section contains data for the organisation required for the NHS Staff Survey indicators used in the Workforce Disability Equality Standard (WDES). It includes the 2018-2022 organisation and benchmarking group median results for q4b, q11e, q14a-d, and q15 split by staff with a long lasting health condition or illness compared to staff without a long lasting health condition or illness. It also shows results for q30b (for staff with a long lasting health condition or illness only), and the staff engagement score for staff with a long lasting health condition or illness, compared to staff without a long lasting health condition or illness and the overall engagement score for the organisation.

This year, the text for q30b was updated and the word ‘adequate’ was updated to ‘reasonable’.

The WDES breakdowns are based on the responses to q30a Do you have any physical or mental health conditions or illnesses lasting or expected to last for 12 months or more?

Workforce Equality Standards

Survey Coordination Centre NHS

This section contains data required for the staff survey indicators used in the Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES). Data presented in this section are unweighted.

Workforce Race Equality Standards (WRES)

Indicator	Qu No	Workforce Race Equality Standard
		For each of the following indicators, compare the outcomes of the responses for white staff and staff from all other ethnic groups combined
5	14a	Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months
6	14b & 14c	Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months
7	15	Percentage believing that their practice provides equal opportunities for career progression or promotion
8	16b	In the last 12 months have you personally experienced discrimination at work from any of the following? b) Manager/team leader or other colleagues

Workforce Disability Equality Standards (WDES)

Indicator	Qu No	Workforce Disability Equality Standard
		For each of the following indicators, compare the responses for staff with a LTC* or illness vs staff without a LTC or illness
4ai	14a	Percentage of staff experiencing harassment, bullying or abuse from patients/service users, their relatives or other members of the public
4aii	14b	Percentage of staff experiencing harassment, bullying or abuse from managers
4aiii	14c	Percentage of staff experiencing harassment, bullying or abuse from other colleagues
4b	14d	Percentage of staff saying that the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it
5	15	Percentage believing that their practice provides equal opportunities for career progression or promotion
6	9e	Percentage of staff saying that they have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties
7	4b	Percentage staff saying that they are satisfied with the extent to which their organisation values their work
8	30b	Percentage of staff with a long lasting health condition or illness saying their employer has made reasonable adjustment(s) to enable them to carry out their work
9a	theme_engagement	The staff engagement score for staff with LTC or illness vs staff without a LTC or illness

*Staff with a long term condition

Survey Coordination Centre

NHS

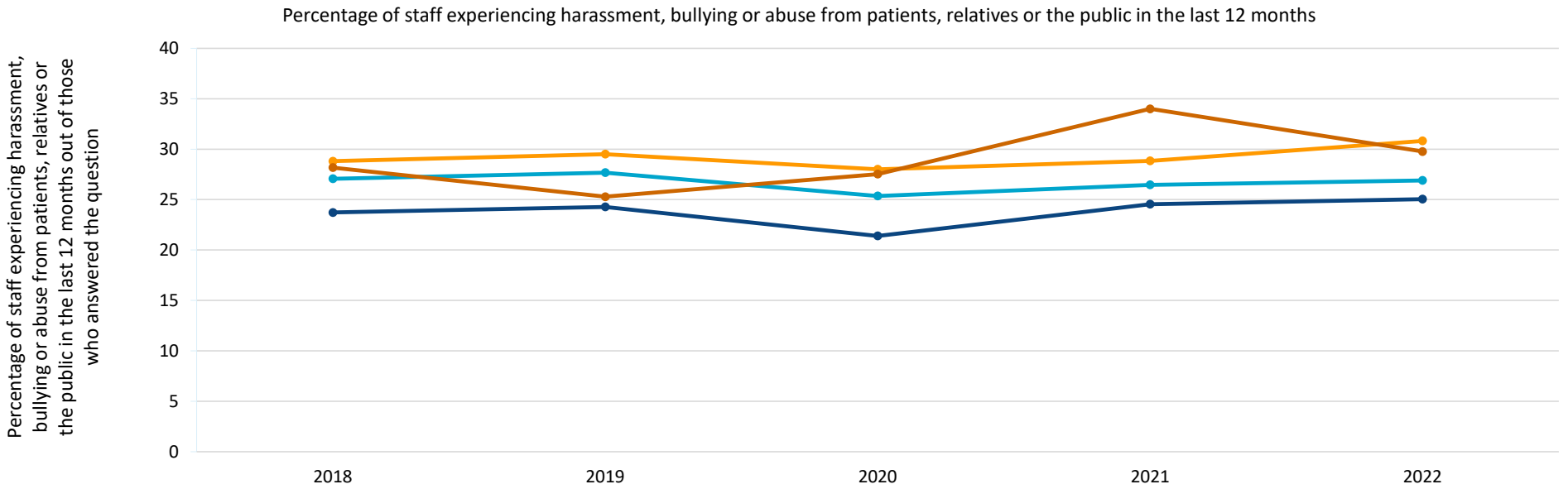
Workforce Race Equality Standards (WRES)

N.B.
Vertical scales on the following charts vary from slide to slide and this effects how results are displayed.
Data shown in the WRES charts are unweighted.

Please note, where there are less than 11 responses for a question this data is not shown in the chart to protect the confidentiality of staff and reliability of results.

Workforce Race Equality Standard (WRES)

Survey Coordination Centre NHS



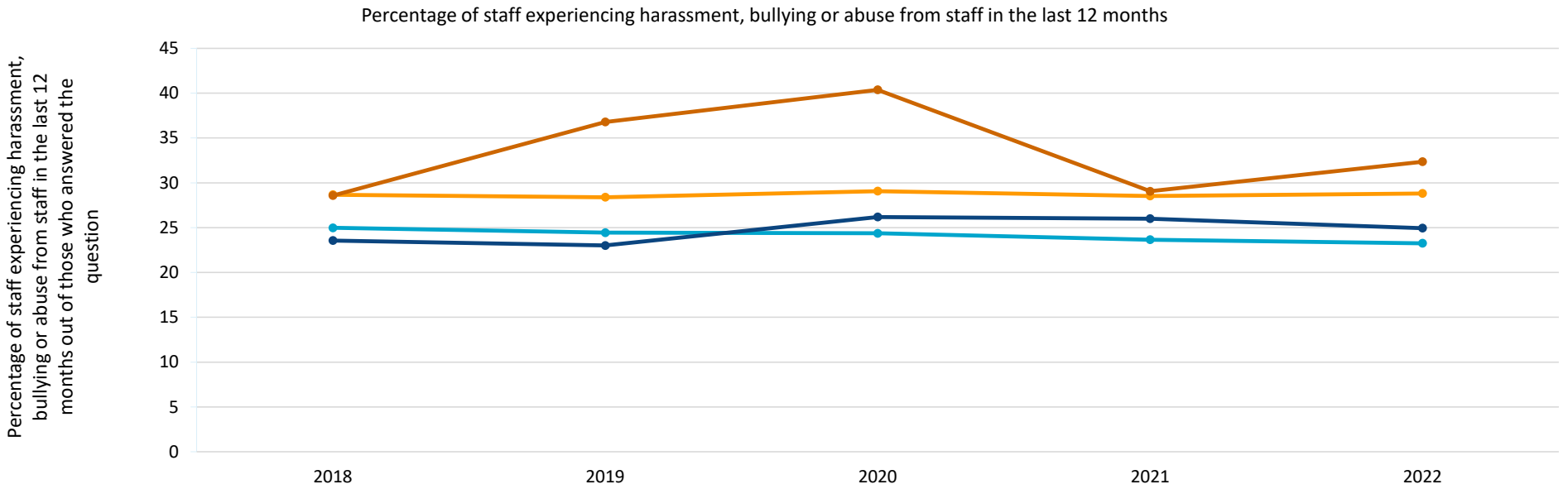
	2018	2019	2020	2021	2022
White staff: Your org	23.7%	24.3%	21.4%	24.5%	25.0%
All other ethnic groups*: Your org	28.2%	25.3%	27.5%	34.0%	29.8%
White staff: Average	27.1%	27.7%	25.4%	26.5%	26.9%
All other ethnic groups*: Average	28.8%	29.5%	28.0%	28.8%	30.8%
White staff: Responses	1210	1104	1201	1332	1210
All other ethnic groups*: Responses	71	87	109	150	168

*Staff from all other ethnic groups combined

Average calculated as the median for the benchmark group

Workforce Race Equality Standard (WRES)

Survey Coordination Centre NHS



	2018	2019	2020	2021	2022
White staff: Your org	23.6%	23.0%	26.2%	26.0%	24.9%
All other ethnic groups*: Your org	28.6%	36.8%	40.4%	29.1%	32.4%
White staff: Average	25.0%	24.4%	24.4%	23.6%	23.3%
All other ethnic groups*: Average	28.7%	28.4%	29.1%	28.5%	28.8%
White staff: Responses	1210	1104	1207	1327	1211
All other ethnic groups*: Responses	70	87	109	148	170

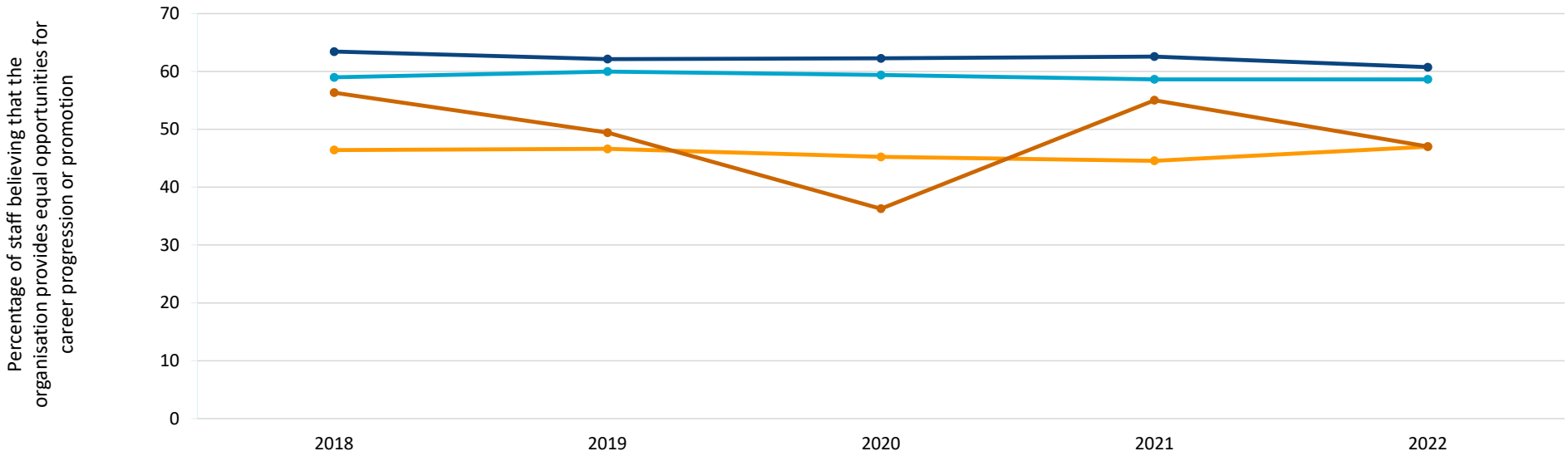
*Staff from all other ethnic groups combined

Average calculated as the median for the benchmark group

Workforce Race Equality Standard (WRES)

Survey Coordination Centre NHS

Percentage of staff believing that the organisation provides equal opportunities for career progression or promotion.



	2018	2019	2020	2021	2022
White staff: Your org	63.4%	62.1%	62.3%	62.6%	60.7%
All other ethnic groups*: Your org	56.3%	49.4%	36.3%	55.0%	47.0%
White staff: Average	59.0%	60.0%	59.4%	58.6%	58.6%
All other ethnic groups*: Average	46.4%	46.6%	45.2%	44.6%	47.0%
White staff: Responses	1209	1104	1206	1323	1210
All other ethnic groups*: Responses	71	87	113	149	168

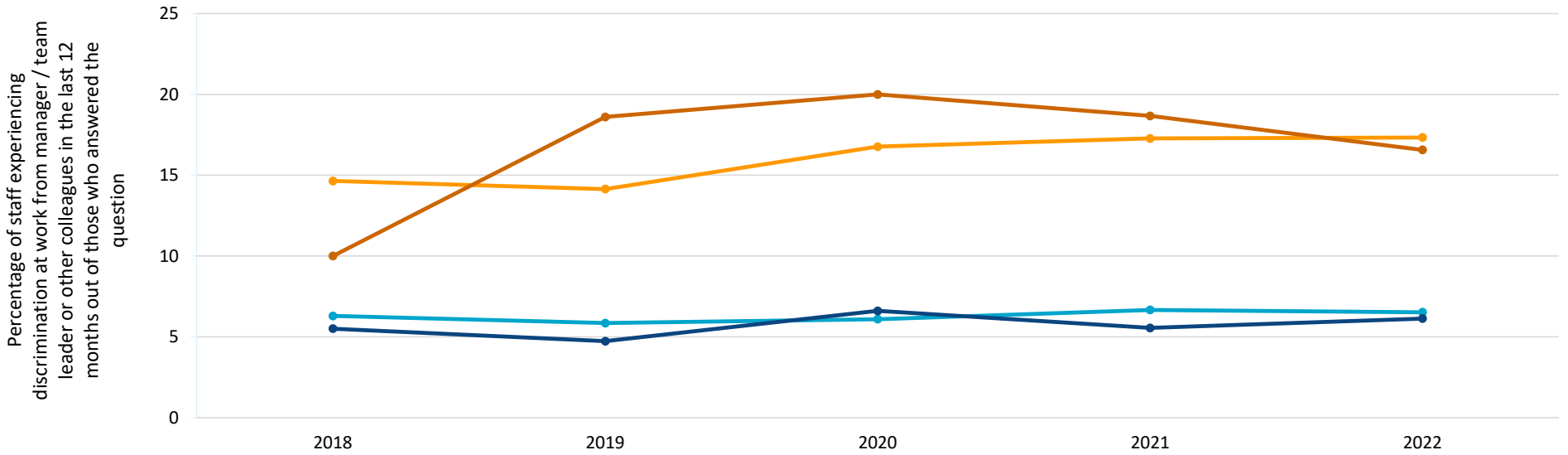
*Staff from all other ethnic groups combined

Average calculated as the median for the benchmark group

Workforce Race Equality Standard (WRES)

Survey Coordination Centre NHS

Percentage of staff experiencing discrimination at work from manager / team leader or other colleagues in the last 12 months.



	2018	2019	2020	2021	2022
White staff: Your org	5.5%	4.7%	6.6%	5.6%	6.1%
All other ethnic groups*: Your org	10.0%	18.6%	20.0%	18.7%	16.6%
White staff: Average	6.3%	5.9%	6.1%	6.7%	6.5%
All other ethnic groups*: Average	14.6%	14.1%	16.8%	17.3%	17.3%
White staff: Responses	1216	1099	1196	1332	1207
All other ethnic groups*: Responses	70	86	110	150	169

*Staff from all other ethnic groups combined

Average calculated as the median for the benchmark group

Survey Coordination Centre

NHS

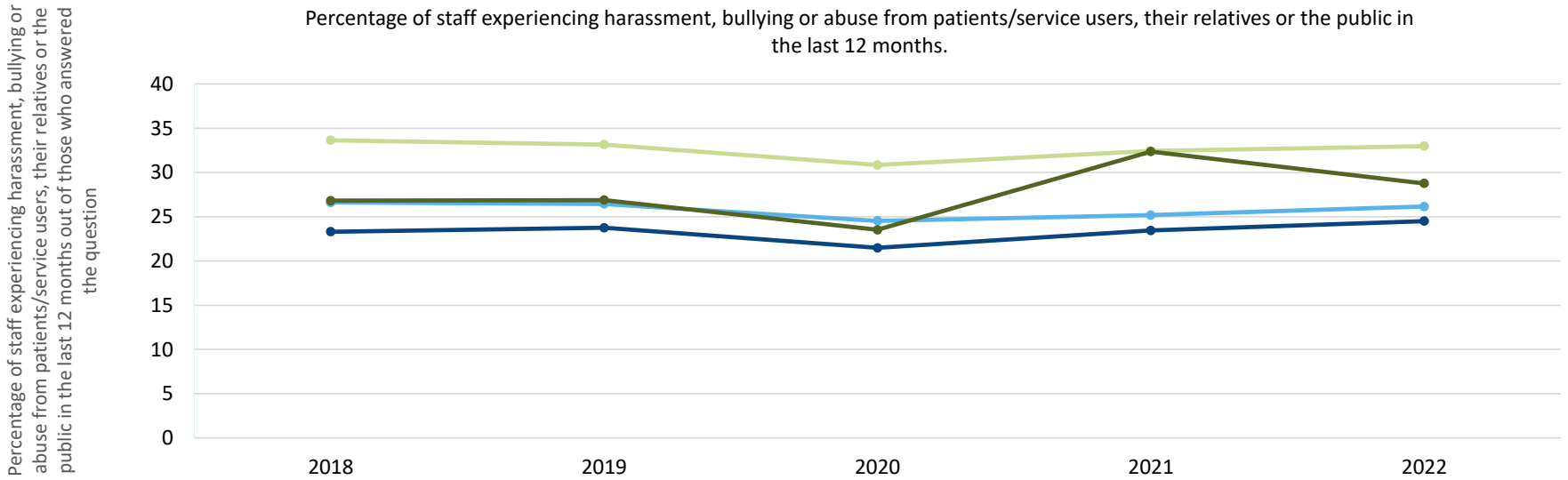
Workforce Disability Equality Standards (WDES)

N.B.
Vertical scales on the following charts vary from slide to slide and this effects how results are displayed.
Data shown in the WDES charts are unweighted.

Please note, where there are less than 11 responses for a question this data is not shown in the chart to protect the confidentiality of staff and reliability of results.

Workforce Disability Equality Standards

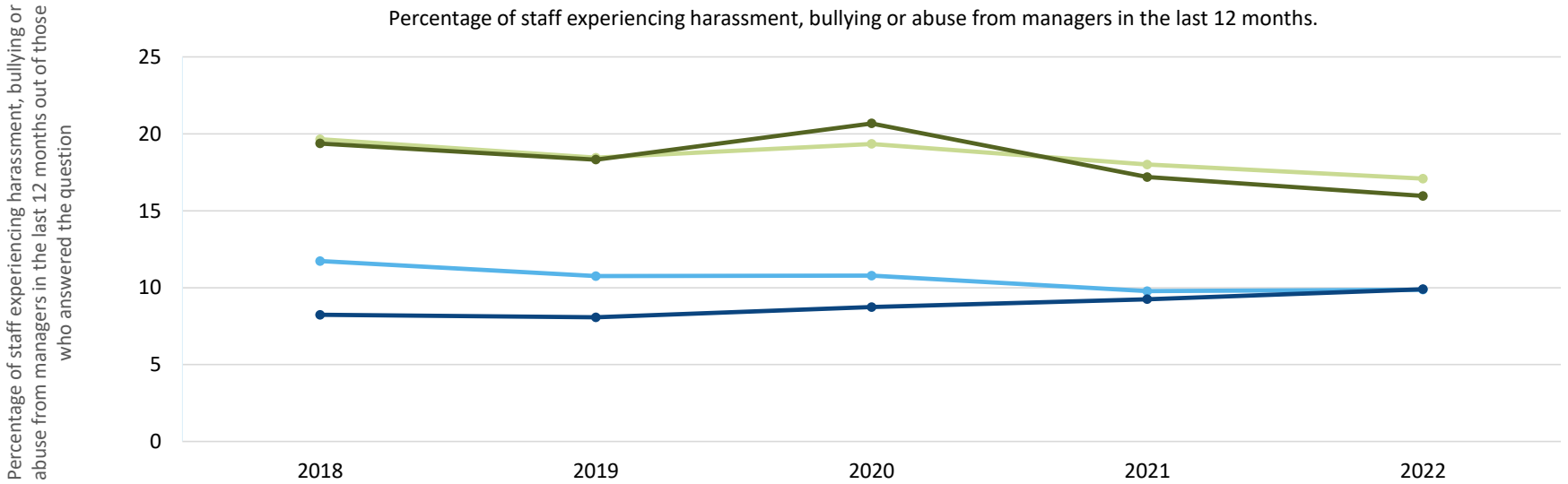
Survey Coordination Centre NHS



	2018	2019	2020	2021	2022
Staff with a LTC or illness: Your org	26.8%	26.9%	23.5%	32.4%	28.8%
Staff without a LTC or illness: Your org	23.3%	23.8%	21.5%	23.4%	24.5%
Staff with a LTC or illness: Average	33.6%	33.2%	30.9%	32.4%	33.0%
Staff without a LTC or illness: Average	26.6%	26.5%	24.5%	25.2%	26.2%
Staff with a LTC or illness: Responses	261	253	323	383	358
Staff without a LTC or illness: Responses	1034	947	1001	1096	1024

Workforce Disability Equality Standards

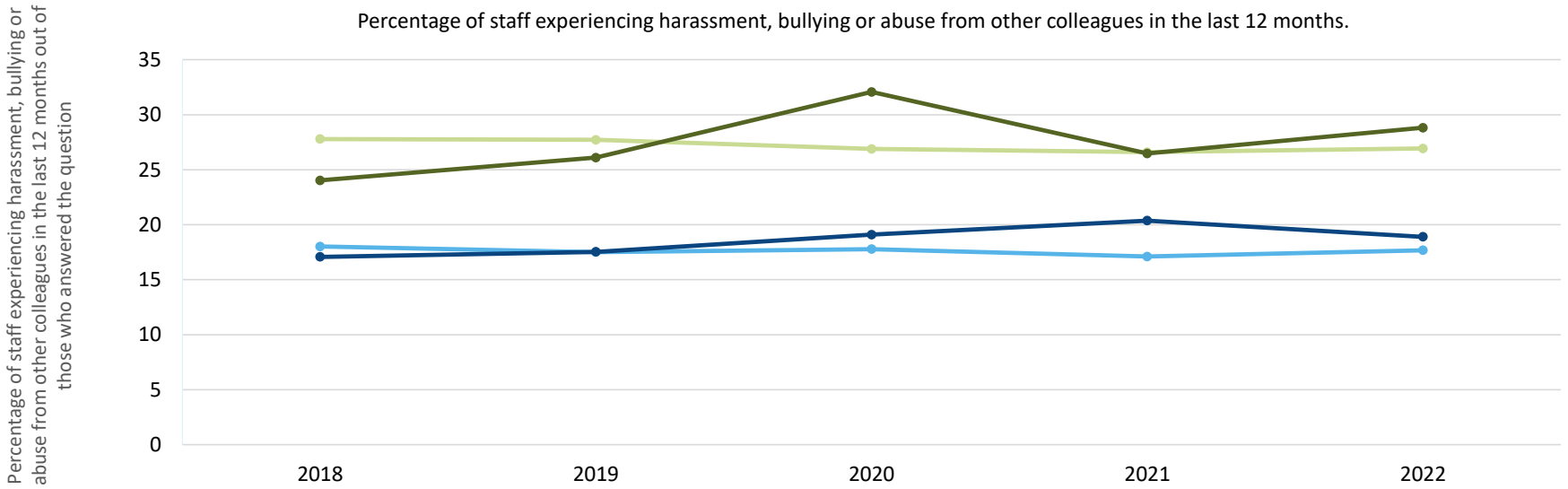
Survey Coordination Centre NHS



	2018	2019	2020	2021	2022
Staff with a LTC or illness: Your org	19.4%	18.3%	20.7%	17.2%	16.0%
Staff without a LTC or illness: Your org	8.2%	8.1%	8.7%	9.2%	9.9%
Staff with a LTC or illness: Average	19.6%	18.4%	19.3%	18.0%	17.1%
Staff without a LTC or illness: Average	11.7%	10.8%	10.8%	9.8%	9.9%
Staff with a LTC or illness: Responses	258	251	324	378	357
Staff without a LTC or illness: Responses	1032	941	995	1092	1020

Workforce Disability Equality Standards

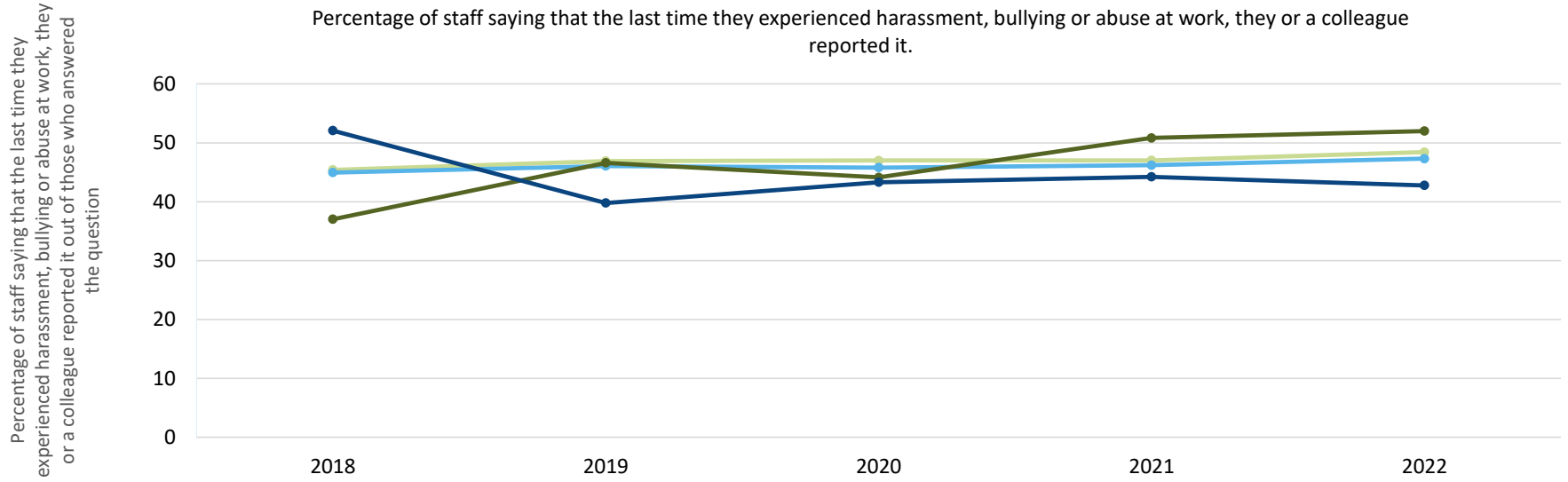
Survey Coordination Centre NHS



	2018	2019	2020	2021	2022
Staff with a LTC or illness: Your org	24.0%	26.1%	32.1%	26.5%	28.8%
Staff without a LTC or illness: Your org	17.1%	17.5%	19.1%	20.4%	18.9%
Staff with a LTC or illness: Average	27.8%	27.7%	26.9%	26.6%	26.9%
Staff without a LTC or illness: Average	18.0%	17.5%	17.8%	17.1%	17.7%
Staff with a LTC or illness: Responses	258	249	318	374	354
Staff without a LTC or illness: Responses	1031	941	995	1080	1021

Workforce Disability Equality Standards

Survey Coordination Centre NHS

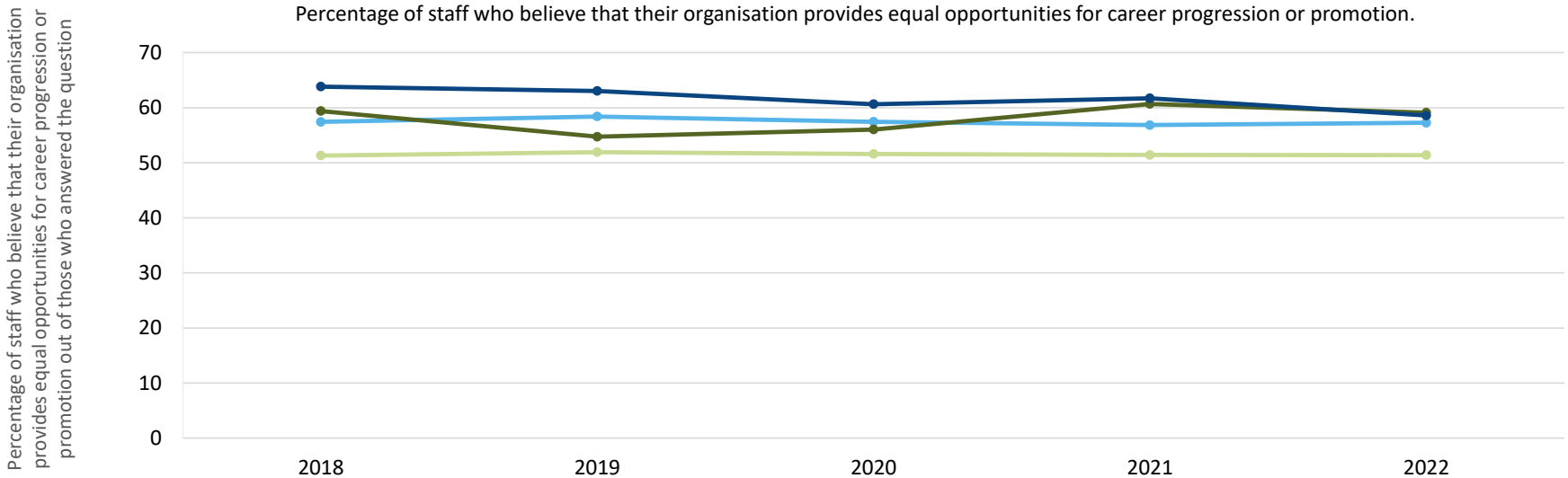


	2018	2019	2020	2021	2022
Staff with a LTC or illness: Your org	37.0%	46.6%	44.1%	50.8%	52.0%
Staff without a LTC or illness: Your org	52.1%	39.8%	43.3%	44.2%	42.8%
Staff with a LTC or illness: Average	45.4%	46.9%	47.0%	47.0%	48.4%
Staff without a LTC or illness: Average	45.0%	46.1%	45.8%	46.2%	47.3%
Staff with a LTC or illness: Responses	108	103	145	181	150
Staff without a LTC or illness: Responses	311	294	314	355	339

Workforce Disability Equality Standards

Survey Coordination Centre NHS

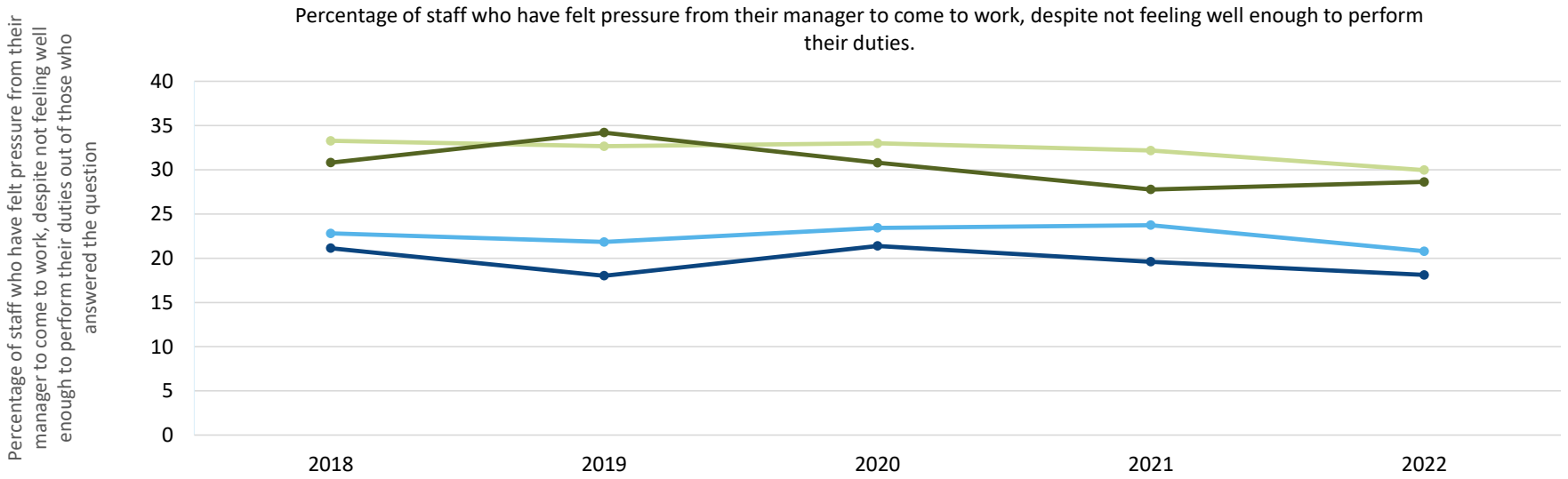
Percentage of staff who believe that their organisation provides equal opportunities for career progression or promotion.



	2018	2019	2020	2021	2022
Staff with a LTC or illness: Your org	59.4%	54.7%	56.0%	60.7%	59.1%
Staff without a LTC or illness: Your org	63.8%	63.0%	60.6%	61.7%	58.6%
Staff with a LTC or illness: Average	51.3%	51.9%	51.6%	51.4%	51.4%
Staff without a LTC or illness: Average	57.4%	58.4%	57.4%	56.8%	57.3%
Staff with a LTC or illness: Responses	261	254	323	379	357
Staff without a LTC or illness: Responses	1034	947	1011	1092	1024

Workforce Disability Equality Standards

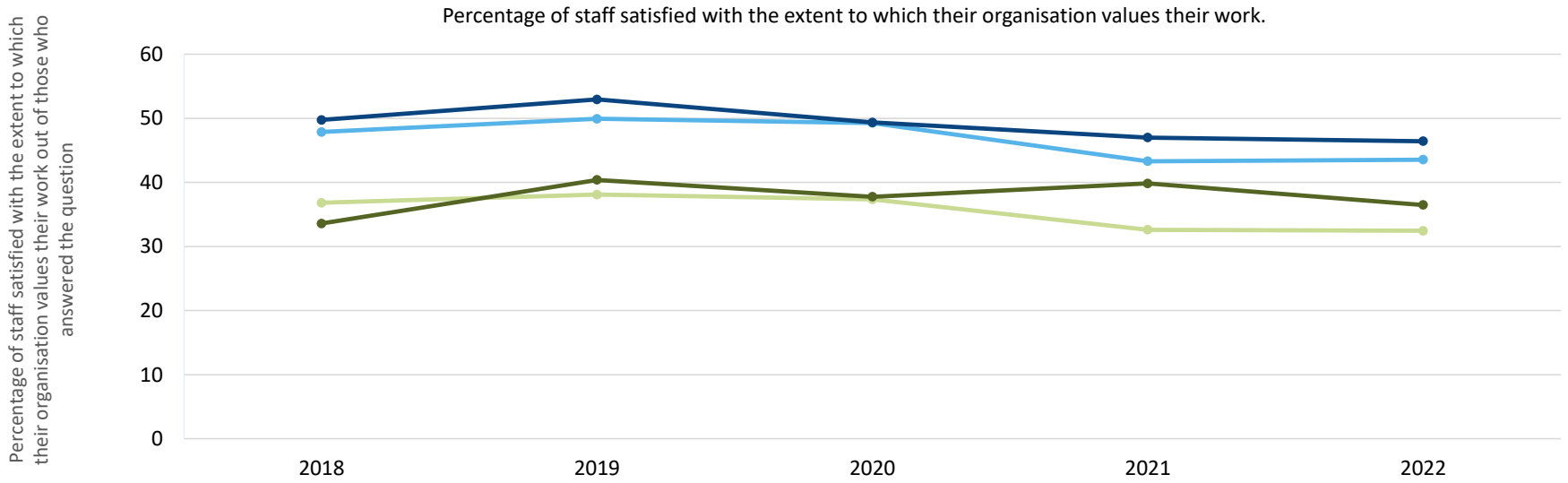
Survey Coordination Centre NHS



	2018	2019	2020	2021	2022
Staff with a LTC or illness: Your org	30.8%	34.2%	30.8%	27.8%	28.6%
Staff without a LTC or illness: Your org	21.1%	18.0%	21.4%	19.6%	18.1%
Staff with a LTC or illness: Average	33.3%	32.7%	33.0%	32.2%	30.0%
Staff without a LTC or illness: Average	22.8%	21.8%	23.4%	23.7%	20.8%
Staff with a LTC or illness: Responses	185	190	211	252	262
Staff without a LTC or illness: Responses	492	455	402	500	519

Workforce Disability Equality Standards

Survey Coordination Centre NHS

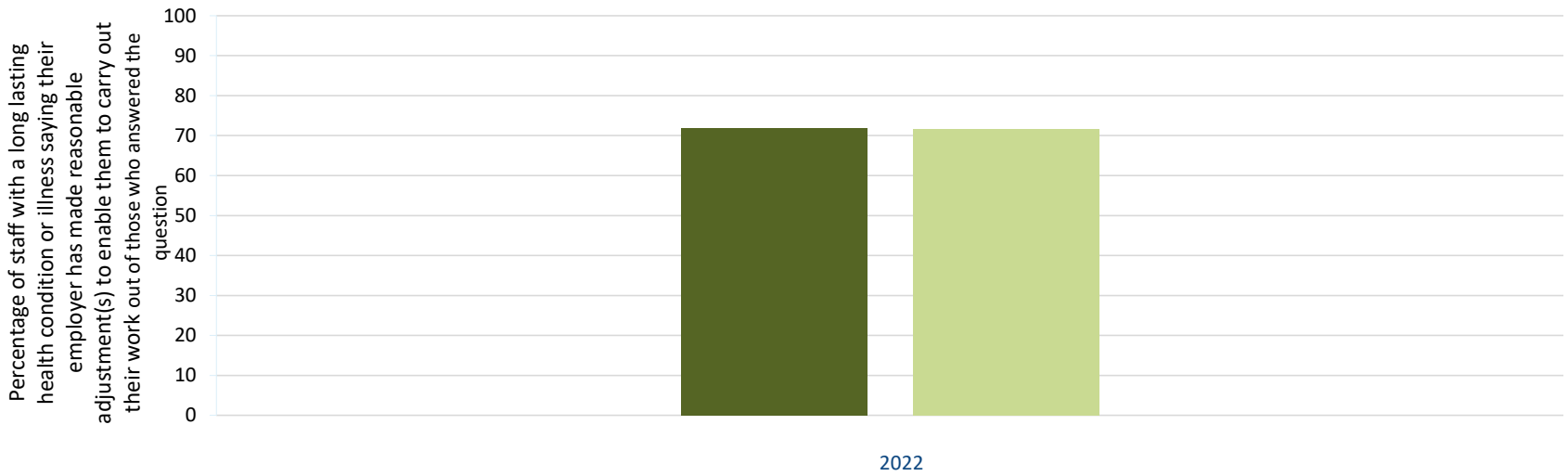


	2018	2019	2020	2021	2022
Staff with a LTC or illness: Your org	33.6%	40.4%	37.8%	39.8%	36.5%
Staff without a LTC or illness: Your org	49.8%	53.0%	49.4%	47.0%	46.4%
Staff with a LTC or illness: Average	36.8%	38.1%	37.4%	32.6%	32.5%
Staff without a LTC or illness: Average	47.9%	49.9%	49.3%	43.3%	43.6%
Staff with a LTC or illness: Responses	262	255	323	384	359
Staff without a LTC or illness: Responses	1035	948	1009	1100	1021

Workforce Disability Equality Standards

Survey Coordination Centre NHS

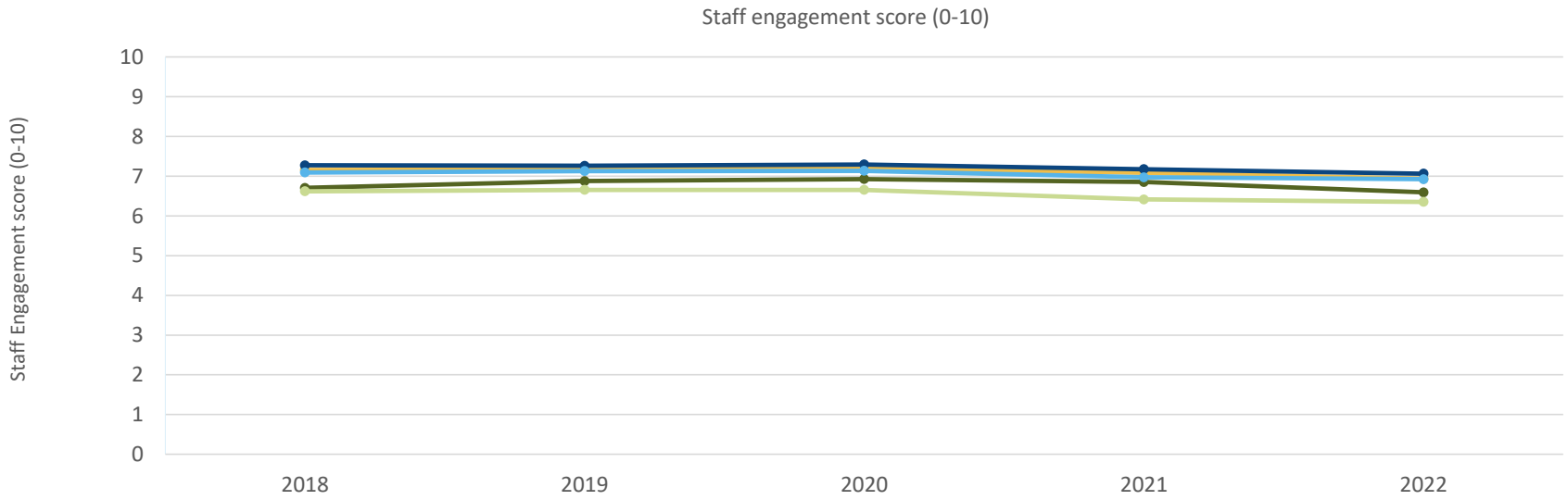
Percentage of staff with a long lasting health condition or illness saying their employer has made reasonable adjustment(s) to enable them to carry out their work.



	2022
Staff with a LTC or illness: Your org	71.9%
Staff with a LTC or illness: Average	71.8%
Staff with a LTC or illness: Responses	203

Workforce Disability Equality Standards

Survey Coordination Centre NHS



	2018	2019	2020	2021	2022
Organisation average	7.2	7.2	7.2	7.1	6.9
Staff with a LTC or illness: Your org	6.7	6.9	6.9	6.9	6.6
Staff without a LTC or illness: Your org	7.3	7.3	7.3	7.2	7.1
Staff with a LTC or illness: Average	6.6	6.7	6.7	6.4	6.4
Staff without a LTC or illness: Average	7.1	7.1	7.1	7.0	6.9
Staff with a LTC or illness: Responses	263	255	326	385	360
Staff without a LTC or illness: Responses	1041	952	1013	1104	1029

N.B. Data shown in this chart are unweighted therefore will not match weighted staff engagement scores in other outputs.

