Ref: DCS/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 **31st May 2023** at **8.30 am to 12.15pm** at **Board Room, Vespasian House, Bridport Road, Dorchester** and via **MS Teams.**

The agenda is as set out below.

Yours sincerely

David Clayton-Smith
Trust Chair

AGENDA

1.	**Staff Story**	Presentation	Emma Hallett	Note	8.30-08.55
2.	**FORMALITIES** to declare the meeting open.	Verbal	David Clayton-Smith Trust Chair	Note	08.55-9.00
	a) Apologies for Absence: Trevor Hughes	Verbal	David Clayton-Smith	Note	
	b) Conflicts of Interests	Verbal	David Clayton-Smith	Note	
	c) Minutes of the Meeting dated 29th March 2023	Enclosure	David Clayton-Smith	Approve	
	d) Matters Arising: Action Log	Enclosure	David Clayton-Smith	Approve	
3.	**Chair's Comments**	Verbal	David Clayton-Smith	Note	9.00-9.10
4.	**CEO Update**	Enclosure	Matthew Bryant	Note	9.10-9.25
5.	**Balanced Scorecard** • System performance update	Enclosure	Nick Johnson	Note	9.25-9.40
6.	**Board Sub-Committee Escalation Reports** (April 2023 and May 2023) a) Finance and Performance Committee b) People and Culture Committee c) Quality Committee d) Charitable Funds Committee	Enclosures	Committee Chairs and Executive Leads	Note	9.40-10.05
7.	**Finance Report**	Verbal	Chris Hearn	Note	10.05-10.15
8.	**Learning from Deaths Q4 Report** (May QC)	Enclosure	Alastair Hutchison	Approve	10.15-10.25
9.	**Quarterly Guardian of Safe Working Report** (May PCC)	Enclosure	Kyle Mitchell	Approve	10.25-10.40
Coffee Break 10.40-10.55					

10.	**Maternity Update** (May QC)	Enclosure	Jo Hartley	Note	10.55-11.10
11.	**Revised Equality, Diversity and Inclusion Strategy and Action Plan** (Item deferred May PCC)	Enclosure	Nicola Plumb Ebi Sosseh	Note	
12.	**WRES and WDES Report** (May PCC)	Enclosure	Nicola Plumb Ebi Sosseh	Note	11.10-11.30
13.	**Freedom to Speak Up and Whistleblowing Bi-annual Report** (May PCC)	Enclosure	Nicola Plumb Lynn Patterson	Note	11.30-11.50
14.	**Social Value Bi-annual Progress Report**	Enclosure	Nick Johnson Simon Pearson	Note	11.50-12.00
15.	**Questions from the Public**	Verbal	David Clayton-Smith	Note	12.00-12.10
	CONSENT SECTION				All items 12.10-12.15
	The following items are to be taken without discussion unless any Board Member requests prior to the meeting that any be removed from the consent section for further discussion.				
16.	**DCH Charity Policies**	Enclosures	Simon Pearson	Ratify	-
17.	**Provider License Update**	Enclosure	Nick Johnson	Note	-
18.	**Subco Quarterly Performance Report** (May FPC)	Enclosure	Nick Johnson	Note	-
19.	**Communications Activity Report** (May PCC)	Enclosure	Nick Johnson	Note	-
20.	**Bank and Agency Usage and Expenditure Annual Report** (May PCC)	Enclosure	Nicola Plumb	Note	-
21.	**ICB Board Minutes Part 1** (Standing Item)	Enclosure	Nick Johnson	Note	-
22.	**Any Other Business** Nil notified	Verbal	David Clayton-Smith	Note	-
23.	**Date and Time of Next Meeting**				
	The next part one (public) Board of Directors' meeting of Dorset County Hospital NHS Foundation Trust will take place at **8.30am** on **Wednesday 26th July 2023 in the Board Room, Vespasian House, Bridport Road, 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 29th March 2023 at Board Room, Trust Headquarters, Dorset County Hospital and via MS Teams videoconferencing.

Present:		
Mark Addison	MA	Trust Chair (Chair)
Margaret Blankson	MB	Non-Executive Director
Matthew Bryant	MBr	Chief Executive Designate
Emma Hallett	EHa	Interim Chief People Officer
Chris Hearn	CH	Chief Finance Officer
Alastair Hutchison	AH	Chief Medical Officer
Nick Johnson	NJ	Interim Chief Executive
Eiri Jones	EJ	Non-Executive Director
David Underwood	DU	Non-Executive Director (till 11.30am)
In Attendance:		
Jodie Crabb	JCr	Matron (attending for Jo Howarth)
Phil Davis	PD	Head of Strategy and Corporate Planning (Item BoD22/100)
Dawn Dawson	DD	Acting CEO Dorset Healthcare NHS Foundation Trust
Trevor Hughes	TH	Head of Corporate Governance *(Minutes)*
Paul Lewis	PL	Deputy Director of Strategy, Transformation and Partnerships
Lauren Ogilvy	LO	Senior Healthcare Assistant, Emergency Department (Staff Story)
Katie Jeffs	KJ	Sister, Emergency Department (Staff Story)
Jonquil Williams	JW	Corporate Business Manager
Attending by video conference:		
Sue Atkinson	SA	Non-Executive Director
Mandy Ford	MF	Head of Risk Management (Item BoD22/101)
Jo Hartley	JHa	Head of Midwifery
Anita Thomas	AT	Chief Operating Officer
Stephen Tilton	ST	Non-Executive Director
Frances West	FW	NED, Dorset Healthcare University NHS Foundation Trust
Members of the Public Attending:		
Mike Byatt	MBy	Public Governor
Judy Crabb	JC	Public Governor
Kathryn Harrison	KH	Public Governor
Lynne Taylor	LT	Public Governor
Apologies:		
Ruth Gardiner	RG	Interim Chief Information Officer
Jo Howarth	JH	Chief Nursing Officer
Stuart Parsons	SP	Non- Executive Director

BoD22/107	**Staff Story**	
	LO and KJ were welcomed to the meeting. LO is a senior Healthcare Assistant working in the Emergency Department and presented a personal account of her previous career path leading her into the NHS and experiences within the Trust during a very pressurised period. LO had worked a farmer before joining the NHS and as a volunteer for the St John's Ambulance service which had ignited her interest in healthcare. LO had also worked in a dementia care home. LO had become unwell requiring a two-week hospital stay and the experience confirmed her ambition to work in healthcare. LO	

	commenced employment in the Trust initially on Barnes ward caring for longer stay dementia patients. There was great team working on the ward and the experience gave her a solid foundation healthcare in skills. LO had also been involved in charitable fund fundraising events and had received a hero award for care given to a patient at the end of her life. During COVID LO had been the only HCA on the ward not to become unwell. The pandemic period had been incredibly difficult mentally, physically and emotionally. In order to expand her skills and take on new challenges, LO decided to work in the Emergency Department (ED). The role had given her an extensive range of training and a diverse skillset. LO explained the staffing structures within the ED, some of the alternative pathways for care and the specialities that the department worked closely with. The department was reliant on agency staffing to support the service. A number of staff that had left the department had been supported to further develop their skills and training and the ambition was that they would return in professional or more senior roles. The department had expended significantly and the need to recruit additional staff was noted. LO comment that the recent completion of the ED15 development had improved working conditions and the patient environment. The ED team worked well together, however the sustained challenge of waiting ambulances and poor patient flow within the hospital presented challenges for the team and long waits for patients. Some patients remained in the department for several days and the department did not have the appropriate facilities to provide patient care in the medium to longer term. Staff also required training to meet the longer stay care needs for patients e.g. nasogastric feeding, that would usually be undertaken on the ward. LO was undecided about the direction of her future career but noted the extensive opportunities and support available to her. MA thanked LO on behalf of the Board for her inspiring story and for sharing the great sense of team work. In response to a question from the Board about what further support could be provided to staff, the Board heard that greater communication between on call and clinical staff, particularly at times of service pressure and at night, would increase the feeling of support and alleviate feelings of isolation.	
	Resolved that: the Staff Story be heard and noted.	
BoD22/108	**Formalities**	
	The Chair declared the meeting open and quorate and welcomed MBr as CEO Designate, DD and FW from DHC, JCr behalf of JH, and Governors to the meeting. Apologies for absence were received from Ruth Gardiner, Jo Howarth, and Stuart Parsons.	

BoD22/109	**Declarations of Interest**	
	There were no conflicts of interest declared in the business to be transacted on the agenda.	
BoD22/110	**Minutes of the Meeting held on the 25th January 2023**	
	The Minutes of the meeting dated 25th January 2023 were approved as an accurate reflection of the meeting noting the following clarifications: • BoD22/097 – it was confirmed that the bullet point items on page 5 related to outcomes of the national maternity survey.	
	Resolved: that the minutes of the meeting held on 25th January 2022 were approved.	
BoD22/111	**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. Fresh Eyes Review – the Board noted the content of the reviews and the particular point to strengthen the quality of the front sheets accompanying reports.	
	Resolved: that updates to the action log be noted with approval given for the removal of completed items.	
BoD22/112	**CEO Update**	
	The report was taken as read. NJ noted that the CQC inspection report and the business plan were both on the agenda and would be discussed later in the meeting. NJ updated on the recent industrial action by junior doctors and noted the extensive preparatory work to mitigate impact. 87 members had taken action. Multidisciplinary team working and the support of consultants had helped to manage care although elective activity had been impacted. Further action was planned to follow the Easter Bank Holiday. National negotiations remained ongoing, and providers were lobbying on the anticipated impact. Lessons were being extracted from hot debrief sessions and discussions with consultants around their 'back to the floor' experiences were ongoing. Feedback from consultants indicated that there was a better understanding of the junior doctor experience and teams were reviewing how they could be better supported by digital solutions. Medical support roles such as Physician Associates were being considered also. The Board heard that medical care in acute areas was in the normal course of events delivered by consultants.. The supplementary roles (training and outpatient work etc.) that consultants undertake had	

	been suspended in times of extremis and this had improved effectiveness, but at a cost. The Board noted that the number of PALS comments and complaints had increased nationally and that there was a reduced public tolerance of treatments being postponed. The Board acknowledged the need to consider additional medical support roles and the need for transformational change, reiterating the exceptional team working and input from wrap around support staff and services during the recent industrial action. The role of Physician Associate and the potential impact on reducing junior doctor training opportunities was highlighted. When the model was mature, it was anticipated that Physician Associates would be able to provide training to junior doctors although this would take some time. The number of patients remaining in hospital with No Reason to Reside (NRTR) remained the most significant factor affecting performance and finances. The Board noted the current installation of the new Discharge Lounge and the additional capacity that this would provide. Collaboration with DHC continued with the joint Chair appointment due to be completed by end of the week. The collaboration programme workstreams continued also. NJ thanked staff for the great things that they do and highlighted that the trust had been highly commended recently in the HSJ awards for effective care design relating to the Dorset health villages and working with patients in a patient centred way.	
	Resolved that the CEO Update be noted.	
BoD22/113	**Balanced Scorecard**	
	NJ commented on the operational challenges throughout the year and reported that the trust had delivered on the majority of headline metrics, performing comparatively well within the region. No patients were waiting longer than 104 weeks for treatment and there was only a small number of patients waiting more than 68 weeks. The trust continued to have one of the lowest ambulance handover times and would deliver a year-end breakeven financial position. The trust continued to aspire to achieving the constitutional standards. The trust was achieving 75.4% of the six-week cancer diagnosis standard and performance had been impacted by the recent periods of industrial action and increased numbers of referrals. Diagnostic performance relating to echocardiograms was poor and reflected the national problem. An insourcing solution was being considered as well as international recruitment. A 4-5 month recovery plan was being developed. Improvements in Endoscopy service performance were being delivered.	