Survey Coordination Centre

NHS

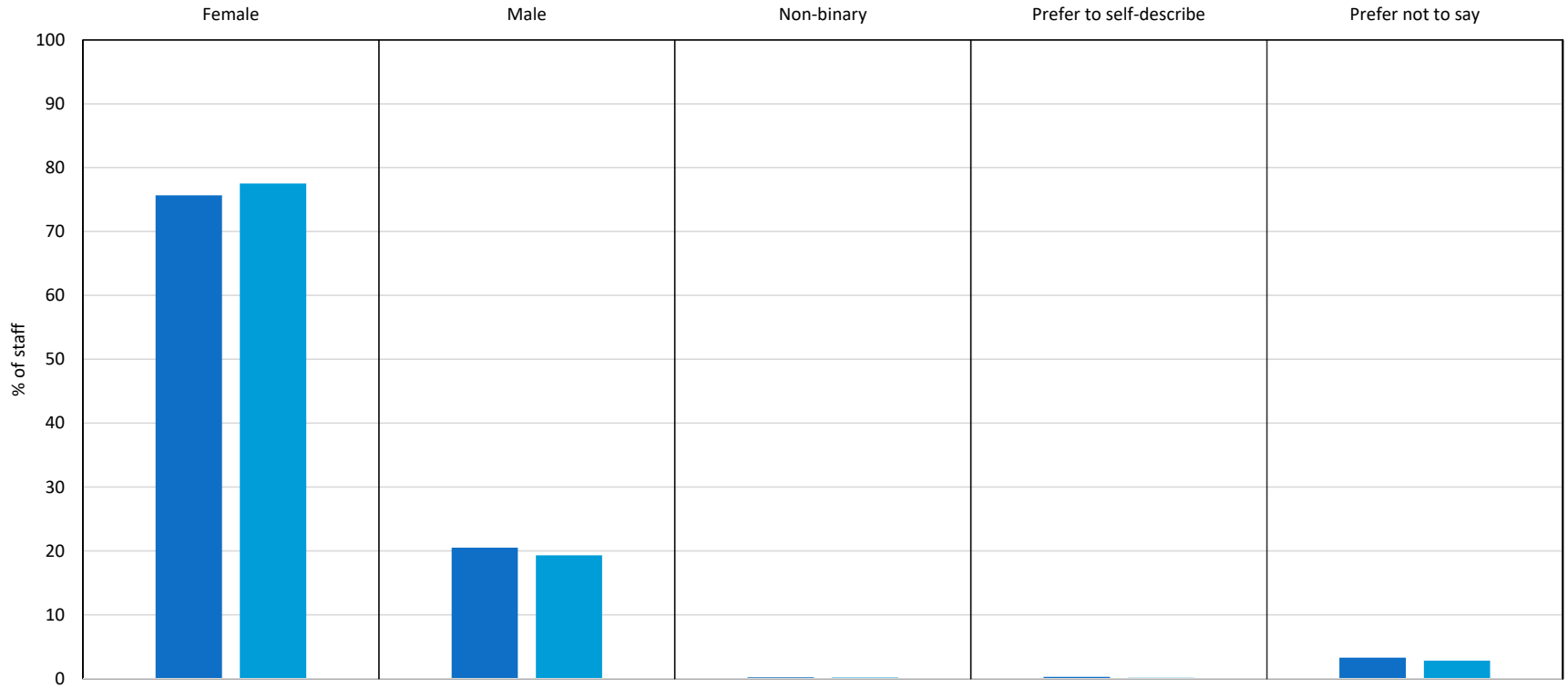
About your respondents

This section will show demographic information for 2022.

Please note, where there are less than 11 responses for a question this data is not shown in the chart to protect the confidentiality of staff and reliability of results.

Background details - Gender

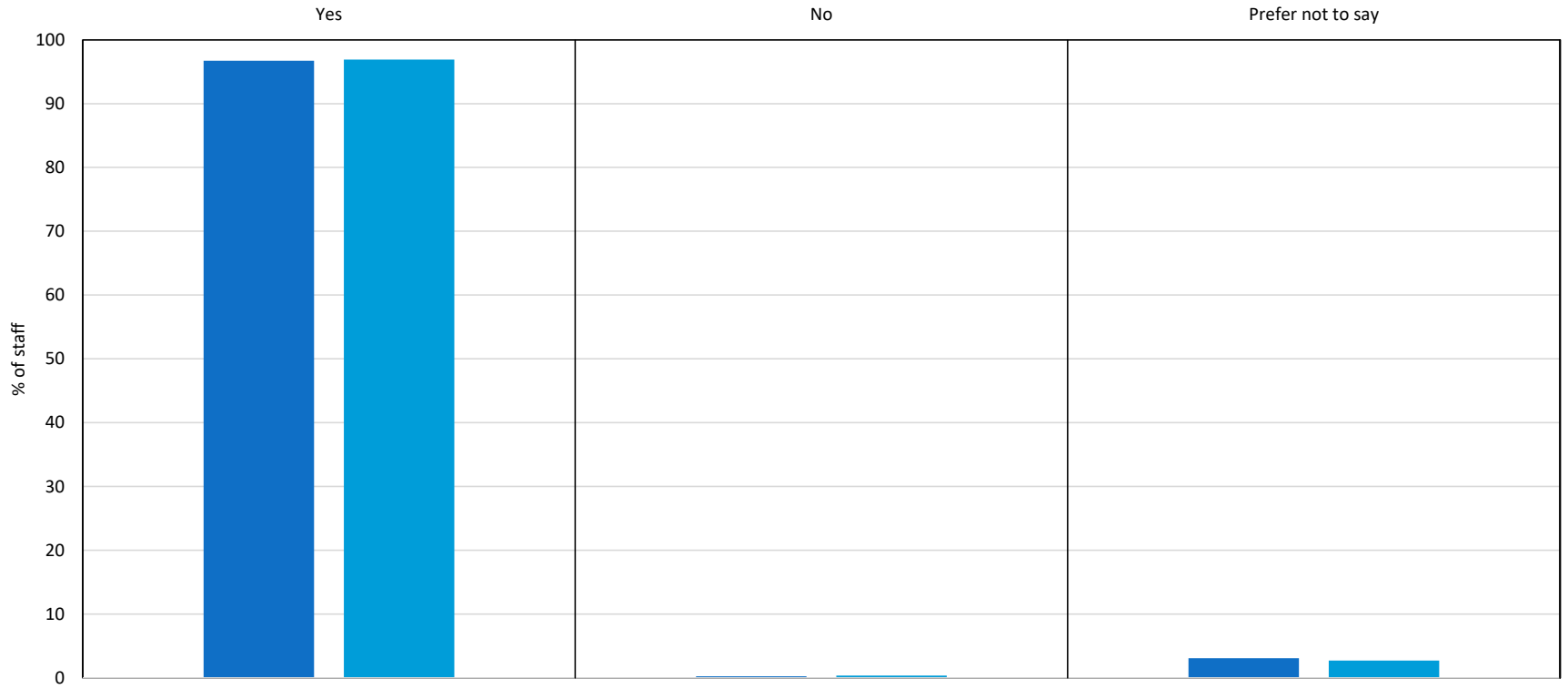
Survey Coordination Centre NHS



	Female	Male	Non-binary	Prefer to self-describe	Prefer not to say
Your org	75.7%	20.5%	0.2%	0.3%	3.3%
Average	77.5%	19.3%	0.2%	0.1%	2.8%
Responses	1394	1394	1394	1394	1394

Background details – Is your gender identity the same as the sex you were assigned at birth?

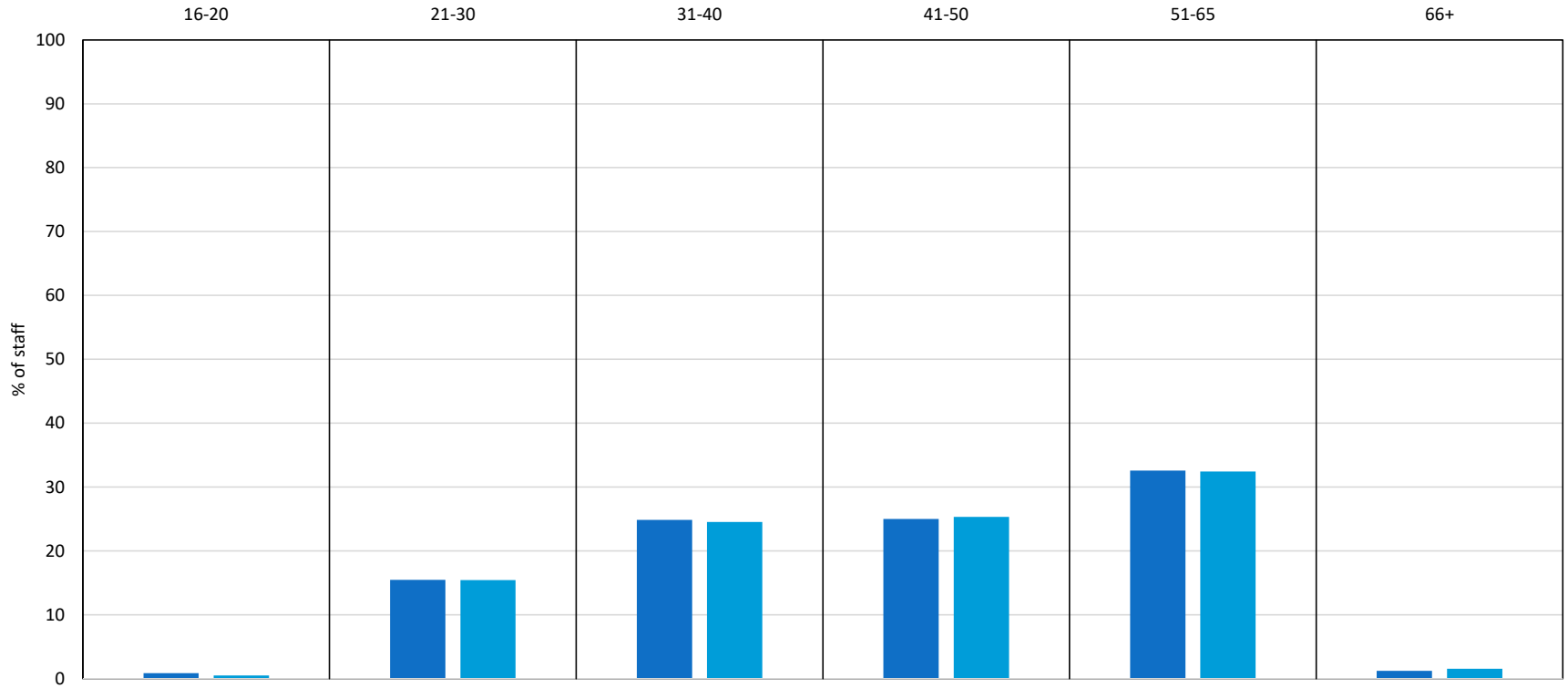
Survey Coordination Centre



	Yes	No	Prefer not to say
Your org	96.7%	0.2%	3.1%
Average	96.9%	0.4%	2.7%
Responses	1308	1308	1308

Background details - Age

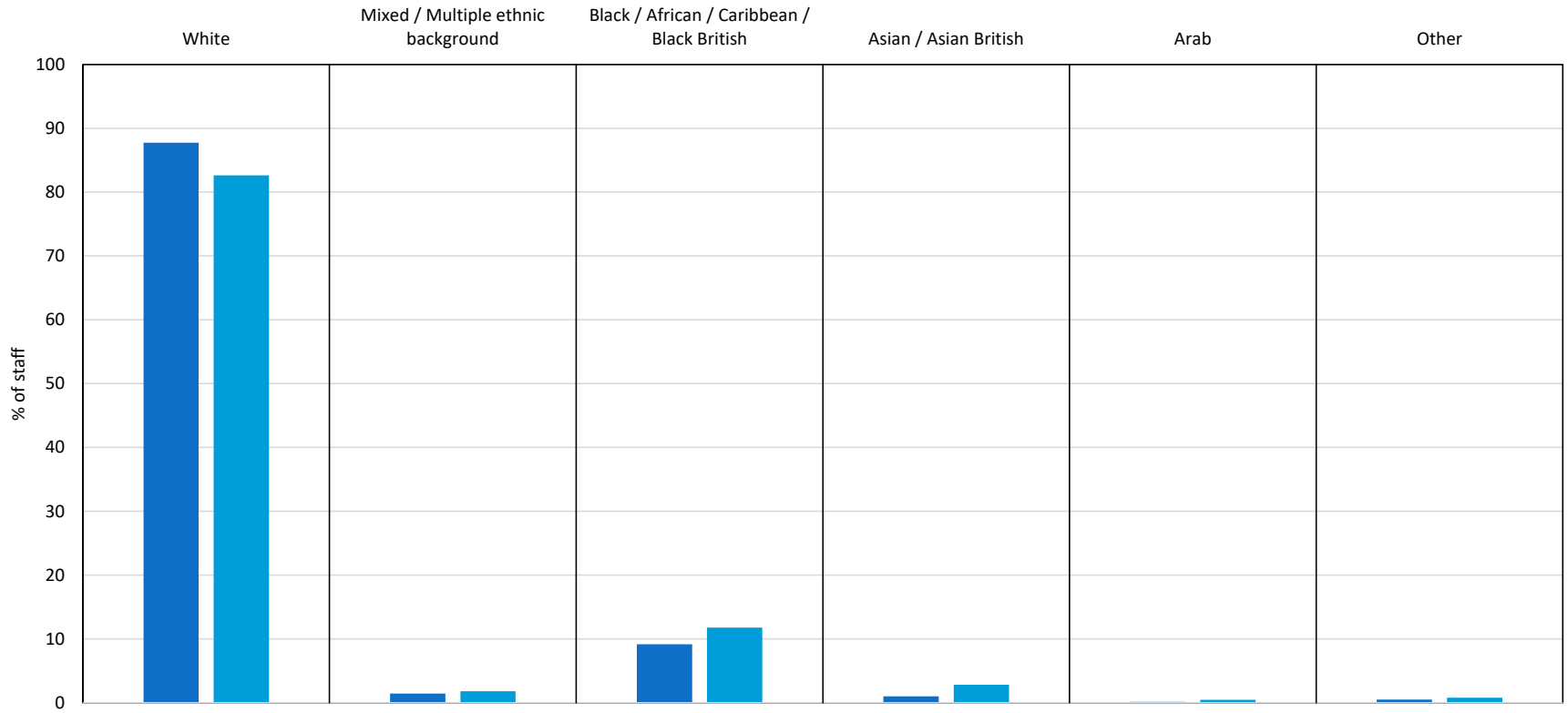
Survey Coordination Centre NHS



	16-20	21-30	31-40	41-50	51-65	66+
Your org	0.9%	15.5%	24.9%	25.0%	32.6%	1.2%
Average	0.5%	15.4%	24.5%	25.3%	32.4%	1.5%
Responses	1384	1384	1384	1384	1384	1384

Background details - Ethnicity

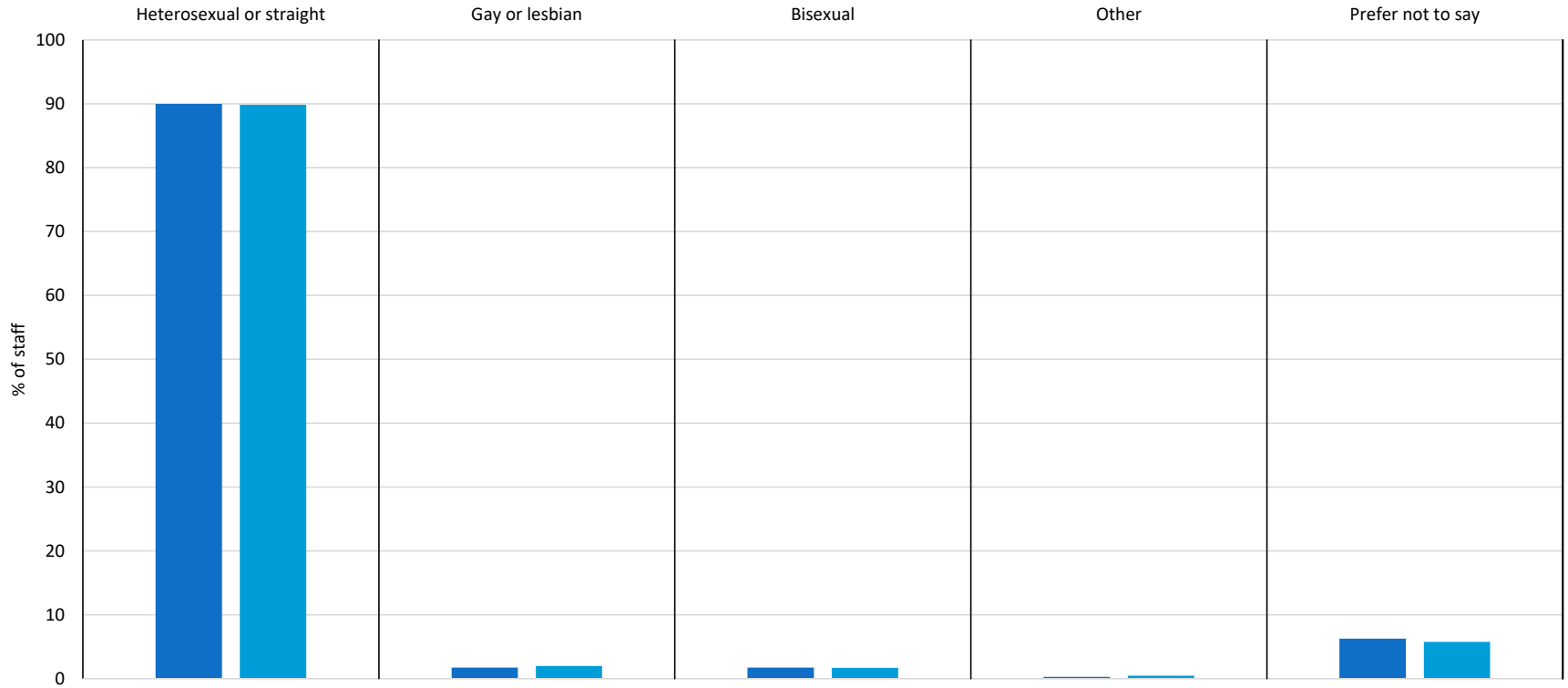
Survey Coordination Centre NHS



	White	Mixed / Multiple ethnic background	Black / African / Caribbean / Black British	Asian / Asian British	Arab	Other
Your org	87.7%	1.4%	9.2%	1.0%	0.1%	0.5%
Average	82.6%	1.8%	11.8%	2.8%	0.5%	0.8%
Responses	1387	1387	1387	1387	1387	1387

Background details – Sexual orientation

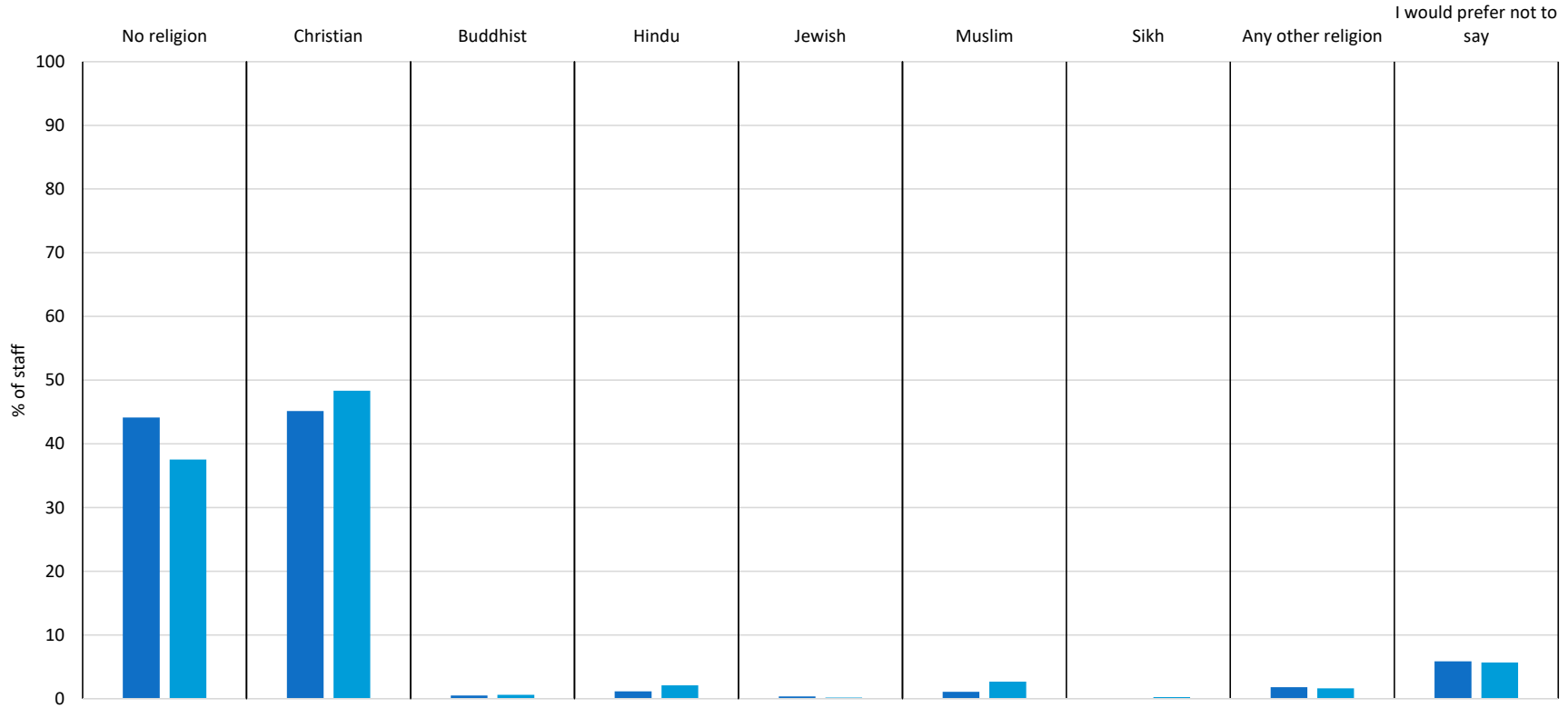
Survey Coordination Centre NHS



	Heterosexual or straight	Gay or lesbian	Bisexual	Other	Prefer not to say
Your org	90.0%	1.7%	1.7%	0.3%	6.3%
Average	89.8%	2.0%	1.7%	0.5%	5.7%
Responses	1389	1389	1389	1389	1389

Background details - Religion

Survey Coordination Centre NHS

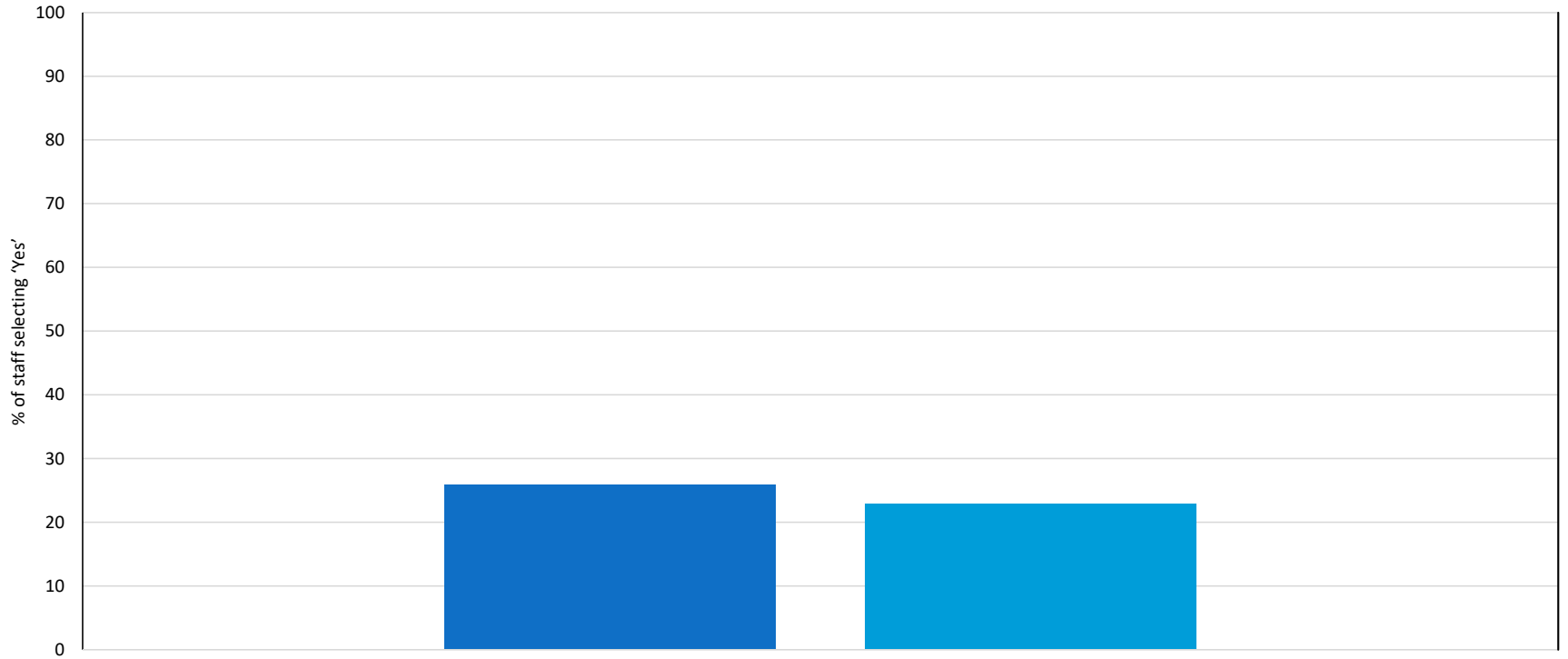


	No religion	Christian	Buddhist	Hindu	Jewish	Muslim	Sikh	Any other religion	I would prefer not to say
Your org	44.1%	45.1%	0.5%	1.2%	0.4%	1.1%	0.0%	1.8%	5.8%
Average	37.5%	48.3%	0.6%	2.1%	0.2%	2.7%	0.2%	1.6%	5.7%
Responses	1387	1387	1387	1387	1387	1387	1387	1387	1387

Background details – Long lasting health condition or illness

Survey Coordination Centre NHS

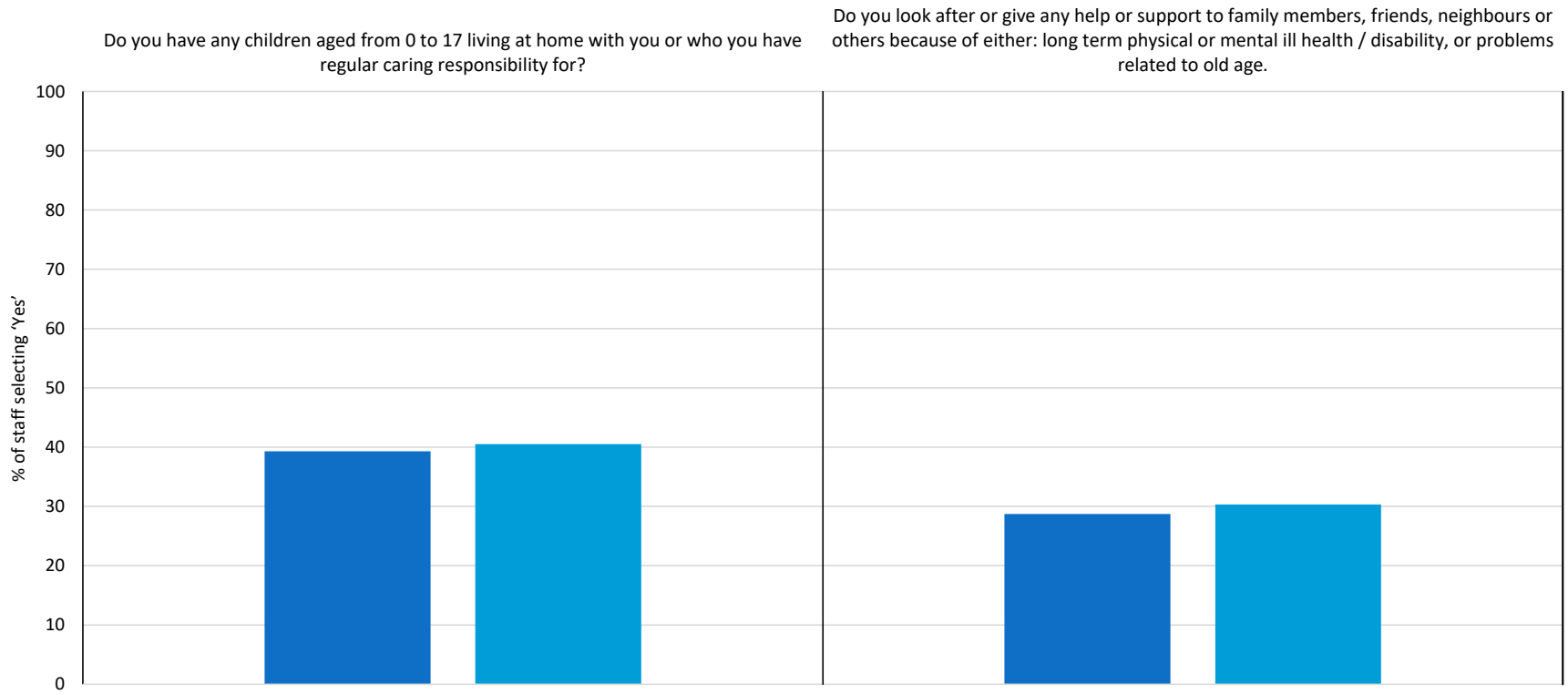
Do you have any physical or mental health conditions or illnesses lasting or expected to last for 12 months or more?



Your org	25.9%
Average	22.9%
Responses	1391

Background details – Parental / caring responsibilities

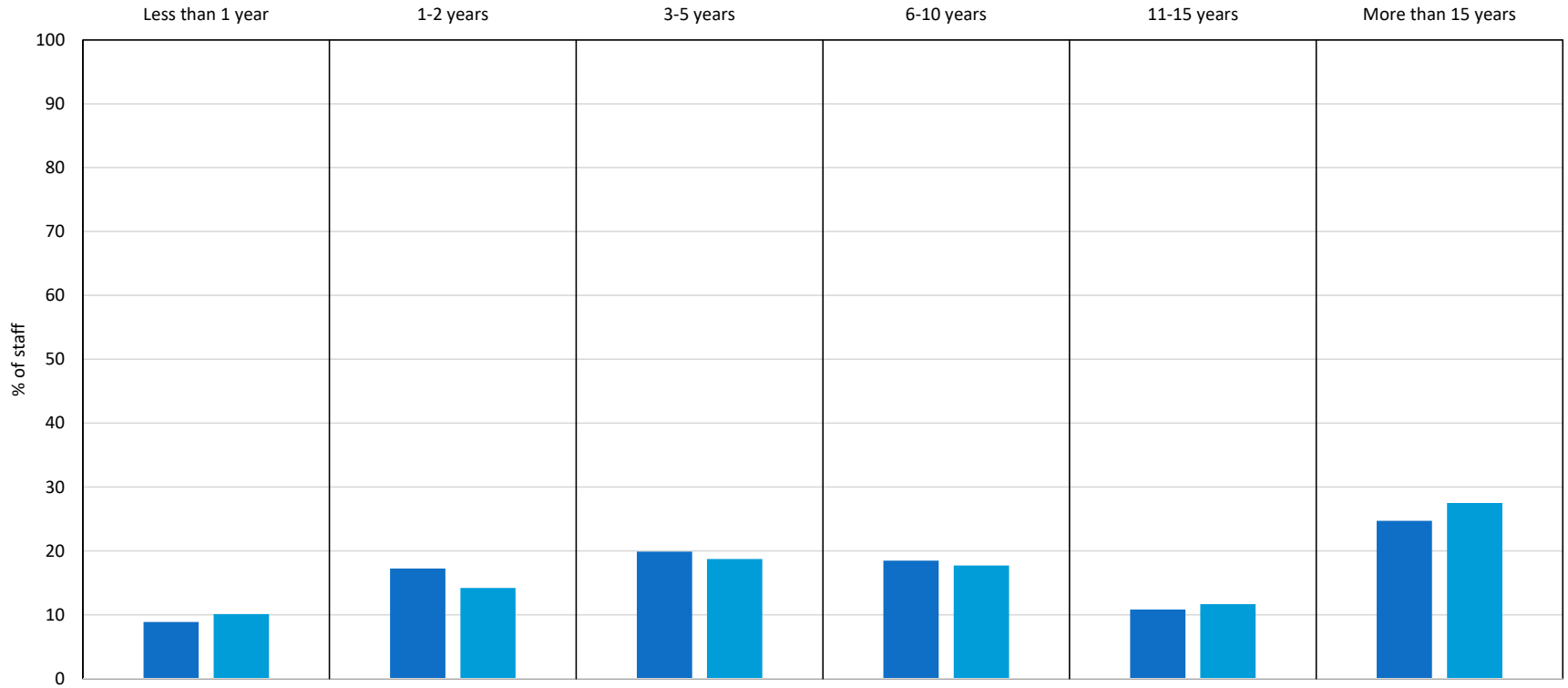
Survey Coordination Centre NHS



	Do you have any children aged from 0 to 17 living at home with you or who you have regular caring responsibility for?	Do you look after or give any help or support to family members, friends, neighbours or others because of either: long term physical or mental ill health / disability, or problems related to old age.
Your org	39.3%	28.7%
Average	40.5%	30.3%
Responses	1387	1382

Background details – Length of service

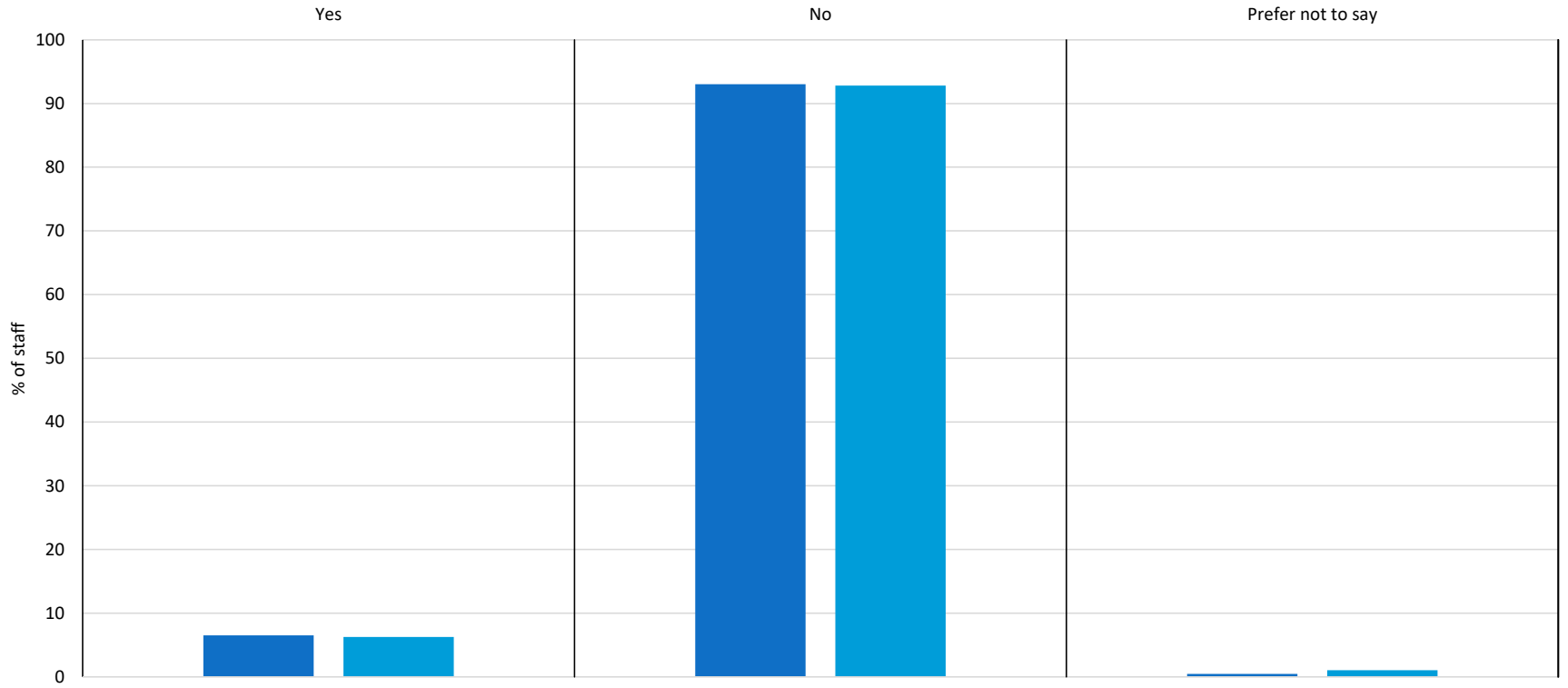
Survey Coordination Centre NHS



	Less than 1 year	1-2 years	3-5 years	6-10 years	11-15 years	More than 15 years
Your org	8.9%	17.3%	19.9%	18.5%	10.8%	24.7%
Average	10.1%	14.2%	18.7%	17.7%	11.7%	27.5%
Responses	1397	1397	1397	1397	1397	1397

Background details – When you joined this organisation were you recruited from outside of the UK?