	Theatre utilisation performance remained comparatively poor and an extensive improvement programme was in place. Performance had also been impacted by the junior doctor industrial action affecting elective activity. The Board noted the recent presentation of the improvement programme to the Finance and Performance and People and Culture Committees. Members commented on the improved score card presentation and helpful matrix overview within the report which indicated areas of focus. The Board requested the addition of brief supporting narrative and the inclusion of actions to address issues identified. Sight of the scorecard at committee meetings going forward would also be useful in facilitating more detailed discussion. The Board were advised of some slippage in externally funded capital schemes but that the trust had delivered capital expenditure to the Capital Development Expenditure Limit (CDEL).	**PL**
	Resolved that: the Balanced Scorecard be received and noted.	
BoD22/114	**Board Subcommittee Escalation Reports**	
	The following subcommittee Escalation Reports were taken as read. Committee Chairs highlighted the following key points: **Finance and Performance Committee** ST noted the Board's discussion relating to waiting lists and the breakeven position and reported the recent deep dive discussion by the committee regarding theatre utilisation. There had also been discussion in respect of finance and activity planning and further discussion of this in Part 2 of the meeting was noted. ST highlighted that winter schemes had delivered a reduction in the number of patients remaining in hospital with No Reason to Reside and the committee had supported long term funding of these schemes. **People and Culture Committee** All items were on the Board agenda. MB reported that the Equality, Diversity and Inclusion (ED&I) strategy had not been presented to the Board as further work was required. The strategy would be returned via committee in April and May and would identify links to community and social value. MA commented on a recent Chairs' and CEOs' meeting that had discussed the new framework in planning for monitoring ED&I in trusts. Further discussion about the strategy and action plan would be added to the Board Development Session future programme. A strategic discussion on the stage of the equality, diversity and inclusion programme was required.	**TH**

	The Bank and Agency Usage Report noted a reduction in spend although there had been an increase in February due to industrial action. The Board acknowledged the work with ward managers and matrons in reducing spend and the non-clinical support provided to clinical staff in delivering the improvements. The importance of clear communications respecting individual decisions regarding participation in industrial action was noted. **Quality Committee** EJ noted the items on the Board agenda for discussion and highlighted the committee's discussion of quality metrics and triangulation of data with other committees. EJ noted the work of the estates team and their contribution to the delivery of aspects of the quality agenda. Despite the additional challenges arising from winter pressures, quality performance and achievement of quality metrics had remained stable and the essential focus on infection prevention and control measures had been maintained. A review of governance arrangements relating to the Blood Bank and Microbiology was underway following withdrawal of UKAS accreditation in order to strengthen corporate oversight and to empower staff to raise concerns where they felt they were unable to meet the required standards. The Clinical Effectiveness Group would have an important role in ensuring that risks were escalated via the risk register process. Arrangements surrounding the trust's policy regarding the notification of external reviews would be further reviewed also. There was a need to check that committees were sighted on forthcoming inspections / reviews. Divisional representation at committee meetings would resume in April and opportunities to align reporting with DHC were noted. The DHC overview report would be shared with Board and committee members. EJ concluded that whilst the focus of the committee had been primarily on patient safety during the pandemic, the committee would refocus on quality and effectiveness. **Risk and Audit Committee** The meeting held the previous week had focussed on year end compliance matters and discussion of the External Audit Plan. A significant financial sustainability risk had been identified based on the month 9 financial position and a number of mitigations had subsequently off set the risk. Delegated financial authority limits within the trust's Standing Financial Instructions had been amend and were recommended to the Board for approval. Further discussion would be had in Part 2 of the meeting.	**NJ / TH** **DD**

	The Internal Audit Plan for the forthcoming year which linked to strategic risk was also approved. **Charitable Funds Committee** 2022-23 had been a recovery period post pandemic. Reserves had recovered to £220k and funds were above the reserves level. The 2023-24 business plan had been approved and focused on the critical care capital appeal launch. A number of policies had been brought up to date including the charity's Standing Financial Instructions and no material changes had been made. These were included for Board approval. **System Performance Update** The paper noted the reporting of system activity to boards and the comparisons were felt to be helpful. In response to questions as to how system partners were being held to account and supporting reductions in the number of patients remaining in hospital with No Reason to Reside, the Board heard that the ICB governance structure and the Integrated Care Partnership would ensure that partners were delivering key actions. The Trust's plans were predicated on a reduction of these patients to 75. Further reductions to 45 patients were dependant on further system actions and progress would be included in future reports. Members felt that it would be useful for committees to have sight of the comparative data and indicators. Executive leads and committee chairs would progress this with support from JW.	**JW**
	Resolved that: Board subcommittee Escalation Reports be received and noted.	
BoD22/115	**Board Subcommittee Escalation Reports**	
	Gender Pay Gap Report	
	EH reported that figures within the report had remained relatively unchanged and explained changes in the workforce demographic. There were no equal pay issues and local actions to close the gender pay gap e.g. maximising flexible working options and supporting staff retention were being undertaken. The Board noted the poor gender position in relation to bonus payments which was based on an historic award scheme for consultant medical staff. There had been no national guidance during COVID, and the national awards had been distributed equally amongst the consultant workforce. If a clinical excellence scheme were to be resurrected, the relevant committee would need to pay careful attention to the gender split.	
	Resolved that: the Gender Pay Gap Report be approved.	
BoD22/116	**Board Assurance Framework (BAF) and Corporate Risk Register**	

	PL presented the 8th iteration of the BAF that had been further developed following feedback received. The reported highlighted the following risks scored over 20: • Ability to attract and retain people. • Inability to recruit clinical staff to meet demand. • Urgent care pathways to meet increasing demand. It was noted that the Board and committees were spending an appropriate amount of time in discussion of the risks, and that reports presented for discussion reflected the risks. Given the national context relating to specialist roles, risk scores on workforce strategies were unlikely to change but there would always be steps the trust could take locally that would have an impact. The recruitment and retention strategy was due to be reviewed by the People and Culture Committee and would focus on ensuring that the trust was seen as a place for staff to grow and develop. Ensuring effective appraisal processes and career conversations would also support further development. The need to ensure that managers were conversant with career path options for staff was noted. Further consideration of lower scoring strategic risk and risks contained within the Corporate Risk Register was required going forward. Discussion of this would be had at the June Board Development Session and lower scoring BAF risks would be considered at committee meetings in order to monitor emerging risks. Members questioned whether the No Reason to Reside risk should be included within the BAF given the wider implications and impact on efficiency and workforce. The risk would be included in the refreshed version of the BAF for the new financial year. It was agreed that the Chief Nursing and Chief Medical Officers would share executive responsibility for the population health risk in addition to the Chief Information Officer. Members suggested that the sustainability risk score needed to be increased from 16 given the scale of the financial and operational challenges. The Board was reminded that executive colleagues were in the process of reviewing Risk Appetite Statements and tolerances for their areas of responsibility and that this would impact future risk scoring. This work was expected to be complete by the end of April when committees would discuss the outcomes. MF provided an update on risks within the Corporate Risk Register noting that the corporate risk register was reported in entirety to the Risk and Audit Committee on an annual basis. EJ advised that the Quality Committee would request a deep dive review into the Ophthalmology waiting times risk and seek assurances	**AT**

	on the mitigating actions. Assurances that no harms as a result of the delays would also be sought. Board members were informed that the industrial action risk score was in line with the national score and further assessment of any resulting harms arising from delays in treatment was being undertaken. The Board advised that the impact on staff wellbeing and levels of service disruption indicated the need for a higher score.	
	Resolved: that the Board Assurance Framework and Corporate Risk Register be received and noted.	
BoD22/117	**Staff Opinion Survey Results**	
	The Board was reminded of the summary report presented earlier that month and that the trust had achieved higher than average scores in 8 of 9 domains. The overall trend however, was of declining scores and this was reflected nationally. Areas where concerns by staff had been raised included: • line management support • feeling pressured to work when unwell. Areas of improvement included: • Staff autonomy levels • feeling valued and recognised • career development and • showing kindness and understanding. Results had been shared with divisional teams who were having local discussions on areas for improvement. The survey would be repeated in October. The Board acknowledged the importance of positive work experiences and autonomous working and the research that demonstrated that where staff felt they had greater control, they lived longer and had a better quality of life. One third of staff from ethnic minority backgrounds had experienced bullying and harassment incidents from staff. The Freedom to Speak Up Guardian (FTSUG) and staff networks provided feedback and narrative on these issues and the importance of the Inclusive Leadership Programme was noted. The recently appointed FTSUG would be invited to a future Board Development session and further consideration of the need to establish an older persons' staff network was remitted to the People and Culture Committee. The Board was directed to WRES and WDES statistics that accompanied the report for further consideration alongside the report.	**TH / MB**
	Resolved that: the Staff Opinion Survey Results be received and noted.	
BoD22/118	**Learning from Deaths Q3 Report**	

	AH presented the Q3 data advising that the SHMI had reached a peak in September 2022 and that the latest figure had dropped. Concerns surrounding the depth of coding had declined and improvements were expected to continue over the coming months. A national maternity dashboard providing national comparator data had been recently published and was not yet included in the report. The low number of incidents within DCH were noted to likely affect percentage swings going forward. AH reported that Intensive Care National Audit and Research Centre (ICNARC) data was reviewed on a monthly basis and showed better than national average results with fewer cardiac arrests on wards than the national average per 1000 admissions. Delays in discharging from ITU were noted and AH reported that hip fracture mortality was being reviewed. SHMI Ah summarised that whilst the SHMI remained elevated there were no indications in data to indicate an excess number of deaths. It was expected that the SHMI would return to within normal range within the next three-month period. The Board was assured that coding issues had impacted the SHMI previously and that triangulation with other data sources provided assurance. The Board noted the impact of NRTR on ITU discharges and on services that were required to undertake duties and responsibilities that they would not routinely undertake, impacting patient experience. EJ advised of detailed scrutiny undertaken by the Quality Committee and discussion of maternity related mortality. Further detailed discussion of the data, and the importance of effective record keeping and training for junior doctors in ensuring clinical coding was accurate, was planned.	
	Resolved that: the Q3 Learning from Deaths Report be approved.	
BoD22/119	**CQC Report and Action Plan**	
	NJ introduced the report which followed the CQC inspection of service provision for children and young people with mental health needs. A summary of the report was provided outlining key action requirements and acknowledging several positive care aspects. An action plan in response had been considered by the Quality Committee and returned to the CQC and progress was being monitored regularly. JC noted the establishment of a new Mental health Steering Group within Trust and greater collaboration with DHC. Learning from the report would be shared nationally.	

	Resolved that: the CQC Report and action Plan be received and noted.	
BoD22/120	**Maternity Update**	
	JHa attended for this item advising that the full report had been reviewed by the Quality Committee Questions were invited. A detailed discussion about serious incidents had been had. DCH was in close contact with UHD regarding call bells. UHD had agreed to share their Standard Operating Procedure for inaudible call systems and the DCH system was to be replaced in the near future as part of the 2023-24 capital programme. Meanwhile, temporary measures were in place.	
	Resolved: that the Maternity Update be received and noted.	
BoD22/121	**Guardian of Safe Working Hours Quarterly Report**	
	The paper was for noting. KM's clinical commitments that morning prevented his attendance at the meeting. The report outlined that the reporting system in place for junior doctors was working well to protect working conditions. Gastroenterology was the top reporting area and the Board recognised there were a number of consultant vacancies within the service. Additional support had been invested in the service. There was a reasonable confidence in the level of reporting although a higher number of reports could be expected from the Emergency Department (ED) team. The ED was noted to have close working relationships which may inhibit reporting. The trust would continue to encourage reporting and openness when issues arose.	
	Resolved that: the Guardian of Safe Working Hours Quarterly Report be received and noted.	
BoD22/122	**Committee Effectiveness Review**	
	The Board noted the summary outcomes of the committee effectiveness review exercise and the recurring theme outlining the need for improved reports and summaries and the timeliness of Board and committee paper circulation. A review of achievements against committee priorities was to be concluded along with the establishment of priorities for the coming year. The Board discussed the need to enforce the standard required for front sheets and mandated the Corporate Governance team to police this, rejecting papers that were not presented to the required standard. It was particularly important to have good summaries. The Board recognised limited capacity of the joint CEOs to attend DCH committees and it was agreed that CEO membership would be replaced by Deputy CEO membership as an option within committee terms of reference.	

	Regular committee Chair meetings to review how committees were working, to identify risks and triangulate data were welcomed and would continue.	
	Resolved that: the Committee Effectiveness Review Summary be received and noted.	
BoD22/123	**Well Led Action Plan Update**	
	NJ reported on the ongoing progression of key actions in response to the PriceWaterhouseCopper review, noting that the majority of recommendation actions had been completed or superseded by the wonder collaboration with DHC. NJ proposed that further actions to be considered within the collaboration project and that this report would be the last report to Board therefore. The Board acknowledged progress on the three key recommendation areas: • Further development of wider system links • Financial sustainability • Ward to Board noting the nearing completion of the governance framework review and development of local performance dashboards.	
	Resolved that: the Well Led Review Action Plan Update be received and noted.	
BoD22/124	**Questions from the Public**	
	MBy was no longer present in the meeting and his questions regarding public communications surrounding site developments were sought outside the meeting. KH expressed disappointment that the papers had not been available in advance as they should be. KH stated that she had been reassured by discussion in the meeting although this appeared somewhat removed from the trust's ambition to deliver outstanding care in ways that mattered to patients. The patient group Your Voice had provided feedback about concerns with signage onsite and had raised concerns about letters being incorrectly sent. There appeared to be little action on these issues. The Board acknowledged the gap and advised on a number of groups in operation to address signage concerns. A more detailed update would be provided. JH would consider the point about letters with AT as necessary and report. The Board noted the need to ensure that Your Voice feedback was being connected into the appropriate committee. FW commented on the good quality of the Board papers and advised that the discussion had been interesting from an acute provider perspective.	**CH** **JH**
	CONSENT SECTION	

	The following items were taken usually without discussion. No questions were previously raised by Board members prior to the meeting.	
BoD22/125	**Gifts and Hospitality Register and Register of Interests**	
	Resolved that: the Gifts and Hospitality Register and Register of Interests be noted.	
BoD22/126	**Going Concern Statement**	
	Resolved that: the Going Concern Statement be approved.	
BoD22/127	**Charity Business Plan**	
	Members commented that the plan did not mention patients specifically and questioned the small team's capacity to deliver the huge ambition within the plan. The Board was advised of the team's previous excellent track record of delivering their plans, being ably supported by a wide number of volunteers. The Charitable Funds Committee would continue to monitor the position going forward. The patient reference point would be followed up.	**DU**
	Resolved that: the Charity Business Plan be approved.	
BoD22/128	**ICB Board Minutes Part 1**	
	Resolved that: the ICB Board Minutes Part 1 be received and noted.	
BoD22/129	**Any Other Business**	
	TH advised that the new Provider License had been launched on 27th March 2023 following a recent consultation by NHS England. The new provider licence aimed to: • support effective system working; • enhance the oversight of key services provided by the independent sector; • address climate change; • and make a number of necessary technical amendments. The following clarifications were also noted: • A definition of 'cooperation' in the licence, which makes clear that NHSE uses this term synonymously with 'collaboration'. • A clarification to condition NHS2: Governance arrangements - that the 'systems and processes' to meet digital maturity guidance are 'corporate and/or governance' systems. • 'hard to replace providers' would be included in condition CoS3: Standards of corporate governance, financial management and quality governance • Clarification to the Integrated Care condition that independent providers would not be expected to take action that risks their commercial sensitivities.	

	NHSE had committed to sending out the new licences later that week. A short briefing paper would be presented to the next Board meeting. MA thanked PL for his contribution over the previous year as roles changed in April. He also thanked DD for her contributions to collegiate partnership working and support in developing greater collaboration between DCH and DHC. MA extended huge thanks to NJ in his role as Interim CEO acknowledging that the Trust had moved from a Strategic Oversight Framework score of 3 to 2, achieved the nationally revised waiting time targets and trajectories, was delivering on several new building schemes including the multistorey car park, ED 15, Discharge Lounge and South Walks House and the New Hospitals Project and had maintained an above national average position in relation to the staff opinion survey. In addition, NJ had supported greater collaboration with DHC. These achievements had been realised against a backdrop of the toughest winter in NHS history, multiple periods of industrial action, patient flow challenges, and the end of the COVID pandemic. NJ had provided calm, thoughtful leadership, putting people first throughout this period and the weekly CEO Brief has been widely commented on in this regard and well as providing clear expectations. NJ stated that it had been a privilege and acknowledged the wider team contribution in achieving what had been delivered. No other business was raised or notified.	**TH**
BoD22/130	**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, Dorset County Hospital** and via **MS Teams.**	

Action Log – Board of Directors Part 1

Presented on: 31st May 2023

Minute	Item	Action	Owner	Timescale	Outcome	Remove? Y/N
Meeting Dated: 29th March 2023						
BoD22/113	**Balanced Scorecard**	Further supporting narrative and the inclusion of actions to address issues identified to be included in future reports. The scorecard to also be made available to committees going forward.	**PL**	May 2023	Update not received.	
BoD22/114	**Board Subcommittee Escalation Reports**	Discussion of the ED&I Strategy and action plan to be added to the Board Development Session future programme	**TH**	April 2023	Added to the programme provisionally in June following presentation of the strategy in May.	**Yes**
		Notification of external review arrangements to be further reviewed.	**NJ / TH**	May 2023	Process being reviewed and refreshed by Corporate Governance to improve reporting lines.	
		The DHC quality overview report to be shared with Board and Quality Committee members.	**DD**	April 2023	**Complete:** Circulated 25/05/2023	**Yes**
		System Performance indicators and performance data to be made available to respective committees.	**JW / Executive leads a Chairs**	May 2023	In progress. JW working with the ICB to receive regular system performance updates.	
BoD22/116	**Board Assurance Framework (BAF) and Corporate Risk Register**	NRTR risk to be included within the refreshed version of the BAF for the new financial year	**AT**	~~May 2023~~ June 2023	Next Board Assurance Framework will be available at the June Risk and Audit Committee.	

BoD22/117	**Staff Opinion Survey Results**	The Freedom to Speak Up Guardian to be invited to a future Board Development Session.	**TH**	April 2023	Noted within the forward programme.	**TH**
BoD22/124	**Questions from the Public**	A detailed update on site signage to be provided in light of the current developments and changes.	**CH**	April 2023	Wayfinding project has commenced, with signage being updated in corridors, stairwell and outside lifts. New signs will replace existing ones, designed in accordance with NHS guidelines, and content being reviewed and updated, with a timeframe of content finalisation in May. After finalisation, signs will be manufactured and installed as soon as complete. External signs and maps are also being updated to reflect new developments such and the discharge lounge, transport hub and Mary Anning unit.	
		JH to consider with AT a solution to letters being sent incorrectly.	**JH**	May 2023	Update not received.	
BoD22/127	**Charity Business Plan**	The plan to include greater reference to patients	**DU**	May 2023	Update not received.	
BoD22/129	**Any Other Business**	A short briefing paper on the new provider license to be presented to the Board.	**TH**	May 2023	On May Agenda	**Yes**
Meeting Dated: 23rd January 2023						
BoD22/100	**Board Assurance Framework**	A Recruitment Plan to be developed and returned via the People and Culture	**EH / JH / MB**	April 2023	**Complete:** Recruitment and Retention Strategy	**Yes**

	(BAF) and Corporate Risk Register	Committee to include service expansion requirements			presented at April Part 2 meeting.	