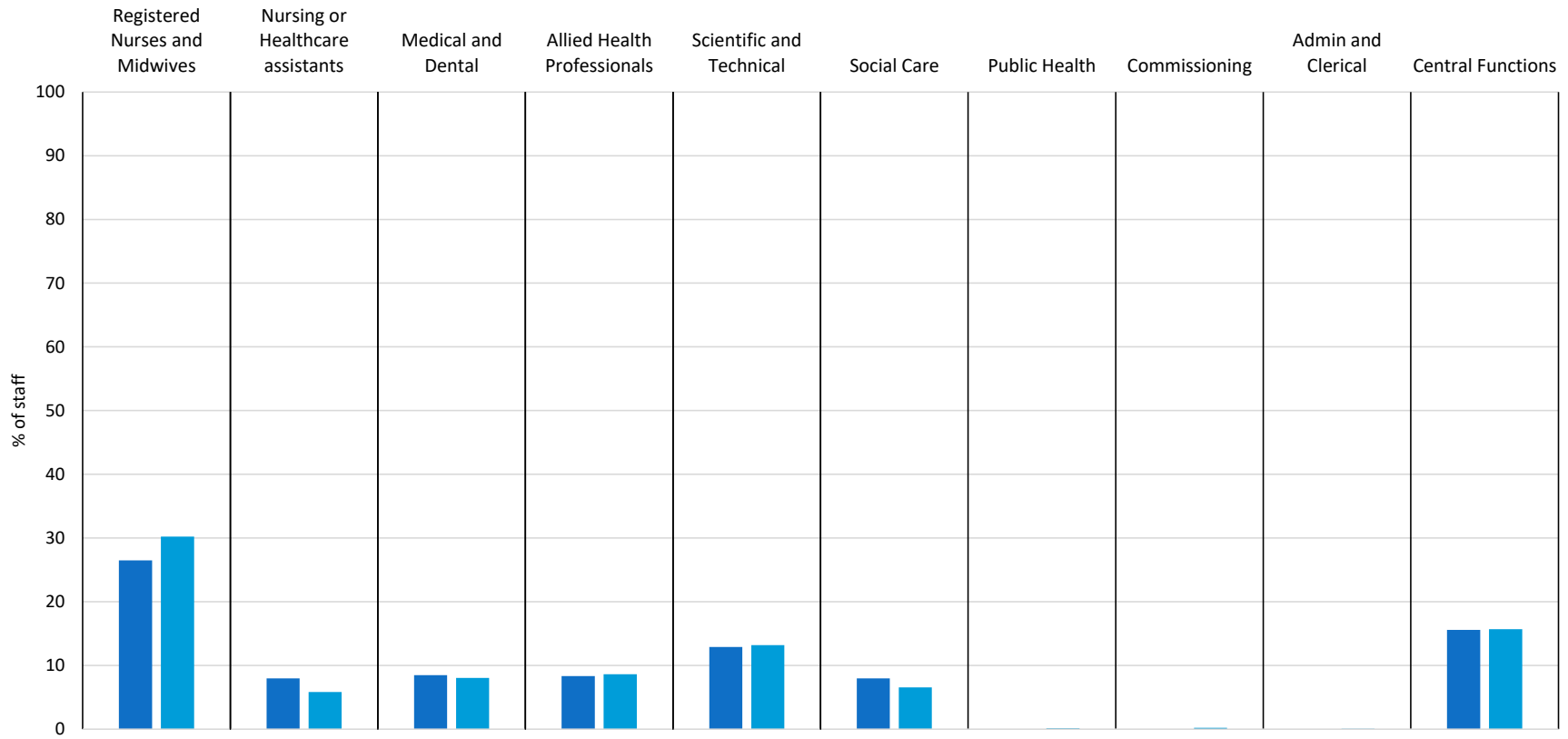
Survey Coordination Centre NHS



	Yes	No	Prefer not to say
Your org	6.5%	93.0%	0.4%
Average	6.2%	92.8%	1.0%
Responses	1336	1336	1336

Background details – Occupational group

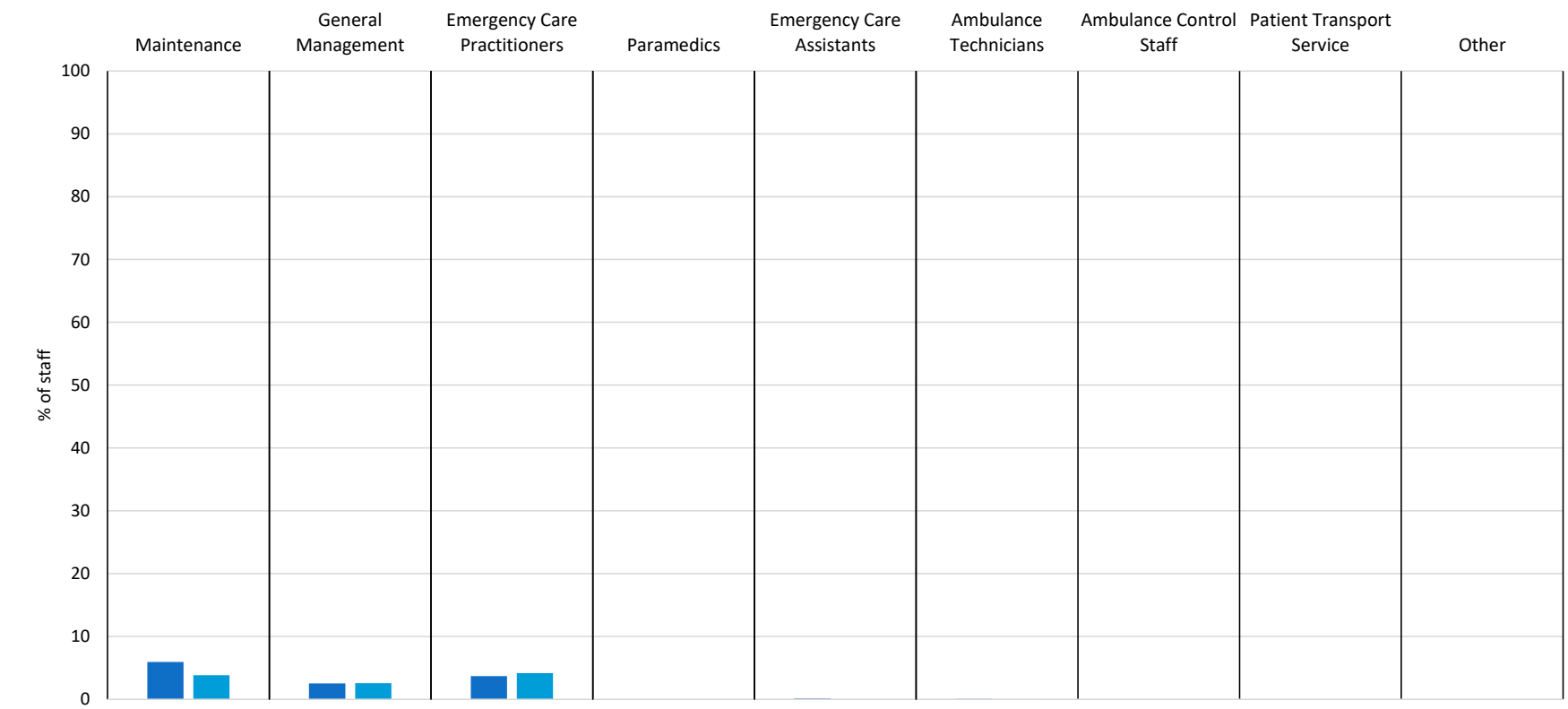
Survey Coordination Centre NHS



	Registered Nurses and Midwives	Nursing or Healthcare assistants	Medical and Dental	Allied Health Professionals	Scientific and Technical	Social Care	Public Health	Commissioning	Admin and Clerical	Central Functions
Your org	26.5%	8.0%	8.5%	8.3%	12.9%	8.0%	0.0%	0.0%	0.0%	15.6%
Average	30.2%	5.8%	8.0%	8.6%	13.2%	6.5%	0.1%	0.2%	0.1%	15.7%
Responses	1382	1382	1382	1382	1382	1382	1382	1382	1382	1382

Background details – Occupational group

Survey Coordination Centre NHS



	Maintenance	General Management	Emergency Care Practitioners	Paramedics	Emergency Care Assistants	Ambulance Technicians	Ambulance Control Staff	Patient Transport Service	Other
Your org	5.9%	2.5%	3.7%	0.0%	0.1%	0.1%	0.0%	0.0%	0.0%
Average	3.8%	2.6%	4.2%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Responses	1382	1382	1382	1382	1382	1382	1382	1382	1382

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NHS

Appendices

Survey Coordination Centre

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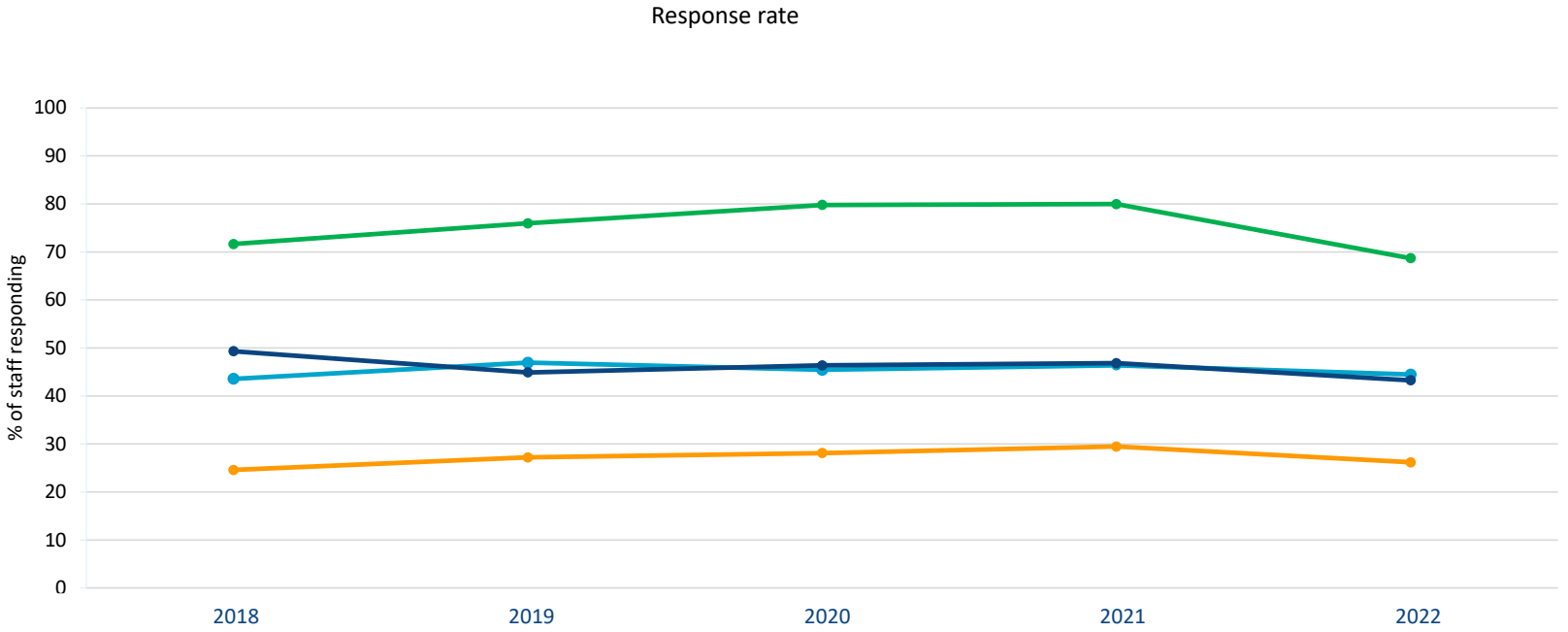
Appendix A: Response rate

Appendix A: Response rate

Survey Coordination Centre NHS



	2018	2019	2020	2021	2022
Your org	49.3%	44.9%	46.4%	46.8%	43.3%
Highest	71.6%	76.0%	79.8%	79.9%	68.7%
Average	43.6%	46.9%	45.4%	46.4%	44.5%
Lowest	24.6%	27.2%	28.1%	29.5%	26.2%
Responses	1321	1238	1358	1517	1404

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Appendix B: Significance testing 2021 vs 2022

Appendix B: Significance testing – 2021 vs 2022

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The table below presents the results of significance testing conducted on the theme scores calculated in both 2021 and 2022*.

People Promise elements	2021 score	2021 respondents	2022 score	2022 respondents	Statistically significant change?
We are compassionate and inclusive	7.5	1515	7.3	1403	Significantly lower
We are recognised and rewarded	6.1	1514	5.9	1396	Significantly lower
We each have a voice that counts	6.9	1497	6.8	1391	Not significant
We are safe and healthy	6.0	1501	5.9	1399	Not significant
We are always learning	5.6	1431	5.5	1336	Not significant
We work flexibly	6.3	1508	6.2	1392	Not significant
We are a team	6.8	1511	6.8	1397	Not significant
Themes					
Staff Engagement	7.1	1515	6.9	1402	Significantly lower
Morale	5.9	1516	5.8	1402	Not significant

* Statistical significance is tested using a two-tailed t-test with a 95% level of confidence. For more details please see the technical document.

Survey Coordination Centre

NHS

Appendix C: Tips on using your benchmark report

Appendix C: Data in the benchmark reports

Survey Coordination Centre NHS

The following pages include tips on how to read, interpret and use the data in this report. The **suggestions are aimed at users who would like some guidance on how to understand the data** in this report. These suggestions are by no means the only way to analyse or use the data, but have been included to aid users.

Key points to note

The seven People Promise elements, the two themes and the sub-scores that feed into them cover key areas of staff experience and present results in these areas in a clear and consistent way. All of the People Promise elements, themes and sub-scores are scored on a 0-10 scale, where a higher score is more positive than a lower score. These scores are created by scoring questions linked to these areas of experience and grouping these results together. Details of how the scores are calculated can be found in the technical document available on the Staff Survey website.

A key feature of the reports is that they **provide organisations with up to five years of trend data**. Trend data provides a much more reliable indication of whether the most recent results represent a change from the norm for an organisation than comparing the most recent results only to those from the previous year. Taking a longer term view will help organisations to identify trends over several years that may have been missed when comparisons are drawn solely between the current and previous year.

People Promise elements, themes and sub-scores are benchmarked so that organisations can make comparisons to their peers on specific areas of staff experience. Question results provide organisations with more granular data that will help them to identify particular areas of concern. The trend data are benchmarked so that organisations can identify how results on each question have changed for themselves and their peers over time by looking at a single graph.

N.B. Historical benchmarking data for 2019 has been revised for the Mental Health & Learning Disability and Mental Health, Learning Disability & Community Trusts, and Community Trusts benchmarking groups. This is due to a revision in the occupation group weighting to correctly reflect historical benchmarking group changes. Historical data is reweighted each year according to the latest results and so historical figures change with each new year of data; however it is advised to keep the above in mind when viewing historical results released in 2022.

Appendix C: 1. Reviewing People Promise and theme results

Survey Coordination Centre NHS

When analysing People Promise element and theme results, it is easiest to start with the **overview** page to quickly identify areas which are doing better or worse in comparison to other organisations in the given benchmarking group.

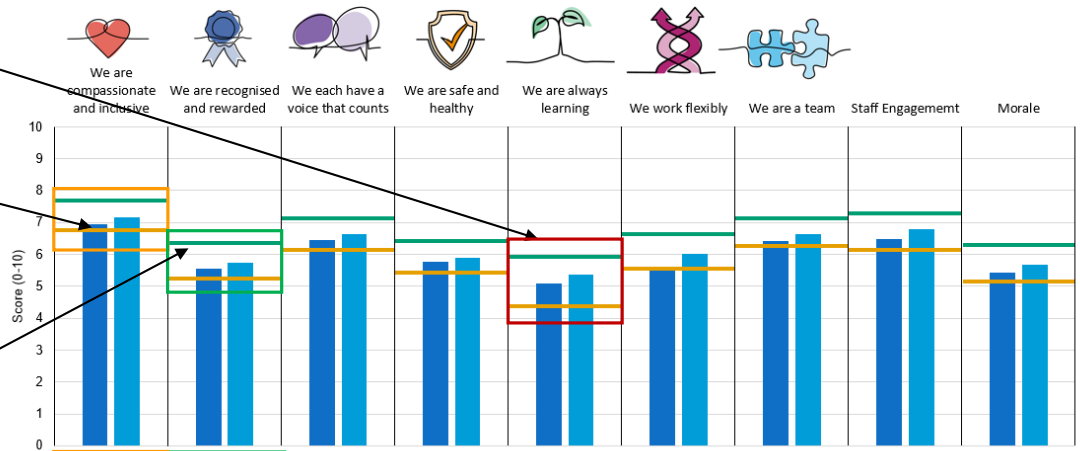
It is important to **consider each result within the range of its benchmarking group 'Best' and 'Worst' scores**, rather than comparing People Promise element and theme scores to one another. Comparing organisation scores to the benchmarking group average is another important point of reference.

Areas to improve

- By checking where the 'Your org' column/value is lower than the benchmarking group 'Average' you can quickly identify areas for improvement.
- It is worth looking at the difference between the 'Your org' result and the benchmarking group 'Worst' score. The closer your organisation's result is to the worst score, the more concerning the result.
- Results where your organisation's score is only marginally better than the 'Average', but still lags behind the best result by a notable margin, could also be considered as areas for further improvement.

Positive outcomes

- Similarly, using the overview page it is easy to identify People Promise elements and themes which show a positive outcome for your organisation, where 'Your org' scores are distinctly higher than the benchmarking group 'Average' score.
- Positive stories to report could be ones where your organisation approaches or matches the benchmarking group's 'Best' score.



	We are compassionate and inclusive	We are recognised and rewarded	We each have a voice that counts	We are safe and healthy	We are always learning	We work flexibly	We are a team	Staff Engagememt	Morale
Your org	7.0	5.5	6.4	5.8	5.1	5.6	6.4	6.5	5.4
Best	7.7	6.4	7.1	6.4	5.9	6.6	7.1	7.3	6.3
Average	7.2	5.7	6.6	5.9	5.4	6.0	6.6	6.8	5.7
Worst	6.8	5.2	6.2	5.4	4.4	5.6	6.3	6.1	5.2
Responses	8284	8225	8175	8244	7877	8187	8264	8288	8294

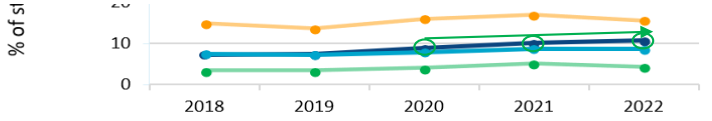
Only one example is highlighted for each point

Appendix C: 2. Reviewing results in more detail

Survey Coordination Centre NHS

Review trend data

Trend data can be used to identify measures which have been consistently improving for your organisation (i.e. showing an upward trend) over the past years and ones which have been declining over time. These charts can **help establish if there is genuine change in the results** (if the results are consistently improving or declining over time), or whether a change between years is just a minor **year-on-year** fluctuation.



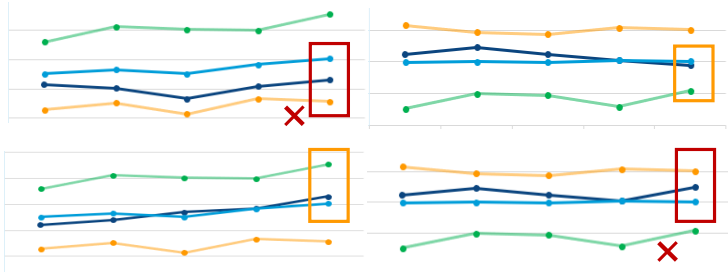
	2018	2019	2020	2021	2022
Your org	7.3%	7.4%	8.9%	10.2%	10.8%
Best	3.4%	3.4%	4.0%	5.1%	4.2%
Average	7.5%	7.3%	7.9%	8.8%	8.7%
Worst	14.9%	13.8%	16.1%	17.2%	15.7%

Benchmarked trend data also allows you to review local changes and benchmark comparisons at the same time, allowing for various types of questions to be considered: e.g. how have the results for my organisation changed over time? Is my organisation improving faster than our peers?

Review the sub-scores and questions feeding into the People Promise elements and themes

In order to understand exactly which factors are driving your organisation's People Promise element and theme scores, you should review the sub-scores and questions feeding into these scores. The **sub-score results** and the '**Question results**' section contain the sub-scores and questions contributing to each People Promise element and theme, grouped together. By comparing 'Your org' scores to the benchmarking group 'Average', 'Best' and 'Worst' scores for each question, the **questions which are driving your organisation's People Promise element and theme results can be identified**.

For areas of experience where results need improvement, action plans can be formulated to **focus on the questions where the organisation's results fall between the benchmarking group average and worst results.** Remember to keep an eye out for questions where a lower percentage is a better outcome – such as questions on violence or harassment, bullying and abuse.



× = Negative driver, org result falls between average & worst benchmarking group result for question

Appendix C: 3. Reviewing question results

Survey Coordination Centre NHS

This benchmark report displays results for all questions in the questionnaire, including benchmarked trend data wherever available. While this a key feature of the report, at first glance the amount of information contained on more than 140 pages might appear daunting. The below suggestions aim to provide some guidance on how to get started with navigating through this set of data.

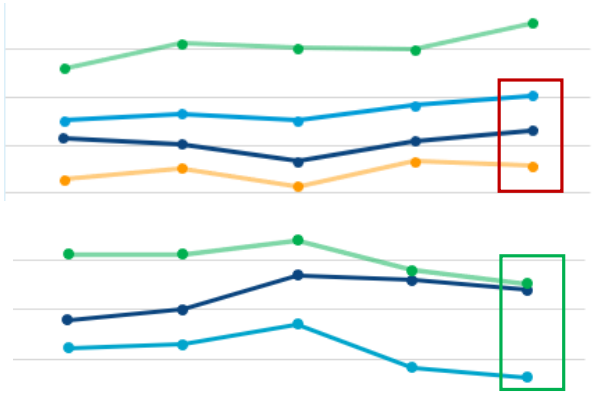
Identifying questions of interest

➢ **Pre-defined questions of interest – key questions for your organisation**

Most organisations will have questions which have traditionally been a focus for them - questions which have been targeted with internal policies or programmes, or whose results are of heightened importance due to organisation values or because they are considered a proxy for key issues. Outcomes for these questions can be assessed on the backdrop of benchmark and historical trend data.

➢ **Identifying questions of interest based on the results in this report**

The methods recommended to review your People Promise and theme results can also be applied to pick out question level results of interest. However, **unlike People Promise elements, themes and sub-scores where a higher score always indicates a better result, it is important to keep an eye out for questions where a lower percentage relates to a better outcome** (see details on the 'Using the report' page in the 'Introduction' section).



- **To identify areas of concern:** look for questions where the organisation value falls between the benchmarking group average and the worst score, particularly questions where your organisation result is very close to the worst score. Review changes in the trend data to establish if there has been a decline or stagnation in results across multiple years, but consider the context of how the trust has performed in comparison to its benchmarking group over this period. A positive trend for a question that is still below the average result can be seen as good progress to build on further in the future.

- **When looking for positive outcomes:** search for results where your organisation is closest to the benchmarking group best result (but remember to consider results for previous years), or ones where there is a clear trend of continued improvement over multiple years.

Survey Coordination Centre

NHS

Appendix D: Additional reporting outputs

Please note, where there are less than 11 responses for a question this data is not shown in the chart to protect the confidentiality of staff and reliability of results.

Appendix D: Additional reporting outputs

Survey Coordination Centre NHS

Below are links to other key reporting outputs that complement this report. A full list and more detailed explanation of the reporting outputs is included in the Technical Document.

Supporting documents

Basic Guide: Provides a brief overview of the NHS Staff Survey data and details on what is contained in each of the reporting outputs.

Technical Document: Contains technical details about the NHS Staff Survey data, including: data cleaning, weighting, benchmarking, People Promise, historical comparability of organisations and questions in the survey.

Other local results

Local Dashboards: Online dashboards containing results for each participating organisation, similar those provided in this report, with trend data and benchmark results for up to five years where possible. These dashboards additionally show the full breakdown of response options for each question.

Breakdown reports: Reports containing People Promise and theme results split by breakdown (locality) for Dorset County Hospital NHS Foundation Trust.

National results

National Dashboards: Online dashboards containing national results for NHS trusts with trend data for up to five years where possible. These dashboards show the results for different trust types and include the full breakdown or response options for each question.

Regional / System overview and **Regional / System breakdown** Dashboards containing results for each region and each ICS.

Detailed spreadsheets Contain detailed weighted results for all participating organisations, all trusts nationally, and for each region and ICS.

Learning from Deaths Report Q3 2022/23

1. Report Details			
Meeting Title:	Board of Directors, Part 1		
Date of Meeting:	29 March 2023		
Document Title:	Learning from Deaths Q3 2022/23		
Responsible Director:	Prof Alastair Hutchison	Date of Executive Approval	14th Feb 2023
Author:	Prof Alastair Hutchison		
Confidentiality:	Public		
Publishable under FOI?	Yes		
Predetermined Report Format?	No. However formatted in line with SW Regional guidance		

2. Prior Discussion		
Job Title or Meeting Title	**Date**	**Recommendations/Comments**
Quality Committee	21st Feb 2023	Accepted
Hospital Mortality Group	15th Feb 2023	Accepted

3. Purpose of the Paper	To inform the Board of Directors of the learning that has occurred as a result of deaths being reported, investigated and appropriate findings disseminated throughout the Trust. Presentation of the Learning from Deaths report at Quality Committee and Trust Board is a mandatory obligation for all Trusts.							
	Note (✓)		*Discuss (✓)*		*Recommend*		*Approve (✓)*	
4. Key Issues	The latest published SHMI data for DCH was above the 'Expected Range' for the rolling 12 months to July, August and September 2022 (page 7), possibly influenced by a fall in the depth of coding. No other local or national indicators suggest excess unexpected deaths are occurring at DCH. Structured Judgement Reviews are used to examine the care of a significant sample of people who died whilst in-patients (around 20% vs national standard of 10%), and to learn from any good practice or lapses in care identified. The DCH Medical Examiners review every death, speak to immediate relatives and highlight any obvious causes for concern. Prof Hutchison will commence an audit of 50 consecutive deaths occurring in September 2022 to look for unexpected deaths, and report to the quality Committee separately as soon as this is complete.							
5. Action recommended	The Board of Directors is recommended to: 1. **NOTE** the report 2. **APPROVE** the report for publication on the DCH internet website							

6. Governance and Compliance Obligations			
Legal / Regulatory Link	**Yes**		Learning from the care provided to patients who die is a key part of clinical governance and quality improvement work (CQC 2016). Publication on a quarterly basis is a regulatory requirement.
Impact on CQC Standards	**Yes**		An elevated SHMI will raise concerns with NHS E&I and the CQC. The previous reduction in SHMI and improvements in coding are acknowledged, but Covid-19 and elective tariff incentivisation targets have adversely influenced coding and therefore recent SHMI figures are inaccurate
Risk Link	**Yes**		• Reputational risk due to higher than expected SHMI • Poor data quality can result in poor engagement from clinicians, impairing the Trust's ability to undertake quality improvement • Clinical coding data quality is improving, but previously adversely affected the Trust's ability to assess quality of care • Clinical safety issues may be under-reported or unnoticed if data quality is poor

				Other mortality data sources (primarily from national audits) are regularly checked for any evidence of unexpected deaths.
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?**		
Strategic Objectives	People	N/A		
	Place	Health inequalities related to 'Place' are well known to impact life expectancy and will be referenced in future reports.		
	Partnership	N/A		
Dorset Integrated Care System (ICS) goals		**Which Dorset ICS goal does this report link to / support?** Understanding and reducing health inequalities		
Improving population health and healthcare			**No**	
Tackling unequal outcomes and access		**Yes**		Health inequalities related to 'Place' are well known to impact life expectancy and will be referenced in future reports.
Enhancing productivity and value for money			**No**	
Helping the NHS to support broader social and economic development			**No**	
Assessments		**Have these assessments been completed?** *If yes, please include the assessment in the appendix to the report.. If no, please state the reason in the comment box below. (Please delete as appropriate)*		
Equality Impact Assessment (EIA)			**No**	Not applicable
Quality Impact Assessment (QIA)			**No**	Not applicable

CONTENTS

1.0 DIVISIONAL LEARNING FROM DEATHS REPORTS

Each Division is asked to submit a quarterly report outlining the number of in-patient deaths, the number subjected to SJR, and the outcomes in terms of assessment and learning.

1.1 Family Services and Surgical Division Report - Quarter 3 Report

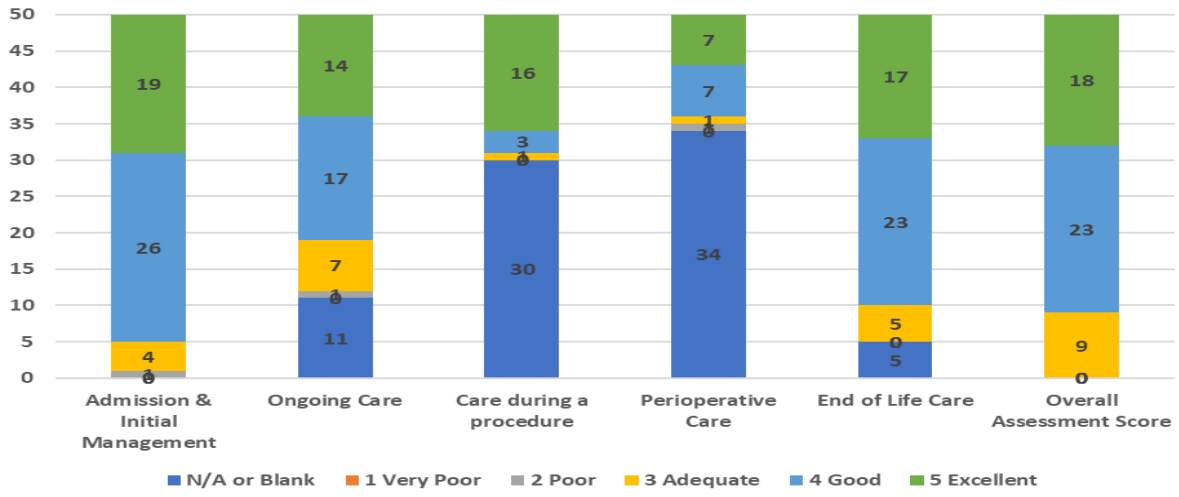
Structured Judgement Review Results: The Family Services & Division had 64 deaths in quarter 3, of which 48 require SJR's to be completed. Of these 6 have had a SJR completed. Within quarter 3 an additional 44 SJR's have also been completed from previous months.

Outstanding SJR's: The Division has completed a large number of SJR's from previous quarters and reduced the backlog significantly, with the oldest outstanding SJR now from quarter 2. The outstanding SJR's for the Division as at 31/01/2023 = 39:

September	October	November	December	January
10	11	5	4	9

Feedback from SJR's completed in quarter 3:

Phase Score	Admission & Initial Management	Ongoing Care	Care during a procedure	Perioperative Care	End of Life Care	Overall Assessment Score
N/A or Blank	0	11	30	34	5	0
1 Very Poor	0	0	0	0	0	0
2 Poor	1	1	0	1	0	0
3 Adequate	4	7	1	1	5	9
4 Good	26	17	3	7	23	23
5 Excellent	19	14	16	7	17	18



Overall Quality of Patient Record:

Blank	Score 1 Very poor	Score 2 Poor	Score 3 Adequate	Score 4 Good	Score 5 Excellent
0	0	0	9	25	16

- ED print out and issue 28 pages but mostly repetition or of no use. To discuss at HMG.
- Difficult to follow timeline re retrospective entries.
- Difficult to follow ED print out. Disconnect between ED documentation and specialist input.
- Theme of ED notes missing.
- Notes all loose in file and some in wrong order.
- Some handwriting difficult to decipher but overall good records. The fluid balance charts are poor, especially given patient's deteriorating renal function. They are mostly incomplete. The figures on the charts bear no relation to the output recorded on VitalPAC.
- Good documentation in general

Still having an issue of records being scanned before SJR. Process set up for any records with Medical Examiners notifications to have a sticker on the front not to be scanned before SJR completed, however this does not capture the records of those that do not have a ME notification but still require a SJR (Family & Surgery Division review all deaths).

Avoidability of Death Judgement Score:

Score 1 Definitely avoidable	**Score 2** Strong evidence of avoidability	**Score 3** Probably avoidable (more than 50:50)	**Score 4** Possibly avoidable but not very likely (less than 50:50)	**Score 5** Slight evidence of avoidability	**Score 6** Definitely not avoidable
0	0	0	3	9	38

Dates of Departmental M&M meetings:

Specialty	July	August	September	October	November	December
Anaesthetics	08/07/22	No meeting due to leave	30/09/22	05/10/22 Paediatrics	25/11/22 Obstetrics	Cancelled due to Christmas leave
Breast	08/07/22 - Yeovil	05/08/22 - DCH - Cancelled due to lack of staff (annual leave)	02/09/22 - Yeovil 30/09/22 - DCH	28/10/22 - Yeovil	25/11/22 - DCH – Replaced by AGM	23/12/22 - Yeovil – Cancelled due to lack of staff (annual leave)
Gastroenterology	06/07/22	Cancelled due to operational pressures	07/09/22	Cancelled due to operational pressures	Cancelled due to operational pressures	Cancelled due to operational pressures
General Surgery + Colorectal	08/07/22	Not quorate – delayed until beg. of Sept	02/09/22 + 30/09/22	28/10/22 – Meeting not quorate (A/L, on calls, sickness)	25/11/22	Due 23/12/22 – cancelled due to Christmas holidays
Orthopaedics	15/07/22	12/08/22	09/09/22	07/10/22	04/11/22	02/12/2022 30/12/2022 – cancelled due to Consultant A/L
Perinatal	21/07/22	24/08/22	28/09/22	26/10/22 See anaesthetics above	23/11/22	Cancelled due to operational pressures
Urology	08/07/22	04/08/22 - Cancelled due to operational pressures	02/09/22 & 29/09/22	27/10/22 - Cancelled due to number of apologies received	25/11/22 – Cancelled due to number of apologies received	22/12/22 – Cancelled due to number of apologies received

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

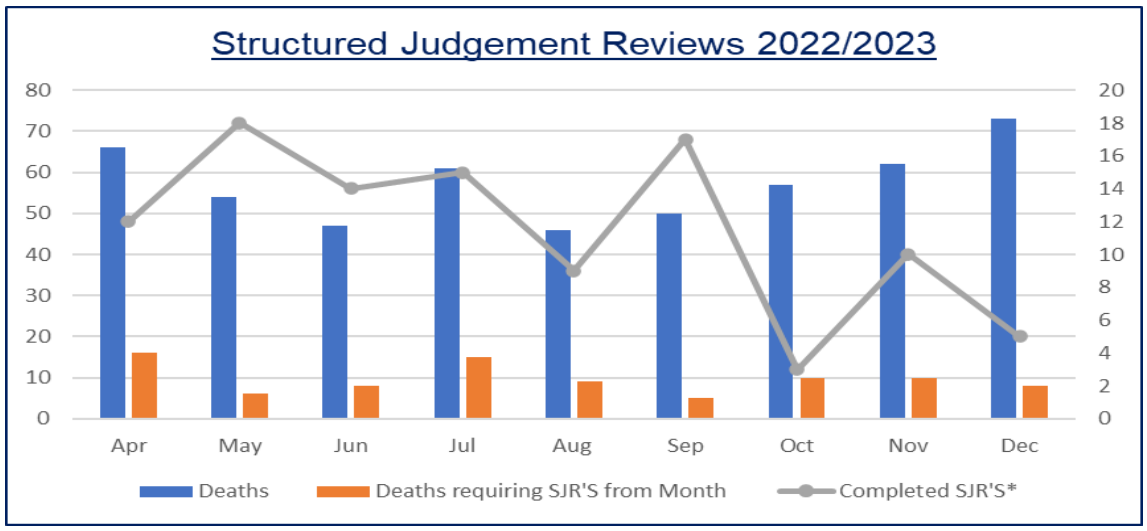
1.2 Division of Urgent & Integrated Care – Quarter 3 Report

Structured Judgement Reviews: In quarter 3 there were 192 deaths, 28 SJR's requested from these deaths and 18 were completed in total (completed SJR's not necessarily from this quarter).

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Total
Deaths	66	54	47	61	46	50	57	62	73	516
Deaths requiring SJR'S from Month	16	6	8	15	9	5	10	10	8	87
Completed SJR'S*	12	18	14	15	9	17	3	10	5	103

Total outstanding SJR's (not including nosocomials) = **29 (15)**
Outstanding SJR's >2 months (prior to 30/11/2022) = **20 (8)**

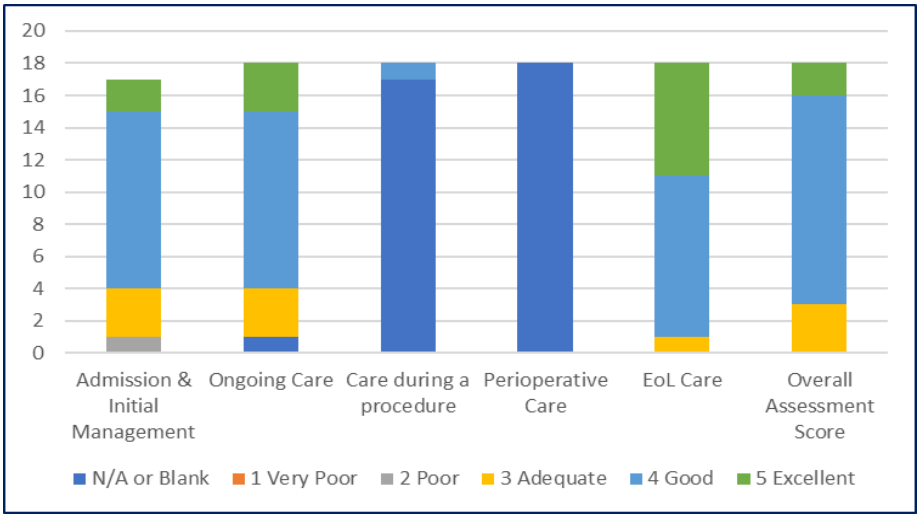
21 Nosocomial deaths (not included in above figures) will be reviewed by James Metcalf and a summary report will be written for HMG (9 reviewed so far on 13/06/22, 12 still to review). – JM Still pending review of final 12.



Phase score from 18 completed SJR's in Quarter 3:

Phase Score	Admission & Initial Management	Ongoing Care	Care during a procedure	Perioperative Care	EoL Care	Overall Assessment Score
N/A or Blank	1*	1	17	18	0	0
1 Very Poor	0	0	0	0	0	0
2 Poor	1	0	0	0	0	0
3 Adequate	3	3	0	0	1	3
4 Good	11	11	1	0	10	13
5 Excellent	2	3	0	0	7	2

*Returned to clinician who completed for score to be added – 30/01/23



Overall quality of patient record

Blank	Score 1 Very Poor	Score 2 Poor	Score 3 Adequate	Score 4 Good	Score 5 Excellent
0	0	1	3	11	3

- Comprehensive entries when consultant has documented their own encounter. Some omissions (Name, time etc) in entries from junior staff
- Poor completion of individual care plan
- Notes on DPR, not in chronological order so difficult to follow.
- Some handwritten entries illegible.
- Fluid balance charts incomplete.

Avoidability of Death Judgement Score

Score 1 Definitely avoidable	Score 2 Strong evidence of avoidability	Score 3 Probably avoidable (> 50:50)	Score 4 Possibly avoidable but not very likely (<50:50)	Score 5 Slight evidence of avoidability	Score 6 Definitely not avoidable
0	0	0	0	0	18

Dates of 2022 M+M meetings:

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

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

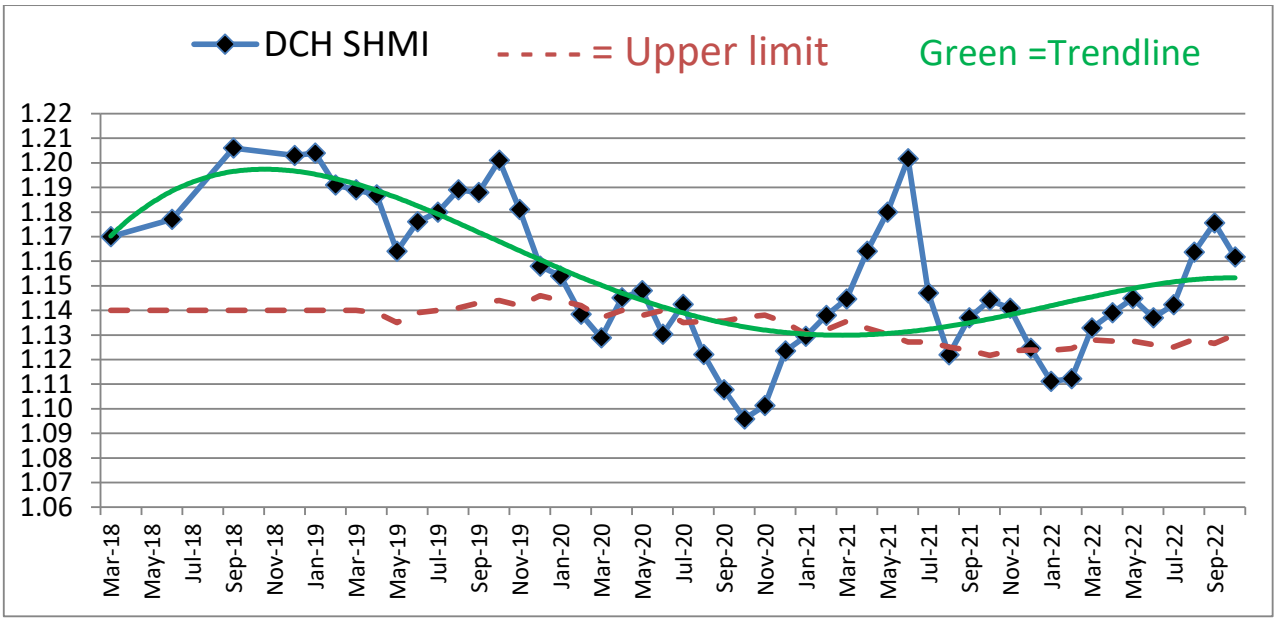
2.0 NATIONAL MORTALITY METRICS AND CODING ISSUES

2.1 Summary Hospital-level Mortality Indicator (SHMI)

SHMI is published by NHS Digital for a 12 month rolling period, and 5 months in arrears. It takes into account all diagnostic groups, in-hospital deaths, and deaths occurring within 30 days of discharge. The most recently published data for March to September 2022 has risen outside the 'Expected Range' and we know that our data continues to be adversely influenced by short staffing in the Coding Department, and a possible under-reporting of 'sepsis' in the medical record. NHS Digital continues to exclude all deaths related a covid from the reported data.

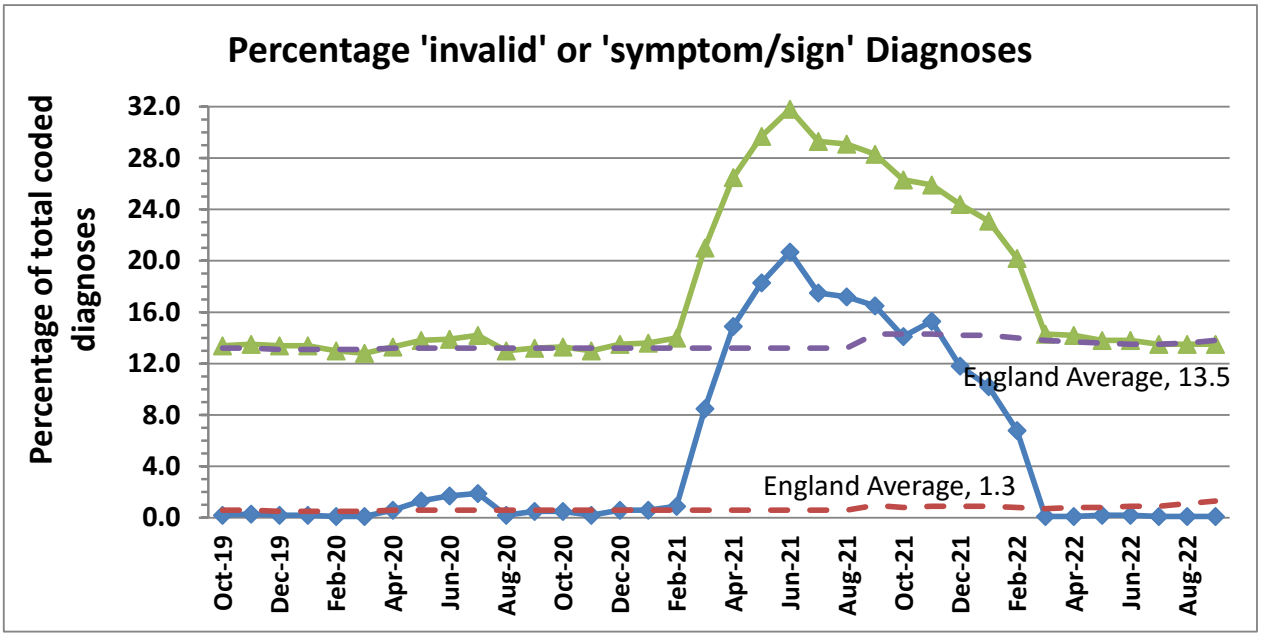
Victoria Stevens has taken up the post of Senior Clinical Coder and commenced work from the beginning of December 2022. She reports that the Clinical Coding Department has a stable coding backlog of approximately 4,000 SPELLS with 3 vacancies for qualified coders. These posts are covered by agency coders. Recruiting for these 3 vacancies would allow release of costly agency coders and effective cover of daily workloads, but will probably not improve the coding backlog. For the purpose of service development and continuity, as well as reducing and eliminating the coding backlog, we also need to recruit 2 trainee coders. Once the qualified and trainee coders are integrated and fully contributing to the work of the Clinical Coding team, DCH will have a robust team that provides a timely service of high quality.