Actions from Committees…(Include Date)						

1. Report Details			
Meeting Title:	Board of Directors		
Date of Meeting:	31st May 2023		
Document Title:	Chief Executive Report		
Responsible Director:	Matthew Bryant, Chief Executive	Date of Executive Approval	24-05-23
Author:	Jonquil Williams – Corporate Business Manager to CEO		
Confidentiality:	No		
Publishable under FOI?	Yes		
Predetermined Report Format?	No		

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

3. Purpose of the Paper	For information							
	Note (✓)	✓	*Discuss (✓)*		*Recommend (✓)*		*Approve (✓)*	
4. Key Issues	National Topics - 02 May 2023 the NHS Staff Council accepted the pay offer made by the Government to Agenda for Change staff in England. - BMA have announced further strike action 14-17 June 2023 - 09 May 2023 Primary Care Recovery Plan was announced Dorset ICS - 05 April 2023 the Home Office confirmed plans to accommodate approximately 500 asylum seekers to be berthed in Portland. - 25 April 2023 Dorset ICP strategy was published. - 19 April 2023 the Dorset ICB people and culture committee approved the Dorset System People Plan. Dorset County Hospital - On 1st May David Clayton-Smith commenced in post as joint Chair and Nicola Plumb, commenced their secondment as Interim Chief People Officer for Dorset County Hospital. - On 3rd April the Mary Anning Unit opened at DCH, a centre of excellence for care of the elderly. - April 23 Jon Fox took part in the World Transplant Games.							
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**	

1. Background

1.1 This report sets out briefing information for Board members on national and local topics of interest.

2. National Topics of Interest

Government Pay Offer Accepted by NHS Staff Council

2.1 On 2 May 2023 the NHS Staff Council accepted the pay offer made by the Government to Agenda for Change staff in England. NHS Employers has indicated that eligible staff can expect to receive the additional 2022/23 payment and the new 2023/24 pay rates (including back pay to 1 April) as part of their pay in June. Planning is underway in line with the national guidance to implement the pay award within the Trust.

2.2 The Royal College of Nursing (RCN) and Unite did not individually vote to accept the pay offer and these trade unions continue to be in dispute with the government, despite the pay offer now proceeding to be implemented. The RCN has announced it will re-ballot its members regarding strike action via a postal ballot from Tuesday 23 May to Friday 23 June.

British Medical Association Industrial Action

2.3 As a result of an ongoing pay dispute with the government, on 22 May 2023 the British Medical Association (BMA) announced a third junior doctors' strike will take place for 72 hours from 14-17 June 2023. The BMA has also launched a consultant strike ballot on 15 May 2023. On 27 April 2023 the BMA GP Committee in England voted to ballot members for industrial action if changes to the GP working contract are not reviewed.

NHS 75

2.4 The NHS marks its 75th birthday this July. NHS England are hosting a range of events and initiatives to celebrate this milestone. Dorset County Hospital will participate in these events and initiatives that focus both on celebrating achievements to date and developing a positive vision for the NHS into the future. A proposed programme is under development for agreement by the Executive team.

2.1 On 22 May 2023 the Chief Executive led a session with a cross section of colleagues from DCH reflecting on the achievements of the NHS, concerns, and hopes for the future. 28 colleagues took part. Three questions were used to reflect on the NHS and the key themes from the session included:

- Celebrating staff
- Maintaining the NHS as free care from the point of access;
- The distance technology and medicine has come whilst recognising that there is more to develop; and
- The importance of inclusivity and improving links with further education to promote NHS as an employer.

NHS England and Health Education England Merger

2.2 On 28 March 2023 NHS England and Health Education England legally merged to create a new, single organisation to lead the NHS in England. This follows the merger of NHS Digital and NHS England on the 1 February 2023, and brings the NHS' people, skills, digital, data and technology expertise together into one national organisation to deliver services. By the end of 2023/24, it is anticipated that the new organisation will be between 30-40% smaller than the current combined size of NHS England, Health Education England and NHS Digital.

Primary Care Recovery Plan

2.3 On 9 May 2023, NHS England published their Primary Care Recovery Plan focusing on four key areas: empowering patients; implementing modern general practice access; building capacity and cutting bureaucracy.

2.4 To support this plan, NHS England and the Department of Health & Social Care have retargeted over £1 billion and committed to the following:

- Retargeting over £240 million of funding in 2023/24 for new technologies and supporting offers for Primary Care Networks and practices that help them plan and implement Modern General Practice Access;
- Investing up to £645 million over the next two years to expand community pharmacy services (subject to consultation);
- Redirecting £246 million of the streamlined Investment and Impact Fund (IIF) towards improving access;
- Delivering on the commitment to make a further £385 million available in 2023/24 to reach the existing target of 26,000 more direct patient care staff and 50 million more appointments in general practice by March 2024; and
- Continuing to allocate System Development Funding (SDF) to ICBs, which for 2023/24 totals c.£170 million (NHS England expects systems to use a large part of this to support primary care transformation).

2.5 Given the scale of proposed change, NHS England intend to launch a major communications campaign to explain the evolving nature of primary care to the public and how they can best use the NHS.

3. Dorset Integrated Care System

System Operational Performance

3.1 The numbers of patients with No Criteria to Reside across the Dorset system continue to fluctuate with evidence of a slight improvement with 297 patients (breakdown as follows: 64 Dorset County Hospital, 131 Poole Hospital, 102 Bournemouth Hospital, 33 Community Hospitals). System-wide plans are in place including daily discharge performance via the Tactical Resilience Group and the multi-agency discharge and flow cell continues to focus on targeted improvement.

Portland Asylum Seeker Accommodation

3.2 On 5 April 2023 the Home Office confirmed plans to accommodate approximately 500 asylum seekers on an accommodation barge to be berthed in Portland port. The barge is currently at Falmouth for refurbishment then will move to Portland, with asylum seekers arriving in mid-June 2023. There are multi-agency arrangements in place to plan and prepare for the barge's arrival and use. The Trust is actively engaged in the planning for the health and care needs of the asylum seekers, working with NHS Dorset and system partners.

Dorset Integrated Care System Operational Plan and Financial Plan 2023/24

3.3 Dorset ICS submitted a breakeven 2023/24 financial plan to NHS England on 30 March 2023. However, there is a level of risk inherent in the plan which will require a different approach to delivery from previous plans, recognising the system commitment to an ambitious cost improvement programme. Dorset was one of six systems in the south west and one of eight nationally to submit a breakeven plan.

3.4 The NHS Dorset final 2023/24 Operational Plan was submitted to NHS England on 30 March 2023. This is a joint commitment and is compliant on the majority of NHS England's operational performance requirements, with plans in place to address areas of non-compliance. This plan recognises the significant challenges in balancing system recovery and ongoing system resilience in the context of workforce and financial pressures.

Dorset Integrated Care Partnership Strategy: Working Better Together

3.5 On 25 April 2022 Dorset's Integrated Care Partnership (ICP) Strategy, *Working Better Together*, was published. Working Better Together sets out how the NHS, councils, and other partners within our ICP will work together to make the best possible improvements in the health and wellbeing of local people. The three priorities set out in the strategy are prevention and early help, thriving communities and working better together. The strategy has been built around views gathered from people in Dorset and will help guide the way we develop and deliver health and care services in the future.

Dorset Integrated Care System Joint Five Year Forward Plan

3.6 The Trust is fully engaged in the work to develop a Joint Forward Plan for Dorset Integrated Care System (ICS) to support the delivery of the ICP Strategy. The initial draft was submitted to NHS England on 30 March 2023 and final submission is due on 30 June 2023. A workshop took place on 18 May 2023 with system partners to discuss and agree the programmes and workstreams that will be conducted to support the system in undertaking the long-term transformational change required to deliver the five Dorset objectives. The outputs of the workshop will further inform the development of the Dorset Integrated Care Board (ICB) Board Assurance Framework (BAF) including the identification and understanding of the strategic risks and mitigations associated with meeting the delivery of the five strategic objectives.

Dorset Integrated Care System Operating Model

3.7 The System Executive Group have held the first two in a series of workshops to develop an understanding of the system operating model and to begin to co-design the key components of the model. The workshops have explored how system organisations operate currently and how decisions will be made together through executing collective accountability and responsibility

across the system. The aim is to submit a final version to the Integrated Care Board meeting in September 2023.

Dorset Integrated Care System People Plan

3.8 On 19 April 2023 the Dorset ICB People & Culture Committee approved the Dorset System People Plan. The plan was co-developed by system partners to transform people services. Its vision is to have one Dorset workforce delivering the best possible improvements in health and wellbeing, maximising the opportunity for system partners to work together to help Dorset become a thriving, productive place as a foundation for tackling inequalities and increasing population wellbeing. The plan sets out both the immediate priorities and the future areas of focus and supports greater collaboration with strategic partners such as the higher education sector and the Local Enterprise Partnership, looking at different ways to address inequalities and the approach to skills development to maximise the potential of the health and care sector.

Appointment of South West Ambulance Service Executive Director of Quality Patient Care

3.9 Jane Chandler has joined South West Ambulance Service Foundation Trust as Executive Director of Quality Patient 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.

4. Strategy

Working Together Programme (Dorset County and Dorset Healthcare Collaboration)

4.1 Since the last update, Matthew Bryant formally commenced as joint Chief Executive on 1 April 2023 and David Clayton-Smith commenced as joint Chair on 1 May 2023. Nicola Plumb has been seconded into the role of Chief People Officer at Dorset County Hospital for an interim period of 12 months, alongside continuing in her existing equivalent role for Dorset HealthCare.

4.2 A Memorandum of Understanding will be considered by the Trust Boards in June in their Part 2 meetings setting out the organisational roles and responsibilities that underpin the alliance arrangement and the Working Together Programme

4.3 The programme has a high level timeline, programme structure and programme brief on a page. These are available as a slide deck to assist presentations and discussions. The Programme Board meets monthly and the workstreams are taking shape, each under executive leadership. This month, there has been a focus on the clinical workstreams, which will be divided into case studies, show-casing areas where teams are already integrating their services, and flagship projects, which will be population focused, transformational, and prioritised and designed by clinicians. The case studies will be presented as stories of what can be achieved, the challenges that need to be overcome and what more could be achieved with project support. The broad themes for the Flagships projects will be prioritised using available data and designed by clinicians to test changes to pathways over the coming 6 months, with a view to recommending permanent changes for 2024/25. The Flagship projects will be linked to the key objectives of the ICS

4.4 The Programme Board recognises that the programme will need to be properly resourced to achieve the identified objectives and is currently assessing this.

New Hospitals Programme

4.5 On 20 April 2023 Bournemouth Christchurch and Poole Council's planning committee voted unanimously in favour of our application to build a new CAMHS psychiatric intensive care unit (PICU) at our Child and Adolescent Mental Health inpatient site in Alumhurst Road, Bournemouth. This will mean seriously ill young people can be cared for locally instead of being sent for specialist treatment elsewhere. Construction work is set to start on the site later this year and should be completed by autumn 2025.

4.6 On 28 April 2023 the Joint Investment Committee approved the CAMHS PICU and St Ann's Campus developments, subject to some conditions. Treasury approval is now being sought.

4.7 On 19 May 2023 Royal Bournemouth Hospital held their topping our ceremony for the new BEACH (Births, Emergency Care and Critical Care and Child Health) Unit. This is strategically important for Dorset County Hospital as it aligns with the requirement for our business cases for ED and CCU.

NHS Oversight Framework Quarter 3 2022/23 Segmentation Review

4.8 As part of the NHS Oversight Framework process, NHS England and Integrated Care Boards undertake quarterly segmentation reviews. On 27 March 2023 the NHS England Regional Support Group agreed that the Trust's segment 2 rating would remain unchanged for Quarter 3 2022/23. The RSG noted that the rationale was based on Elective recovery.

Patient Safety Incident Response Framework (PSIRF)

4.9 The NHS England Patient Strategy (published in 2019) includes the introduction of a new approach for responding to patient safety incidents, replacing the current Serious Incident Framework with the Patient Safety Incident Response Framework (PSIRF) from September 2023.

4.10 Work is well underway within the Trust to plan for the implementation of this new approach. The PSIRF framework is planned for a roll out in September 2023 for Dorset County Hospital. The Patient Safety Team will continue to update colleagues and our service users of the progress, preparing us for the change and signposting to where further information can be accessed.

5. Operational Delivery

Industrial Action

5.1 The second junior doctors' strike took place for 96 hours from 11-15 April 2023. The RCN organised a 48-hour strike from 30 April-1 May 2023. These strike days were carefully planned and coordinated, and the trust's incident room was in operation to provide further oversight and coordination. Colleagues worked hard to manage the impact of the strike and maintain safe and effective care for patients. Work is underway to plan for the third junior doctors' strike due to take place from 14-17 June 2023. The Trust fully recognises and respects the right of colleagues to participate in industrial action.

6. Dorset County Hospital

Mary Anning Unit

6.1 On 3 April 2023 Day Lewis Ward and Barnes Unit joined to become the Mary Anning Unit, a centre of Excellence for the care of older people. The new specialist unit will meet the complex care needs of frail older people in an environment that promotes multi-professional support and training.

Multi-Storey Car Park Update

6.2 The Multi-story car park has been physically operational for a number of months, allowing staff and patients to park on the site. The outstanding for the project has been the number plate recognition and payment software, which distinguishes between staff and visitors and charges appropriately.

6.3 On 25 April 2023, the first successful test for the barrier and software system was carried out. This will be followed up with a wider test day (with support from wider leadership in the Trust). On 4 May 2023 barriers and payment mechanisms were tested on a larger scale. Communication will go out to staff in May 2023, giving a month's notice ahead of turning on the barriers and payment systems (further testing will be completed in this time). Charges will be a day rate of £1.50 band 1-5, £2.50 band 6 and above (or equivalent salary). This has been agreed with the staff side chair, and is significantly lower than the original tiered payment proposal.

Friends of the Hospital – Comfort Bag for Patients

6.4 Patients who are unexpectedly admitted to hospital with no belongings will now receive a free comfort bag, thanks to the Friends of Dorset County Hospital.

6.5 The charity has donated bags full of essential toiletries for patients who have been admitted to the Emergency Department and need to be transferred to a ward. Items include:

- Toothpaste and toothbrush
- Deodorant
- Wash cloth
- Tissues
- Wipes
- Comb/hairbrush
- Shower gel
- Shaving kit
- Pen

Jon Fox – World Transplant Games

6.6 In April this year Jon Fox, Service Manager Head and Neck took part in the World Transplant games in Perth. He competed in Badminton Singles, Mens doubles and Mixed doubles and won a Bronze in both the mens and mixed doubles. He has also been privileged to be the Badminton captain for Team GB for a number of years and had the joy to again lead the GB badminton team this year.

7. Recommendation

7.1 The Board is asked to note the report.

Matthew Bryant, Chief Executive
May 2023

Report Front Sheet

1. Report Details			
Meeting Title:	Board of Directors		
Date of Meeting:	Wednesday 31st May 2023		
Document Title:	Balance Scorecard		
Responsible Director:	Nick Johnson, Deputy CEO and Director STP	Date of Executive Approval	25-05-2023
Author:	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**
Shared amongst Exec sponsors	w/c 21/05/23	Commentary added, which Board is asked to note.

3. Purpose of the Paper								
	Note (✓)	X	Discuss (✓)		Recommend (✓)		Approve (✓)	
4. Key Issues	**Performance** 1. Apr-23 saw improvement in ambulance handover delays, and 4-hr standard &12 hours waiting in the ED department, however we can't give SPC assurance of consistently meeting targets at this point. % Conversion in ED (not shown in Exec dashboard) has increased, but Trust has moved patients out of ED onto Wards in a timelier way, rather than waiting in diagnostic tests setting. 2. Elective performance has been on track or achieving better than plan, with SPC statistically backing 52wk and 78wk performance improvements. More work is needed at a system level to understand activity levels and impact on income. 3. Cancer performance improved in month in terms of a reduction in patients waiting over 62 and 104 days. The 28-day standard has fallen (but SPC assurance of hitting target can't be given yet) and total cancer waiting list has slightly increased. 4. Diagnostic performance remained static at a modality level, with a marginal improvement at a Trust level. The reduction in the waiting list and backlog is artificially improved with the transfer of the Audiology service to Dorset HealthCare. **Finance** 1. Adjusted position: Impact of inflationary pressures (gas, electric, catering supplies & maintenance contracts) above planned levels along with higher than planned agency usage providing cover during peak industrial action							

	periods. 2. Agency Spend: higher than planned agency usage providing cover during peak industrial action periods. 3. Capital Expenditure: Marginally behind plan in month due to timings of capital expenditure payments made. 4. Efficiency Delivery: Marginal over delivery against plan in month covering Corporate, Digital, Covid and Prothesis programmes. 5. Off Framework Agency Spend:Impact supporting industrial action and specialist areas ED, CrCU, SCBU, Kingfisher. Bank rates and on framework agency rate reviews currently underway to mitigate off framework usage aligned to collaborative System working.x **People** 1. An overview of the key people metrics is provided to the People and Culture Committee via the monthly People Dashboard. 2. The overall sickness percentage decreased in Month 12 (March) to 4.2% and has reduced each month since October 2022. 3. Substantive workforce capacity remained static in Month 1 and turnover decreased marginally to 11.6%. 4. Essential skills compliance remained at the internal target of 90% in month 1. 5. The Trust appraisal rate is improving, it has increased from 70% to 76% since August 2022.
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 May 2023 Board

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

NHS
Dorset County Hospital
NHS Foundation Trust

Summary of Data

Report Reference
Executive Dashboard

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

2023-05-16 15:01:10
data last refreshed:

30 April 2019
metric data from:

30 April 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		76%	90%
Essential Skill Rate	F	H	90%	90%
Sickness rate (one month in arrears)	?	H	4%	3%
Staff Turnover Rate	P	H	11%	12%
Vacancy Rate (substantive)	F	H	9%	5%

PERFORMANCE

Metric Name	Assurance	Variation	Value	Target
Cancer (ALL) - 104 days from referral to treatment			21	
Cancer (ALL) - 28 day faster diagnosis standard	?	H	69.02%	75%
ED - 12 Hour Waits			93	
ED - Ambulance Handover Delays Average Time Lost per Day			7.88	
ED - Overall 4 Hour Performance %	?	H	82.84%	76%
Elective Recovery - Day Case Activity vs 2019/20	?	H	96.94%	104%
Elective Recovery - Elective Inpatients Activity vs 2019/20	F		62.84%	104%
Elective Recovery - Outpatient Activity vs 2019/20	?		85.37%	104%
Elective Recovery - Total Elective Activity vs 2019/20	?		87.84%	104%
Inpatient - Percent Bed Occupied by No RTR		L	17.25%	
Outpatient - Virtual Activity %	F	H	21.86%	25%
RTT - 52+ week waits		L	1129	
RTT - 78+ week waits		L	10	
RTT - Waiting List Size		H	20353	
Theatre - Utilisation	F		68.16%	85%

QUALITY & SAFETY

Metric Name	Assurance	Variation	Value	Target
Complaints - Total Number Received (Informal & Formal)		H	92	
Friends and Family - Overall - Recommend Rate	?	H	99%	94%
Incidents - Never Events	F	L	0	0.02
Incidents - Number of falls resulting in fracture or severe harm or death			0	
Incidents - Number of Medication Incidents		H	64	
Incidents - Pressure Ulcers - Hospital acquired (grade 3) confirmed avoidable			1	
Incidents - Serious Incidents investigated and confirmed avoidable	?		1	0
Infection Control - C-Diff Hospital Onset Healthcare Associated	?		1	3
Infection Control - Gram Negative Blood Stream Infections	?		3	5
Inpatient - % Emergency Re-Admissions (16+ & <30 Days) (1 month arrears)	P	L	7.05%	13%
Inpatient - Percentage of EDS available within 24 hours of discharge	F	H	79.81%	90%
Inpatient - Percentage of EDS available within 7 days of discharge	F		87.41%	100%
Inpatient - SHMI Value			1.14	

FINANCE

Metric Name	Assurance	Variation	Value	Target
Adjusted Financial Position	?		0	7
Agency Spend (Monthly)			1040	833
Capital Expenditure (Monthly)	?		1392	1407
Efficiency Delivery	?		385	350
Off Framework Agency Spend			136	83

Matrix Overview

Dorset County Hospital NHS Foundation Trust

Variance \ Assurance	P	?	F		Total
H		4	3		7
L	1		1	3	5
		8	4	6	18
H	1	1	1	3	6
L			1		1
				2	2
Total	2	13	10	14	39

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

The reporting month of April 2023 for the non-elective standards shows improvement against ambulance handover delays, the 4-hour standard and those waiting over 12 hours in the ED department. Admissions as a proportion of attendances and in terms of volume has significantly increased in April, but the Trust has managed well and has been driven by patients being moved out of ED, onto Wards in a timelier way, rather than waiting in ED for diagnostic tests and then discharged from that setting.