The latest published SHMI (rolling year to October 2022) is shown below:



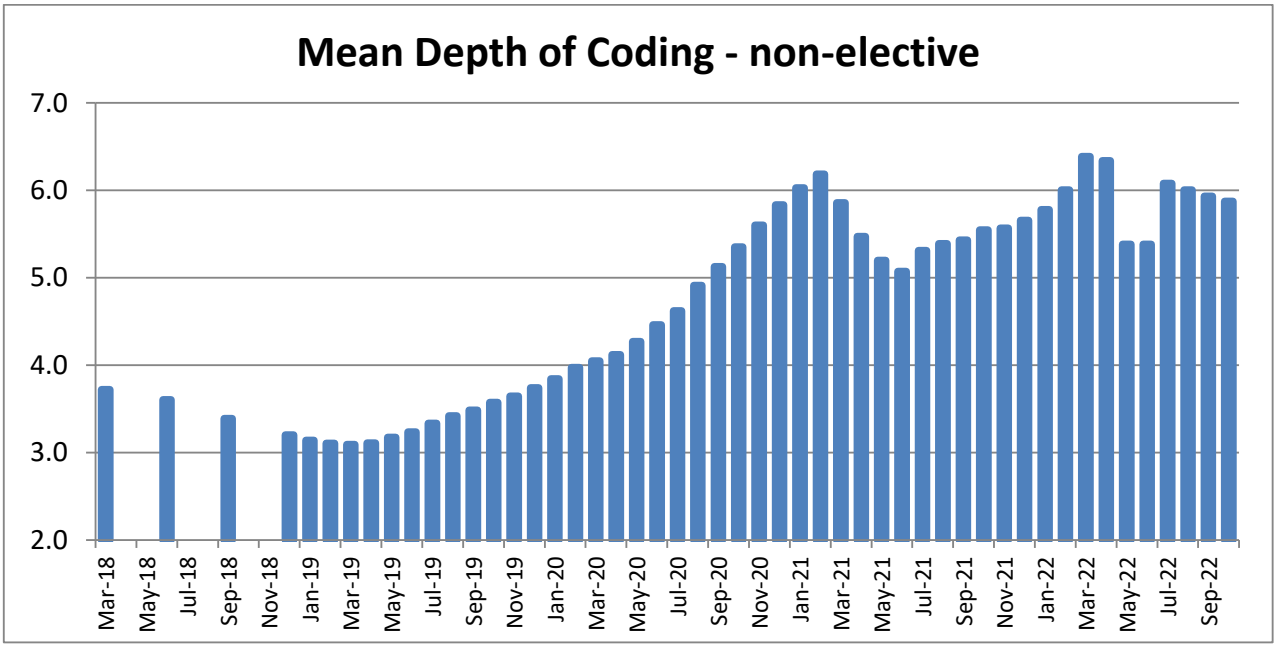
SHMI is calculated by comparing the number of observed (actual) deaths in a rolling 12 month period to the expected deaths (predicted from coding of all admissions). From October 2019 onwards there had been a steady trend of improvement in DCH's SHMI as a result of investment in the coding department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

2.2 Percentage of provider spells with a primary diagnosis which is a symptom or sign: DCH has recently had a very high but now normalised number of spells with a primary diagnosis which is a symptom or sign – for example either no entry at all (uncoded), or 'chest pain' rather than 'myocardial infarction' – at 31.8% for June 2021 but improving progressively to below the average for England of 13.5%.



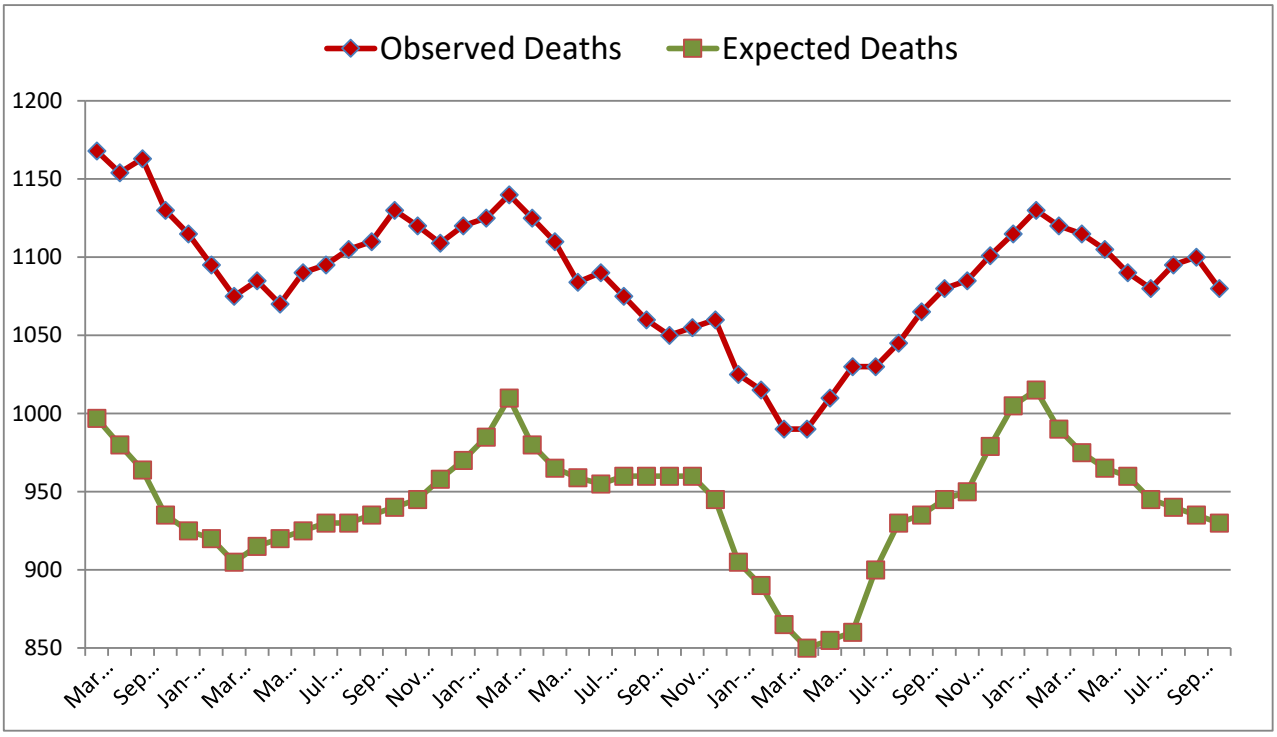
2.3 Depth of coding: NHS Digital states "*As well as information on the main condition the patient is in hospital for (the primary diagnosis), the SHMI data contain up to 19 secondary diagnosis codes for other conditions the patient is suffering from. This information is used to calculate the expected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

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



2.4 Expected Deaths (based on diagnoses across all admissions (except covid) per rolling 12 months):

The chart below shows observed (actual) and expected deaths over the past 3+ years (rolling years from March 18 to Sept 22), and whilst both observed deaths have tended to increase (as the total number of in-patients increases post covid-19), the expected deaths have decreased over the 6 months to October 22, possibly as a result of the focus on recovery of the coding backlog.



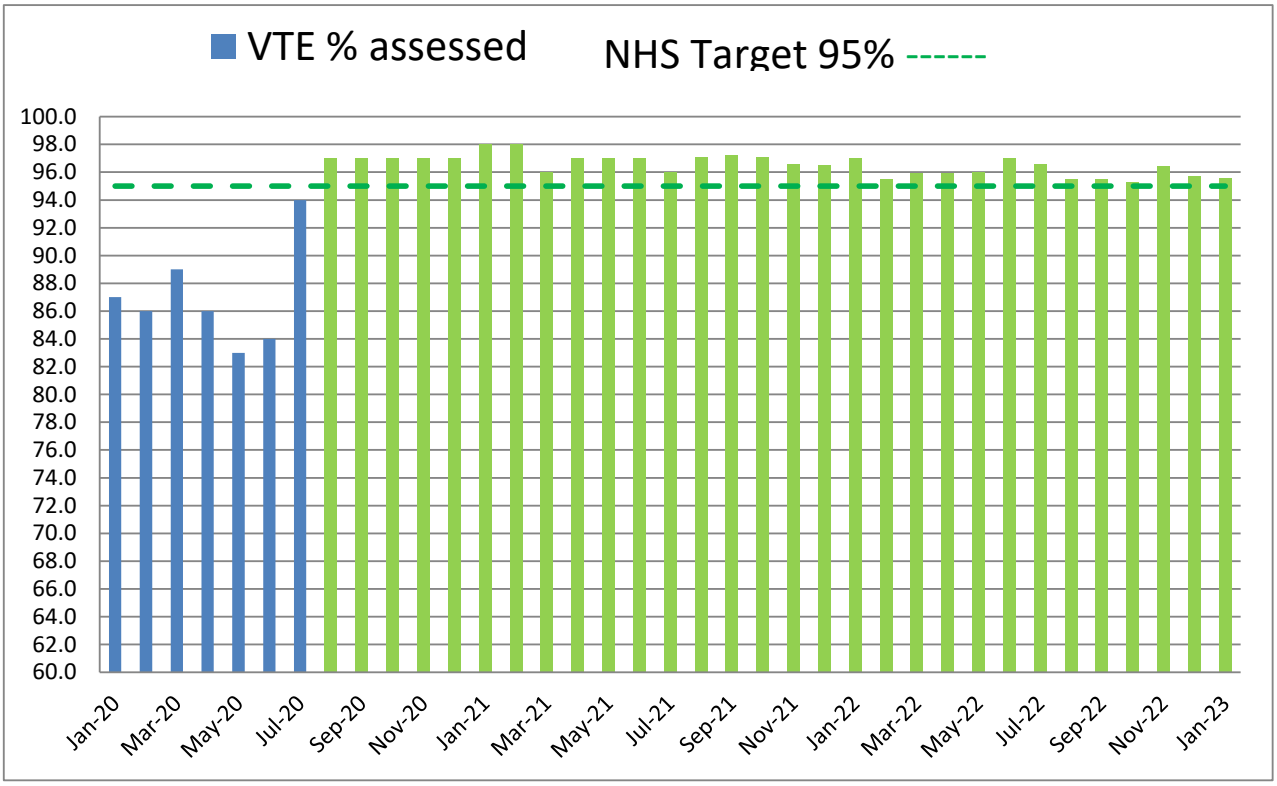
3.0 OTHER NATIONAL AUDITS/INDICATORS OF CARE

The DCH Learning from Deaths Mortality Group continues to meet on a monthly basis to examine any other data which might indicate changes in standards of care. The following sections report data available from various national bodies which report on Trusts' individual performance. However much of this data has also been interrupted by covid-19 and is only gradually catching up again.

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

In light of various issues related to maternity units and excess deaths of both children and mothers, NHS Digital has now published the first iteration of a "National Maternity Dashboard". The Quality Committee is asked to consider whether any part of this dashboard should be duplicated in future DCH Learning from Deaths reports, or noted as part of the DCH Quality Dashboard.

DCH VTE risk assessment recording reached 97% in August 2020 with the introduction of a more accurate reporting system, and after a process of data cleansing which removed a number of duplicate reports in Surgery it is clear that the Trust is now consistently achieving the required standard of >95%. Dr Aruna Arjunan has taken over as chair of the VTE Group and is auditing compliance with the VTE prophylaxis policy which has been revised.

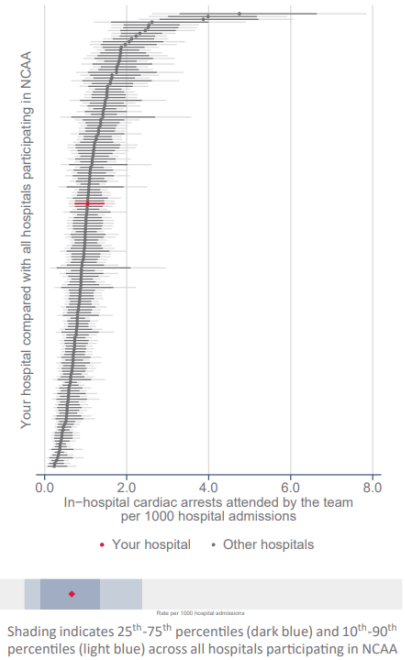


3.1 NCAA Cardiac Arrest data

The national Cardiac Arrest audit for DCH including data from April 2022 to September 2022 (quarters 1 and 2) was published on 05/12/2022. Frequent cardiac arrest calls suggest unanticipated deterioration in a patient's condition, whereas fewer calls suggest higher standards of care, although this is unproven. A total of 35 cardiac arrest calls were recorded for this 6 month period, but not all were definite cardiac events since the cardiac arrest call is also used for any serious or unexpected patient event.

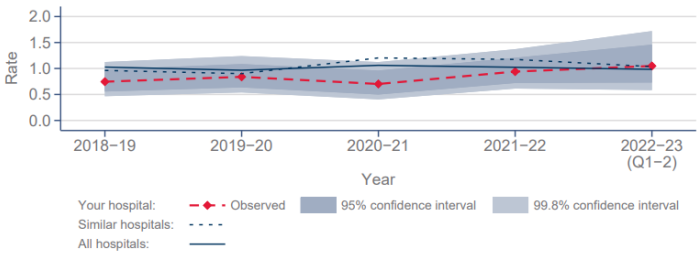
The graph below represents the number of in-hospital cardiac arrest calls attended by the team per 1,000 admissions for all adult, acute care hospitals in the NCA Audit. DCH is indicated in red, and lower on the chart is better. The table to the right gives more detail by quarter year, and the graph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

Rate of cardiac arrests per 1000 hospital admissions



Shading indicates 25th-75th percentiles (dark blue) and 10th-90th percentiles (light blue) across all hospitals participating in NCAA

	Hospital admissions	Eligible team visits	Rate per 1000 hospital admissions	95% confidence interval	99.8% confidence interval
Quarter 1	16802	19	1.13	(0.68, 1.77)	(0.49, 2.18)
Quarter 2	16587	16	0.96	(0.55, 1.57)	(0.39, 1.97)
Quarter 3					
Quarter 4					
Year to date	33389	35	1.05	(0.73, 1.46)	(0.58, 1.72)



Definition

- Hospital admissions: Total includes elective, non-elective, day cases, babies born in your hospital and neonates
- Eligible team visits: All reported in-hospital cardiac arrests attended by the team
- Observed rate: The total number of cardiac arrests attended by the team divided by the total number of admissions to your hospital multiplied by 1000 to give a rate per 1000 hospital admissions
- Confidence interval: Reflects the degree of uncertainty surrounding your observed rate, given the total number of admissions to your hospital

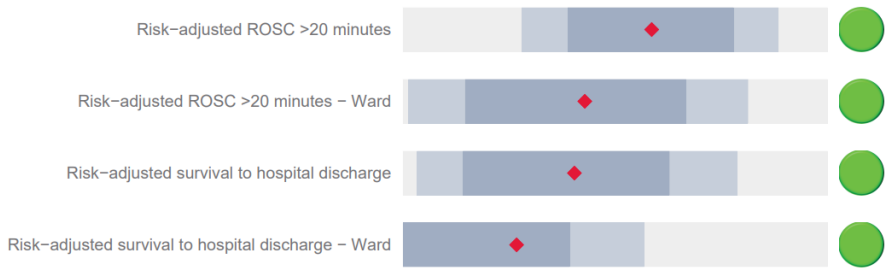
Dorset County Hospital
NCAA Report: 1 April 2022 to 30 September 2022

4

Date of report: 05/12/2022
©Resuscitation Council (UK) & ICNARC

The graph below shows two outcome measures:
a) Return of Spontaneous Circulation (a measure of resuscitation effectiveness) and
b) Survival to Discharge.
These and all other measures in the report get a 'green' indicator for the most recently reported Quarters 1 2 (2022/23).

Risk-adjusted outcomes: Dashboard



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

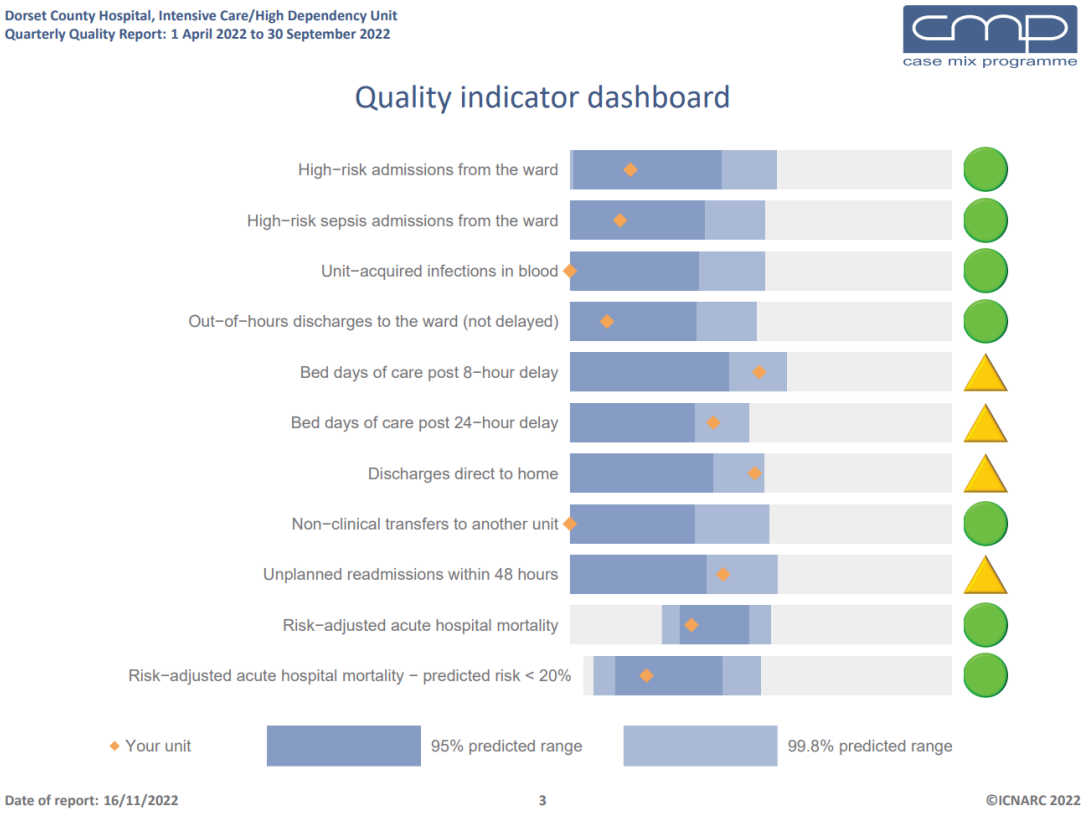
Results Summary		Dorset County Hospital	National results
Patient Characteristics and Diagnosis		**n = 88**	**n = 10174**
Gender	Male Female	43% 57%	48% 52%
Age	Median (IQR)	78 (61-84)	75 (61-85)
Cohort Severity (CURB65 score)	0-1 2 3-5	42% 31% 27%	47% 29% 24%
Inpatient mortality	Proportion deceased	7%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

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

3.3 ICNARC Intensive Care survival latest data for April to September 2022; published 06 December 2022; n = 311 patients.

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

Unplanned readmissions were higher than expected in Q1 (4% versus expected 1%) but normalised during Q2 (1.0% versus expected 0.9%). However, the combined result for Q1 + Q2 remains higher than expected.

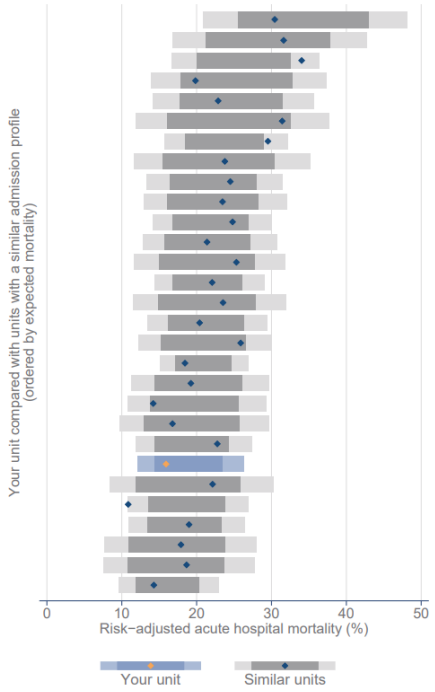


The charts below show the “risk adjusted acute hospital mortality” following admission to the DCH Critical Care Unit, Q1 + Q2 2022/23. They compare observed and expected death rates in a similar fashion to SHMI.

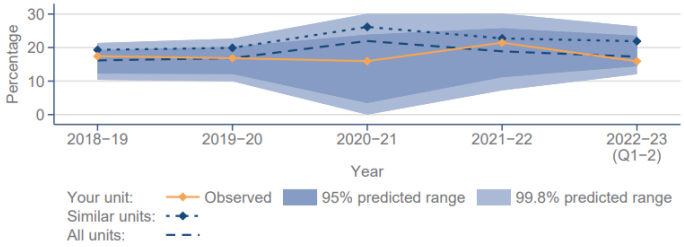
Dorset County Hospital, Intensive Care/High Dependency Unit
Quarterly Quality Report: 1 April 2022 to 30 September 2022

case mix programme

Risk-adjusted acute hospital mortality



	N	Eligible	Observed percentage	Expected percentage	95% predicted range	99.8% predicted range	
Quarter 1	146	135	14.8	18.7	(12.0, 25.1)	(8.7, 29.4)	
Quarter 2	165	154	16.9	19.3	(13.0, 25.4)	(9.8, 29.4)	
Quarter 3							
Quarter 4							
Year to date	311	289	15.9	19.0	(14.4, 23.5)	(12.1, 26.3)	



Definition

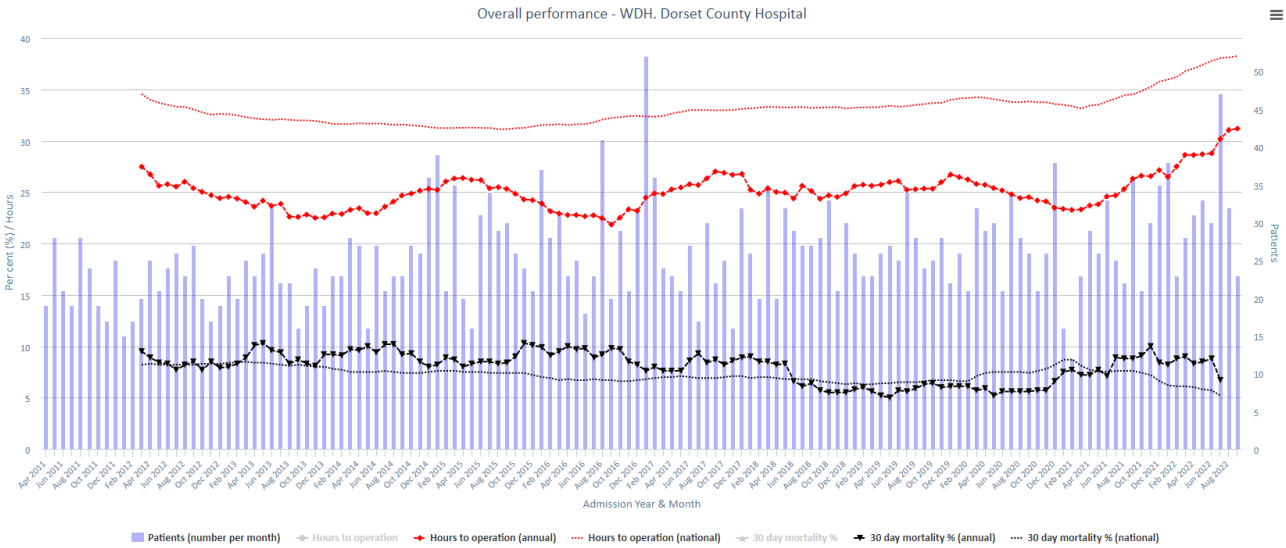
- Eligible: All critical care unit admissions, excluding readmissions, patients dead on admission and those admitted to facilitate organ donation
- Observed percentage: The percentage of eligible admissions that died before ultimate discharge from acute hospital
- Expected percentage: The expected percentage of acute hospital deaths among eligible admissions, calculated as the mean predicted risk of death from the ICNARC$_{H-2018}$ model for eligible admissions to your unit
- Predicted range: We expect a unit's observed percentage to lie within the 95% predicted range 19 times out of 20 and within the 99.8% predicted range 998 times out of 1000

Date of report: 16/11/2022 13 ©ICNARC 2022

These results are within the expected range and therefore score 'green'.

3.5 National Hip Fracture database to April 2021

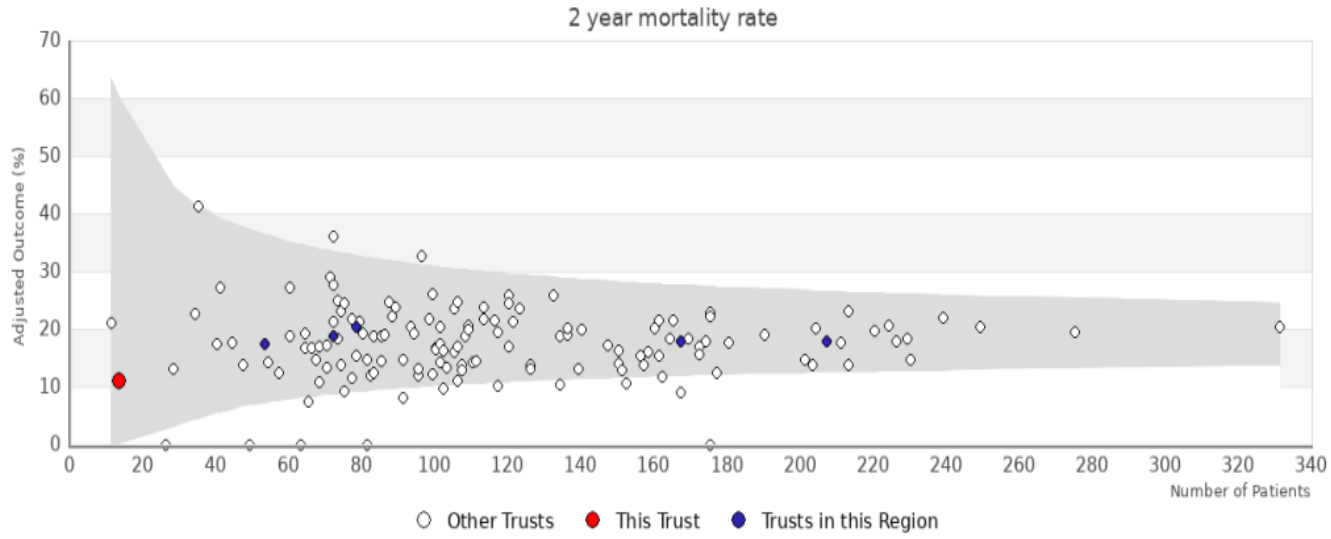
Mortality data had been delayed by contract negotiations with NHS Digital and were published in full for Q1, but it has not been updated from the previous Q1 report, and so the graph below is unchanged.



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

3.6 National Bowel Cancer Annual audit

New data has now been published for 2 year survival after bowel cancer surgery for patients in England and Wales diagnosed with bowel cancer 1 April 2020 – 31 March 2021. The graph below shows the latest available 2 year survival data for these patients compared to all other NHS Trusts, with other Wessex Trusts in dark blue. The numbers are very small reflecting the effect of the covid pandemic on admissions, however 2-year survival data for DCH is good with an expected death rate of 10.9% versus an actual rate of 7.8%. This percentage difference probably reflects a difference of a single patient's survival.



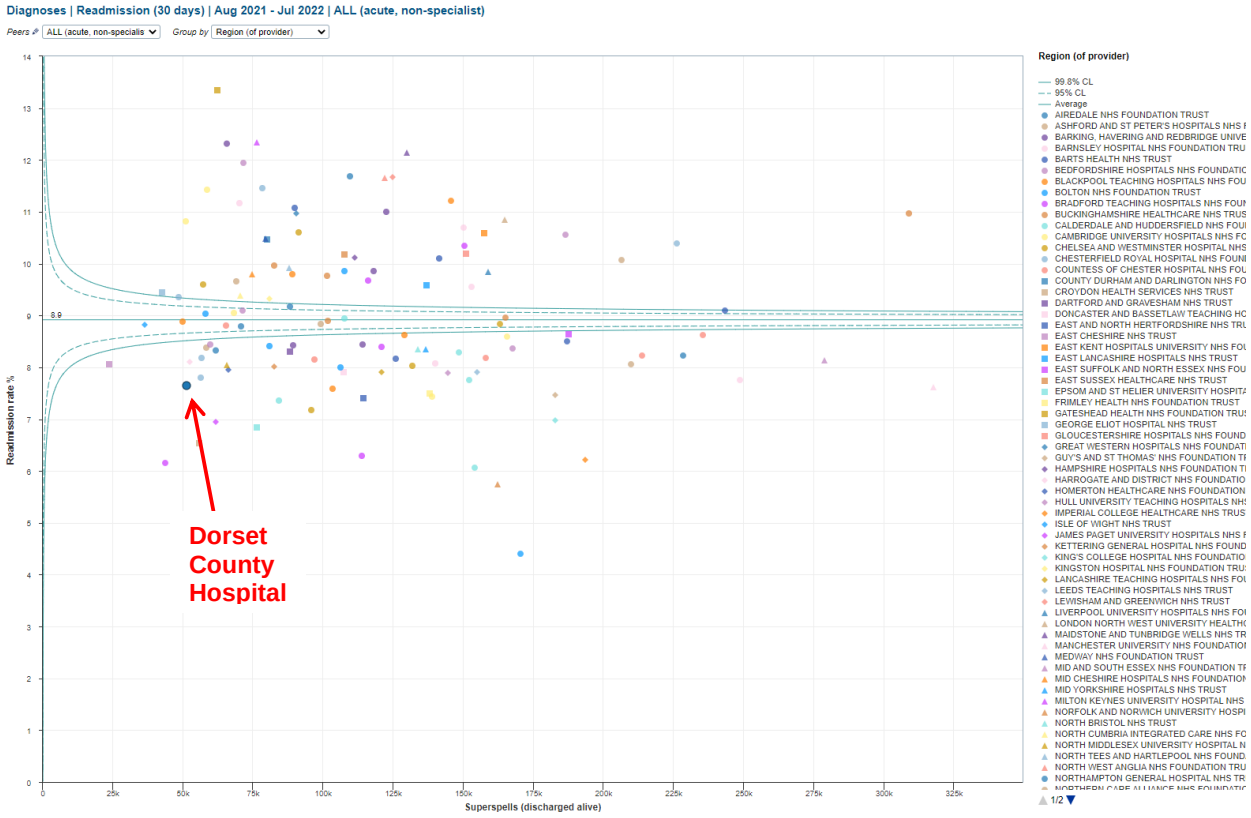
3.7 Getting it Right First Time; reviews in Qtr 3

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

3.8 Trauma Audit and Research Network

DCH is a designated Trauma Unit (TU) providing care for most injured patients, and has an active, effective trauma Quality Improvement programme. It submits data on a regular basis to TARN which then enables comparison with other TUs. No new data has been published since that reported in the previous Q2 Learning from Deaths report. The data is therefore unchanged and reports up to December 2021 only. No explanation is currently available for this.

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



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

3.10 Dr Foster Safety Dashboard

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

4.0 QUALITY IMPROVEMENT ARISING FROM SJRs

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

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

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

c) With an elevated SHMI and in the absence of any obvious flags from SJRs, an audit of 50 consecutive deaths is being undertaken in March 2023 (strikes permitting) to re-examine the accuracy and quality of the SJR scrutiny.

5.0 MORBIDITY and MORTALITY MEETINGS

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

6.0 LEARNING FROM CORONER'S INQUESTS Q3

DCH has been notified of 17 new Coroner's inquests being opened in the period October 2022 – December 2022.

11 inquests were held during Quarter 3. 4 inquests were heard as Documentary hearings, not requiring DCH attendance. 2 required the clinician to attend Court in person. 3 required attendance remotely from the DCH 'virtual courtroom' (in THQ) using Microsoft Teams. 2 inquests were held hybrid – attending in person and some clinicians joining remotely.

We currently have 57 open Inquests. The Coroner has reviewed all outstanding cases to decide whether any can be heard as documentary hearings. 0 pre-inquest reviews were listed during this period.

We continue to work with the Coroner's office, and will continue to support staff at these hearings. The coroner requested that from May 2022 witnesses should attend the court room at the Town Hall, Bournemouth in person. Authority is now required if we wish the clinician to attend remotely. The number of inquests being listed appear to be increasing which logistically causes challenges. We have a date in February, where 3 inquests are scheduled on one day.

7.0 LEARNING FROM CLAIMS Q3

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

Claims pattern this Quarter:

New potential claims	10
Disclosed patient records	22 (including disclosure to the Coroner as well as claims)
Formal claims	3 clinical negligence, XX employee claim
Settled claims	3 clinical negligence, 1 employee claim
Closed - no damages	0 clinical negligence, 0 employee claim

8.0 SUMMARY

SHMI has not improved as expected following the updated HES data for 2021/22, submitted to NHS Digital by the deadline of 19th May 2022. A stable coding backlog exists of around 4,000 cases and the coding department continues to attempt to recruit to vacancies to solve this problem. All mortality data requires on-going scrutiny and an audit of approximately 50 deaths is about to commence to look for any evidence of 'avoidability' or poor care, as well as closer examination of diagnostic groups that are indicating higher observed than expected deaths.

No other metrics of in-patient care suggest that excess mortality is occurring at DCH and much of the national data suggests better than average mortality, although National Hip Fracture mortality is less good than it was. Nevertheless the Hospital Mortality Group remains vigilant and will continue to scrutinise and interrogate all available data to confirm or refute this statement on a month by month basis. At the same time internal processes around the completion and recording of SJRs, M&M meetings and Learning from Deaths are now well embedded and working effectively within the Divisional and Care Group Teams.

Report Front Sheet

1. Report Details			
Meeting Title:	Board of Directors, Part 1		
Date of Meeting:	29 March 2023		
Document Title:	CQC Targeted Inspection Report and Action Plan		
Responsible Director:	Jo Howarth, Interim Chief Nursing Officer	Date of Executive Approval	16/03/23
Author:	Jo Howarth		
Confidentiality:	No		
Publishable under FOI?	Yes		
Predetermined Report Format?	The format of the report been set in order to meet regulatory requirements as determined by the CQC		

2. Prior Discussion		
Job Title or Meeting Title	**Date**	**Recommendations/Comments**
Quality Committee	21 March 2023	Approved, pending minor updates to actions

3. Purpose of the Paper	The quality Committee are asked to receive and note the final report following CQC inspection of services for children and young people with mental health issues, learning disabilities or autism and the resulting Trust action plan.							
	Note (✓)		*Discuss (✓)*		*Recommend (✓)*		*Approve (✓)*	
4. Key Issues	The report of services for children and young people with mental health issues, learning disabilities or autism follows and a CQC inspection undertaken during August 2022. A summary of the key points in the paper to consider are as follows: - Systems and processes to investigate and follow up safeguarding concerns were not always effective. Not all staff had completed the safeguarding training required of their role. - Facilities and premises in the emergency department were not in line with national guidance to ensure children and young people were kept safe, including those who presented with an acute mental health episode and/or had a learning disability and/or autistic children and young people. - Staff did not document environmental risk assessments to ensure children and young people admitted were kept safe. - Staff did not document using the risk assessment tool as required in the trust's Children and Young People Mental Health Policy. - Staff absence was high at the time of our inspection. - There were no regular audits to assess if care and treatment provided was compliant with care pathways based on national guidance. - There was a lack of clarity regarding the clinical leadership for overseeing treatment of children and young people who needed treatment of mental health conditions. - There was a lack of documented evidence to confirm staff had the correct knowledge and understanding of how to obtain consent for treatment for children and young people. - Clinical leaders did not feel empowered to escalate concerns externally when this was required. - There was a lack of governance processes to effectively assess and							

	record the capacity of children and young people, throughout the service and with partner organisations, to ensure children and young people with mental health needs received effective treatment. However: - Staff on the inpatient ward worked to improve the environment to ensure it was safe and met the needs of children and young people. - The service had enough staff with the right qualifications, skills, training and experience to keep children, young people and their families safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix. - Staff kept detailed records of children and young people's care and treatment when children were admitted with physical health needs. Records were clear, up to date, stored securely and easily available to all staff providing care. - The service mostly managed patient safety incidents well. Managers investigated incidents and shared lessons learned with the whole team and the wider service. - Staff gave children, young people and their families enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. - The service was inclusive and took account of children, young people and their families' individual needs and preferences. Staff made reasonable adjustments to help children, young people and their families access services. As a result of inspection, the CQC identified 4 'Must Do' actions: - The trust must ensure care and treatment is provided with the consent of relevant persons. There was a lack of documented evidence that the child's voice was heard, and that staff fully understood the complexity of consent, capacity and competency (Regulation 11 (1)). - The trust must ensure all risks, including environmental risks, associated with children and young people admitted to the hospital are assessed and mitigated. Clear evidence of this must be recorded in patients' medical notes (Regulation 12 (2) (a) (b)) - The trust must improve systems and processes to investigate and follow up on any allegations, evidence or concerns raised about safeguarding issued when children and young people present to the emergency department and/or are admitted to the paediatric service (Regulation 13 (2) (3)). - The trust must assess the impact of the building work in the emergency department to ensure mitigating actions are identified to ensure the premises are suitable for the purpose for which they are being used (Regulation 15 (1) (c))
5. Action recommended	The Board is recommended to: 1. **NOTE** the inspection report

6. Governance and Compliance Obligations			
Legal / Regulatory Link	**Yes**		**As above**
Impact on CQC Standards	**Yes**		**As stated**
Risk Link	**Yes**		

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	Training and education for staff		
	Place	Opportunity to strengthen services available to Children and Young People in our care		
	Partnership	Opportunity to strengthen relationships with partner agencies		
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**		*Early intervention and support for CYP with mental health, learning disabilities and autism needs*
Tackling unequal outcomes and access		**Yes**		*Opportunity to deliver more effective and compassionate care to those most in need and where equity of access is impeded by the current system*
Enhancing productivity and value for money		**Yes**		*Opportunity to reduce length of stay or support admission avoidance*
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)			**No**	
Quality Impact Assessment (QIA)			**No**	

Report on actions you plan to take to meet Health and Social Care Act 2008, its associated regulations, or any other relevant legislation.

Please see the covering letter for the date by when you must send your report to us and where to send it. **Failure to send a report may lead to enforcement action.**

Account number	RBD
Our reference	INS2-14773300228
Location name	Dorset County Hospital NHS Foundation Trust

Regulated activity	**Regulation**
Treatment of disease, disorder or injury	**Regulation 11** **Need for consent**
	How the regulation was not being met:
	The trust must ensure care and treatment is provided with the consent of relevant persons. There was a lack of documented evidence that the child's voice was heard, and that staff fully understood the complexity of consent, capacity and competency (Regulation 11 (1)).

Please describe clearly the action you are going to take to meet the regulation and what you intend to achieve

Review and update of Trust consent policy – complete and ratified (March 2023, embedded).

Delivery of targeted update training on consent, capacity, and competency by Trust solicitors to ED, Paediatrics and Trust wide teams, including Maternity. Dates confirmed. Wk/Bg 24.04.23

Development of hard copy and digital records to ensure consent is clearly recorded. Digital consent project to commence 2023. Funding and procurement agreed Feb' 23.

Competency template developed for use with Children and Young People - embedded.

Enc 1. Competency template.pdf

Consent to Examination or Treati

Who is responsible for the action?	Chief Medical Officer (Policy) Chief Nursing Officer (Training and audit) Chief Information Officer (digital records)

How are you going to ensure that the improvements have been made and are sustainable? What measures are going to put in place to check this?

Monitoring of training compliance

3 monthly audit of documentation and policy compliance - Clinical Audit and Safeguarding Teams

Audit of Consent – Quarter 1 Internal Audit programme 2023/24

Review of performance at Clinical Effectiveness Committee and by Risk and Audit Committee

Who is responsible?	Chief Medical Officer (Chair of Clinical Effectiveness

	Committee)
What resources (if any) are needed to implement the change(s) and are these resources available?	
Time, training capacity, support from Clinical Effectiveness Manager and Clinical Audit Team. Resources secured.	
Date actions will be completed:	Policy for ratification March 2023 Training commenced March 2023 (ongoing) Audit programme Quarter 1 2023/24

How will people who use the service(s) be affected by you not meeting this regulation until this date?
Inconsistent approach to capacity assessment and consent that may increase the risk that the voice of the child is not heard and documented clearly.

Completed by: (please print name(s) in full)	Joanna Howarth
Position(s):	Chief Nursing Officer
Date:	23.03.2023

Regulated activity	Regulation
Treatment of disease, disorder or injury	**Regulation 12** **Safe care and treatment**
	How the regulation was not being met:
	The trust must ensure all risks, including environmental risks, associated with children and young people admitted to the hospital are assessed and mitigated. Clear evidence of this must be recorded in patients' medical notes (Regulation 12 (2) (a) (b))

Please describe clearly the action you are going to take to meet the regulation and what you intend to achieve

Deliver Mental Health Act (MHA) 1983 Section 5(2) holding powers for inpatient training to targeted individuals. Training programme by Dorset Healthcare University Foundation Trust in place and underway. 20th February and 6th March 2023.

Deliver Safe Holding training in identified areas for both adults and children. Delivery agreed by Dorset University Healthcare Trust. Dates and lesson plan embedded.

Utilisation of the Paediatric Reasonable Adjustment form (table 2. in the CYP Mental Health Policy) embedded. This assesses environment, cognancy and clinical risk.

Standardise risk assessments and mitigations/interventions – Utilise CYP safety observation chart (embedded) with recommended observation frequency and actions to implement following risk assessment for level of Mental Health observations required. CYP Mental Health Policy embedded.

New de-escalation room and ligature free bathroom work in progress. Full engagement with Dorset Health Care, ASD Nurse Specialist and Matron to ensure fit for purpose and inclusive for the variation in required need.

Ligature policy development - awaiting ratification.

Use of PDOC (patient specific care plans) to ensure known risks are managed from the point of arrival to facilitate appropriate location if admission required and staffing levels that meet individualised care needs to ensure patient safety.

Paediatric Reasonable Adjustme

Safe holding Training groups 2023.docx

Session Plan DCH.docx

Scan.pdf

Who is responsible for the action?	Chief Nursing Officer with support from Head of Nursing, Family and Surgical Division Head of Risk

How are you going to ensure that the improvements have been made and are sustainable? What measures are going to put in place to check this?

Monitoring of training compliance via Division and Trust Mental Health steering group.

Audit of policy including compliance with Safety Observation form, care plan utilisation and CYPMH continuation sheet. Monitoring of Departmental Risk Register for completeness via Care Group and Division Review of progress and performance at Mental Health steering group and Quality Committees	
Who is responsible?	Chief Nursing Officer
What resources (if any) are needed to implement the change(s) and are these resources available?	
Time, support from clinical audit and risk teams	
Date actions will be completed:	May 2023

How will people who use the service(s) be affected by you not meeting this regulation until this date?
Risks may not be fully mitigated and reduced.