Performance of the elective trajectories are all on track or achieving better than plan. However, further work is needed at a system level to understand activity levels and the impact they have on the systems income.

Diagnostic performance remained static at a modality level, with a marginal improvement at a Trust level. The reduction in the waiting list and backlog is artificially improved with the transfer of the Audiology service to Dorset HealthCare.

Cancer performance has improved in month in terms of a reduction in patients waiting over 62 and 104 days, and the Breast two week wait standard has been changed. The 28-day standard has fallen and the total cancer waiting list has slightly increased.

VariationIcon	Pass	Hit or Miss	Fail	Empty	Total
Improvement		3	1	3	7
Common Cause		2	2	3	7
Concern				1	1
Neither					
Empty					
Total		**5**	**3**	**7**	**15**

Metric	Group	Latest Month	Value	Target	Variance to Target	Previous Year	YTD Value	Variation	Assurance
Cancer (ALL) - 104 days from referral to treatment	0 - Total	Apr-23	21			20	21		
Cancer (ALL) - 28 day faster diagnosis standard	0 - Total	Apr-23	69.02%	75%	-5.98%	69.73%	69.02%		
ED - 12 Hour Waits	0 - Total	Apr-23	93			283			
ED - Ambulance Handover Delays Average Time Lost per Day	0 - Total	Apr-23	7.88			26.41	7.88		
ED - Overall 4 Hour Performance %	0 - Total	Apr-23	82.84%	76%	6.84%	70.02%	82.84%		
Elective Recovery - Day Case Activity vs 2019/20	0 - Total	Apr-23	96.94%	104%	-7.06%	91.4%	96.94%		
Elective Recovery - Elective Inpatients Activity vs 2019/20	0 - Total	Apr-23	62.84%	104%	-41.16%	64.37%	62.84%		
Elective Recovery - Outpatient Activity vs 2019/20	0 - Total	Apr-23	85.37%	104%	-18.63%	90.92%	85.37%		
Elective Recovery - Total Elective Activity vs 2019/20	0 - Total	Apr-23	87.84%	104%	-16.16%	91.05%	87.84%		
Inpatient - Percent Bed Occupied by No RTR	0 - Total	Apr-23	17.25%			32.83%	17.25%		
Outpatient - Virtual Activity %	0 - Total	Apr-23	21.86%	25%	-3.14%	20.87%	21.86%		
RTT - 52+ week waits	0 - Total	Apr-23	1129			1629	1129		
RTT - 78+ week waits	0 - Total	Apr-23	10			488	10		
RTT - Waiting List Size	0 - Total	Apr-23	20353			17535	20353		
Theatre - Utilisation	0 - Total	Apr-23	68.16%	85%	-16.84%	72.16%	68.16%		

Quality and Safety

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

Group: 0 - Total

MetricName: All

NHS Dorset County Hospital NHS Foundation Trust

Commentary

- 54% compliance with monitoring weight on admission.
- Cannulation Observation Audit has highlighted a need revisit back to basics teaching of the importance of cannula checks
- No incidents where harm has been caused to patients with No Criteria to Reside. There is ongoing work to improve data measurements and undertake a thematic review.
- Over April 2023, the Trust experienced better bed capacity which in turn relieved some of the operational pressures. Workforce challenges related to Industrial Action by nurses and junior doctors, however, risks were mitigated and no incidents reported as a result. The focus on aligning the quality governance framework is in the final process of completion with updated quality reports reflecting this.
- The Trust maintains a zero report for Never Events and Number of medication incidents resulting in severe harm or death. Last incident for both metrics is November 2021.
- VTE Assessment - the mandated electronic system for reporting these assessments was reinstated in April following a pause during strike action.

VariationIcon	Pass	Hit or Miss	Fail	Empty	Total
Improvement	1	1	2		4
Common Cause		3	1	2	6
Concern				2	2
Neither					
Empty					
Total	**1**	**4**	**3**	**4**	**12**

SAFE

Metric	Group	Latest Month	Value	Target	Variance to Target	Previous Year	YTD Value	Variation	Assurance
Incidents - Never Events	0 - Total	Apr-23	0	0.02	-0.02	0			
Incidents - Number of falls resulting in fracture or severe harm or death	0 - Total	Apr-23	0			0			
Incidents - Number of Medication Incidents	0 - Total	Apr-23	64			50			
Incidents - Pressure Ulcers - Hospital acquired (grade 3) confirmed avoidable	0 - Total	Apr-23	1			0			
Incidents - Serious Incidents investigated and confirmed avoidable	0 - Total	Apr-23	1	0	1.00	0			
Infection Control - C-Diff Hospital Onset Healthcare Associated	0 - Total	Apr-23	1	3	-2.00	2			
Infection Control - Gram Negative Blood Stream Infections	0 - Total	Apr-23	3	5	-2.00	4			

EFFECTIVE

Metric	Group	Latest Month	Value	Target	Variance to Target	Previous Year	YTD Value	Variation	Assurance
Inpatient - % Emergency Re-Admissions (16+ & <30 Days) (1 month arrears)	0 - Total	Mar-23	7.05%	13%	-5.95%	6.66%	7.05%		
Inpatient - Percentage of EDS available within 24 hours of discharge	0 - Total	Apr-23	79.81%	90%	-10.19%	78.21%	79.81%		
Inpatient - Percentage of EDS available within 7 days of discharge	0 - Total	Apr-23	87.41%	100%	-12.59%	90.97%	87.41%		

CARING

Metric	Group	Latest Month	Value	Target	Variance to Target	Previous Year	YTD Value	Variation	Assurance
Complaints - Total Number Received (Informal & Formal)	0 - Total	Apr-23	92			77			
Friends and Family - Overall - Recommend Rate	0 - Total	Apr-23	99%	94%	5.00%	91%	99%		

People

Group: 0 - Total

MetricName: All

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

Dorset County Hospital NHS Foundation Trust

Commentary
Essential skills compliance remained at the internal target of 90% in month 1.
Substantive workforce capacity remained static in Month 1 and turnover decreased marginally to 11.6%.
The overall sickness percentage decreased in Month 12 (March) to 4.2% and has reduced each month since October 2022.
The Trust appraisal rate is improving, it has increased from 70% to 76% since August 2022.

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

Metric	Group	Latest Month	Value	Target	Variance to Target	Previous Year	YTD Value	Variation	Assurance
Appraisal rate	0 - Total	Apr-23	76%	90%	-14.00%	65%	76%		
Essential Skill Rate	0 - Total	Apr-23	90%	90%	0.00%	91%	90%		
Sickness rate (one month in arrears)	0 - Total	Mar-23	4%	3%	1.00%	6%	4%		
Staff Turnover Rate	0 - Total	Apr-23	11%	12%	-1.00%	11%	11%		
Vacancy Rate (substantive)	0 - Total	Apr-23	9%	5%	4.00%	6%	9%		

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
Adjusted position:Impact of inflationary pressures (gas, electric, catering supplies & maintenance contracts) above planned levels along with higher than planned agency usage providing cover during peak industrial action periods.
Agency Spend:higher than planned agency usage providing cover during peak industrial action periods.
Capital Expenditure:Marginally behind plan in month due to timings of capital expenditure payments made.
Efficiency Delivery:Marginal over delivery against plan in month covering Corporate, Digital, Covid and Prothesis programmes.
Off Framework Agency Spend:Impact supporting industrial action and specialist areas ED, CrCU, SCBU, Kingfisher. Bank rates and on framework agency rate reviews currently underway to mitigate off framework usage aligned to collaborative System working.

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

Metric	Group	Latest Month	Value	Target	Variance to Target	Previous Year	YTD Value	Variation	Assurance
Adjusted Financial Position	0 - Total	Apr-23	0	7	-7.00	-1711			
Agency Spend (Monthly)	0 - Total	Apr-23	1040	833	207.00				
Capital Expenditure (Monthly)	0 - Total	Apr-23	1392	1407	-15.00	419			
Efficiency Delivery	0 - Total	Apr-23	385	350	35.00	49			
Off Framework Agency Spend	0 - Total	Apr-23	136	83	53.00				

Glossary

MetricName

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 - Percentage of 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 - Adjusted Financial Position	Finance Spend (£000) Adjusted financial performance surplus or deficit. Sourced from Finance team.
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 - Efficiency Delivery	Paid CIP (£000) for efficiency delivery. Sourced from Finance team.
Fin - Off Framework Agency Spend	Off Framework Agency 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.

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
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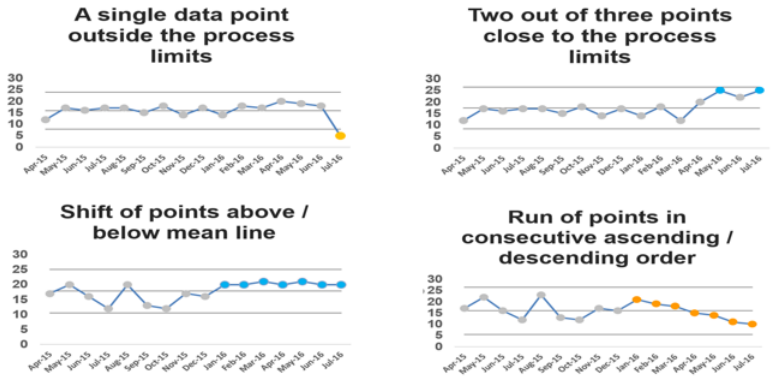
Is Performance Changing?

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?

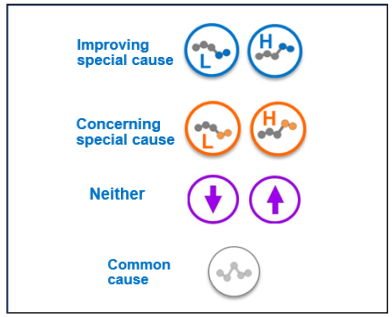
Blue icons indicate significant improvement or low pressure.

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?

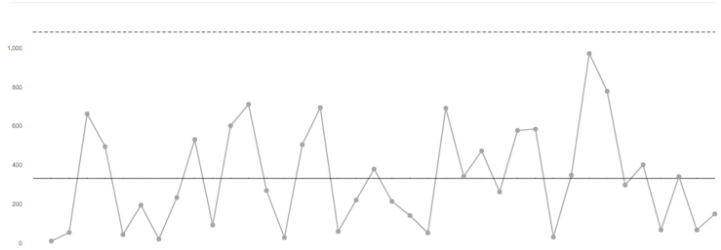
Moving range chart (seen on right) helps to assess the variation in a process by taking the absolute difference between consecutive points.

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: (blank)
H	Special cause of an improving nature where the measure is significantly **HIGHER**. This process is capable and will consistently **PASS** the target.	Special cause of an improving nature where the measure is significantly **HIGHER**. This process will not consistently **HIT OR MISS** the target. This occurs when the target lies between process limits.	Special cause of an improving nature where the measure is significantly **HIGHER**. This process is not capable. It will **FAIL** the target without process redesign.	Special cause of an improving nature where the measure is significantly **HIGHER**. Assurance cannot be given as a target has not been provided.
L	Special cause of an improving nature where the measure is significantly **LOWER**. This process is capable and will consistently **PASS** the target.	Special cause of an improving nature where the measure is significantly **LOWER**. This process will not consistently **HIT OR MISS** the target. This occurs when the target lies between process limits.	Special cause of an improving nature where the measure is significantly **LOWER**. This process is not capable. It will **FAIL** the target without process redesign.	Special cause of an improving nature where the measure is significantly **LOWER**. Assurance cannot be given as a target has not been provided.
(common cause)	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.

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Report Front Sheet

1. Report Details			
Meeting Title:	Board of Directors		
Date of Meeting:	Wednesday 31st May		
Document Title:	System Performance Scorecard		
Responsible Director:	Matthew Bryant, Chief Executive	Date of Executive Approval	24-05-23
Author:	Jonquil Williams, Business Manager		
Confidentiality:	No		
Publishable under FOI?	Yes		
Predetermined Report Format?	No		

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

3. Purpose of the Paper	For information							
	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 remains high in both acute and community hospitals, impacting patient flow leading to delays in timely access to emergency departments with consequences in ambulance handover delays and planned inpatient activity. The impact of Discharge to Assess (D2A) is expected to improve system flow for 2023/24 consequently improving system performance. A recent resilience alert issued due to the increasing severity of the challenge which has implications for wider system partners eg mental health patients waiting presenting at ED who subsequently require a bed. Exception reports have been prepared for the main areas of challenged performance, it is worth noting that timescales vary for each performance section depending on the most recent reportable data.							
5. Action recommended	N/A							

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

Impact on Social Value		**No**	If yes, please summarise how your report contributes to the Trust's Social Value Pledge	
Trust Strategy Link		**How does this report link to the Trust's Strategic Objectives?** *Please summarise how your report will impact one (or multiple) of the Trust's Strategic Objectives (positive or negative impact). Please include a summary of key measurable benefits or key performance indicators (KPIs) which demonstrate the impact.*		
Strategic Objectives	People			
	Place			
	Partnership			
Dorset Integrated Care System (ICS) goals		**Which Dorset ICS goals does this report link to / support?** *Please summarise how your report contributes to the Dorset ICS key goals.* *(Please delete as appropriate)*		
Improving population health and healthcare		**No**	*If yes - please state how your report contributes to improving population health and health care*	
Tackling unequal outcomes and access		**No**	*If yes - please state how your report contributes to tackling unequal outcomes and access*	
Enhancing productivity and value for money		**No**	*If yes - please state how your report contributes to enhancing productivity and value for money*	
Helping the NHS to support broader social and economic development		**No**	*If yes - please state how your report contributes to supporting broader social and economic development*	
Assessments		**Have these assessments been completed?** *If yes, please include the assessment in the appendix to the report.* *If no, please state the reason in the comment box below.* *(Please delete as appropriate)*		
Equality Impact Assessment (EIA)		**Yes**	**No**	
Quality Impact Assessment (QIA)		**Yes**	**No**	

Dorset Integrated Care Board Performance Report

1. Introduction

1.1 The purpose of the paper is to provide members with an overview of current performance against national operational targets for 2022/23, including exceptions and remedial actions.

2. Report

Elective Recovery - Waiting Times

2.1 The table below shows position in current performance against the 78 weeks target of zero by 31 March 2023, reflecting the impact of industrial action, patient choice and increase in covid cases. Dorset system is at 174 (138 admitted, 36 non admitted) against system projected end of year position of 123. However unvalidated data for 31 March shows an improved position of 116 (DCH: 19; UHD: 96 Spa Medica:1)- against a forecast of 123**.**

>78 weeks summary			
Trust	**Performance at 26 March 2023**	**End April Forecast**	**Reason**
Dorset County Hospital	23	0	• 7 non admitted, 16 admitted pathways • Specialities include colorectal, gynae, ophthalmology and orthopaedics
University Hospitals Dorset	148	89	• 29 non admitted, 119 admitted pathways • 160 surgical procedures were cancelled, of which 48 patients were categorised as P2s and are being rescheduled in April 2023
Spa-Medica	3	1	• Specific lenses on order for patient with long lead time for delivery

2.2 The system continued to focus on the six actions in Sir Jim Mackey NHSE letter (12 January 2023) and performance against these e.g. validation and booking patients is closely monitored at regional level. There is continued and constant patient level monitoring and validation alongside weekly calls with regional team.

2.3 During 2023/24 the Dorset System has planned to deliver zero 65 weeks by 31 March 2024, in line with national planning guidance.
Current performance at 26 March 2023 is 1,431 patients waiting 65 weeks, breakdown is as follows:
• Dorset County Hospital- 241
• University Hospitals Dorset- 1180
• Harbour- 1
• SpaMedica- 9

2.4 The national target for the number of patients waiting over 52 weeks is zero by March 2025, however the South West Region have set local ambition as follows:
• Zero patients waiting for a first outpatient appointment by the end of September 2023
• Zero patients waiting for a non-admitted, no patient should be waiting over 52 weeks by the end of December 2023.

2.5 Currently the Dorset position at 26 March 2023 is 5,260 patients waiting 52 weeks, breakdown is as follows:
• Dorset County Hospital- 1165
• University Hospitals Dorset- 4083
• Harbour- 2
• SpaMedica- 10

2.6 Both Dorset County Hospital and University Hospitals Dorset are currently off plan due to long waiters in the 78 weeks group and cancer patients. Work has been focussed on the key specialities to support delivery of the waiting list targets.

2.7 As reported in the February 2023 update, the performance against 25% outpatient activity conducted virtually continues to be at 21%. Work continues to be progressed 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.

Cancer

2.8 Both Trusts have continued to improve the Faster Diagnosis Standard, the charts on slide 16 in Appendix 1 shows the latest verified position at February 2023 showing 71.7% at Dorset County Hospital and 66.2% in University Hospital Dorset against the 75% performance target. Unverified 1 March position shows continued improvement and system is delivering 76% (78.8%% at Dorset County Hospital and 75% in University Hospital Dorset).

2.9 There has been positive improvement in position following focus on 62-day cancer backlog reduction supported by Wessex Cancer Alliance funding for additional waiting list initiatives. The Dorset system is very close to the March trajectory – 70 patients at DCH vs trajectory of 60, and 227 patients at UHD vs trajectory of 209. The April trajectory is 70 and 258 respectively so currently being achieved.

2.10 It is worth noting that we are an expecting increase in backlog in April due to industrial action and potential impact of lead histopathologist retirement at end of March at Dorset County Hospital. Detailed action plans are in place including those actions supporting Faster Diagnosis Standard in paragraph 2.11 and we are expecting to be delivering the trajectory by Quarter 2 2023/24.

Diagnostics

2.11 Audiology- although performance has improved by 6.7% and now achieving 26.8% we are still not achieving the target of 25% of patients waiting 6+ weeks for a diagnostic test. The creation of one Audiology service with Dorset County Hospital and Dorset Healthcare is underway and will complete by September 2023. Dorset Healthcare data is now included within the performance report, further work is ongoing to understand performance improvement trajectories

2.12 Endoscopy- the 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. Overall performance has improved and is currently 74.1%. Insourcing, mobile endoscopy service, recruitment drives and a longer term plan for the Dorset Endoscopy strategy are in place

Urgent and Emergency Care

2.13 The numbers of patients with No Criteria to Reside continue to fluctuate with evidence of a slight improvement with 297 patients (breakdown as follows 64 Dorset County Hospital, 131 Poole Hospital, 102 Bournemouth Hospital, 33 CoHo) no longer meeting the criteria to reside at 3 April 2023. Although there is no statutory target, our system target is to deliver at least a 30% reduction by June 2023 and 50% reduction by September 2023.

2.14 System wide plans are in place including daily discharge performance via the Tactical Resilience Group and the multi-agency discharge and flow cell continues to focus on targeted improvement and interventions in line with plans set at the Winter Implementation Group. As part of 2023/24 operational planning profiling demand and capacity for the next twelve months has taken place, including bed modelling and impact of all schemes covering pre, in and post hospital.

2.15 During March Dorset was seeing 58 minute handover delays. Reasons for the continued low performance is due to lack of patient flow through the hospitals (including No Criteria to Reside patients), increased numbers of patients in the Emergency Department (ED) 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.