Completed by: (please print name(s) in full)	Joanna Howarth
Position(s):	Chief Nursing Officer
Date:	23.03.2023

Regulated activity	Regulation
Treatment of disease, disorder or injury	**Regulation 13** **Safeguarding service users from abuse and improper treatment**
	How the regulation was not being met:
	The trust must improve systems and processes to investigate and follow up on any allegations, evidence or concerns raised about safeguarding issued when children and young people present to the emergency department and/or are admitted to the paediatric service (Regulation 13 (2) (3)).

Please describe clearly the action you are going to take to meet the regulation and what you intend to achieve

All ED/PAU attendances and admissions to Kingfisher are subject to review by the Safeguarding Team – established.

All interventions and advice, including MDT, Professionals and Strategy meetings will be formally recorded in patient medical records and on DPR – established.

Oliver McGowan e-learning training launched to replace Trust local training programme for Learning and Autism awareness.

Improve Level 3 Children's Safeguarding training compliance. Lesson plan embedded. Current compliance 84% with trajectory agreed.

Implement and comply with Dorset CYP Memorandum of Understanding – complete, in use and embedded.

Learning objectives and lesson plan.doc

0972-supporting-people-with-a-learning

MoU Dorset System support for CYP in acu

Who is responsible for the action?	Head of Safeguarding Chief Nursing Officer

How are you going to ensure that the improvements have been made and are sustainable? What measures are going to put in place to check this?

Internal audit of compliance with consent, capacity and competency, and associated records, to be completed in Q1.

Ongoing monitoring of compliance with Safeguarding training

Complete Section 11 audit and review compliance via Trust Safeguarding and Quality Committees

Who is responsible?	Chief Nursing Officer

What resources (if any) are needed to implement the change(s) and are these resources available?

Time, support from Internal Auditors

Date actions will be completed:	March 2023

How will people who use the service(s) be affected by you not meeting this regulation until this date?
All actions complete – monitoring underway

Completed by: (please print name(s) in full)	Joanna Howarth
Position(s):	Chief Nursing Officer
Date:	23.03.2023

Regulated activity	Regulation
Treatment of disease, disorder or injury	**Regulation 15** **Premises and equipment**
	How the regulation was not being met:
	The trust must assess the impact of the building work in the emergency department to ensure mitigating actions are identified to ensure the premises are suitable for the purpose for which they are being used (Regulation 15 (1) (c))

Please describe clearly the action you are going to take to meet the regulation and what you intend to achieve	
Whilst mitigations were in place during the capital build programme at the time of inspection, all estates and building work is now complete. Dedicated Safe Room and Paediatric Waiting Room both in use.	
Who is responsible for the action?	Chief Finance Officer Head of Estates and Facilities
How are you going to ensure that the improvements have been made and are sustainable? What measures are going to put in place to check this?	
Estates and building work now fully completed.	
Who is responsible?	Chief Finance Officer
What resources (if any) are needed to implement the change(s) and are these resources available?	
None	
Date actions will be completed:	January 2023

How will people who use the service(s) be affected by you not meeting this regulation until this date?
Not applicable

Completed by: (please print name(s) in full)	Joanna Howarth
Position(s):	Chief Nursing Officer
Date:	23.02.2023

Report Front Sheet

1. Report Details			
Meeting Title:	Board Meeting		
Date of Meeting:	29 March 2023		
Document Title:	**Maternity Safety Report**		
Responsible Director:	Jo Howarth, CNO	Date of Executive Approval	21st March 2023
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	21 March 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 February 2023 and where relevant, quarter three. This is to provide assurances of maternity quality and safety and effectiveness of patient care with evidence of quality improvements to the Trust Board.

- Data from Power BI provided
- Summary of HSIB actions as shared with the Joint LMNS Safety Meeting Dorset & Somerset
- New guidelines noted.
- Two complaints plus informal feedback
- Training figures improved
- Entonox levels remain a concern with actions detailed
- Call bell and emergency bell volume remains a concern with an update below
- Update of actions from Insight Visit. Overall good compliance with further clarification required for three actions and non-compliance on the requirement for a face-to-face handover from day to night consultant

4. Action recommended

The committee is recommended to:

1. **NOTE** the report
2. **DISCUSS** any performance issues
3. **APPROVE** the report

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			**No**	
Helping the NHS to support broader social and economic development			**No**	
Assessments		**Have these assessments been completed?** *If yes, please include the assessment in the appendix to the report..* *If no, please state the reason in the comment box below.* *(Please delete as appropriate)*		
Equality Impact Assessment (EIA)			**No**	
Quality Impact Assessment (QIA)			**No**	

Dorset County Hospital
NHS Foundation Trust

Maternity Quality and Safety report

March 2023 (February activity)

Submitted by Jo Hartley, Director of Midwifery & Neonatal Services

Executive sponsor: Jo Howarth CNO

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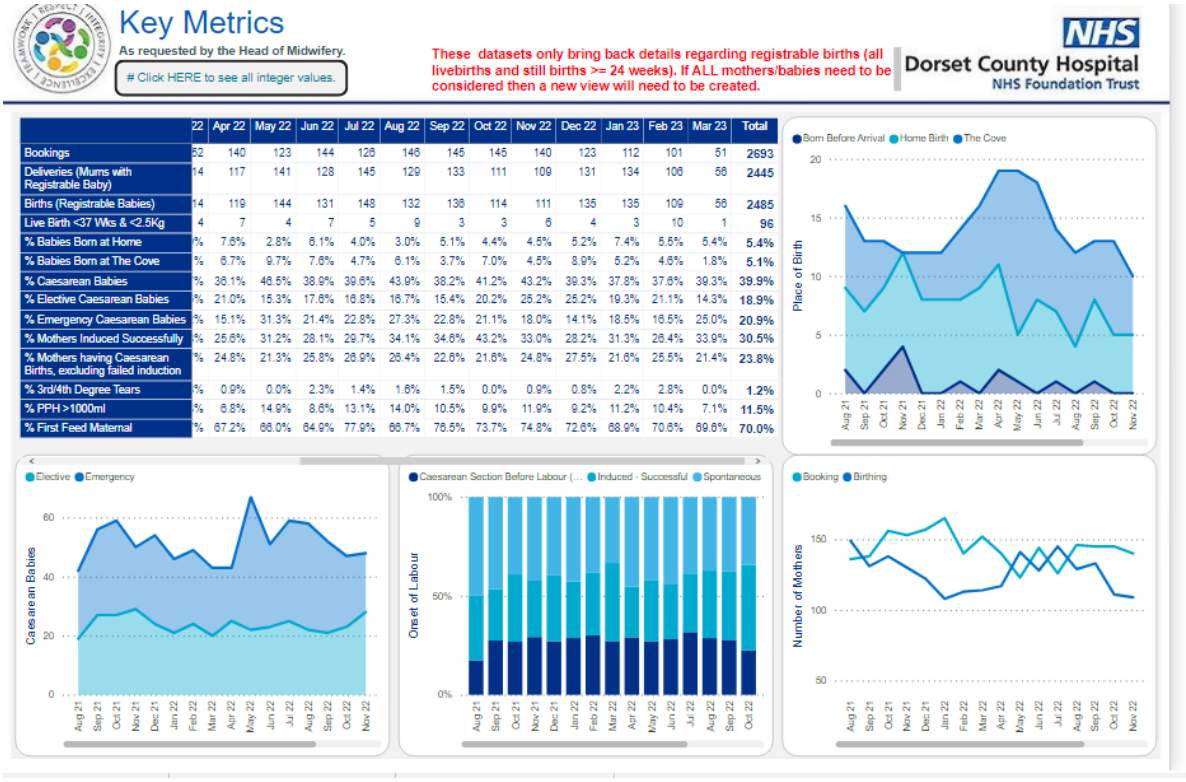
Executive Summary

This report sets out to the Trust Quality Committee the quality and safety activity covering the month of February 2023 and where relevant, quarter three. This is to provide assurances of maternity quality and safety and effectiveness of patient care with evidence of quality improvements to the Trust Board.

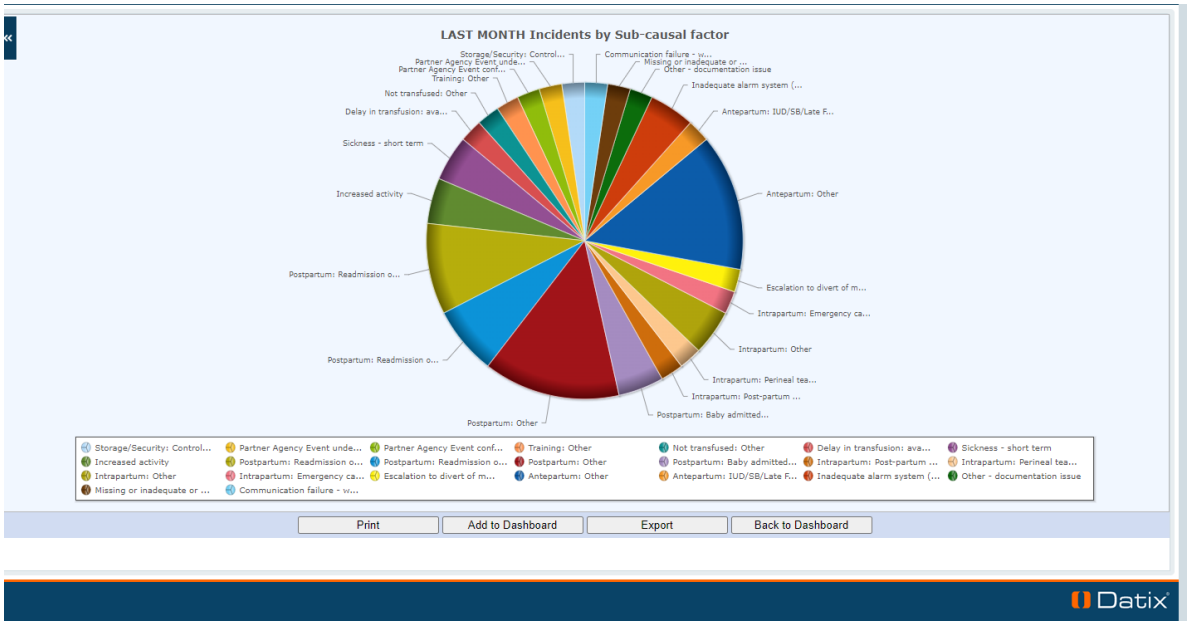
- Data from Power BI provided
- Maternity staffing is improving
- Summary of all SIs and HSIB actions as shared with the Joint LMNS Safety Meeting Dorset & Somerset
- New guidelines noted.
- One formal and one informal complaint received
- Training figures improved
- Update on current SIs and RCAs
- Entonox levels remain a concern with actions detailed
- Call bell and emergency bell volume remains a concern with an update below
- Update of actions from Insight Visit. Overall good compliance with further clarification required for three actions and non-compliance on the point below
- Although not currently a formal expectation, it is expected that later this year all obstetric services will be mandated to have an MDT day to night handover with consultant presence. Currently we are compliant but our last handover with consultant presence is 1730. A day to night handover will require an increase in the consultant wte

Activity



	22	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Total
Bookings	52	140	123	144	126	146	145	145	140	123	112	101	51	2693
Deliveries (Mums with Registrable Baby)	14	117	141	128	145	129	133	111	109	131	134	106	56	2445
Births (Registrable Babies)	14	119	144	131	148	132	136	114	111	135	135	109	56	2485
Live Birth <37 Wks & <2.5Kg	4	7	4	7	5	9	3	3	6	4	3	10	1	96
% Babies Born at Home	%	7.6%	2.8%	6.1%	4.0%	3.0%	5.1%	4.4%	4.5%	5.2%	7.4%	5.5%	5.4%	5.4%
% Babies Born at The Cove	%	6.7%	9.7%	7.6%	4.7%	6.1%	3.7%	7.0%	4.5%	8.9%	5.2%	4.6%	1.8%	5.1%
% Caesarean Babies	%	36.1%	46.5%	38.9%	39.6%	43.9%	38.2%	41.2%	43.2%	39.3%	37.8%	37.6%	39.3%	39.9%
% Elective Caesarean Babies	%	21.0%	15.3%	17.6%	16.8%	16.7%	15.4%	20.2%	25.2%	25.2%	19.3%	21.1%	14.3%	18.9%
% Emergency Caesarean Babies	%	15.1%	31.3%	21.4%	22.8%	27.3%	22.8%	21.1%	18.0%	14.1%	18.5%	16.5%	25.0%	20.9%
% Mothers Induced Successfully	%	25.6%	31.2%	28.1%	29.7%	34.1%	34.6%	43.2%	33.0%	28.2%	31.3%	26.4%	33.9%	30.5%
% Mothers having Caesarean Births, excluding failed induction	%	24.8%	21.3%	25.8%	26.9%	26.4%	22.6%	21.6%	24.8%	27.5%	21.6%	25.5%	21.4%	23.8%
% 3rd/4th Degree Tears	%	0.9%	0.0%	2.3%	1.4%	1.6%	1.5%	0.0%	0.9%	0.8%	2.2%	2.8%	0.0%	1.2%
% PPH >1000ml	%	6.8%	14.9%	8.6%	13.1%	14.0%	10.5%	9.9%	11.9%	9.2%	11.2%	10.4%	7.1%	11.5%
% First Feed Maternal	%	67.2%	66.0%	64.9%	77.9%	66.7%	76.5%	73.7%	74.8%	72.6%	68.9%	70.6%	69.6%	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 February 202-January 2023

Mar	Apr	May	June	July	Aug	Sep	Oct	Nov	Dec	Jan	Feb
55	70	93	79	76	70	63	74	62	60	34	44
Number of incidents overdue: 14						Overdue incidents relate to delayed responses across different specialities as well as maternity. Some of these can be closed easily but others awaiting a response. To be followed up as a priority					

Red Flag incidents: A midwifery red flag event is a warning sign that something may be wrong with midwifery staffing.

Red flag	Descriptor	Incidence
RF1	Escalation to divert of maternity services & poor staffing numbers, including medical staffing and SCBU	2 maternity diverts and 4 datix for staffing
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

Of note is the reduction in numbers of datix submitted. Whilst it is possible the number of incidents has reduced, it is also possible staff are suffering from "datix-fatigue". Different forums will be utilized to remind staff of the importance of submitting a datix for any and all concerns

HSIB update

Slides submitted to the Joint Safety Team meeting with DCH and Somerset LMNS

HSIB cases at DCH – 5 in total

Themes:

- 4 investigations had recommendations, one case had none.
- Recommendations range from one to four.
- Fetal monitoring - 2 investigations.
- Clinical assessment - 2 investigations.
- Information for families - 1 investigation
- Guidance (clinical) - 3 investigations.
- Communication (SBAR) - 1 investigation.
- Risk assessment - 1 investigation.

Trust Actions

- Embedding of fetal monitoring lead midwife and obstetric consultant. K2 mandatory. Regular on line sessions of cases presented for learning.
- Information regarding transfer rate from home to hospital provided by home birth team.
- Unfamiliarity of performing episiotomy. This issue has been raised in Prompt training with indications discussed and undertaking an episiotomy demonstrated.
- Home birth equipment in different bags. Baby life line bags sourced for all home birth team members.
- Guidelines updated: *Intrapartum care for women in labour*
- Sending placentas for histology-lots of work undertaken to ensure the correct placentas are sent for histology. (Tea trolley, face book page, discussed at multiple forums)
- Use of SBAR. Work undertaken to improve SBAR across the maternity unit. Presenting cases in SBAR format. SBAR video made by Practice Education midwife and sent to all staff. New labour ward board using SBAR.
- Trust to ensure that when IOL is unsuccessful all management options are discussed with the mother and documented in the records. Discussed at every forum.

Risk Register

ID	Title	Risk Statement	Open	Risk	Risk Level
1623	Obstetric team handover in the evenings	historically, the obstetric SHO, registrar and consultant do not all finish at the same time for the evening handover. Currently there is a 5pm handover (registrars and SHO) followed by a 5.30pm handover when the consultant arrives. There is a risk that important information is lost or not handed over correctly as it has to be repeated twice, rather than once within the MDT **March update** Service manager reviewed handover times and planned alignment	20/02/2023 Quarterly review	moderate	Care group
1578	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, this will be noted during any upcoming inspection with required actions and possible penalties. The service is currently working towards BSOTS but it is likely that an extra midwife will be required for ANDAU at the weekend as the triage system requires two midwives as a minimum. Triage cannot be provided by a non-registrant **Feb 2023** The reallocation of ANDAU continues with the new site due for completion in approx 4-6 weeks. Training for BSOTS continues with the team aware of the importance of ensuring that high risk women (reduced or absent FMs, bleeding, possible premature labour for example) and seen as quickly as possibly (ideally within 15-030 minutes) and escalated to the coordinator if this isn't possible) **Mar 2023** Work is progressing well on the new ANDAU and training is almost complete for the use of BSOTS. It is likely staffing will need to be increased to allow for triaging seven days a week	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. A "quick fix" is being considered so the room can be used, with building required to address the problem in the long-term **February 2023** The repair is planned for completion this month **Update Mar 2023** The work in The Cove has commenced and the room will be back in use very soon	03/01/2023 Monthly review	moderate	divisional

1497	Emergency buzzers not heard consistently throughout the Maternity unit when activated	The emergency buzzers are 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** Estates involved and this is part of a replacement programme but no start date identified. Although not linked to a poor outcome, this represents a risk to safety. Estates are still in the process of planning route to market for capital replacement systems and a try to the compliant process. Maternity have been asked to identify mitigation but no effective mitigation has been identified **February 2023** The interim solution is available. Estates awaiting confirmation of implementation process. Matrons will meet with team next week (delayed due to workload and AL) **March 2023** This issue remains challenging and the initial interim solution may now, not be fit for purpose. Following a review of the system on other wards in the hospital, concerns have been raised in the following email from the matron leading on this project: *Dear Jo* *Following my previous email which included the quote for the temporary system, myself & Jane have walked around the unit with Michael (from Estates) this morning to discuss where each display point could be mounted as they require a plug point. This will incur considerable extra money as they need to be mounted high or we risk the display screen (plus sound) will be unplugged which will render it useless. The cost of each of these would be approx. £500 and this will also increase the installation timeframe.* *Other concerns regarding the temporary system is each call point will rely on batteries and whereas now we have the lights over each room to identify who is calling, including where the emergency is, staff will have to rely on going to a display point to see which room is calling.* *Considering the cost/extra time/workload for this temporary system, would it be possible to consider installing the new system now, instead of spending up to £25000 for what is only sold as temporary system and will not be as quick as we first thought due to the complexities of what is required on maternity.*		high	divisional

		The CFO has taken a keen interest in this issue and is currently working with Estates to consider a more permanent option. UHD have recently completed installation of their new call bell system and have offered any advice and/or a visit if that's helpful. They also have a SoP for raisi			
	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. UHD had available cots but their Labour Ward wouldn't accept (although not in escalation). Woman transferred to Portsmouth and arrived requiring immediate intervention on arrival.	14/07/2022 Quarterly review	moderate	Care group

1227	Provision of the smoking cessation service to pregnant women	All pregnant women to be tested for their CO levels at booking, at 36 weeks and ideally at any opportunity. Referral is then made to the smoking cessation service. Currently, there is a shortage of the cardboard tubes that are required for the test. Furthermore, although the recent audit of CO testing was positive, there is evidence that women are not always screened - sometimes due to lack of access to the monitor. **Update 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. **Feb 2023** Key action to improve CO at booking is a return to face to face bookings. Once fully recruited into new establishment (currently in business planning) all bookings to be done face to face.	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 **Feb 2023** Awaiting results of assessment ***Mar 2023*** Recent email update from matron leading on this: *The results from our recent tests on rooms 25 and 27 showed 5 results within safe limits and 5 results over. All other rooms measured within safe levels. Currently in discussions with Estates about increasing the airflow changes. Below is an email provided by the matron leading on this issue* *Guidance on minimising time weighted exposure to nitrous oxide in healthcare settings in England* ***Environmental ventilation –** there is environmental ventilation in every room Entonox is used however it does not fulfil the 10 changes an hour as recommended in the report The report recognises that some units will predate current design guidance and have insufficient air changes. I have already requested that rooms 25 and 27 have the environmental ventilation updated to increase the air changes as these two rooms have shown inconsistencies in Entonox levels , with 5 tubes recording a safe limit and 5 tubes above 100ppm, which is a cause for concern.* ***Local extract ventilation –** In 2021 the work was completed to increase the size and power of the extractor fans and add a sensor system in each room so the fans come on automatically rather than needing to be turned on and off. Every room where Entonox is used has an extractor fan which is on an exterior wall as well as a grate in the door to draw air in from the corridor.* ***Patient located between the air inlet and air outlet** – all our delivery beds are located between the air inlet and air out let systems.*	24/12/2019	High	Division

		Ensure that ventilation is turned on and unobstructed *all the rooms have sensors within them which automatically turn the extraction fan on if anyone walks into the room, thus preventing staff or patients being able to turn it off.* ***Annual testing –*** *I have all the reports from 2015 until present day. We use Cairn Technology Ltd who provide us with 10 sorbent tubes for personnel testing – these are worn by staff when looking after a woman using Entonox.* ***Human factors –*** *women are shown how to use the Entonox and when they should start and stop breathing it. Staff are positioned between the air inlet and outlet to ensure flow of air is taking the exhales Entonox away from the midwife.* *Apart from the night core midwives none of our midwives work on labour ward all the time as midwives do in a more traditional midwifery setting, so staff exposure is not on a daily basis and none of the night core work full time and tend to swap and change which area they work in from one night to the next.*			
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 **Feb 2023** Staffing is beginning to improve. Night shifts remain the most significant challenge. Recruitment Agreed for NQMs	20/07/2021 Quarterly review	moderate	division

Complaints – formal and informal

Month	Mar	Apr	May	June	July	Aug	Sep	Oct	Nov	Dec	Jan	feb
total	1	2	2	2	3	1	3	2	1	0	1	2

C22530 Relates to booking information required	The questions asked are standard questions required during booking about mental health, safeguarding and a wide variety of other questions. The learning is: Sensitivity and a clear explanation required around certain questions asked during booking
P22541 This relates to a woman pregnant with her first baby. She needed more support and advice about managing early labour than she received.	A response has been sent. Apologies offered and an acknowledgement that better preparation is required by some women, for this early stage of labour. Telephone contact was also made and an apology offered. The specific learning is: The importance of talking to women during their pregnancy about the early stages of labour – the backpain, the tightenings and how exhausting and disheartening it can be for women who aren't sure what is happening and travel in and out of hospital The importance of not focusing on the standard advice of "contracting 3 times in every 10 minutes, before coming into hospital". Some women need midwifery support before they are contracting this regularly and need to know they are always welcome to come to the The importance of providing reassurance for women in the early stage of labour. Of making them feel welcome and taking time to answer their questions
Conversation between the DoM, a woman & her partner Relates to the provision of pain relief promptly and prior to any examination	Historically there is sometimes a reluctance to 'allow' Entonox until labour is confirmed. This is not correct and pain relief should be provided as needed and especially if the women requests it and an examination is required. Learning shared in the newsletter and staff meeting

Update on actions required from the Insight Visit

action	progress	Outcome

Opportunity for quadrumvirate to be further developed and meet formally		Meetings now occurring monthly
To consider opportunities for earlier involvement of MVP when making service changes or developing resources		This is circumscribed by MVP time and availability and therefore difficult for DCH to influence. However, there is already evidence of excellent co-production and consideration of the MVP joining interview panels for key posts
Opportunity to raise profile of safety champions		New safety champions board ready for collection and display. Safety walkabouts ongoing. Update in the newsletter about the safety champions and their role
Review PA's for 'Consultant' specialist roles (eg governance and Clinical Director)		Completed – recruited successfully into specialist roles
Explore further opportunities for joint training with neonates and maternity.		This in ongoing with the practice educator teams working together on joint MDT simulation training
Implement in-person consultant-led multi-disciplinary evening handover between day and night shift		Currently DCH meets the required standard of two (3 during the week) MDT handovers during the shift every day (0830, 1330 and 1730) with a handover to night staff at 2100 registrar to registrar) However, the requirement that the second handover should be the day to night (2100) will require an increase in consultant establishment as a third session will be required.
Ensure staff are using BadgerNet to full extent to enable service users to see the information and it is published in timely fashion.		Seeking clarification on this action
To work with MVP to ensure review website and update as indicated		Seeking clarification around which website this actions refers to
Review of Advanced Neonatal Nurse Practitioner clinical supervision		Seeking clarification on this action

Morbidity including M&M meetings

M&M Overview & Learning Joint Perinatal Meeting February 2023

13

Overview case 1 Baby born prematurely **Learning and Actions** Neonatal lead identified possible care concerns and has requested an external review from within the Neonatal Network. Duty of candour with parents For SCBU lead DS to review contents of Neonatal Resus trolley.	**Overview case 2** Baby born in poor condition **Learning and Actions** Temperature management in postnatal room Baby taken to SCBU before respiratory support initiated – this could have been provided in the Postnatal Resuscitation area. Resuscitation notes not shared between maternity and neonatal Badgernet.

Current Maternity Safety Guidelines and SoPs published recently

Safe staffing and escalation to divert
Standard Operating Procedure for Birth Debriefs and Previous Birth Trauma

Claims

Training

Maternity staff compliance for training

Training	Staff grade	Percentage of attendance
PROMPT (Practical Obstetric Emergency Procedure Training)	**Obstetric Anaesthetists**	83.5% (4 non-compliant)
	Obstetric Consultants	100%
	Obstetric registrars & trainees	78% (2 non-compliant)
	Midwives	92% (11 non-compliant)
	MSW	69.5% (some new starters with work commitments in other areas of the Trust)
K2 Fetal Monitoring training	**Doctors**	100%
	Midwives	83%

NLS (4 yearly accredited course)	**Senior Midwives & Homebirth Midwives**	93%
NLS (yearly update)	**Midwives**	92%
Governance Lead tasked to prioritise training numbers, particularly medical staff due to consistently unsatisfactory levels		

Maternity Staffing

Sickness absence	february 2023
midwives	7%

Sickness absence	february 2023
MSW	5.6%

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

Service user feedback - Friends And Family

Report Front Sheet

1. Report Details			
Meeting Title:	Board of Directors Part 1		
Date of Meeting:	29 March 2023		
Document Title:	**Quarterly Guardian Report of Safe Working report: Doctors in Training (Oct 2022 – Dec 2022)**		
Responsible Director:	Alastair Hutchinson, Chief Medical Officer	Date of Executive Approval	07/03/2023
Author:	Kyle Mitchell, Guardian of Safe Working		
Confidentiality:	No		
Publishable under FOI?	Yes		
Predetermined Report Format?	Yes		

2. Prior Discussion		
Job Title or Meeting Title	**Date**	**Recommendations/Comments**
People and Culture Committee	20/03/2023	Noted, recommended to Board

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

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

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

Title of Meeting	**People and Culture Committee**
Date of Meeting	**20/03/2023**
Report Title	**Quarterly Guardian Report of Safe Working report: Doctors in Training (Oct 2022 – Dec 2022)**
Author	**Mr Kyle Mitchell, Guardian of Safe Working (GoSW)**

1. Executive summary

- An effective Exception Reporting mechanism remains in place in Dorset County Hospital
- There is excellent engagement from both Junior Doctors and Educational Supervisors
- Exception Reporting has previously highlighted particular operational and medical staffing pressures in both Trauma & Orthopedics, and in Gastroenterology/ Medical Outliers; the Guardian has seen active engagement from clinical leadership in both areas to change this. Neither area remains an outlier in this quarter.
- Efforts to halt, and perhaps reverse, 2 decades of real-term erosion in the remuneration that Junior Doctors receive has become a priority for the workforce at DCH.

2. Introduction

All eligible doctors in training at the Trust between October and December 2022 were working under the terms of the 2016 Junior Doctors Contract with 2019 updates; all have the opportunity to submit Exception Reports; and all work schedules complied with contractual commitments under the 2016 Contract. The provision of quarterly report from the Guardian of Safe Working is a contractual requirement outline in the T&CS of the 2016 Contract.

3. High level data

Number of training post (total):	192	(195 Q2)
Number of doctors in training post (total):	174.8	(174.5 Q2)
Annual average vacancy rate among this staff group:	13.1	(13.4 Q2)

Exception reports in order of number raised

Exception reports by department				
Specialty	No. exceptions carried over from last report	**No. exceptions raised**	No. exceptions closed	No. exceptions outstanding
Gastroenterology	0	**13 (1 ISC)**	13	0
T&O	0	**4**	2	2
Geriatric medicine	1	**7**	8	0
Urology	1	**2**	3	0
General Medicine	0	**1**	1	0
General Practice	0	**1**	1	0
Paediatrics	0	**2**	2	0
Cardiology	1	**6**	7	0
General Surgery	0	**10**	10	0
Obs & Gynae	0	**1**	1	0
Respiratory Medicine	0	**8**	8	0
Emergency Dept.	1	**1**	1	1
ENT	0	**2**	2	0
Renal Medicine	0	**3**	3	0
Acute Medicine	0	**3 (1 ISC)**	3	0
Total	4	**64**	65	3

Exception reports by grade				
Grade	No. exceptions carried over from last report	No. exceptions raised	No. exceptions closed	No. exceptions outstanding
FY1	1	32	33	0
FY2	2	11	10	3
CT1	0	11	11	0
CT2	0	1	1	0
CT3	1	5	6	0
ST1	0	4	4	0
Total	4	64	65	3

4. Work schedule reviews

Upon the submission of an Exception Report that suggests a mismatch between a junior doctor's work schedule and the actual clinical demands required in that post, it is the responsibility of that doctor's educational supervisor to trigger a *Level 1 (Work Schedule) Review*. Example outcomes of such a review include no requirement for change, a prospective requirement to adjust existing work schedules, or even institutional change.

The Exception Report is closed at Level 1 if the junior doctor and educational supervisor agree an outcome or escalated to *Level 2 Review* (with involvement of Guardian/DME and service management) if the junior doctor is not in agreement with the outcome. *Level 3 Review* constitutes a formal grievance hearing with HR representation.

Exception Reports taken to Level 1 Work Schedule Review

Specialty	Grade	Number	Rota
Gastroenterology	F2	2	2022 F2 MED 03/08/2022-06/12/2022
Otolaryngology	F1	2	2022 GPST LY ENT 03/08/22-01/11/22
Acute Medicine	F1	1	2022 F1 Medical 03/08/2022-06/12/2022
Renal Medicine	CT1	2	2022 IMT 1/2 MED 03/08/2022-06/12/2022

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

5. Immediate Safety Concerns.

Two Exception Reports were highlighted as being of Immediate Safety Concern (ISC), submitted within Gastroenterology and Acute Medicine. Both highlighted a lack of middle grade support coinciding with an increased workload. Both were promptly escalated and scrutinized, and there was active involvement of both Divisional Manager & Director.

6. Vacancies

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

7. Fines

There were no fines levied during this period.

8. Other issues arising

Well attended Junior Doctors Forums continue to meet on a scheduled basis in line with contractual requirements.

Upcoming Industrial Action represents an unprecedented challenge for doctors of all grades and for the hospital management structures. At an exceptional meeting of the Junior Doctors Forum, it was recognised that this is a national issue and does not relate to any local employment arrangements.

The assembled junior doctors and representatives of the Trust agreed that they shared the objective of being able to provide excellent and sustainable care. A representative of the executive provided the assurance that the Trust would fully support the decision of each individual Junior Doctor regarding what, if any, action to take; and reminded those present the importance of upholding trust values throughout. BMA Junior Doctor Representatives expressed their appreciation for the support from the Trust, specifically with respect to patient safety, and support for the welfare of junior doctors, during planned industrial action.

9. Summary

The changes made to medical staffing within T&O, and gastroenterology/ medical outliers, have ensured that neither remains as an outlier in this quarter. This matches informal feedback that the Guardian has received from Junior Doctors working in these areas. Evidence derived from Exception Reporting contributed to these changes and has been fed back at the JDF.

10. Recommendation

The Guardian asks the committee to note this report and to consider it to provide an assurance of compliance with the safeguarding aspects of the 2016 Junior Doctors Contract.

APPENDICES

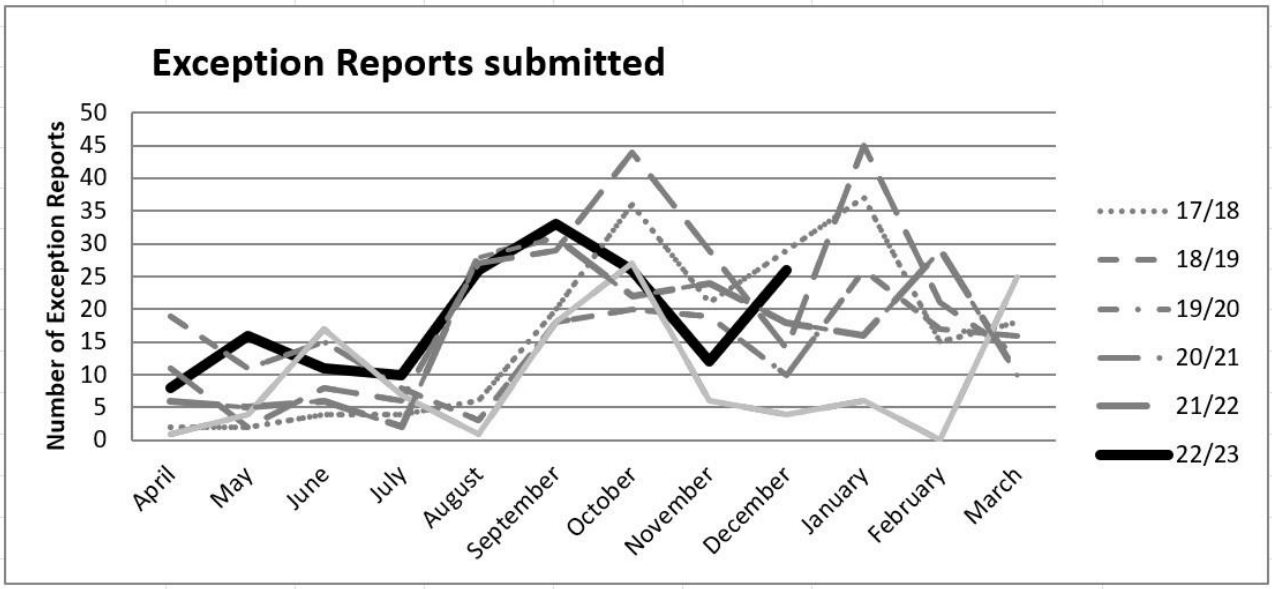
QUARTERLY GUARDIAN REPORT ON SAFE WORKING HOURS: DOCTORS IN TRAINING

OCTOBER 22 – DECEMBER 2022

Appendix 1 – Trainee Vacancies within the Trust

Department	Grade	Rotation Dates	Oct 22	Nov 22	Dec 22	Average Q3
Paediatrics	ST3	Sept	0.8	0.8	0.8	0.8
Paediatrics	ST4+	Sept	0.2	0.2	0.2	0.2
O&G	ST1	Oct	0	0	0	0.0
O&G	ST3+	Oct	0	0	0	0.0
ED	ST3+	Sept and Feb	1.2	1.2	1.2	1.2
Surgery	CT1	Aug	0	0	0	0.0
Surgery	CT2	Aug	0	0	0	0.0
Surgery	ST3+	Oct	0	0	0	0.0
Orthopaedics	ST3+	Sept	1	1	1	1.0
Anaesthetics	CT1/2	Aug	1	1	1	1.0
Anaesthetics	ST3+	Aug and Feb	0.4	1.4	2.4	1.4
Medicine	CT1/2	Aug	3	3	3	3.0
Medicine COE	ST3+	March	0.4	0.4	0.4	0.4
Medicine Diab/Endo	ST3+	Aug	1	1	1	1.0
Medicine Gastro	ST3+	Sept	0	0	0	0.0
Medicine Resp	ST3+	Aug	0	0	0	0.0
Medicine Cardio	ST3+	Feb	0	0	0	0.0
Medicine Renal	ST3+	Aug	1	1	1	1.0
Haematology	ST3+	Sept	0	0	0	0.0
Med/Surg	FY1	Aug	0	0	0	0.0
Med/Surg	FY2	Aug	0	0	1	0.3
GPVTS	ST1	Aug & Feb	1.4	1.4	1.4	1.4
GPVTS	ST2	Aug & Feb	0.4	0.4	0.4	0.4
GPVTS	ST3	Aug & Feb	0	0	0	0.0
Orthodontics	ST3+	March	0	0	0	0.0
Total			11.8	12.8	14.8	13.1

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



Report Front Sheet

1. Report Details			
Meeting Title:	Board of Directors, Part 1		
Date of Meeting:	29th March 2023		
Document Title:	**Annual Committee Review - Terms of Reference and Work Plan**		
Responsible Director:	Chris Hearn, Chief Finance Officer Anita Thomas, Chief operating Officer	Date of Executive Approval	
Author:	Trevor Hughes, Head of Corporate Governance		
Confidentiality:	Not Confidential		
Publishable under FOI?	Yes		
Predetermined Report Format?	No		

2. Prior Discussion		
Job Title or Meeting Title	**Date**	**Recommendations/Comments**
Prior consultation and discussion by committee members	January - February 2023	• Terms of Reference to be updated Committee work programmes to be reviewed and agreed
Risk and Audit Committee	21/03/2023	Approved
Terms of References and Workplans reviewed by each committee	20/03/2023 and 21/03/2023	Approved

3. Purpose of the Paper	The purpose of the report is to present the outcome of the annual committee review of effectiveness process and seek approval of the committee revised Work Plan and Terms of Reference for the coming year.							
	Note (✓)		*Discuss (✓)*		*Recommend (✓)*		*Approve (✓)*	✓

4. Key Issues

Good governance practice determines that committees of the Board of Directors should undertake an annual review of their effectiveness in order to inform changes to their terms of reference, priorities and work programmes for the forth coming year, so demonstrating effective leadership and supporting development and delivery of the overall strategy objectives.

There have been a number of Director portfolio changes in year resulting in changes to committee membership and the COVID-19 pandemic has impacted the governance model, Executive and service operational capacity, priorities and the committee work programme. The committee reviews have been undertaken this year within this context.

Each committee has undertaken a review of effectiveness using an appreciative enquiry approach and the model questionnaire contained within the Audit Committee Handbook 2014. Key findings are summarised as:

Areas of good practice

- Communication between committees is much improved.
- The Work Plan is sufficiently flexible to reprioritise as appropriate.
- There are good working relationships between the Auditors and the Committee Chair.
- Improved visibility on strategic risks and mitigations in year.
- The quality of reports is improving.

	Areas for development • Reports could better set out how their purpose and effectiveness in mitigating risk. • Risks could be escalated in a more timely manner to allow for assurances to be sought. • The timeliness of paper circulation ahead of meetings could be improved. • Action Log updates are often given verbally in the meeting. • Front sheets still need to better summarise the issues for consideration. • Clinical Audit needs to be better connected with more updates being presented to the committee. • The Agendas are very full and do not always allow for an appropriate level of discussion. In line with the ongoing Governance Framework review and following the appointment of a new Chief Finance Officer, the committee's Terms of Reference have been revised to reflect changes to the groups reporting directly to the committee. The annual Work Plan has remained fundamentally unchanged.
5. Action recommended	The Risk and Audit Committee is asked to: 1. **NOTE** the outcome of the committee effectiveness review 2. **APPROVE** the revised Terms of Reference 3. **APPROVE** the committee Work Plan for the forthcoming year.

6. Governance and Compliance Obligations				
Legal / Regulatory Link		**Yes**		Committees of the Board are required to undertake an annual review of their effectiveness
Impact on CQC Standards		**Yes**		Supports delivery of the Well Led standard
Risk Link		**Yes**		Committees seek assurances on controls and mitigations to manage risks to delivery of the Strategy which informs their programmes of work
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	Committees monitor the Trust's performance and delivery of the Strategy which informs their programmes of work		
	Partnership			
Dorset Integrated Care System (ICS) goals		**Which Dorset ICS goal does this report link to / support?** *Please summarise how your report contributes to the Dorset ICS key goals.* *(Please delete as appropriate)*		
Improving population health and healthcare			**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)		**No**	
Quality Impact Assessment (QIA)		**No**	

Board Committee Effectiveness Review – March 2023

Introduction

As part of the Board of Directors' corporate governance and performance management arrangements, committees that the Board has established undertake an annual review of their performance and Terms of Reference and report these to the Risk and Audit Committee. This requirement provides assurance to the Board that its committees are working effectively and provides information to the Board of Directors. This paper reflects the key points arising from the committee annual reviews undertaken during 2022/23 in relation to the period April to March 2023 in order to inform planned discussion by the Board of the respective committee Terms of Reference and work plans.

Annual reviews of committee performance and effectiveness for 2022/23 were completed using the performance checklist and effectiveness questionnaire contained within the fifth edition of the Audit Committee Handbook published in the autumn 2014 as a basis for the reviews. An Appreciative Enquiry approach was included in order to invite comment and suggestions on areas for committee development.

Board Committees

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

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

A feature throughout the year has been sustained service operational pressures with increasing demand on urgent and emergency care and cancer and diagnostic services. These pressures were compounded in the latter part of the year by staff shortages due to increases in the number of winter respiratory illness cases and industrial action being taken by ambulance workers and nurses.

In quarter 4, the Board agreed a protocol for reduced reporting and attendance by service staff at committee meetings in order to release service operational capacity and to maintain the Board's focus on key issues and mitigating actions. A number of scheduled items per respective committee work programmes were subsequently deferred during this period although the corporate risk register and Board Assurance Framework continued to be reported to committees.

Governance Framework Review

A wider review of the Governance Framework was undertaken during the year in order to more clearly articulate management and committee decision making routes for service teams and the strengthen committee oversight. The review considered reporting and escalation for working groups reporting directly into committees and presented an opportunity to review these and to also improve the quality of reports being presented to committees.

As part of the review, Internal Auditors undertook a benchmarking review of the Risk and Audit Committee and delegated financial authority limits within the Trust's Standing Financial Instructions. These were reported separately to the Board although amendments arising from these reviews are reflected in the respective committee Terms of Reference and Work Plans for 2023/24.

Committee Reviews

The Audit Committee Handbook 2014 was used to form the basis of the 2022/23 committee reviews undertaken during quarter 4 and included:

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

Committee and Strategic Risk Review Process

The Audit Committee Handbook 2014 was published in autumn 2014. The Audit Committee Handbook provides guidance on Board reporting arrangements, production of Annual Reports, review of work plans and other best practice guidance and was used as the basis for the subcommittee reviews in 2022/23.

The Board Assurance Framework (BAF) provides a register of strategic risks, controls and mitigations potentially impacting delivery of the Trust's strategic objectives. Oversight monitoring of the BAF and mitigating actions is undertaken by the Risk and Audit Committee. Respective committees have been actively sighted on the strategic risks relating to each committee's portfolio responsibilities and Work Programmes since March 2021, providing greater scrutiny and oversight of mitigating actions. The Board remains sighted on strategic risks and mitigations via

committee Escalation Reports following each committee meeting and via regular receipt of the BAF at public Board meetings.

Committee Membership Changes

The following changes to membership of the Board and its committees were made in year:

- The Chief Executive Officer left the Trust in July 2022 and an interim appointment was made until the end of the financial year.
- The Chief People Officer left the Trust in August 2022 and an interim appointment was made until the end of the financial year.
- The Chief Information Officer left the Trust in August 2022 and an interim appointment was made until the end of the financial year.
- The Chief Nursing Officer left the Trust in October 2022 and an interim appointment was made in November 2022 until the end of the financial year.
- The Chief Finance Officer retired in October 2022 and his replacement commenced in post in October 2022.
- The Associate Non-Executive Director left the Trust at the end of his term of office in December 2022 and this post was not replaced.
- The Vice Chair (Non-Executive Director) and Chair of the Quality Committee left the Trust at the end of their second term of office in August 2022 and both roles were taken on by an existing Non Executive Director.
- The Chief Executive Officer Designate, appointed jointly with Dorset Healthcare University NHS Foundation Trust, took up post in March 2023.

Changes to the membership of committees has not affected the conduct of committee meetings or attendance throughout the year.

Table 1 – Board Committee Reviews at a Glance for Period April 2022 to March 2023

	Audit and Risk Committee	**Finance and Performance Committee**	**Quality Committee**	**People and Culture Committee** (Workforce Committee)
Attendance and Quoracy	Met on six occasions. Committee has been quorate on all occasions.	Met on 13 occasions. Committee has been quorate on all occasions.	Met on 12 occasions. Committee has been quorate on all occasions.	Met on 12 occasions. Committee has been quorate on all occasions.
Membership	• Three Non-Executive Directors • Chief Finance Officer • Chief Operating Officer • Chief Medical Officer and/or Chief Nursing Officer • Chief Executive (for Annual Report and Accounts)	• Three Non-Executive Directors (one will be clinical) • Chief Executive Officer • Chief Finance Officer • Chief Operating Officer • Director of Strategy, Transformation and Partnerships • Chief People Officer • Chief Medical Officer and/or Chief Nursing Officer	• Three Non-Executive Directors • Chief Executive Officer • Chief Nursing Officer • Chief Medical Officer • Chief Operating Officer	• Three Non-Executive Directors • Chief People Officer • Chief Executive Officer • Chief Operating Officer • Chief Medical Officer • Chief Nursing Officer • Director of Strategy and Transformation
Quorum	• Two Non-Executive Directors • Two Executive Directors (One must be clinical)	• Two Non-Executive Directors • Two Executive Directors	• Two Non-Executive Directors • Two Executive Directors (One must be clinical)	• Two Non-Executive Directors • Two Executive Directors
Attendance	• Head of Corporate Governance • Internal and External Audit representation at each meeting • Anti-Fraud Specialist	• Head of Corporate Governance • Divisional Senior Management Representation • No additional co-opted members	• Head of Corporate Governance • Divisional Clinical Directors • Divisional Associate Directors of Nursing • No additional co-opted members	• Head of Corporate Governance • Head of Education • Head of Workforce Resourcing • Head of HR Operations • Head of Diversity and Inclusion • Divisional Directors • No additional co-opted members

	Audit and Risk Committee	Finance and Performance Committee	Quality Committee	People and Culture Committee (Workforce Committee)
Board Reporting	• Escalation Report provided post meeting	• Escalation Report provided post meeting	• Escalation Report provided post meeting	• Escalation Report provided post meeting

Meeting Terms of Reference / Summary of Work Undertaken	• Internal Audit reports on a range of activities within the Internal Audit Plan
	• External Audit review of financial statements and Annual Governance Statement
	• Progress reports on Anti-Fraud activities
	• Board Assurance Framework
	• Head of Internal Audit Opinion
	• Policy approval
		• Medium and long term financial strategy and planning
		• Performance reporting and management / trouble shooting and detailed scrutiny:
		  ○ Cost Improvement Plans
		  ○ Agency expenditure
		  ○ Underlying deficit.
		• Review and approval of performance indicators and Balanced Score Cards
		• Business case approval and oversight
		• Capital Programme management.
			• Strategy approval and policy ratification
			• Corporate Risk Register
			• CQC compliance
			• Complaints, claims and inquests
			• Sub-committee reports and work plan approval
			• Infection prevention and control monitoring
			• Patient safety and experience
			• Maternity safety
			• Safeguarding and serious case reviews
			• Learning from Death Reports
			• Medicines Management Updates
			• Clinically focussed policy and strategy monitoring and approval.
			• DCHFT response to national report findings
			• Divisional Presentations
				• Workforce Strategy and planning
				• Operational workforce performance and metrics
				• HR policies
				• Education and leadership development
				• Recruitment and retention – including overseas
				• Workforce risk
				• Bank and Agency usage
				• Equality Diversity and Inclusion
				• Workforce policies

Review of Terms of Reference	Annual review to be approved in March 2023	Annual review to be approved in March 2023	Annual review to be approved in March 2023	Annual review to be approved in March 2023
Cycle of Business	Annual review to be approved in March 2023	Annual review to be approved in March 2023	Annual review to be approved in March 2023	Annual review to be approved in March 2023
Areas for Development	• Need to develop more timely reporting of strategic risk mitigations. • Papers are not always sufficiently focussed or	• Need to develop more timely reporting of strategic risk mitigations.	• Papers are not always sufficiently focussed or distributed in a timely manner. • Action Log updates are routinely given verbally.	• Need to develop more timely reporting of strategic risk mitigations.

	Audit and Risk Committee	Finance and Performance Committee	Quality Committee	People and Culture Committee (Workforce Committee)
	distributed in a timely manner. • Action Log updates are routinely given verbally. • Report front sheets need to be more concise and articulate the key issues for consideration more succinctly. • Clinical Audit needs to be better connected.	• Papers are not always sufficiently focussed or distributed in a timely manner. • Action Log updates are routinely given verbally. • Report front sheets need to be more concise and articulate the key issues for consideration more succinctly. • The Agenda could be more strategically focussed. • Need greater discussion of Breakeven risk mitigations.	• Report front sheets need to be more concise and articulate the key issues for consideration more succinctly. • Could do more on strategic risk mitigations. • Need to better understand the Clinical Audit Cycle.	• Papers are not always sufficiently focussed or distributed in a timely manner. • Action Log updates are routinely given verbally. • Report front sheets need to be more concise and articulate the key issues for consideration more succinctly. • Agency usage and recruitment risk mitigations require further focus

Conclusion

All committees of the Board have completed an annual review and self-assessment of performance and effectiveness using a standardised approach in 2022/23.

Member attendance has remained good throughout 2022/23, and this has been supported by committee meetings being conducted via teleconferencing arrangements. All committee meetings have been quorate allowing committee business to be appropriately transacted.

Each committee has appropriately encouraged attendance by management representatives although capacity for attendance by this group has been limited by service operational pressures in the latter part of the year. No committee has needed to co-opt membership in order to facilitate its understanding of the business to be transacted.

Each committee has continued to meet its Terms of Reference and has delivered a comprehensive programme of work on behalf of the Board, providing reporting and escalation of issues via Escalation Reports following each meeting. Changes in Executive Director portfolios and Non-Executive membership of the Board of Directors did not adversely affect the operation of committees.

The Internal Audit programme was maintained and there has been no unreasonable delay in completing programmed audits. No external / third party reviews of performance or Board / subcommittee effectiveness were undertaken during the reporting period. A comprehensive External Audit Value for Money Audit was completed during Quarter 3.

Whilst committees acknowledged progress made in 2022/23, particularly regarding committee ownership of the Board Assurance Framework and some improvements in the quality of some reports and front sheets, committees continued to state the following small number of areas for development during 2023/24::

- The need to develop more timely reporting of strategic risk mitigations.
- Papers were not always sufficiently focussed or distributed in a timely manner.
- Action Log updates were routinely given verbally.
- Report front sheets needed to be more concise and to articulate the key issues for consideration more succinctly.

Other areas for specific committees to address included:

- Clinical Audit needs to be better connected. and the programme needs to be better understood.
- There is a need greater discussion of Breakeven risk mitigations.
- Agency usage and recruitment risk mitigations require further focussed discussion.

These recommendations will be incorporated within subcommittee work programmes for 2023/24.

Recommendations

The Risk and Audit Committee is asked to:

1. **Note** the findings of Board sub-committee annual effectiveness reviews.
2. **Recommend** the refreshed Risk and Audit Committee Terms of Reference and Cycle of Business to the Board for approval.

Trevor Hughes

Head of Corporate Governance

March 2023

TERMS OF REFERENCE
PEOPLE AND CULTURE COMMITTEE

Constitution

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

Authority

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

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

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

Purpose

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

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

Membership

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

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

Deputies

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

In attendance will be:

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

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

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

Quorum

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

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

Frequency of Meetings

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

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

Duties

The People and Culture Committee will:

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

- To review its own performance, Constitution and Terms of Reference on an annual basis to ensure it is operating at maximum effectiveness.
- To review and approve trust policies that fall within its remit.
- To set the direction and monitor the work of the reporting groups that inform the work of the committee and receive, and review Escalation Reports of said groups.

Maintaining Board Oversight

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

- Security Management – violence and aggression

Reporting

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

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

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

a. Equality, Diversity & Inclusion Steering Group

b. Health and Wellbeing Steering Group

The Committee will also receive regular reports from the following groups:

a. Operational Education Group

b. Medical Education Group

c. Medical and Dental Local Negotiating Committee

d. Partnership Forum
e. International Recruitment Oversight Group

The committee will also receive Escalation Reports from divisional leadership / governance meetings and givisional representation at committee will be required.

Administration

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

Review

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

Appraisal

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

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

People and Culture Committee Work plan - 23 24

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

TERMS OF REFERENCE
QUALITY COMMITTEE

Constitution

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

Authority

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

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

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

Purpose

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

Additionally, the committee has responsibility for scrutinising and assuring delivery of relevant aspects of the Trust's 'Place' objective and ensuring that associated risks are adequately mitigated; supporting the identification and promotion of shared learning, best practice and outstanding care.

Membership

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

Director of Strategy, Transformation and Partnerships
Chief Nursing Officer
Chief Medical Officer
Chief Operating Officer

Deputies

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

In Attendance

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

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

Quorum

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

Frequency of Meetings

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

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

Duties

The committee has the following primary duties and functions:

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

General

The committee will:

1. Review the adequacy of the trust's clinical strategies and monitor delivery of outcomes;
2. Monitor strategic risks within the Board Assurance Framework and the Corporate Risk Register to ensure that risks are being managed and mitigated sufficiently, and that risks are escalated appropriately.
3. Receive details of all Serious Incidents, escalating to the Board where appropriate and receive assurance around the actions taken to prevent recurrence.
4. Monitor on-going compliance with contractual, National and Care Quality Commission standards and seek assurance that any areas of weakness are being addressed.
5. Monitor on-going compliance with the Well Led element of the CQC standards as they relate to the Board to ensure maintenance/improvement of the trust's governance risk rating.
6. Monitor compliance in relation to safeguarding children and adults.

7. Ensure procedures stipulated by professional regulators of chartered practice (i.e. General Medical Council and Nursing and Midwifery Council) are in place and are complied with to a satisfactory standard.
8. Monitor the impact of Cash Releasing Efficiency Programmes and significant service changes on quality.
9. Receive updates on an exception basis against key strategies that are approved by the committee and those that are approved by the Board where deemed appropriate, escalating to the Board as necessary

Clinical Governance:

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

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

Policy Approval

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

Maintaining Board Oversight

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

- Hip fractures, falls and dementia
- Palliative and end of life care
- Resuscitation
- Learning from Deaths
- Safeguarding
- Safety and Risk

- Lead for children and young people

Reporting

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

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

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

- Clinical Outcomes and Effectiveness Committee
- Mental Health Steering Group
- Medicines CommitteeInfection Prevention and Control Committee
- Safeguarding Committee
- Patient Safety Committee
- End of Life Committee
- Patient Experience and Public Engagement Committee
- Research and Development Steering Group Health Inequalities Group
- Reproductive Health Clinical Governance Committee

The committee will also receive Escalation Reports from divisional leadership / governance meetings and divisional representation at committee will be required.

Administration

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

Review

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

Appraisal

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

Approved by Quality Committee –
Ratified by the Board –

Quality Committee Work plan - 2023-24

	Author	Committee Action	Frequency	April	May	June	July	August	September	October	November	December	January	February	March
SAFETY & QUALITY															
Quality aspect of integrated performance report: Patient Safety, Effectiveness and Experience Report - including safer staffing	Kerry Little	Note	Monthly												
Clinical Plan	Jo Howarth Alastair Hutchison	Note	Quarterly												
Sub-Committee Escalation reports (see below)		Note	Monthly/Bi-monthly/Quarterly												
Divisional escalation / exception reports - including Clinical Audit Outcomes, improvement actions & monitoring process, with particular reference to quality improvement.	Sonia/Jodie	Note	Monthly												
Topic area deep dive (from integrated performance and escalation reports)		Note	Bi-monthly												
Learning from Deaths (Mortality) Report	AH	Note	Quarterly		Q4			Q1			Q2			Q3	
Transformation Update	Phil Davis	Note	Quarterly												
National Audit (publication of results and anuual planned programme)		Approve/Note	Quarterly												
Maternity Safety Report	Jo Hartley	Note	Monthly												
Mmbrace	Jo Hartley	Note	Bi-annual												
Continuity of Carer Report (Maternity)	Jo Hartley	Note	Quarterly												
Quality Risk Report	Mandy Ford	Note	Quarterly												
National Patient Survey Results	Ali Male	Note	Quartlery (as published)												
Board Assurance Framework	Phil Davis	Note	Quarterly												
Walkarounds - Outputs Report	Kerry Little	Note	Quarterly												
Feedback from Maternity Voices Partners	Jo Howarth	Note	Quarterly												
ANNUAL ASSURANCE															
Annual Quality Report	KL	Approve	Annual	DRAFT	FINAL										
Safe Staffing Annual Report	JH/Ehoy	Approve/Note	Bi-annual				Mid-point review							Annual review	
Committee Annual Review of ToRs, workplan and priorities	TH	Approve	Annual												
Committee Annual Review of Effectiveness	TH	Approve	Annual												
Safeguarding Children and Adults Annual Report	Sarah Cake	Note	Annual												
Infection Prevention and Control Annual report	Emma Hoyle	Note	Annual												
Risk Management Strategy update	Mandy Ford	Approve	Annual												
Assurance Report on Nutrition Strategy	Kathryn Cockerell	Note	Annual												
QI Strategy Report	Jo Howarth	Note	Bi-annual												
PLACE Annual Review	Sarah Jenkins	Note	Annual						TBC (Nationally set)						
Complaints Annual Report	Ali Male	Note	Annual												

TERMS OF REFERENCE
RISK AND AUDIT COMMITTEE

Constitution

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

Authority

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

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

Purpose

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

Membership

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

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

Deputies

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

Attendance

The following will normally be in attendance:

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

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

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

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

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

Frequency

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

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

Duties

The duties of the committee are as follows:

Governance, Risk Management and Internal Control

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

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

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

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

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

Internal Audit

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

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

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

Counter Fraud

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

External Audit

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

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

Other Assurance Functions

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

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

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

Management

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

Financial Reporting

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

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

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

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

Quality Reporting

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

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

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

Reporting

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

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

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

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

The committee wil receive Escalation Reports from the Health and Safety Group that records key issues and decision making and escalation of risks and issues for the committee's attention.

Administration

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

Review

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

Appraisal

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

Approved by Risk and Audit Committee –
Ratified by the Board –

Risk and Audit Committee Cycle of Business 2023-24

	Author (exec)	Comm Action	Frequency	Apr 23	May 23 Extra	June 23	Sept 23	~~Dec 23~~	Jan 24	
Governance										
Review the BAF	CD (NJ)	Note	Quarterly	X		X	X	~~X~~	X	
Corporate Risk Register	MF JH	Note	Quartlerly	X		X	X	~~X~~	X	
Review Standing Orders, SFIs, and Scheme of Delegation	CH / ML	Approve	Annual						X	
Review Losses and Special Payments	ML CH	Note	Annual	X						
Review of Tender Activity and Waivers	ML CH	Review	Annual						X	
Risk Summit			Annual						X	
Review of Risk Appetite	TH/NL	Review	Annual						X	
Annual Clinical Audit Assurance Report	AH, Divisional Leads	Note	Annual	X						
Charitable Funds Consolidation (Annual Accounts)	JC CH	Approve	Annual	X						
Review of accounting policies areas of estimation	ML, JC, JH CH	Note	Annual	X						
Going Concern Report	ML CH	Approve	Annual	X						
Engagement of External Auditors for Non-Audit Services Policy Review	ML CH	Approve	3 yearly - due 2024				X			
Annual Report and Accounts (inc Quality Account)										
Draft Annual Report and Accounts	DCH	Approve	Annual		X					
Draft Quality Account	DCH	Approve	Annual		X					
ISA 260 Report	KPMG	Receive	Annual		X					
Annual Audit Report	KPMG	Receive	Annual		X					
Draft External Audit Opinion	KPMG	Receive	Annual		X					
Draft Letter of Representation	KPMG	Receive	Annual		X					
Report on the Quality Account	KPMG	Receive	Annual			??				Date TBC for 2021/22 report
External Audit - KPMG										
Agree final annual report and accounts timetable and plans	KPMG	Approve	Annual						X	
External audit plans and fees	KPMG	Approve	Annual	X						
Review the effectiveness of external audit	KPMG	Review	Annual				X			
Review external audit progress reports, technical update and benchmarking	KPMG	Review	Quartlerly	X		N/A	X	~~X~~	X	
Anti Crime (Previously Counter Fraud) - TiAA										
Approve the annual work plan	TiAA	Approve	Annual	X						
Progress Report	TiAA	Review	Biannual			X		~~X~~		
Review the effectiveness of counter fraud	TiAA	Review	Annual						X	
Review the annual report on counter fraud	TiAA	Review	Annual			X				
Self Review Tool	TiAA	Review	Annual			X				
Internal Audit - BDO										
Review and agree work plan	BDO	Approve	Annual	Final					Draft	
Progress Report	BDO	Review	Quartlerly	X		X	X	~~X~~	X	
Recommendations Follow Up Report	BDO	Review	Quartlerly	X		X	X	~~X~~	X	
Internal audit reports - as per the Audit Plan Red = advised by BDO	BDO	Review	Quartlerly							
Review the annual effectiveness of internal audit	BDO	Review	Annual	X						
Internal Audit Annual Report and Annual Statement of Assurance, inc Head of Internal Audit Opinion	BDO	Review	Annual	x						
Other										
Annual Declarations of compliance with License conditions (prior to May Board)	TH	Approve	Annual		X					
Review of Terms of Reference	TH	Review	Annual	X						
Review of Effectiveness of Audit Committee	TH	Review	Annual	X						
Committee Workplan and Priorities	TH	Review	Annual	X						
Declarations of Interest and Register of Gifts and Hospitality	TH	Review	Annual	X						
Auditors meet Chair without management	N/A	N/A	Annual	X			X			
Referred items from other committees/emerging themes - as required	TBA	TBA	Quartlerly	X	X	X	X	~~X~~	X	
ICB Risk and Audit Committee Minutes Bi-monthly (pending confirmation of timings from LB)	ICB	Note	Quartlerly	x	x	x	x	~~x~~	x	
Escalations from Sub-Groups										
~~Information Governance Group~~	~~DG~~	~~Receive~~		~~X~~	~~X~~	~~X~~	~~X~~	~~X~~	~~X~~	
~~Emergency and Resilience Planning Group~~	~~AT~~	~~Receive~~		~~X~~	~~X~~	~~X~~	~~X~~	~~X~~	~~X~~	

Report Front Sheet

1. Report Details			
Meeting Title:	**Board of Directors, Part 1**		
Date of Meeting:	**29 March 2022**		
Document Title:	**Register of Interests and Register of Gifts and Hospitality**		
Responsible Director:	**Nick Johnson, Interim Chief Executive**	Date of Executive Approval	
Author:	**Trevor Hughes, Head of Corporate Governance**		
Confidentiality:	No confidential		
Publishable under FOI?	Yes		
Predetermined Report Format?	No		

2. Prior Discussion		
Job Title or Meeting Title	**Date**	**Recommendations/Comments**
Risk and Audit Committee	22/03/2023	Noted

3. Purpose of the Paper	To receive and note for information and assurance.							
	Note (✓)	✓	*Discuss (✓)*		*Recommend (✓)*		*Approve (✓)*	

4. Key Issues

The Trust is obliged to comply with national guidance published in 2016/17 regarding declarations of interests and the need to maintain a register of gifts and hospitality received by staff.

Declarations of Interest Report

All staff are required to notify any interests that they hold. In particular, decision making staff are required to declare any interests on an annual basis. Decision making staff are defined as those staff that are:

- Executive directors or equivalent decision makers responsible for spending tax-payers money
- Members of advisory groups
- Banded 8a or above
- Administrative or clinical staff with the power to enter into contracts or commission goods and service

For the financial year 2022/23, declarations were received from 129 staff out of the 423 who are required, under the criteria above, to make a declaration. This excludes the Board and governors who are recorded separately. Of the 129 staff that made a declaration, 18 declared an interest and 118 had nothing to declare.

Staff who are required to make a declaration have received an email from the Electronic Staff Record (ESR) system asking them to make or review their declaration, and a message has been published in the weekly Staff Bulletin. A reminder email will be sent from ESR directly to those individuals concerned and a general reminder will also be published in the Weekly Bulletin.

	A summary of the declarations held on ESR is attached as appendix one. The Register of Interests for the Board of Directors and Council of Governors are attached as appendices two and three. As in the previous year and in line with best practice and in agreement with the Council of Governors, we have requested that governors sign a self-declaration that they meet the requirements of the Fit and Proper Persons Test. Receipt of the self-declaration is record in appendix three. All Board members and governors with declarations outstanding have been sent reminder emails, which will be followed up before publication of the registers. **Gifts and Hospitality Report** Revisions to the Conflicts of Interest (standards of Business Conduct) for Trust Employees Policy were approved in July 2021. The policy makes clear the requirement for any gifts or hospitality received by staff to be notified via line management arrangements to the Corporate Governance team who will maintain the central record. There was one declaration made for the receipt of gifts or hospitality during the financial year 2022/23. This is in part due to limited capacity of staff due to operational pressures to attend external functions, such as meetings and conferences.. The Corporate Governance team will continue to promote the declaration of gifts and hospitality in the coming months to ensure greater compliance with the Conflicts of Interest (standards of Business Conduct) for Trust Employees Policy for the financial year 2023/24.
5. Action recommended	The Risk and Audit Committee is asked to: **NOTE** the note the report and planned action to promote staff awareness of the need to submit declarations of interests and gifts or hospitality received.

6. Governance and Compliance Obligations				
Legal / Regulatory Link		**Yes**		Failure to comply with the guidance may result in actions being enforced on the Trust. Compliance with guidance on the receipt of gifts and hospitality and protects decision makers and those with responsibility for authorising public body expenditure.
Impact on CQC Standards		**Yes**		An effective governance process for the management of staff interests and the receipt of gifts and hospitality supports compliance with the Trust's provider license and registration with the CQC.
Risk Link		**Yes**		Effective management of declared interests supports risk mitigation and compliance with the Trust's Standing Financial Instructions.
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)		**No**	
Quality Impact Assessment (QIA)		**No**	

Appendix One: Staff Declarations (at 14th March 2023)

Available from the Corporate Governance office.

Appendix Two: DCHFT Board of Directors Declarations of Interest 2022/23 (at 14th March 2023)

Name	Role	Description of Interest	Relevant Dates	
			From	To
Anita Thomas	Chief Operation Officer	Nil to declare	02/02/2023	01/02/2024
Ruth Gardiner	Interim Chief Information Officer	Nil to declare	22/02/2023	21/02/2024
Emma Hallett	Interim Chief People Officer	Nil to declare	23/02/2023	22/02/2024
Chris Hearn	Chief Finance Officer	Nothing to Declare	06/02/2023	05/02/2024
Jo Howarth	Interim Chief Nursing Officer	Independent Governor Yeovil College	02/02/2023	01/02/2024
Alastair Hutchison	Chief Medical Officer	Director Wessex Academic Health Science Centre. No remuneration of any type for this role	02/02/2023	01/02/2024
Nick Johnson	Interim Chief Executive Officer	1) Directorships: a) DCH SubCo Ltd b) Dorset Estates Partnership LLP 2) Wife is Programme Manager for Argenti (owned by PA Consulting) providing care technology services to Dorset Council, Hampshire Council and Barnet Council 3) Director Wessex Academic Health Science Centre - no remuneration	02/03/2023	01/03/2024
Mark Addison	Chair	Nil to declare	02/02/2023	01/02/2024
Sue Atkinson	NED	Chair and Director: PHAST – Public Health Action Support Team (not for profit Social Enterprise Community Interest Company) Ownership: Sue Atkinson Associates Ltd Shareholdings: PHAST (as above) Voluntary Organisations: 1. Co Chair Climate and Health Council (Charity) 4. Chair of Global Climate Health Alliance (International body coordinating and leading the health voice of climate change globally) Spouse/Family: 1. Spouse Peter Coe – Director Sue Atkinson Associate Ltd (as in b) above) 2. Daughter- Art Psychotherapist. Working partly in NHS, South London and Maudsley NHS Foundation Trust, partly in a charity – Family Action - in Hackney London 3. Step Daughter – Manager and Policy Officer in Compassion in Dying –Charity	09/03/2023	08/03/2024

Margaret Blankson	NED	Trustee: Over The Wall is a UK charity that provides residential summer camps for children and their families coping with serious illnesses and conditions. It is a member of the Serious Fun Children's Network, a worldwide association of camps for seriously ill children	02/03/2023	01/03/2024
Eiri Jones	Vice Chair	Non-Executive Director Salisbury NHS Foundation Trust Director of own company (details to follow) Trustee and School Governor (details to follow) Advisory member of the Board for Allocate	13/02/2023	12/02/2024
Stuart Parsons	NED	Nil to declare	06/02/2023	05/02/2024
Stephen Tilton	NED	Director of DCH SubCo Ltd.	02/03/2023	01/03/2024
Dave Underwood	Senior Independent Director (NED)	Chair of Royal British Legion Club West Hill Ltd Registered IP23677R on the FCA Mutuals Public Register Associate of Exeter College - College of Further Education Policy Board member of the SW Business Council - The economic partnership for the South West of the UK Chair of the West Country Computing Hub	14/03/2023	13/03/2024
Richard Sim	Clinical Director	Director of Private ENT Practice. No NHS work undertaken in that setting		
Paul Lewis	Deputy Director of Strategy, Transformation and Partnerships	Nil to declare	02/02/2023	01/02/2024

Appendix Three: DCHFT Council of Governors Declarations of Interest 2022/23 (at 16th March 2023)

Name	Role	Description of Interest	Relevant Dates	
			From	To
Simon Bishop	Governor	Nil	03/02/2023	02/02/2024
Sarah Carney	Governor	Nil	08/02/2023	07/02/2024
Judy Crabb	Governor	Nil	03/02/2023	02/02/2024
David Cove	Governor	Trustee and Chair of Trustees of Citizens Advice Central Dorset Trustee and vice chair of Citizens Advice in Dorset Trustee of Dorset Health Trust	03/02/2023	02/02/2024
Kathryn Harrison	Governor	Nil	03/02/2023	02/02/2024
Steve Hussey	Governor	Nil	02/02/2023	01/02/2024
Margaret Alsop	Governor			
Mike Byatt	Governor	Nil	02/02/2023	01/02/2024
Stephen Mason	Governor	Nil	02/02/2023	01/02/2024
David Richardson	Governor			
Dave Stebbing	Governor			
Maurice Perks	Governor	Nil	24/02/2023	23/02/2024
Lynn Taylor	Governor	Nil	02/02/2023	01/02/2024
Kathryn Cockerell	Governor	Nil	02/02/2023	01/02/2024
Tracy Glen	Governor	Nil	02/02/2023	01/02/2024
Tony Petrou	Governor	Nil	02/03/2023	01/03/2024
Barbara Purnell	Governor	Nil	02/02/2023	01/02/2024
Terri Lewis	Governor	Member of the Older Persons sub-committee for Mental Health Integration Board with the NHS CEO of Age UK North, South & West Dorset	28/02/2023	27/02/2024
Tony Alford	Governor	Councillor Dorset Council	13/02/2023	12/02/2024
Jean-Pierre Lambert	Governor	Retired, previous employment at Stifel Europe with deferred compensation plan. Weldmar Hospicecare Trustee Wife is Director of Zoe withers ltd and CFO of Victoria Beckham Holdings Ltd, and is a former employee of FaceGym.	25/01/2023	24/01/2024
Dawn Harvey	Governor	Dawn is the Chief People Office at NHS Dorset	09/03/2023	08/03/2024

Report Front Sheet

1. Report Details			
Meeting Title:	Board of Directors Part 1		
Date of Meeting:	29th March 2023		
Document Title:	Going Concern Review		
Responsible Director:	Chris Hearn, Chief Financial Officer	Date of Executive Approval	13/03/2023
Author:	Mark Lovett, Financial Controller		
Confidentiality:	No		
Publishable under FOI?	Yes		
Predetermined Report Format?	No		

2. Prior Discussion		
Job Title or Meeting Title	**Date**	**Recommendations/Comments**
Risk and Audit Committee	21/03/2023	Approved

3. Purpose of the Paper	For approval to prepare Trust Annual Accounts on a going concern basis.							
	Note (✓)		*Discuss (✓)*		*Recommend (✓)*		*Approve (✓)*	✓
4. Key Issues	Each year the Trust is required to carry out an assessment of whether it is appropriate to prepare its accounts on a going concern basis.							
5. Action recommended	The Board is recommended to: 1. Review the draft assessment of going concern and 2. If satisfied with assessment then recommend it to the Board for approval.							

6. Governance and Compliance Obligations				
Legal / Regulatory Link		**Yes**	**No**	To comply with the terms of the Trust's authorisation
Impact on CQC Standards		**Yes**	**No**	
Risk Link		**Yes**	**No**	
Impact on Social Value		**Yes**	**No**	
Trust Strategy Link		**How does this report link to the Trust's Strategic Objectives?** *Please summarise how your report will impact one (or multiple) of the Trust's Strategic Objectives (positive or negative impact). Please include a summary of key measurable benefits or key performance indicators (KPIs) which demonstrate the impact.*		
Strategic Objectives	People			
	Place	To ensure the financial sustainability of the Trust it requires a realistic assessment of whether the going concern basis is appropriate.		
	Partnership			
Dorset Integrated Care		**Which Dorset ICS goal does this report link to / support?**		

System (ICS) goals	*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**	

GOING CONCERN BASIS FOR ACCOUNTS PREPARATION

1. INTRODUCTION

1.1 The annual report and accounts of the Trust will be approved after consideration by the Board of Directors and signed by the Chief Executive as Accounting Officer. The completed report is submitted to NHSE and later formally laid before Parliament.

1.2 All Foundation Trusts are required to prepare their annual accounts in accordance with accounting standards and company law, and must also be compliant with the additional requirements contained in the Department of Health and Social Care Group Accounting Manual 2022-23 (GAM).

1.3 The financial statements should be prepared on a going concern basis unless informed by the relevant national body or DHSC sponsor of the intention for dissolution without transfer of services or function to another entity.

1.4 This includes the concept of the accounts being prepared on the basis that the entity is a going concern and is expected to continue its business operations for the foreseeable future. A key consideration of going concern is that the Trust has sufficient cash resources to meet its obligations as they fall due. In the context of going concern, foreseeable future is deemed to mean at least 12 months from the expected date of signing of the accounts. eg Q1, 2023/24.

1.5 The purpose of this paper is to provide assurance to the Trust Board that the Trust can consider itself a going concern.

2. REQUIREMENTS

2.1 There is no presumption of going concern status for NHS foundation trusts. Directors must decide each year whether or not it is appropriate for the Trust to prepare its accounts on the going concern basis, taking into account best estimates of future activity and cash flows.

2.2 The Department of Health and Social Care Group Accounting Manual 2022-23 (GAM) reminds NHS Foundation Trusts; “The anticipated continuation of the provision of a service in the future, as evidenced by inclusion of financial provision for that service in published documents, is normally sufficient evidence of going concern.”

2.3 The Trust should include a statement on whether or not the financial statements have been prepared on a going concern basis and the reasons for this decision, with supporting assumptions or qualifications as necessary (*Code of Governance C.1.2*).

2.4 Where there is a material uncertainty over the going concern basis (for instance, continuing operational stability depends on finance or income that has not yet been approved), or where the going concern basis is not appropriate, the directors will need to disclose the relevant circumstances and should discuss the basis of accounting and the disclosures to be made with their auditors.

3. TRUST ASSESSMENT

3.1 The Trust Board assessed the going concern basis for the 2021/22 annual accounts and concluded that the Trust accounts should be prepared on the going concern basis.

3.2 The Trust's financial and cash flow forecasts are monitored on a monthly basis by NHSE.

3.3 The latest available financial outturn indicates that the net Income and Expenditure outcome for 2022/23 is a breakeven position and closing cash position of £15.1m. The Trust has currently forecast a deficit of £25.4m for 2023-24 with a borrowing requirement of £9.0m.

3.4 The Trust's forecast cash position for 2021/22 to 2023/24 is as follows:

	Actual 2021-22	Forecast Out-turn 2022-23	Plan 2023-24
Surplus (Deficit) from Operations	**3,263**	**4,145**	**(20,515)**
Non-cash or non-operating income and expense	8,136	5,840	9,673
Net cash inflow/(outflow) from operating activities	**11,399**	**9,985**	**(10,842)**
Investing activities	(19,619)	(27,338)	(21,515)
Net cash inflow/(outflow) from investing activities	**(8,220)**	**(17,353)**	**(32,357)**
Financing activities	16,473	6,482	18,679
Net cash inflow/(outflow) from financing activities	**8,253**	**(10,871)**	**(13,678)**
Opening cash and cash equivalents less bank overdraft	17,698	25,951	15,080
Net cash increase / (decrease)	8,253	(10,871)	(13,678)
Closing cash and cash equivalents less bank overdraft	**25,951**	**15,080**	**1,402**

3.5 The Trust has a loan of £4.6 million from the Foundation Trust Finance Facility (FTFF), which is due to be repaid in March 2026.

3.6 The Trust will have contracts with its local commissioners with services being commissioned in the same manner as in previous years.

3.7 The Trust has no plans to discontinue any operations, transfer services and significantly amend its structure.

4. CONCLUSION

4.1 The latest available financial forecast indicates that the Income & Expenditure outcome for 2022/23 will be a breakeven position and the closing cash position of £15.1m.

4.2 A first draft financial plan for 2023/24 for a deficit of £25.4m, plans are being developed to improve this position.

4.3 The Cash flow forecast shows the need for interim revenue Public Dividend Capital during 2023/24 to maintain liquidity, if the plan remains the same there will be a further requirement for interim revenue Public Dividend Capital in the 1st quarter of 2024/25.

4.4 The Trust will have contracts with local commissioners for 2023/24 and the Board of Directors have made no decisions to discontinue any operations, transfer services or significantly re-structure the organisation.

4.5 The regulator (NHSE) have not issued any communications that impact on our going concern assessment.

4.6 It is therefore concluded that the Foundation Trust has no material uncertainty with its financial sustainability on profitability and liquidity.

4.7 The Trust therefore meets the requirements of Department of Health and Social Care Group Accounting Manual 2022/23 as there is evidence of provision of a service in the future, and therefore it is appropriate that it prepares its accounts on a going concern basis and includes a statement to this effect in its Annual Report and Accounts.

5. GOING CONCERN – STATEMENT FOR THE 2022/23 ANNUAL REPORT AND ACCOUNTS

5.1 Based on the above conclusion, it is proposed to include the following statement in the Annual Report and as a note in the Annual Accounts, as required by the Department of Health and Social Care Group Accounting Manual (GAM) 2022/23:

"International Accounting Standard 1 requires the board to assess, as part of the accounts preparation process, the Trust's ability to continue as a going concern. In the context of non-trading entities in the public sector, the anticipated continuation of the provision of a service in the future is normally sufficient evidence of going concern. The financial statements should be prepared on a going concern basis unless there are plans for, or no realistic alternative other than, the dissolution of the Trust without the transfer of its services to another entity within the public sector.

After making enquiries, the directors have a reasonable expectation that the services provided by the NHS foundation trust will continue to be provided by the public sector for the going concern period, being 12 months from the date of signing this Annual Report.

In preparing the financial statements, the Board of Directors have considered the Trust's overall financial position against the requirements of IAS1.

The Trust is reporting a surplus of £(forecast of £0.1 million) million for the year ended 31 March 2023 with a closing cash position of £(forecast of £15.1 million).. The Trust anticipates an operating deficit of (first draft - £25.4 million) in 2023/24 and a closing cash position of (first draft - £1.4 million), this will include the need to apply for financial support through interim revenue public dividend capital anticipated to be to the value of (first draft - £9.0 million).

The directors have adopted the going concern basis in preparing the accounts, following the definition of going concern in the public sector adopted by HM Treasury's Financial Reporting Manual.

6. ACTION REQUIRED BY THE BOARD

6.1 The Board is requested to:

a) receive this report on the going concern assessment undertaken;

b) note the impact on the going concern position of the Trust;

c) consider whether the Board accepts and agrees with the conclusion reached by the author;

d) if so, to resolve that the annual accounts for the year ended 31 March 2023 should be prepared on a going concern basis.

Chris Hearn
Chief Financial Officer
March 2023

Report Front Sheet

1. Report Details			
Meeting Title:	DCHFT Board		
Date of Meeting:	29 March 2023		
Document Title:	**DCH Charity Business Plan 23/24** ***(incl. DCH Arts in Hospital Plan 23/24)***		
Responsible Director:	Paul Lewis, Deputy Director, Strategy, Transformation & Partnership	Date of Executive Approval	
Author:	Simon Pearson, Head of Charity & Social Value		
Confidentiality:	No		
Publishable under FOI?	Yes		
Predetermined Report Format?	No		

2. Prior Discussion		
Job Title or Meeting Title	**Date**	**Recommendations/Comments**
DCH Charity Strategy Group	3.1.2023	DCHC Business Plan 23/24 review
DCH Charitable Funds Committee	17.1.2023	CFC recommends DCHC Business Plan 2023/24 for Board approval
Executive Management Team	16.2.23	Approved DCH Arts in Hospital budget 23/24

3. Purpose of the Paper	DCH Charity Business Plan 2023/24 outlining key fundraising objectives; activities and budgets.							
	Note (✓)		*Discuss (✓)*		*Recommend (✓)*		*Approve (✓)*	✓
4. Executive Summary	The key elements of the DCH Charity Business Plan 23/24 (including Arts in Hospital Plan) include: • Strategic overview • DCH Charity objectives • Primary Fundraising activities • Capital Appeal Plan (ED/CrCU) • Fundraising timeline • DCHC Budget 2023/24 • DCHC 5Yr Budget (indicative) • Fundraising roadmaps DCH Arts in Hospital Plan 23/24							
5. Action recommended	The DCHFT Board is recommended to: 1. **APPROVE** DCH Charity Business Plan 2023/24.							

6. Governance and Compliance Obligations			
Legal / Regulatory Link	**Yes**		Charities Act (2011/2022)
Impact on CQC Standards		**No**	*If yes, please summarise the impact on CQC standards. (Please delete as appropriate)*
Risk Link	**Yes**		DCH Charity Risk Register
Impact on Social Value	**Yes**		DCH Charity/Arts in Hospital supports DCH 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	DCH Charity contributes funding to support staff welfare.		
	Place	DCH Charity working with Dorset NHS Charities to provide community grants from NHS Charities Together grant.		
	Partnership	DCH Charity works in partnership with organisations throughout our community.		
Dorset Integrated Care System (ICS) Objectives		**Which Dorset ICS Objective does this report link to / support?** *Please summarise how your report contributes to the Dorset ICS key objectives.* *(Please delete as appropriate)*		
Improving population health and healthcare		**Yes**		DCH Charity's purpose is to enhance patient care.
Tackling unequal outcomes and access		**Yes**		DCH Charity working with Dorset NHS Charities to provide community grants from NHS Charities Together grant to address health inequalities.
Enhancing productivity and value for money		**Yes**		Contributing financially to Dorset County Hospital.
Helping the NHS to support broader social and economic development		**Yes**		DCH Charity delivers social value contributing to the social and economic health of our local communities.
Assessments		**Have these assessments been completed?** *If yes, please include the assessment in the appendix to the report..* *If no, please state the reason in the comment box below.* *(Please delete as appropriate)*		
Equality Impact Assessment (EIA)		**Yes**	**No**	N/A
Quality Impact Assessment (QIA)		**Yes**	**No**	N/A

DORSET COUNTY HOSPITAL CHARITY BUSINESS PLAN 2023-24 (incl. DCH Arts in Hospital Plan 23-24)

The power of giving

DCH Charity Strategy 2022-25

Dorset County Hospital Charity's overarching aim is to raise significant funds to help enhance patient care and staff welfare at Dorset County Hospital and become recognised as a leading charity across our community and Dorset ICS. To achieve this goal we will need to continue to invest time and resource to build the level and sustainability of our income. The impact of the Covid-19 pandemic and current adverse economic conditions will continue to present significant risk for UK Charities' income through 2023/24. A major positive outcome has been increased support for the NHS nationally. Our Business Plan 2023/24 reflects this situation and plans for financial sustainability, whilst maintaining our ambition to grow our income with a major focus on the new Capital Appeal (ED/CrCU) during the strategic period to 2025.

DCH Charity: Vision & Mission

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

Vision statement:

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

Mission statement:

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

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

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

The DCHC Strategic Business Plan focuses on sustaining and building our income during the period 2023/24-25/26. The pandemic has negatively impacted overall income in recent years. This was counter-acted by significant levels of NHS Charities Together Covid Appeal grants. We continue to plan to secure our charity's finances, build financial sustainability and plan for future growth. National and local economic conditions will determine how fast and far we are able to grow our income as the UK economy works to recover over the medium-term. We have presented our budget forecasts for 2023/24 and through to 2025/26 accordingly. Please see budget table section.

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

Unrestricted reserves: The level of the charity's unrestricted reserves will be a key indicator of our ability to sustain our fundraising operation over the period. Our target unrestricted reserves level is approved in our DCHC Reserves Policy as £220K. In addition to our planned fundraising activities, the Charitable Funds Committee has reviewed the structure of our charitable funds (unrestricted/restricted funds) to re-structure our funds through rationalising the number of restricted funds and converting these funds to unrestricted income.

This approach aims to reduce the risk of low reserve levels, build our income base and continue to make a significant contribution to enhance patient care at DCH.

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

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

The table below presents an overview of DCHC budget forecasts for the strategic period 2022/23-2025/26 (See Appendices 1.1/1.2):

Budget	Total Income	Total Expend	As % of Income	Income ratio	£Patient contribution
DCHC 2022-25 budget forecast	**£4040K**	**£872K**	**21%**	**5:1**	**£3168K**

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

Business Plan
2023/24

DCH Charity Business Plan 2023/24

Our priority will be the implementation of our fundraising business plan for 2023/24.

The negative impact of the Covid-19 pandemic and prevailing economic instability will continue to present significant risk for our income through 2023/24. Our Business Plan 2023/24 reflects this situation and plans for financial sustainability, whilst maintaining our ambition to grow our income during the strategic period to 2025/26. We will aim to build on the increased support for the NHS, promoting the value of charitable support across all areas of DCH patient care utilising our Greatest Need Appeal and in the delivery of our new £2.5M Capital Appeal.

Our primary aim during 2023/24 will be to continue to improve our financial sustainability through budget management and building our unrestricted reserves. We will focus on maximising income from our current supporter base, whilst implementing new plans to engage new supporters. Our 2023/24 budget reflects the impact of external pressures on charitable giving on our forecast annual income; together with the opportunity to focus on securing significant income for the Capital Appeal.

DCH Charity Objectives 2023/24

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

Primary Focus Areas

Our objectives for 2023/24 will be focused on delivery of our primary focus areas including:

- **Major Capital Appeal (See Appendix 2. Capital Appeal Plan):** DCH Charity has commenced the private phase of its major c.£2.5M Capital Appeal to contribute to enhancements for the ED/CrCU new build. The DCHC Capital Appeal Plan presented with this business plan details the case for support including the funding focus areas, key appeal phases, funding sources, appeal leadership and targeted financials required to deliver the major capital appeal.

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

  Appeal Board: establishment of the DCHC Appeal Board, focused on the new Capital Appeal, with a key objective to develop a major donor fundraising programme. Please see Appeal Board 'roadmap' in the Capital Appeal Plan (Appendix 2).

- **Greatest Need Appeal:** will raise funds to provide support where it is needed most across our hospital, funding equipment and projects that make a real difference to our patients which would otherwise not be funded. Funds will be received by our General Fund, which will enable a proportion of these funds to be used for the operational requirements of the charity, primarily fundraising costs. This will be in line with budgeted cost to income ratios as detailed in the DCHC Budget 2023/24. (*See Appendix 3. Greatest Need Appeal Roadmap)*.

- **Community and Events fundraising:** (*See Appendix 4. Community/Events Roadmap*)the pandemic had a significant impact on fundraising from our community due to the restrictions. During 2022/23 community events, local organisations and individual fundraisers started to re-commence fundraising activity. Dependent on the prevailing economic situation, we expect to see a steady rebuilding of Community and Events fundraising income as we move through 2023/24. We will also aim to secure charity selection from high value events, which have previously generated valuable income for our charity.

  NHS 75th Anniversary 2023: We will consider fundraising plans to capitalise on the NHS 75th Anniversary celebrations in 2023 with a focus on the 5th July anniversary date. NHS Charities Together will also be developing fundraising initiatives and campaigns in which DCH Charity will participate as appropriate.

- **Individual Giving:** We will take a planned approach to supporter acquisition, donor development and stewardship to maximise the value of our donor base over the lifetime of our supporters. We will utilise our 'Power of Giving' fundraising brand statement to promote Individual Giving generating new income, including unrestricted income (to build the General Fund), to grow our income base, increase reserve levels and contribute to the sustainability of the Charity's operation. This income will be achieved from a range of existing and new sources and will include the following specialist fundraising activities:

  - ✓ Digital fundraising including DCHC website, online fundraising platforms and contactless donation points in the hospital. (*See Appendix 5. Digital Fundraising Roadmap*)
  - ✓ Legacies and In Memoriam giving (*See Appendix 6. Legacy Marketing Roadmap*)
  - ✓ Major donor fundraising programme*, with a particular focus on the Capital Appeal.
  - ✓ Patient engagement to encourage patients and families to take an active role in supporting the hospital. *(See Appendix 7. Patient Engagement Roadmap)*
  - ✓ Donor stewardship to build loyalty and ongoing support from our donor base. *(See Appendix 8. Donor Stewardship Roadmap)*

  ***Major donor programme:** linked initially to the Capital Appeal we will develop a focused approach to identifying and engaging support from major donors (Individual donors £1K+), as well as mid-level donors (£500-£1K). Development of the DCHC Major Donor programme will form the basis for future growth in this key income stream, focused on funding for new DCH projects and major equipment. DCH Arts in Hospital programme will also

provide an unique opportunity to engage with new networks of influence/affluence to enlist high value supporters with a strong interest in Arts & Health related projects and initiatives.

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

  Capital Appeal grants: please see the DCHC Capital Appeal Plan presented with this business plan and DCHC budgets 2022/23-25/26 for forecast grant income.

  NHS Charities Together grants: We expect to receive the balance of grant funding during 23/24 from NHSCT Covid Appeal Stage 2 Community Partnership, in addition to new income from their Development Grant and Stage 3 Recovery grants schemes; as well as new NHSCT grant programmes as these are announced.

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

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

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

- **DCHFT Staff Welfare:** Supporting DCH staff welfare, including recognising the current financially challenging economic situation, will remain a priority for DCHC during 2023/24 including funding from NHS Charities Together grants.

- **DCHC Personnel:** We will continue to review the structure, skills and investment required in the Charity's fundraising team, needed to deliver the fundraising programme during the period 2023/24-25/26.

- **DCHC Volunteers:** DCH Charity will aim to recruit new charity volunteers, where the need is identified. DCHC will also work with DCH Volunteer Manager to identify/recruit new charity volunteers. DCH Governor engagement to support the charity's activities. DCHC has Volunteer recruitment and management procedures based on DCH Volunteering procedures.

- **GDPR:** we will continue to monitor GDPR regulatory updates which apply to charitable fundraising/activity. We will continue to implement, review and report on our DCH Charity GDPR Action Plan, working within the wider DCHFT Information Governance structure.

- **Charity Governance:** A DCHC Governance Review was carried out during 2022/23. We will work with the Corporate Trustee, Charitable Funds Committee and the Trust Head of Governance to monitor and review the governance of DCH Charity. The Charity Commission's *Charity Governance Code* represents a standard of good governance practice to which all charities should aspire. The new Charities Act 2022 was introduced in Autumn 2022. DCH Charity is registered as a member of the Fundraising Regulator.

- **Arts in Hospital 2023/24** *(Please see Appendix 10. Arts in Hospital Plan 23/24)*
  Our priorities include developing the AiH Steering Group membership/role; curating the forthcoming exhibitions programme; AiH Assistant support role; developing new Arts projects including for major capital projects such as the new ED/CrCU; planning AiH organisational development and building-up the AiH charitable fund. The DCH AiH 2023/24 budget (funded by DCHFT) is presented in Appendix 10.2 for information. This budget will need to be approved through the Trust's business planning process.

DCH Charity Objectives 23/24

DCH Charity Objectives 2023/24

DCH Strategic Themes	Vision/Mission	DCHC Strategic Objectives	Primary Focus Areas	Measures
People: Putting our people first to make DCH a great place to work and receive care. **Place:** Building a better and healthier place for our patients and population. **Partnership:** Working together to ensure outstanding services, accessible to our patients and population.	**Vision:** *Dorset County Hospital Charity's vision is to become a leading charity in the heart of our community.* **Mission:** *Dorset County Hospital Charity raises significant funds to support DCH to deliver outstanding care for people in ways which matter to them.*	Delivery of outstanding fundraising activities, support and standards	• Increase profile/awareness of DCH Charity • Improve financial sustainability • Greatest Need Appeal promotion • Secure income for Specialist Care Areas • Implement Capital Appeal (ED/CrCU)	• Income targets achieved • Increase unrestricted reserves • Maximise value donor base • Maintain regulatory requirements
		Our Fundraising plans and priorities will be aligned to DCH Strategy	• Reflect Trust's Vision/Mission and Strategic Themes (PPP) • Integrate Trust/Charity key messages in FR appeals 'Case for Support' development • Build on board/senior management/clinician engagement in fundraising programme	• Strong, emotive integrated Case for Support • New Capital Appeal implemented • Increased SLG involvement in fundraising • Establish DCHC Appeal Board
		Fundraising in collaboration with our Charity partners, staff and supporters	• Proactive donor acquisition programme • Develop fundraising leadership • Support and advise staff fundraisers • Provide excellent support to community fundraisers • Build relationships with major funding organisations	• Grow value of DCHC donor base • Support Community/Events (incl. online) • Sustained major funding • Increase digitally raised income • Engage major funders (New Appeal) • Staff engagement levels
		Engaging with staff, partners and other supporters to enable successful fundraising in support of the Trust	• Engage appropriately and effectively with our patients and donors and fundraisers • Build support for donors and fundraisers in the community we serve • Planned donor development/stewardship • Grow digital fundraising activity	• Increased income from patient supporters • Rebuild community fundraising • Increase digital fundraised income • Support fundraisers (incl. online)
		Ensuring we are productive, effective and efficient to deliver long term sustainable income growth	• DCH Charity Fundraising Strategy 2023-25 • Greatest Need Appeal communications • Power of Giving brand statement • Communications/marketing plan • Charity website • Utilise digital fundraising technologies/social media • Continual monitoring and review of fundraising performance	• Charity Strategy 2023-25 implemented • New Capital Appeal implemented • Secure new major donors/funders • Increased awareness driving income growth • Digitally fundraised income growth • SMART income targets achieved

DCHC Fundraising timeline 2023/24

Table A. DCH Charity: Key fundraising activity 2023/24													
Fundraising activity	**Lead**	**Apr-23**	**May-23**	**Jun-23**	**Jul-23**	**Aug-23**	**Sep-23**	**Oct-23**	**Nov-23**	**Dec-23**	**Jan-24**	**Feb-24**	**Mar-24**
Greatest Need Appeal (General Fund)	**RC**	GNA comms	GNA comms	GNA comms	GNA comms	GNA comms	GNA comms	GNA comms	GNA comms	GNA comms	GNA comms	GNA comms	GNA comms
Capital Appeal ED/CrCU (Private phase)	**SP**	Private phase	Private phase	Private phase	Private phase	Private phase	Private phase	Private phase	Private phase	Private phase	Private phase	Private phase	Private phase
Capital Appeal (Appeal Board)	**SP**	1st meet	Prospecting	Prospecting	2nd meet	Prospecting	Prospecting	3rd meet	Prospecting	Prospecting	4th meet	Prospecting	Prospecting
Capital Appeal (Grants/Major donors)	**SP**	Proposals - ongoing	Proposals - ongoing	Proposals - ongoing	Proposals - ongoing	Proposals - ongoing	Proposals - ongoing	Proposals - ongoing	Proposals - ongoing	Proposals - ongoing	Proposals - ongoing	Proposals - ongoing	Proposals - ongoing
Individual Giving (Legacies, digital etc)	**JH**	Legacy comms	Legacy comms	Legacy comms	Legacy comms	Legacy comms	Legacy comms	Free Will promotion	Free Will promotion	Legacy comms	Legacy comms	Free Will promotion	Free Will promotion
Community & Events	**FO**	Events - ongoing	Events - ongoing	Events - ongoing	Events - ongoing	Events - ongoing	Events - ongoing	Events - ongoing	Events - ongoing	Events - ongoing	Events - ongoing	Events - ongoing	Events - ongoing
Grants (NHSCT)	**SP**	Stage 3 grant	Stage 2 Yr2 grant						Stage 2 Yr2 grant				Future grants tbc
Corporate (Networking; corporate support)	**FO**	Ongoing	Ongoing	Ongoing	Ongoing	Ongoing	Ongoing	Ongoing	Ongoing	Ongoing	Ongoing	Ongoing	Ongoing
Charity Governance (GDPR; Regulation)	**SP**	Ongoing	Ongoing	Ongoing	Ongoing	Ongoing	IG Ctt	Ongoing	Ongoing	Ongoing	Ongoing	Ongoing	Ongoing
Key:													
High-level activity													
On-going/lower-level activity													
SP: Simon Pearson, Head of Charity & Social Value													
RC: Fundraising & Communications Manager													
JH: Individual Giving Manager													
FO: Fundraising Officer													

Business Plan Review & Monitoring

Our fundraising plans aim to improve the charity's financial sustainability impacted by the Covid pandemic and adverse economic situation. We will regularly review and monitor our financial position. Key performance indicators for managing the charity's financial position include annual income and the level of unrestricted reserves. Income will be reviewed in line with approved budgets (see Appendices 1.1/1.2). Our 2023/24 target unrestricted reserves level required to maintain our charitable operation equates to £220K. In line with charity sector standards we should maintain our reserves level at or above 6 months operating costs.

Key review points will be as follows:

- **Monthly:** Head of Charity and DCH Deputy Financial Controller review monthly income/reserves level
- **Bi-monthly:** Charitable Funds Committee review Finance reports incl. DCHC Risk Register (Corporate Trustee receives Charitable Funds Committee Escalation Report)
- **Financial Review (Quarterly):** DCHC Strategy Group full financial review including DCHC Risk Register. The Group will provide a progress report to the Corporate Trustee and Charitable Funds Committee.
- Matters requiring decision by the Corporate Trustee will be escalated accordingly.

DCH Charity: Budget (2022/23-25/26)

As a result of the impact of the pandemic and adverse economic situation on UK charity income we have needed to review our income forecasts accordingly. Our revised income forecast position during the period 2022/23-25/26 now aims to achieve £4040K, delivering an average annual income of £1010K and £3168K income contribution to patient care and staff welfare during the period.

To achieve our potential over the period we will need to focus on improving the charity's financial sustainability through income generation to increase our unrestricted reserves; promoting increased giving across DCH specialist care areas through our Greatest Need Appeal and delivering a new major £2.5M Capital Appeal (ED/CrCU). Our overall aim will be to maximise our return on investment and the contribution the charity makes to patient care and staff welfare. We will continue to review the investment required in our fundraising capacity and resources to achieve return on investment targets to grow our income and contribution to patient care and facilities. Forecast budgets are presented in Table 1 below and Appendices 1.1/1.2 incorporating income and expenditure budgets.

Table 1 DCH Charity 22/23-25/26 budget forecast

Budget	Total Income	Total Expend	As % of Income	Income ratio	£Patient contribution
DCHC 2022-25 budget forecast	**£4040K**	**£872K**	**21%**	**5:1**	**£3168K**

We will monitor our forecast income on a monthly/quarterly/annual basis and budget forecasts may need to be reviewed through the year as there remains significant economic uncertainty and constraints on traditional fundraising activities. The budget 2022/23-25/26 includes the £2.5M target (including fundraising appeal costs) for the Capital Appeal (ED/CrCU). Due to the current economic uncertainty all budgets from 2024/25 onwards are indicative and will be reforecast more accurately on an annual basis to reflect the prevailing economic conditions and DCHC income performance. Our DCHC Business Plan budget 2023/24 is presented in Appendix 1.1.

DCHC budgets are based on our primary fundraising activities during 2023/24-25/26 as follows:

- Greatest Need Appeal (General Fund)
- Major Capital Appeal (ED/CrCU). Full financial details are presented in the separate DCHC Capital Appeal Plan (Appendix 2).

Appendix 1.1 DCHC Annual Budget 2023/24

Dorset County Hospital Charity - Budget 2022/23-2023/24

Activity	Budget 2022/23			Budget (Yr end reforecast) 2022/23			Budget forecast 2023/24		
	DCH Charity/ GH Appeal	ED/CrCU Appeal	Total	DCH Charity/ GH Appeal	ED/CrCU Appeal	Total	DCH Charity/ GH Appeal	ED/CrCU Appeal	Total
Income (£k)									
Legacies	75	0	**75**	280	0	**280**	100	0	**100**
Donations	75	100	**175**	60	5	**65**	75	150	**225**
Community/Events	60	15	**75**	55	0	**55**	75	0	**75**
Corporate	5	0	**5**	10	0	**10**	10	15	**25**
Grants	345	200	**545**	340	70	**410**	205	75	**280**
Total Income	560	315	**875**	745	75	**820**	465	240	705
Total Net Income (net NHSCT Stg 2 distrib	**470**	**315**	**785**	535	75	**610**	**375**	**240**	**615**
Capital Appeal (ED/CrCU) pledges				0	155	**155**		425	**425**
Total Income (Actual/Pledged)				**535**	**230**	**765**	**375**	**665**	**1040**
Costs (£k)									
Staff									
Head of Charity (0.8 WTE)	12	46	**58**	12	46	**58**	10	50	**60**
Fundraising&Comms Manager (0.8 WTE)	18	18	**36**	20	20	**40**	31	10	**41**
Fundraising Support Assistant (0.6 WTE)	0	0	**0**	4	1	**5**	7	1	**8**
Fundraising Officer (0.7 WTE)	12	8	**20**	16	5	**21**	12	0	**12**
Fundraising Officer (mat cover) (0.6 WTE)	0	0	**0**	5	1	**6**	10	2	**12**
Individual Giving Manager (1.0 WTE)	11	30	**41**	20	24	**44**	15	30	**45**
Capital Appeal Officer (0.8 WTE) funded by NHSCT	0	0	**0**	0	0	**0**	0	26	**26**
Administrator (Bank)	0	0	**0**	1.5	0	**1.5**	0	0	**0**
Support costs (provided by DCH, funded by Charity)	6	0	**6**	6	0	**6**	8	0	**8**
Total Staff Costs (£k)	**73**	**106**	**179**	**84.5**	**97**	**181.5**	**93**	**119**	**212**
Non-Staff Costs									
Design & Printing costs (leaflets, banners etc)	4	1	**5**	4	1	**5**	4	1	**5**
Stationery	0.5	0	**0.5**	0.5	0	**0.5**	0.5	0	**0.5**
Training	0	0	**0**	0	0	**0**	0	0	**0**
Insurance costs	1	0	**1**	1	0	**1**	1	0	**1**
Database costs	2.5	0	**2.5**	2.5	0	**2.5**	2.5	0	**2.5**
Website	2	0	**2**	2	0	**2**	2	0	**2**
Prospect Research	0	5	**5**	0	5	**5**	0	2.5	**2.5**
Marketing/Fundraising Consultancy	2	0	**2**	2	0	**2**	2	0	**2**
Equipment (Contactless point/s etc)	1	0	**1**	1	0	**1**	3	0	**3**
Subscriptions (NHSCT, Trustfunding, Abobe, Chambe	2	2	**4**	2	2	**4**	2	2	**4**
Donor recognition	1.5	0	**1.5**	1.5	0	**1.5**	1	0	**1**
Travel	0	0	**0**	0	0	**0**	0	0	**0**
Hospitality (networking events, donor meetings, etc)	0	1	**1**	0	1	**1**	0	2	**2**
Total Non-Staff Costs (£k)	**16.5**	**9**	**25.5**	**16.5**	**9**	**25.5**	**18**	**7.5**	**25.5**
Total Budget (£k)	**89.5**	**115**	**204.5**	**101**	**106**	**207**	**111**	**126.5**	**237.5**
As % income	**20**	**35**	**26**	**19**	**43**	**27**	**29**	**16**	**22**
Contribution to Patient Care (£k)	**380.5**	**200**	**580.5**	**434**	**124**	**558**	**264**	**538.5**	**802.5**

Appendix 1.2. DCH Charity Budget 2022/23-25/26 (indicative)

DCH Charity Budget 2022-26														
Activity	Budget 2022/23 (Reforecast)			Budget 2023/24			Budget 2024/25 (indicative only)			Budget 2025/26 (indicative only)			Av pa (4yr)	Totals (4yr)
	DCH Charity/ GNA Appeal	ED/CrCU Appeal	Total	DCH Charity/ GNA Appeal	ED/CrCU Appeal	Total	DCH Charity/ GNA Appeal	ED/CrCU Appeal	Total	DCH Charity/ GNA Appeal	ED/CrCU Appeal	Total		
Income (£k)														
Legacies	280	0	280	100	0	100	125	0	125	150	0	150		
Donations	60	5	65	75	150	225	75	250	325	75	250	325		
Community/Events	55	0	55	75	0	75	50	150	200	50	200	250		
Corporate	10	0	10	10	15	25	10	15	25	10	25	35		
Grants	340	70	410	205	75	280	25	550	575	50	175	225		
Total Income	745	75	820	465	240	705	285	965	1250	335	650	985		
Total Net Income (net NHSCT Stg 2 distribution)	535	75	610	375	240	615	285	965	1250	335	650	985	1010	4040
Capital Appeal (ED/CrCU) pledges	0	155	155		425	425								
Total Income (Actual/Pledged)	535	230	765	375	665	1040								
Costs (£k)														
Staff (£k)														
Head of Charity (0.8 WTE)	12	46	58	10	50	60	10	50	60	10	50	60		
Fundraising&Comms Manager (0.8 WTE)	20	20	40	31	10	41	31	10	41	31	10	41		
Fundraising Support Assistant (0.6 WTE)	4	1	5	7	1	8	7	1	8	7	1	8		
Fundraising Officer (0.7 WTE)	16	5	21	12	0	12	11	11	22	11	11	22		
Fundraising Officer (mat cover) (0.6 WTE)	5	1	6	10	2	12	0	0	0	0	0	0		
Individual Giving Manager (1.0 WTE)	20	24	44	15	30	45	15	30	45	15	30	45		
Capital Appeal Officer (0.8 WTE) funded by NHSCT	0	0	0	0	26	26	0	0	0	0	0	0		
Administrator (Bank)	1.5	0	1.5	0	0	0	0	0	0	0	0	0		
Support costs (provided by DCH, funded by Charity)	6	0	6	8	0	8	8	0	8	8	0	8		
Total Staff Costs (£k)	84.5	97	181.5	93	119	212	82	102	184	82	102	184		
Total Non-Staff Costs (£k)	16.5	9	25.5	18	7.5	25.5	16	14	30	16	14	30		
Total Budget (£k)	101	106	209	111	126.5	237.5	98	116	214	98	116	214	218	872
As % income	19	43	27	29	16	22	33	9	16	29	18	21	21	21
Contribution to Patient Care (£k)	434	124	558	264	538.5	802.5	187	849	1036	237	534	771	792	3168

Appendix 2. Capital Appeal Plan

Dorset County Hospital Charity – Capital Appeal Plan – Emergency & Critical Care Appeal

Capital Appeal

This plan outlines Dorset County Hospital Charity's approach to the development of its major capital fundraising appeal to raise £2.5M (c.£2.1M net contribution to NHP project) for the planned ED/CrCU new build for Dorset County Hospital. Charitable support will fund important enhancements to this major project which will improve patient care and transform the experience of Emergency and Critical Care patients and their families. Importantly, the charitable funding will contribute to the NHS NHP capital funding budget for the ED/CrCU new build. DCHC's contribution will contribute to enhancements in the new build, over and above NHS funding.

1. Appeal planning

DCH Charity has held a series of appeal planning meetings with the DCH NHP project team including Strategic Estates, ED/CrCU Consultants and Finance. Meetings have focused on aligning the appeal planning with the project development plans and identifying the key funding focus areas and associated targets. Meetings focussed on identifying the charitable funding elements and costs to enable DCH Charity to quantify the appeal target and produce a comprehensive Capital Appeal Plan.

Appeal planning process: the following provides an outline of the key steps in the development of the DCH Charity Capital Appeal Plan:

Appeal Planning activity	Timeline
Appeal planning meetings with project team	During 2021-Mar 22
DCH NHP Board: update on Appeal planning	Meetings during 2021 and 2022/Ongoing
DCH Charitable Funds Committee: Appeal planning and proposed approach	3.11.21

Prospect research (HNWIs/Trusts)	Mar-Jun 22 (HNWI) / Trusts - ongoing
Appeal Case for Support drafting – key appeal messages, funding focus areas, case stories	Nov 21-Mar 22 Ongoing
Appeal Plan drafting (DCHC Business Plan 22/23)	Nov 21-Mar 22
DCH Charitable Funds Committee: Appeal development progress report	15.12.21
DCH Charitable Funds Committee: draft Appeal Plan for review	28.2.22
DCH NHP Board: draft plan (for information)	8.3.22
DCHFT Board: Capital Appeal Plan approved	30.3.22

2. Appeal planning - assumptions

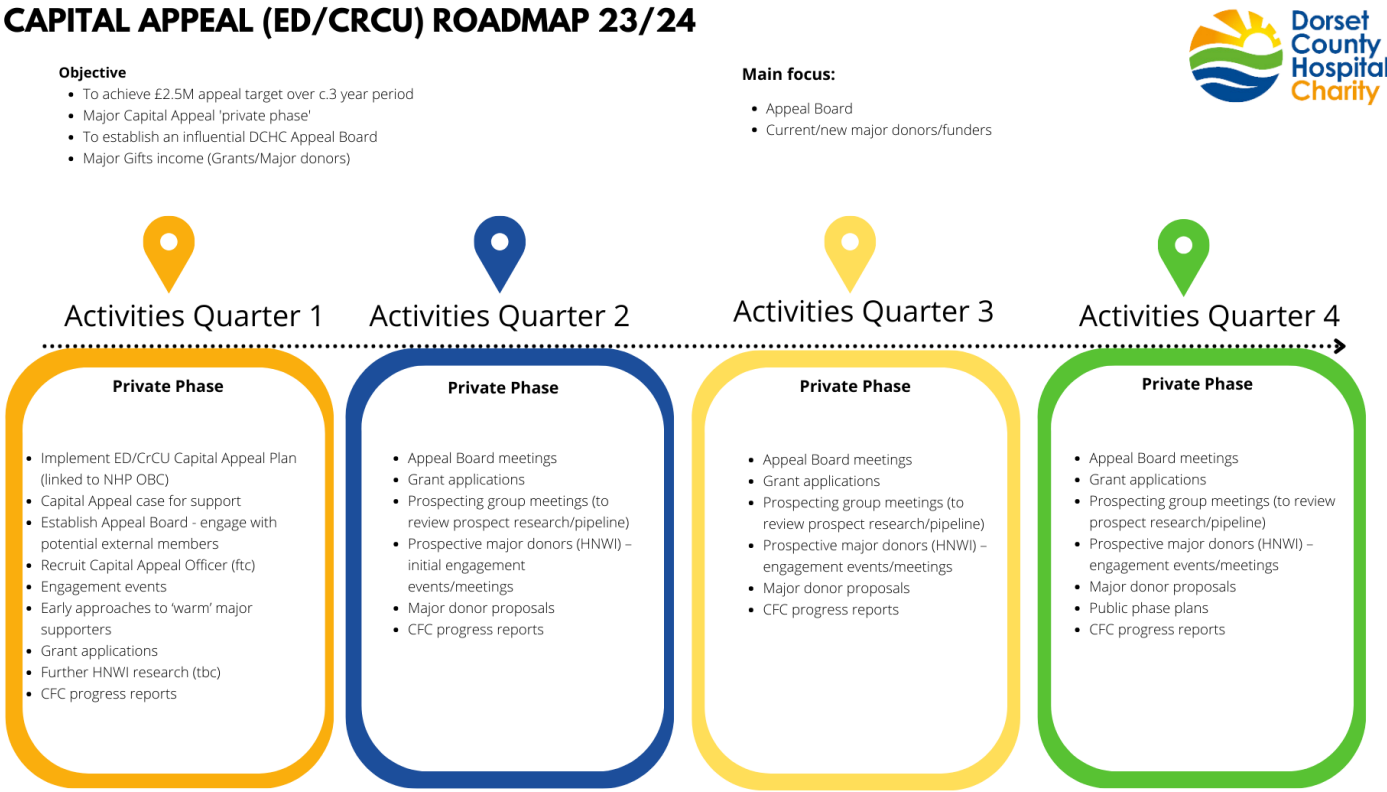
As represented by the forecast funding targets in section 7 and in DCH Charity Case for Support – Capital Appeal diagram (section 6), the CrCU and ED elements represent two distinct areas in fundraising terms; albeit part of the same integrated project. The Capital Appeal Plan has been developed based on the Charity's previous capital appeal target levels achieved (c£2M for DCH Cancer Appeal); fundraising team capacity; level and feasibility of securing capital funding targets within the project development timeline and with regard to the continuing impact of the pandemic on charity fundraising, together with the prevailing, challenging economic situation. We need to plan prudently and realistically to maximise our chances of securing significant capital funding in support of the overall project.

Key planning considerations:

- Ongoing impact of the pandemic and economy on charity fundraising. However, good will for the NHS has been heightened due to the pandemic; and there has been increased profile of the role of NHS Charities. Strong reputation of DCH in local community.
- Previous Appeals successful track record – Cancer Appeal, Chemotherapy Appeal, Covid Appeal. Significant major grants from trusts and other charitable organisations have previously been achieved.
- The Charity's fundraising team provides skills and experience and is planning to increase capacity in fundraising support and administration function to help maximise fundraising efficiency and performance.

- Evaluation of major funding research to determine the feasibility of achieving the proposed appeal target. Appeal target needs to be realistic and deliverable.
- Taking an integrated approach, focused primarily on Critical Care (CrCU) with ED (Trauma Care) areas, will enable DCH Charity to work on identifying and engaging with prospective major funders in parallel.
- We will develop a focused and emotive 'case for support' which can be clearly communicated to potential donors. Points to be considered:
  - From public/donors' perspective the role of Critical Care/ICUs during the pandemic remains 'front and centre'. The CrCU elements provide a strong 'story' focussed on patient, relatives and staff welfare; together with enhancing the care environment.
  - ED plays an essential role in this integrated pathway, though may be considered less appealing in fundraising terms with public expectations that Govt/NHS should provide this funding. Re-positioning our 'ask' for Trauma Care is considered more emotive and integrates with the 'story' of Critical Care provision.
- Dorset County Hospital's leadership at Board and Executive team strong commitment/engagement with the appeal.
- Clinical staff engagement is strong including Critical Care and ED Consultants and DCH Charity will work closely with key staff to engage major donors (ie. Donor events, meetings, site tours), as well as in promoting the public fundraising phase of the appeal.
- Influential Appeal Board will be established, to drive major donor income, grants, high-value events and corporate support. Please see section 9 'Appeal Board roadmap'.
- Digital fundraising through new DCH Charity website, fundraising platforms, contactless donations and social media promotion.
- DCH Charity will need to continue to monitor competitor/comparator appeals within Dorset; including other NHS charities and local/national charities, which could have an impact on our appeal fundraising.
- The development and success of our appeal will be dependent on the ED/CrCU Project business case (SOC/OBC) approvals, construction timeline and any matters which may impact the project's delivery. We are working closely with the NHP Strategic Estates team to ensure our Capital Appeal Plan aligns to the project's development plans accordingly.

3. Capital Appeal Roadmap 2023/24



4. Appeal timeline

DCH Charity's major Capital Appeal needs to align with the DCH NHP ED/CrCU project timeline outlined below:

DCH ED/ICU project timeline

Project Plan Milestone	Date
Strategic outline case	April 2021
Outline business case approval	September 2022
Outline planning permission	December 2022 tbc
Enabling works commence	January 2023
Full business case submission	July 2023
Construction commences	April 2024
Completion of new build	September 2025
Completion of refurbishment elements	March 2026

DCHC Capital Appeal phases

The DCH ED/CrCU project build timeline provides a three-year period from 2023-25 for delivery of the DCH Charity Capital Appeal. As with all major capital appeals, activity will be delivered through two key fundraising phases – 'private' phase which is major gifts led to secure majority of funding, then 'public' phase with a media launch and focus on community events, corporate and individual giving.

The table below provides a high-level timeline for the DCH Charity Capital Appeal phases:

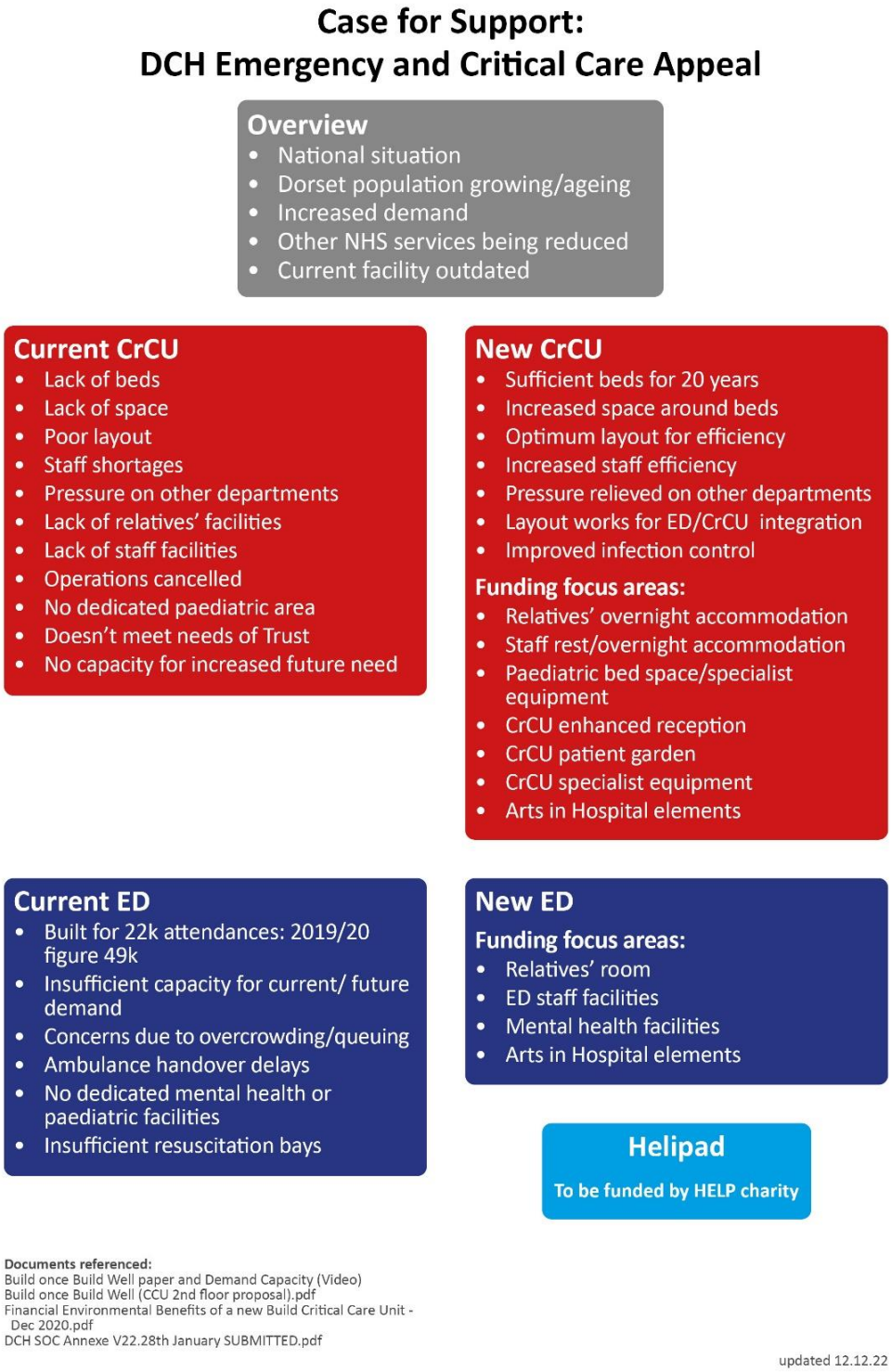
DCH Charity Appeal Activity	Fundraising activity	Timeline
Appeal planning phase	Appeal Plan development/approvals	Oct 21 – Mar 22
	Initial funding research (HNWIs/Trusts)	Mar 22 – Jun 22
Private Phase	Private phase (Further funding research; Appeal Board set up; Major donor engagement; Major gifts fundraising)	Apr 22 – Mar 24
Public Phase	Public phase (PR launch; Community/Events fundraising led; final Major donor gifts)	Apr 24 – Dec 25
Appeal close/thank PR	Media comms/major donor recognition	Dec 2025

5. Proposed funding areas/targets

In discussions with the DCH NHP project team, DCH Charity has identified potential key project areas as strong, emotive elements for the capital appeal. The table below outlines the proposed areas with costings (rounded up for fundraising purposes).

Project Area	DCHC Capital Appeal target (*cost rounded up*)
1. Critical Care (CrCU)	
Relatives' overnight accommodation (x2)	£200K
Staff rest/overnight accommodation (x2)	£300K
Staff rest area	£140K
Staff quiet room	£200K
Paediatric CC bed/equipment	£220K
Enhanced CrCU reception	£150K
CrCU patient garden and conservatory	£150K
CrCU specialist medical equipment	£100K
Arts in Hospital elements	£75K
Sub-total	**£1.5M**
DCH Charity fundraising costs (c.20%)	c£300K
Critical Care total	**£1.8M**
2. Emergency Dept (ED)	
ED Relatives Room	£160K
ED staff facilities	£120K
ED-CrCU Consultant Office	£140K
ED Child & Adolescent Mental Health Suite	£100K
Arts in Hospital elements	£75K
Sub-total	**£595K**
DCH Charity fundraising costs (c.20%)	c£120K
ED total	**£715K**
Overall Appeal total	**c.£2.5M**
Net contribution to NHP project (excl. fundraising costs)	**c.£2.1M**

6. Capital Appeal – Case for Support (summary)



7. Appeal target

Based on the appeal planning meetings with members of the DCH NHP project team including Strategic Estates, Finance and CrCU/ED Consultants, the project funding areas/targets identified equate to an overall Capital Appeal target (including fundraising costs) estimated in region of c£2.5M over 3 years. This aims to deliver a c.£2.1M net contribution to the DCH NHP ED/CrCU project.

Capital Appeal by income stream (indicative)

The following information provides indicative targets for key Capital Appeal income streams, based on the indicative forecasts in the DCH Charity 2022-25 Strategic Business Plan budgets. Initial income stream forecasts will be reviewed on an annual basis in line with DCH Charity Business Plan and Capital Appeal income stream performance as the appeal progresses.

Table 1.

Income Stream	Target	Source
Grants	£1,450K	Major national/local trusts; local charities
Donations	£650K	Major donors (HNWI), other individual donations, legacies
Events & Community	£350K	Community organisations; Events (incl Major/High Value events); DCH Staff fundraising
Corporate	£50K	Local corporate supporters, business networks
Total	**£2.5M**	**Gross appeal income (incl. fundraising costs)**

8. Prospect Research

DCH Charity are working with specialist wealth intelligence research agency Prospecting for Gold (PFG). Established in 1999, Prospecting for Gold is a leading prospect research agency to the not-for-profit sector offering a full range of fundraising and prospect research services.

Prospect Research work programme

High Net Worth Individuals research

Data Protection/GDPR: PFG will advise on GDPR requirements in relation to HNWI research and charity database screening. Data security and data sharing contracts have been agreed, with reference to advisory from DCH IG Manager.

Phase 1 research – May/June 2022 (completed)

1. **Wealth screening** of DCH Charity donor database to identify any current supporters with the capacity to give at major gift levels.

2. **New HNWI names research:** to identify 50 HNW individuals not yet connected to the charity, based on research brief, to identify good prospects for the capital appeal. PFG have around 4,500 millionaires on their research database across Dorset. In this first phase of research they suggest we focus on people within the county, while those with current/past connections to the County are included in second phase research.

3. **Presentation to DCH Charitable Funds Committee (Jun 2022)** by Prospecting for Gold research team to discuss research services, first phase research findings and major donor development for Capital Appeal.

Phase 2 additional research (*tbc, if required*) – Mar/Apr 2023

To further expand the HNWI prospect pool for the Capital Appeal, if required. Depending on DCH Charity's requirements this may include some of the following research elements:

1. **Additional HNWI new names** – building on the work in phase 1. This research would focus on HNWI prospects both within Dorset and/or with connections to Dorset.

2. **HNWI Prospect briefings** – reports on individual prospects which include:
    - **Biographical** information & career history
    - **Wealthband**
    - **Spouse** information
    - **Business** and philanthropic links
    - **Membership** of clubs and other associations
    - **Interests** and motivations
    - **Other** points of interest

3. **DCH Historic donors research:** as recorded on the historic donor boards displayed in the hospital, the former hospital was supported by influential donors and families in/and with connections to Dorset. These names would be screened against PFG's wealth intelligence database and other research sources to identify any current family members and/or connections to these donors. Our aim thereafter would be to engage the people identified to ascertain their interest in continuing the philanthropic legacy of their forebears.

Trusts and Foundations research

Grant making charitable trusts will include local, regional and national Trusts/Foundations and other charities which have previously supported DCH Charity; as well as new prospects.

DCH Charity is carrying out desk research using online grant research platforms to identify new Trusts with capital grant-giving criteria related to Health/Medical causes. This will include local Dorset based Trusts, as well as larger national Trusts with an interest in the related project, Health/Medical and/or Dorset based charitable causes. DCH Charity team will also work with members of the DCH Charity Appeal Board to identify known connections to grant-giving organisations and utilise these to introduce, advocate and apply for support for the capital appeal accordingly.

8.1 Capital Appeal - Table of Gifts

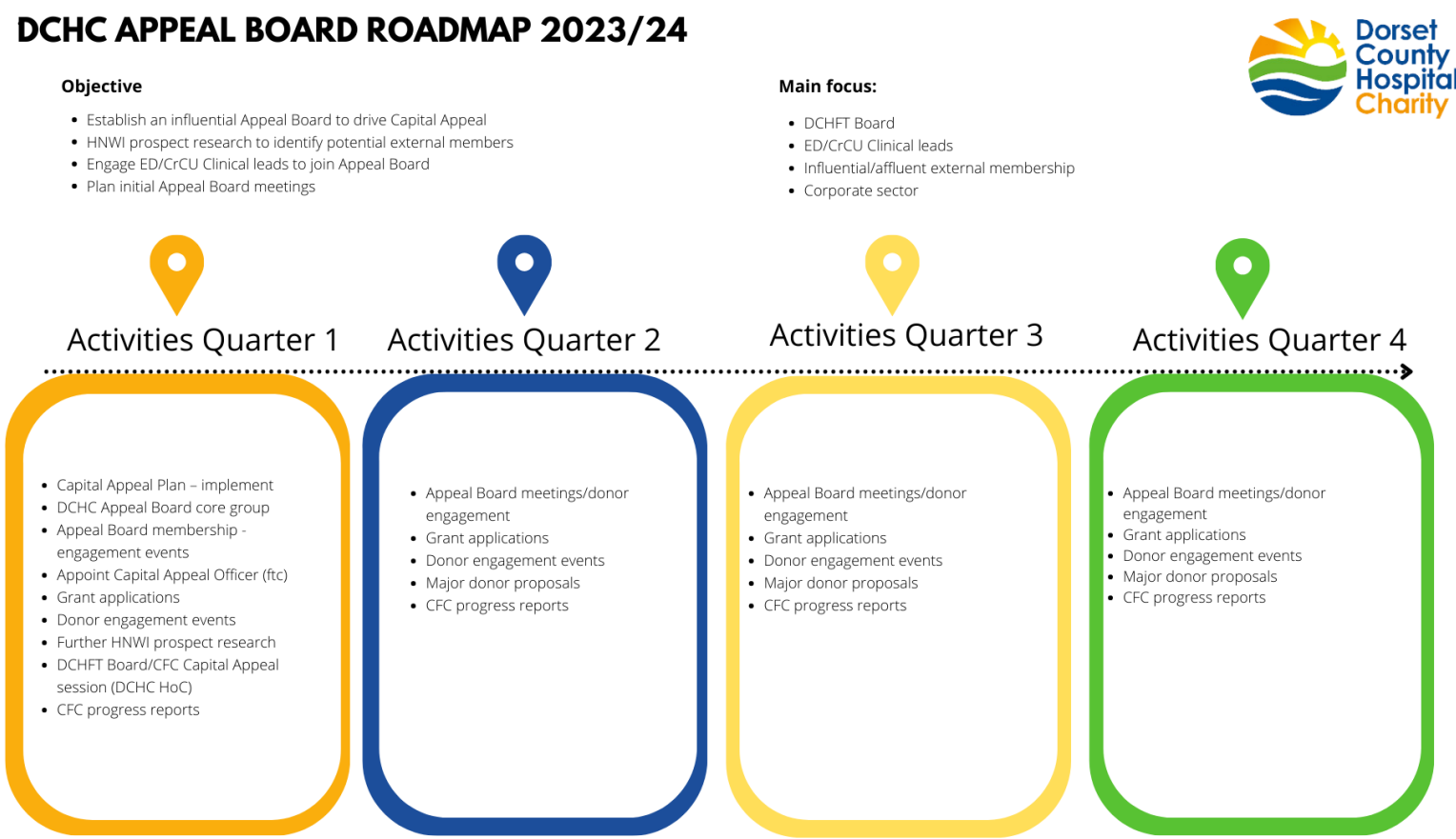
DCH Charity continues to assess the prospect research findings for the appeal and has developed a Capital Appeal Table of Gifts; this a key tool for planning and managing a major appeal. It presents the number of donations at specific donation levels required to achieve the target most effectively. The Capital Appeal Table of Gifts is presented in Table A. below:

Table A. Capital Appeal (ED/CrCU) Table of Gifts

Ideal forecast			
Giving Level	Giving Level	No. Donors required	Financial projections based on need
£250,000+	£250,000.00	1	£250,000.00
£100,000+	£100,000.00	8	£800,000.00
£50,000+	£50,000.00	10	£500,000.00
£25,000+	£25,000.00	15	£375,000.00
£10,000+	£10,000.00	27	£270,000.00
Total for £10,000+			**£2,195,000.00**
£5,000+	£5,000.00	30	£150,000.00
£2,500+	£2,500.00	15	£37,500.00
£1,000+	£1,000.00	78	£78,000.00
£500+	£500.00	50	£25,000.00
Less than £500	£500.00	29	£14,500.00
Total for under £10,000			**£305,000.00**
	Total		**£2,500,000.00**

(Please note – the Table of Gifts will be adjusted periodically during the 3 year Appeal period to reflect actual pledges/income)

9. Appeal Leadership: DCHC Appeal Board development



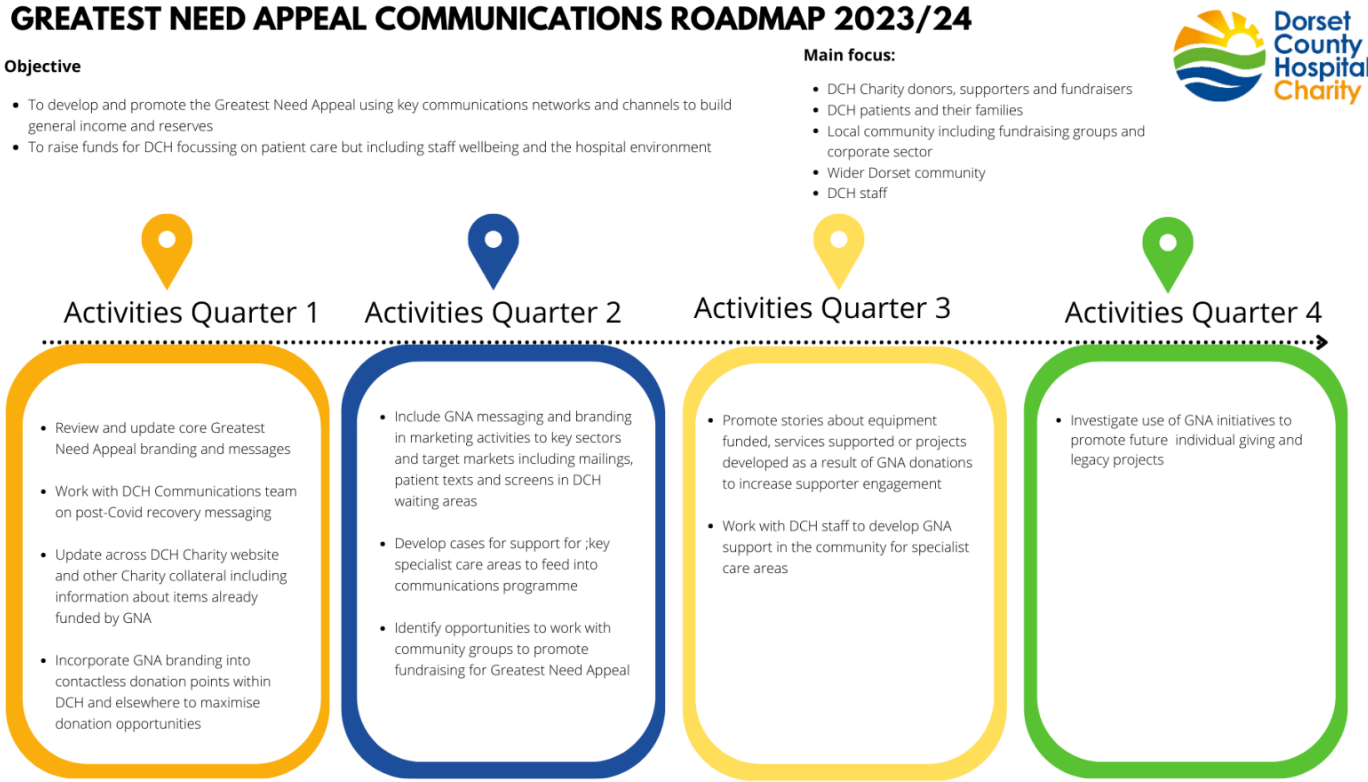
10. DCH Charity Capital Appeal Budget *(2022/23-25/26) indicative*

Income Stream	**Target (£K)** (Indicative)	**Actual t/d** (Inc/Pledge td)	**Source**
Grants	£1,450K	**£250K**	Major/local trusts; local charities
Donations	£650K	**£5K**	Individual donations, major donors, in memoriam, legacies
Events & Community	£350K	**£**	Community events; High Value Events; Staff fundraising
Corporate	£50K	**£**	Local corporate supporters
Total	**£2,500K**	**£255K**	**Balance to be achieved: £2,245K (*as of Feb 2023*)**

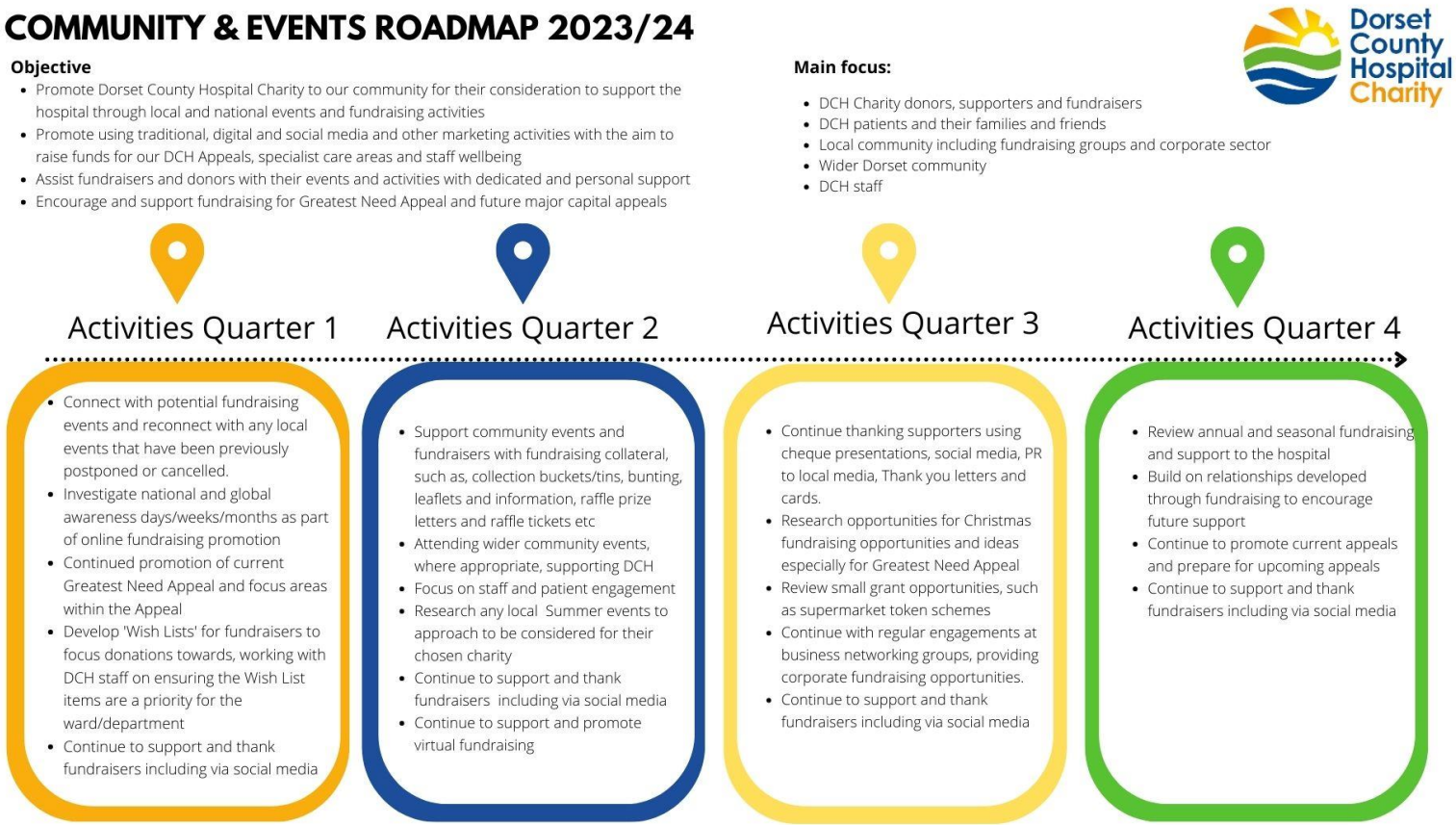
Appeal Budget (£K	**2022/23 (forecast)**	**2023/24 *(indicative)***	**2024/25 *(indicative)***	**2025/26 *(indicative)***	**Totals**
Capital funds target (£K):	**£230K**	**£665K**	**£965K**	**£650K**	**£2510K**
Staff costs related to Appeal					
Head of Fundraising (0.8)	£46K	*£50K*	*£50K*	*£50K*	**£196K**
Fundraising & Comms Manager (0.8)	£20K	*£10K*	*10K*	*£10K*	**£50K**
Individual Giving Manager (1.0)	£24K	*£30K*	*£30K*	*£30K*	**£114K**
Capital Appeal Officer (0.8) 12mth ftc	£0K	*£26K*	*£0K*	*£0K*	**£26K**
Fundraising Officer (0.7)	£5K	*£0K*	*£11K*	*£11K*	**£27K**
Fundraising Officer (0.6 mat cover;12mth ftc)	£1K	*£2K*	*£0K*	*£0K*	**£3K**
Fundraising Support Assistant (0.6;12mth ftc)	£1K	*£1K*	*£1K*	*£1K*	**£4K**
Total Staff Costs (£K)	**£97K**	***£119K***	***£102K***	***£102K***	**£420K**
Non-Staff Costs related to Appeal					
Marketing, Design & Printing	£2K	*£1K*	*£12K*	*£12K*	**£27K**
Funding Research	£5K	*£5K*			**£10K**
Donor engagement events	£2K	*£1K*	*£2K*	*£2K*	**£7K**
Total Non-Staff Costs (£K)	**£9K**	***£7K***	***£14K***	***£14K***	**£44K**
Total Appeal Costs (£K)	**£106K**	***£126K***	***£116K***	***£116K***	**£464K (18.5% C:I)**
Net contribution to NHP project (£K)	**£124K**	**£539K**	**£849K**	**£534K**	**£2046K**

DCH Charity - Fundraising Roadmaps

Appendix 3. Greatest Need Appeal (Communications) Roadmap



Appendix 4. Community & Events Roadmap

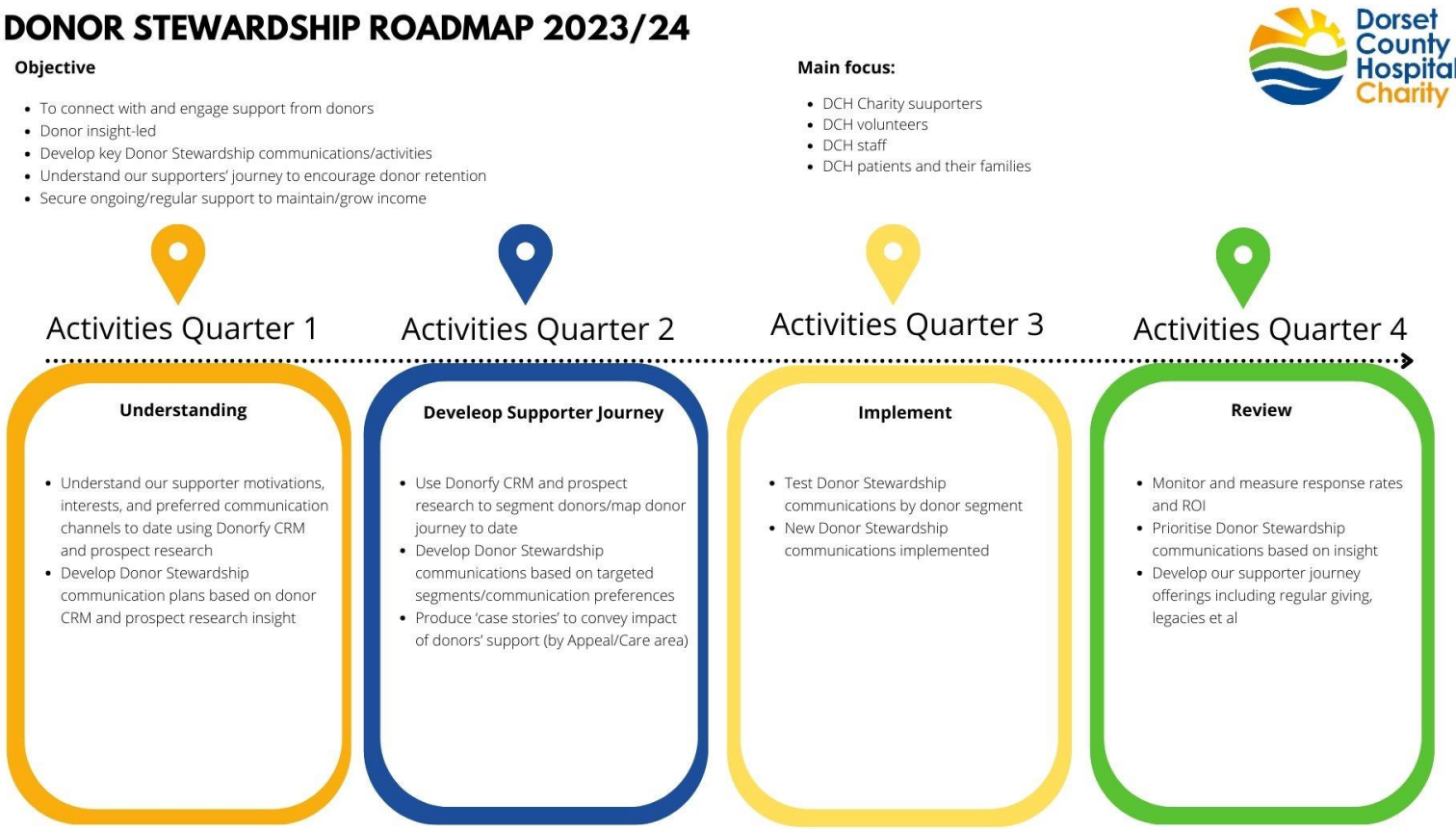


Appendix 5. Digital Fundraising Roadmap

Appendix 6. Legacy Marketing Roadmap

Appendix 7. Patient Engagement Roadmap 23/24

Appendix 8. Donor Stewardship Roadmap



Appendix 9. NHS Charities: Comparator Analysis (Regional) 2020/21

Table 1 provides a summary of comparator performance information from regional NHS Charities' 2020/21 Annual Accounts.

Table 1

NHS Charities 2020/21	DCH	UHD (formerly Poole & Bournemouth charities)	Salisbury	Southampton	Taunton	Yeovil	Exeter
Population	250,000	1,050,000	250,000	1,300,000	340,000	185,000	450,000
Income £000's	£500K	£1295K	£1470K	£3590K	£764K	£677K	£861K
Fundraising/Gov/Investment expenditure	£100K	£348K	£248K	*£188K *(*13 employees)*	£266K	£105K	*£16K (HoF employed by NDHFT)
Income:Cost ratio	5:1	3.7:1	5.9:1	*19:1	2.8:1	6.4:1	*N/A
FR expend as % of income	20%	26%	17%	*5%	35%	15%	*N/A
£/popln	£2.00	£1.24	£5.88	£2.76	£2.25	£3.65	£1.91

(Source: Charity income/fundraising expenditure figures provided via Charity Commission website)

Appendix 10. DCH Arts in Hospital Plan 23/24

The key actions for the year ahead are below:

- Work with Screenplay to produce audio version of the 35th Anniversary Art Map.
- Design and produce signage relating to 35th Anniversary Art Map + Screenplay project.
- Look to schedule Adult Eczema touring exhibition at DCH.
- Complete new mural for Kingfisher.
- Arts provision + plan for Chemotherapy refurb.
- Continue to upload collection to AIH website.
- Install art in ED15.
- Work with NHS Dorset on art + wayfinding provision for SWH.
- Evaluate, restore and repair collection.
- History wall, potentially part of NHP.
- Commission artist for work in education centre.
- Supervise Farrah Fortnum's external mural.
- Work with Bev Lagden, new sustainability manager on outside spaces + courtyard improvement. (John Hubbard garden tribute.)

- Work with Hannah Robinson getting artists onto wards + train her volunteers to participate in arts and crafts activities with patients.
- Programme 2023/24 Temporary Exhibitions.
- NHP arts provision budget + timetable + research and development for commissions.
- Explore arts related grants for NHP.
- Consider private events with charity for donor engagement for fundraising appeal.
- Reinstate AIH Assistant. The role to focus on patient engagement + manager support.
- Expand CPD and possible MA in collections care.

Appendix A. DCH AIH Activity Timetable 2023-24

Activity	***Month***	***Notes***
Exhibition change over	*January 10 + 11*	*Paul Cleden to Into the Woods Collective*
Assess and photograph stone for Richard Harris sculpture	*January 16 - 18*	*First steps towards finalising the reworked sculpture for ED15.*
Kingfisher Mural	*January 23 - 25*	*Collate feedback for Marina*
NHP Budget and schedule	*January*	*Create a workable 3 year map/plan to be able to start work asap*
Education Centre commission	*January-March*	*Prepare and release call to artists*
NHS Dorset re SWH	*January - March*	*Meet with the SWH team within NHS Dorset and work with AUB students on a brief for interior design for SWH.*
Artwork into ED15	*January - March*	*Finalise the print for photos and illustrations and install*

Unmasked exhibition out of Museum	*February*	*Commission Andy to produce a contact image of the project*
Plan for art as part of chemo refurb	*February - April*	*Hope to have a budget and finalise mood board and be able to engage artists*
Kingfisher Mural	*March*	*In house painting*
Exhibition change over	*March 22 + 27*	*Out of the Woods – Greener NHS*
Continue to add collection to AIH website	*April onwards*	*We have had some slides converted so have additional quality images to add*
Input to volunteer programme	*Spring*	Work with Hannah Robinson re artists onto wards + train volunteers in AIH activities
Exhibition change over	*May 3*	*Greener NHS out*
Programme 2024 Temporary Exhibitions	*Ongoing – In place by Sept*	*TBC*
NHP	*October -*	*Hope to be able to begin work on History wall and engage photographers*
Exhibition change over	*October 12 + 13*	*TBC*

Add AIH donation to Donorfy		*To ensure there are more thorough records and that we can use the information in future*

Appendix B. DCH Arts in Hospital budget 23/24

The 2023/24 DCH Arts in Hospital (AIH) budget was approved by EMT on 16.2.2023 (please see below).

The rationale for the additional budget elements for 2023/24 includes the following:

Collections maintenance/repairs: We have budgeted £2K to commence much needed repairs on our the DCH arts collection valued at c.£1M. This budget is essentially seed funding to establish a 'Restoration and Maintenance Plan' over several years. It would give us a modicum of match funding when applying for grants and will include paying for a site visit from a specialist conservator to produce a collections report. Please see images, below, of some of the DCH Art collection pieces requiring repair. These are on paintings with between a £3K - £28K asset value. It is essential we avoid further deterioration of key pieces in our collection and an inevitable loss of value.



If we want to secure future funding for DCH AIH projects from bodies like ACE (Arts Council England) and HLF (Heritage Lottery Fund) we need to evidence that we are formally maintaining our collection. Much of DCH's collection was purchased with ACE funding in 1997.

Interpretation Display - materials/printing: Budgeted £2.8K to provide exhibition interpretation display materials for DCH AIH temporary exhibitions programme including to accompany the DCH AIH 35th Anniversary Art Map. This celebrates our collection and makes it more accessible. Interpretation includes the labels, panels and information associated with the artwork - signage. Patients, staff and visitors must be able to understand what a piece of work is and why it's there.

Arts Projects Development – staff travel: Budgeted £1K for increased travel to visit artists in their studios to select work for DCH AIH temporary exhibitions. In addition, travel to select artists who will work on the NHP (ED/CrCU) arts projects commissions. The DCH AIH Manager also needs to travel to 2 CPD events a year.

Arts in Health is currently very topical, we need to make the best of our collection, care for it and work with our departments to do new, inspiring and interesting projects. Around 90% of the activity delivered by the DCH AIH Manager uses other wards/departments budgets to deliver AIH projects, as outlined in the DCH AIH 23/24 Annual Plan. However, we need to invest a minimal level for key elements to protect the DCH Art collection and support the DCH AIH operation.

Account		22/23 Annual	22/23 Ytd re-forecast	2023/24	Explanation
Code	Description	Budget £	Budget £	Budget £	Budget £
20406	Agenda For Change Band 6	25,254	25,254	26,095	
20410	Agenda For Change Band 2	4,361	4,361	4,506	
	Pay Codes	**29,615**	**29,615**	**30,601**	
31101	Mse General	0	100	100	
31138	Medical Equipment Maintenance	3,000	3,000	3,000	
33000	Interpretation Display - Materials/Printing	0	300	2,800	Interpretation display materials to accompany DCH AIH 35th Anniversary project and Screenplay audio project
33001	Stationery	0	150	150	
33018	Arts Projects Development - Staff Travel	0	750	1,000	AIH Manager studio visits to commission artists for DCH annual programme and NHP (ED/CrCU) arts projects.
34017	Computer Licences	0	750	750	Continue to build the AiH website digital collections archive
34021	Insurance Premises	3,000	4,400	4,500	Annual premium
36500	Consultancy Costs	0	0	0	
	Projects		0	0	
	Collections Maintenance		0	2,000	To commence much needed repairs to DCH AIH collection
	Nonpay Codes	**6,001**	**9,450**	**14,300**	
	Report Total	**35,615**	**39,065**	**44,901**	

Appendix 11. Professional Memberships

Organisation	Membership Type	Professional Qualifications/Nominals
Fundraising Regulator	Registered Charity	
Chartered Institute of Fundraising	Individual (Simon Pearson)	MCIOF (Full Member)
Chamber for Business (Dorchester)	Organisation	
Social Value UK	Organisation (DCHFT)	

Minutes of the meeting of the ICB Board – Part 1 - Public
of NHS Dorset
Thursday 5 January 2023 at 10am
Board Room at Vespasian House, Barrack Road, Dorchester, DT1 1TG
and via MS Team

Members Present:		
	Jenni Douglas-Todd (JDT)	ICB Chair
	John Beswick (JB)	ICB Non-Executive Member
	Cecilia Bufton (CB)	ICB Non-Executive Member
	Jonathon Carr- Brown (JCB)	ICB Non-Executive Member
	Dawn Dawson (DD)	Acting Chief Executive Dorset Healthcare NHS Foundation Trust and ICB NHS Provider Trust Partner Member
	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
	Patricia Miller (PM)	ICB Chief Executive
	Rob Morgan (RM)	ICB Chief Finance Officer
	Karen Rampton (KR) (Virtual)	Local Authority Partner Member (East) Nominated Deputy for Drew Mellor
	Debbie Simmons (DSi)	ICB Chief Nursing Officer
	Manish Tayal (MT)	Interim Non-Executive Member
	Kay Taylor (KT)	ICB Non-Executive Member
	Forbes Watson (FW)	GP Alliance Chair, Primary Care Partner Member
	Dan Worsley (DW)	ICB Non-Executive Member
Invited Participants Present:		
	Neil Bacon (NB)	ICB Chief Strategy and Transformation Officer
	Louise Bate (LBa) (virtual)	Manager, Dorset Healthwatch
	David Freeman (DF)	ICB Chief Commissioning Officer
	Dawn Harvey (DH)	ICB Chief People Officer
	Nick Johnson (NJ) (virtual)	Interim Chief Executive Officer, Dorset County Hospital NHS Foundation Trust
	Karen Loftus (KL) (virtual)	Chief Executive, Community Action Need
	Matt Prosser (MP)	Chief Executive, Dorset Council
	Andrew Rosser (AR)	Chief Finance Officer, SWAST
	Ben Sharland (BS)	Primary Care Participant
	Jon Sloper (JS)	Chief Executive, Help and Kindness
	Stephen Slough (SS)	ICB Chief Digital Information Officer
	Dean Spencer (DSp)	ICB Chief Operating Officer
In attendance:		
	Frances Aviss (FA) (for ICBB23/005) (virtual)	ICB Senior Public Engagement Lead
	Liz Beardsall (LBe) (minutes)	ICB Company Secretary
	Kirsty Hillier (KH) (for item ICBB23/005) (virtual)	ICS Communications Lead
	Fran Pingarelli (FP) (for ICBB23/012)	ICB Workforce Redesign Lead

	Sarah Smith (SSm) (observing)	Deputy Chief Finance Officer
	Natalie Violet (NV)	Business Manager to the ICB Chief Executive
Public:		
	1 member of the public in attendance 8 members of the public via Livestream	
Apologies:		
	Sam Crowe (SC)	Director of Public Health Dorset
	Graham Farrant (GF)	Chief Executive, Bournemouth, Christchurch and Poole Council
	Spencer Flower (SF)	Leader Dorset Council and ICB Local Authority Partner Member (West)
	Leesa Harwood (LH)	ICB Associate Non-Executive Member
	Drew Mellor (DM)	Leader Bournemouth, Christchurch and Poole Council and ICB Local Authority Partner Member (East)

ICBB23/001 **Welcome, apologies and quorum**

The Chair declared the meeting open and quorate. There were apologies from Sam Crowe, Graham Farrant, Spencer Flower, Leesa Harwood and Drew Mellor.

ICBB23/002 **Conflicts of Interest**

There were no conflicts of interest declared in the business to be transacted on the agenda.

ICBB23/003 **Minutes of the Part One Meeting held on 3 November 2022**

The minutes of the Part One meeting held on 3 November 2022 were agreed as a true and accurate record.

Resolved: the minutes of the meeting held on 3 November 2022 were approved.

ICBB23/004 **Action Log**

The action log was considered and approval was given for the removal of completed items. It was noted that all items were complete or in hand.

Resolved: the action log was received, updates noted and approval was given for the removal of completed actions.

ICBB23/005 **Board Story: 100 Conversations**

The Chief People Officer introduced the Board Story video presentation on the 100 Conversations project. The video shared the experiences of three members of the community, the key themes that the 100 Conversations had raised and how these had shaped the priorities in the ICP Strategy. The next stage would be to work on co-designing solutions to the themes raised.

Kirsty Hillier, ICS Communications Lead, and Frances Aviss, ICB Senior Public Engagement Lead, joined the meeting to discuss the video with the Board.

The Board welcomed the opportunity to hear from participants in the 100 Conversations project and discussed the need to:

- Simplify access to, and navigation through, the system
- Personalise services where possible, noting the requirement to balance this with the need for pathways
- Close the feedback loop to those people who had participated in the conversations
- Embed solutions in the community and resist medicalising social issues
- Look at solutions at a place/community/neighbourhood level
- Consider how these issues felt for the workforce in the system
- Communicate with the community about what is going well, to counter the negative media narrative about health and social care
- Equip the workforce so they can assist people in accessing the right services and information
- Embed the 100 Conversations approach across all partners, so that services can be co-designed around people's needs.

The ICB Chief Strategy and Transformation Officer noted the importance of a single point of access for all services and offered to take ownership of this from the transformation perspective. He would bring a proposal back to the Board.

ACTION: NB

It was noted that the national deadline for the Forward Plan had been moved to June, but it had been agreed locally to work towards the original deadline of March. The Forward Plan would be discussed at the Board Development Session in February to enable the Board to feed into the planning process.

The Board thanked the team for all their work on the 100 Conversations and asked for the Board's thanks to be fed back to all the participants from the community.

Action: FA, KH

ICBB23/006 Chief Executive Officer's Report

The ICB Chief Executive Officer (CEO) introduced the previously circulated CEO's Report, which was taken as read. Highlights included:

- Steve Barclay's reinstatement as Secretary of State for Health and Social care. The ICB CEO and Chair had a very positive meeting with him before Christmas
- An update on the Hewitt Review, including the CEO's involvement
- Details of upcoming planned industrial action and reflections on the impact of action in December
- The allocation of the £500 million Adult Social Care Fund, and the related requirement to reduce No Criteria to Reside patient numbers
- The operating model for the ICB was nearly finished and this would be brought to Board shortly for sign-off.
- The work on the Forward Plan was on track and would be shared with Board at the February Board Development Session
- Positive updates from the GP Alliance, provider partners, ambulance trust and local authorities were noted.

In relation to GP direct access to diagnostic scans, the ICB Chief Operating Officer would meet with the Primary Care Partners to discuss the position in Dorset further.

ACTION: DSp, BS, FW

In response to the CEO's Report, the Board discussed the hot-desking opportunities at the Department of Health; the lack of reference in the 2023/24 planning guidance to workforce and the guidance that was expected later in the year on workforce strategy; the challenges faced by the ambulance workforce; and the need to manage expectations and communications with the community.

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

Items for Decision

ICBB23/007 Quality and Safety Committee and Risk and Audit Committee Workplans and Committee Terms of Reference

The Company Secretary asked the Board to approve the workplans for the Quality and Safety and Risk and Audit committees, which had been approved by the respective committees. The Board was also asked to approve an amendment to the Terms of Reference for the regular Board committees to reflect that the meetings were now being held bi-monthly rather than monthly.

The Chair of the Risk and Audit Committee confirmed that advice on the workplan had been taken from external and internal audit, as well as from management. The workplan would be reviewed and revised as necessary for the next financial year.

Resolved: The Board approved the Quality and Safety Committee and Risk and Audit Committee workplans, and approved the amendment to the regular Board committees' Terms of Reference.

Items for Noting/Assurance/Discussion

ICBB23/008 Quality Report

The ICB Chief Nursing Officer introduced the previously circulated Quality Report, which had previously been discussed in detail at the Quality and Safety Committee (QSC). This was a new version of the report, which would evolve to provide the QSC and Board with relevant quality and risk information. Areas highlighted included the continued focus on maternity services, the completion of the section 11 audit for health, the action plan relating to initial health assessments, Care Quality Commission (CQC) visits to University Hospitals Dorset (UHD) and positive progress with quality improvement initiatives.

The ICB Chief Nursing Officer offered to support the UHD CEO with using the Dorset Intelligence & Insight Service (DIIS) to drill down into the data underpinning the Quality Report.

ACTION: DSi/SH

The Board discussed the CQC visits at UHD and the impact, consistency and proportionality of CQC visits during this period of significant challenge, noting the importance of maintaining high standards even in times of pressure.

Resolved: the Board noted the Quality Report.

ICBB23/009 **Performance Report**

The ICB Chief Operating Officer introduced the previously circulated Performance Report, highlighting the differences between November, which had seen performance improving, and December which had been negatively impacted by cold weather, industrial action and pressure over the Christmas period. The current performance for 104 and 78 weeks waits were noted, as was the positive performance against the cancer standards and the improving productivity in diagnostics. The challenges regarding ambulance standards and No Criteria to Reside (NCTR) patients were also noted.

The Board discussed performance for the children and young people's eating disorder service and mental health service (CAHMS). It was noted that there would be a deep dive on mental health performance at the next ICB Finance and Performance Committee meeting. The Interim CEO Dorset HealthCare offered to bring a deep dive on the eating disorder service figures to the next Board meeting.

ACTION: DD

The ICB Chief Commissioning Officer provided a brief update on the mental health teams in schools programme and offered to bring further report on CAHMS to the next Board meeting (following discussion at the System Executive Group).

ACTION: DF

The Board discussed the issue of ambulance handover times, noting the range of factors that contributed to this, and that it was a symptom of other pressures on flow in the system. The need for a faster rate of change to address pathway problems was discussed, and the Board agreed that a test-and-learn culture needed to be encouraged, where people could 'fail safely' and the speed of change could be accelerated as a result.

There was a brief discussion of the Winter Plan (included in the circulated Board papers as a consent item), noting that the three workstreams in the plan supported managing the current pressures and planning for the future.

The Chair requested that Cllr Karen Rampton liaise with the ICB Chief Commissioning Officer regarding the Raizer emergency lifting chairs programme and its impact on reducing ambulance calls.

ACTION: KR/DF

Paul Johnson and Dean Spencer left the meeting.

Resolved: the Board noted the Performance Report.

ICBB23/010 Finance Report

The ICB Chief Finance Officer introduced the previously circulated Finance Report, which summarised the financial position of the Integrated Care System (ICS) at November 2022 and incorporated month 8 reporting for ICS providers and NHS Dorset. At month 8 the ICS was reporting a deficit of £23.2m against breakeven plans submitted to NHS England: £13.2m relating to Dorset ICB and £10.0m relating to NHS providers. There were some signs of improvement regarding cost pressures, but prescribing, independent sector providers, personal health commissioning and agency spend remained key cost pressures.

It was noted that a further discussion would be held in the Part Two ICB Board meeting about the current financial position.

Resolved: the Board noted the Finance Report.

ICBB23/011 International Recruitment Update

The ICB Chief People Officer drew the Board's attention to the previously circulated update on international recruitment, following on from the Board Story video in November. The report provided an overview on the international recruitment work across the ICS and demonstrated how partners addressed issues which impacted on the experience of internationally recruited colleagues.

The large amount of work which had been done to improve the experience of overseas recruits since 2018 was noted especially regarding pastoral support, accommodation, integration, education and career progression. However challenges remained around issues including the cost of accommodation in Dorset, transport in rural areas, and the UK cost of living. Some, but not all, of these could be addressed in the ICS's longer-term planning. The ambition was to look to reduce reliance on international recruitment and the People Plan would look to balance the need for international recruitment and opportunities for local recruitment.

It was noted that retention of overseas recruits was not deemed to be an issue, however it was difficult to extract data on this metric from the overall retention data.

The CEO Dorset Council reported that a date had now been set for a round-table discussion regarding housing, as had been discussed at the previous ICB Board meeting in relation to overseas recruitment.

The Board discussed the ambition for a system wide approach to pastoral support, the importance of learning from colleagues from collectivistic societies; the need to influence the national requirements around international recruitment; how the system could position itself as a leader in this work; and how the system's successes to date could be used to further promote the Dorset system as a good place to work.

Resolved: the Board noted the International Recruitment Update.

ICBB23/012 System Workforce Race Equality Standards and Workforce Disability Equality Standards Deep Dive

The ICB Chief People Officer referred the Board to the previously circulated System Workforce Race Equality Standards (WRES) and Workforce Disability Equality Standards (WDES) Deep Dive. The meeting was joined by Fran Pingarelli, ICB Workforce Redesign Lead, who co-authored the paper with Emma Hallett, ICS System Equality, Diversity and Inclusion Lead.

The report, which had been discussed in detail at the ICB People and Culture Committee, provided a baseline position to inform the priorities in the People Plan. The Board agreed that the report made for sobering reading and there was much work to be done. There was a need for a cultural step-change to ensure a compassionate and inclusive culture across the ICS.

The positive impact of work at Dorset County Hospital in 2020/21 demonstrated that positive change was possible and that Dorset could become a leading system in this work. This ambition would require a commitment from the ICB Board members to a common approach to equality, diversity and inclusion (ED&I). It was noted that discussion on the possibility of a proactive anti-racist statement would form part of the People Plan work.

The Board supported having a consistent, system-wide approach to ED&I and the Board noted its appetite to be a leading system in this work

Louise Bate left the meeting.

Resolved: the Board noted the System Workforce Race Equality Standards (WRES) and Workforce Disability Equality Standards (WDES) Deep Dive to inform the People Plan, and committed to having a consistent, system-wide approach to equality, diversity and inclusion.

ICBB23/013 **Reading the Signals Update**

The ICB Chief Nursing Officer drew the Board's attention to the previously circulated report which provided an overview of Reading the Signals Report of the independent investigation into maternity and neonatal services in East Kent and outlined the Dorset Local Maternity and Neonatal System (LMNS) next steps in response. Delivery of the actions was being overseen by the LMNS, in addition to a regional return on monthly basis.

It was noted that the two Dorset providers had done well in delivering on the actions arising from the first Ockenden Report. A template and national timescale for delivery was awaited from NHS England regarding the actions arising from Ockenden Two and Reading the Signals, but the system had already commenced work.

The cultural issues raised in the Reading the Signals report were discussed. The Board noted that a range of assurance measures, including Insight visits, incident reporting and serious incident panels, were in place to ensure that similar cultural failings did not arise in Dorset. It was note that the increased risks for those from Black, Asian and mixed ethnic groups and those living in the most deprived areas were addressed

in the Maternity Equity and Equality Action Plan which would be discussed in the Part Two ICB Board meeting.

The Board welcomed the news of the recruitment of an ICB Deputy Director of Maternity and Perinatal Services, which would provide additional assurance on these matters.

Resolved: the Board noted the Reading the Signals Update.

Items for Consent
The following items were taken without discussion.

ICBB23/014 Dorset ICS Quality Framework

Resolved: the Board noted the Dorset ICS Quality Framework.

ICBB23/015 Dorset ICS Winter Plan

Resolved: the Board noted the Dorset ICS Winter Plan.

ICBB23/016 Emergency Planning Annual Report for 2022

Resolved: the Board noted the Emergency Planning Annual Report for 2022.

ICBB23/017 Bournemouth, Christchurch and Poole Council Special Educational Needs and Disabilities Joint Commissioning Plan 2022-23

Resolved: the Board noted the Bournemouth, Christchurch and Poole Council Special Educational Needs and Disabilities Joint Commissioning Plan 2022-23.

ICBB23/018 Questions from the Public
No questions were received in advance of the meeting from members of the public.

ICBB23/019 Any Other Business
There was no other business discussed.

ICBB23/020 Key Messages from the Meeting
The Chair summarised the key messages from the meeting as:

- The importance of adopting a consistent, system-wide approach to the WDES and WRES work, influencing national policy and learning from partner organisations, to ensure that Dorset ICS was a leading organisation in this work.
- The importance of developing a test-and-learn culture, and the role of the Board members in role-modelling this behaviour.

ICBB23/021 Date and Time of Next Meeting
The next meeting of the ICB Board would be held on Thursday 2 March 2023 at 10am, in the Boardroom, Vespasian House, Barrack Road, Dorchester, Dorset DT1 1TG

ICBB23/022 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.

Signed by: 

Jenni Douglas-Todd, ICB Chair

Date: 2 March 2023