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1.0 Service Delivery Scorecard – Elective Performance

NHS
Dorset

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 *Jan 23 Position*	
Total Waiting List Size	Feb 23	-	64,799	72,522		-	17,122	19,397		-	81,921	91,919		-	-	-	-	-
>104 Week waits	Feb 23	0 Jun 22	0	0			0	0			0	0			-	-	-	-
>78 Week Waits	Feb 23	0 Mar 23	95	274			50	60			145	334			-	4	-	14
>65 Week Waits	Feb 23	0 Mar 24	-	1,147			-	267			-	1,414			-	3	-	-
>52 Week Waits	Feb 23	0 Mar 25	2,559	3,861			1,100	1,197			3,659	5,058			-	4	-	12
Elective Recovery Productivity/Transformation																		
Total Ouptatient - Virtual (%)	Feb 23	25.0%	29.4%	20.2%			18.0%	21.8%			25.6%	21.8%			-	-	-	-
Patient Initiative Follow ups % (PIFU)	Feb 23	5.0%	-	8.2%			-	5.9%			-	8.9%			5.60%	3	2.30%	3
Advice & Guidance % of 1st Outpatient	Dec 22	16.0	-	-	-	-	-	-	-	-	-	9.6			-	-	-	-
Diagnostic Recovery																		
Total Diagnostic Waiting List	Feb 23	-	-	11,040			-	5,222			-	16,262		-	-	-	-	-
% waiting over 6 weeks	Feb 23	25% Regional 1% National	-	7%			-	31%			-	15%			36%	2	-	-
Number waiting over 26 weeks	Feb 23	0		15	-		-	372	-		-	387	-		-	-	-	-
Cancer Recovery																		
Faster Diagnosis Standard (FDS) 28 days	Jan 23	75%	-	65%			-	73%			-	67%			67%	5	66%	23
Number of patients waiting <62 days to 1st definitive treatment	Jan 23	85%	-	64%			-	66%			-	63%			57%	2	54%	23
62 day backlog	Feb 23	<220	-	286			-	83		-	-	359			-	-	-	-
Number of patients waiting <31 days to treatment	Jan 23	96%	-	95%			-	88%			-	92%			90%	1	89%	35
Cancer two week wait		93%	-	-	-	-	-	58%			-	-	-	-	-	-	-	-
Cancer 2ww referrals	Jan 23	-	-	-	-	-	-	-	-	-	-	3,830		-	-	-	-	-
104 days back stop	Feb 23	-	-	76		-	-	14		-	-	85		-	-	-	-	-

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

1.5 Elective Recovery – Cancer – Exception Report – Faster Diagnostics Standard (FDS) 28 Day
1.6 Elective Recovery – Cancer – Exception Report – 62 day backlog
1.7 Elective Recovery – Cancer – Exception Report – Number of patients waiting <62 days to 1st definitive treatment

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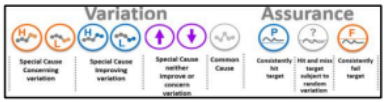
Dorset County Hospital
NHS Foundation Trust

NHS Dorset

3.0 Service Delivery Scorecard – Urgent & Emergency Care

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 (Type 1) Admissions v 19/20 actual - Month	Feb 23	5,374 (19/20)	3,160 (4,011 - 19/20)	-	-	1,186 (1,363 - 19/20)	-	-	4,346	-	-	-	-	-	-
A&E attendances V 19/20 actual - Month	Feb 23	15,289 (19/20)	11,498 (11,595 - 19/20)	-	-	3,757 (3,694 - 19/20)	-	-	15,255	-	-	-	-	-	-
12 hour breaches ED	Feb 23	-	228		-	59		-	287			476 (Average)	3	-	-
% of 12 hour breaches ED	Feb 23	<10%	2.0%	-	-	1.6%	-	-	1.9%	-	-	-	-		
No criteria to reside (NCTR) number of patients (Daily)	21 Mar 23	-	255		-	75		-	330		-	-	-	-	-
No criteria to reside % of beds occupied (Daily)	21 Mar 23	-	24.6%		-	23.8%		-	24.1%		-	20.3%	7	15.2%	42
Adult general and acute type 1 bed occupancy (Daily)* Data being reveiwedby UHD	21 Mar 23	<92%	95.5%	-	-	99.6%	-	-	96.3%	-	-	97.00%	1	95.90%	9

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 - Dec 22 Benchmark	
Mean 999 Call answering times (Minutes/Seconds)	Feb 23	00:00:10	-	-	-	-	-	-	00:00:06			00:00:06	4
Dorset Category 1 Ambulance Response Times (Minutes)	Feb 23	7	-	-	-	-	-	-	8.1			-	-
Dorset Category 2 Ambulance Response Times (Minutes)	Feb 23	18	-	-	-	-	-	-	31.1			-	-
111 Call abandonment (Dorset HealthCare)	Jan 23	<=3%	-	-	-	-	-	-	8.6%			28%	1
Average Hours Lost to ambulance handover delays per handover (Hours)	Feb 23	-	1.35		-	0.6		-	1.24		-	2	-
Total Hours lost to ambulance handover delays (month)	Feb 23	-	3758		-	483		-	4241		-	-	-
SWAFST - Category 2 Ambulance Response Times (Minutes)	Feb 23	18	-	-	-	-	-	-	40			40	9
SWAFST - Average Hours Lost to ambulance handover delays per handover (Hours)	Feb 23	-	-	-	-	-	-	-	1.12		-	1.12	-



3.1 Urgent & Emergency Care – Exception Report – No criteria to reside % of beds occupied (NCTR)

3.2 Urgent & Emergency Care – Exception Report – Handover Delays

Escalation Report

Executive / Committee: Finance and Performance Committee

Date of Meeting: Monday 17th April 2023

Presented by: Stephen Tilton (Chair)

Significant risks / issues for escalation to Committee / Board for action	• Closure of the ED 15 Project noting the excellent team working to deliver the scheme. The following were approved by the committee and are recommended to the Board for approval: • Annual Safe Staffing Return • PACS and RIS Contract • Microsoft Licensing 3 year Enterprise Agreement • Oral Surgery Outsourcing – Wentworth • Hearing Aid Contract

Key issues / matters discussed at the Committee	The meeting considered the following items:
	• Urgent and Integrated Care Divisional report noting:
	  ○ Continued good ambulance handover performance compared to benchmark although plans in place to deliver targets.
	  ○ Challenges within the Histopathology service, Oncology and Cardiology with mitigating plans in place and discussions with partners ongoing
	• Family and Surgical Services Divisional Report noting:
	  ○ Ongoing review of Theatre productivity
	  ○ Arrangements to deliver the 65 week waiting time target
	  ○ Some improvements in patient flow and slight reductions in bed occupancy rates.
	  ○ Challenges within the MRI and CT services.
	• The Performance Report noted:
	  ○ An increase in the number of patients with various winter infectious diseases impacting bed management, activity and flow.
	  ○ Positive performance in urgent and emergency care
	  ○ Waiting list growth due to activity and referral growth.
	  ○ Growth in cancer referrals.
	• Month 12 Finance Report noting:
	  ○ Delivery of Control Total and £4.7m cost improvements and efficiencies.
	  ○ Agency expenditure remained above trajectory
	  ○ The impairment of several capital projects amounting to £5m, including New Hospital Project building schemes.
	  ○ £18.9m Cash at the bank.
	  ○ Delivery of the Capital Development Expenditure Limit (CDEL)
	• Escalation Reports from the following subgroups were noted:
	  ○ Capital Planning and Space Utilisation Group
	  ○ Sustainability Working Group
	  ○ DCH Subco Ltd.

Decisions made by the Committee	The following items were approved by the committee: • Annual Safe Staffing Return

	• PACS and RIS Contract • Microsoft Licensing 3 year Enterprise Agreement • Oral Surgery Outsourcing – Wentworth • Hearing Aid Contract
Implications for the Corporate Risk Register or the Board Assurance Framework (BAF)	• Nil new.
Items / issues for referral to other Committees	• Nil new

Escalation Report

Executive / Committee: Finance and Performance Committee

Date of Meeting: Monday 22nd May 2023

Presented by: Stephen Tilton (Chair)

Significant risks / issues for escalation to Committee / Board for action	The following were approved by the committee and are recommended to the Board for approval: • Enabling Works – New Hospitals Programme – demolition of the West Annex was approved. • Delegated authority was given to the Chief Finance Officer and Deputy Chief Executive to approve spends up to £500k on further enabling works. • The CFO and Deputy CEO would sign the new Partnering Agreement with the New Hospitals Programme following receipt of legal advice.

Key issues / matters discussed at the Committee	The meeting considered the following items:
	• Urgent and Integrated Care Divisional report noting:
	  ○ Continued good Emergency Department performance.
	  ○ Appointment of DCH as the pan Dorset provider of the sleep study service
	  ○ Clinical collaboration with UHD within the Oncology service
	  ○ Senior consultant vacancy within the Pathology service.
	  ○ Cardiology recovery plan.
	  ○ Discussion of insourcing and outsourcing arrangements.
	  ○ Commercial partnering arrangements to support the aseptic pharmacy service.
	• Family and Surgical Services Divisional Report noting:
	  ○ Increasing activity addressing the elective backlog linked to the theatre productivity programme.
	  ○ Upward performance trajectory for MRI and CT services.
	  ○ Discussion of the potential opportunities arising from greater use of the Model Hospital data to support performance and sustainability improvements.
	• The Performance Report noted:
	  ○ Static waiting list size (noting increased referrals and increased activity) and reducing follow up backlog.
	  ○ Sustained achievement of the 5% patient Initiated Follow Up (PIFU) target.
	  ○ Increasing challenges meeting the 28 cancer standard for diagnosis.
	  ○ The need to include health inequalities data again in future reports following recent changes in the report format.
	• Finance Report noting:
	  ○ The Month 1 report was an internal report.
	  ○ £491k deficit driven by industrial action and inflationary pressures.
	  ○ Ongoing discussion and collaboration with system partners.
	  ○ Discussion of efficiency, sustainability and governance plans to further explore and mitigate the underlying deficit position including consideration of external support and facilitation, review of workforce models and assumptions on achieving reductions in the number of patients with No Reason to Reside.

	• The Cyber Security Update was not received.
	• Patient Pathway Improvement Programme Quarterly Update noting examples of transformational change resulting from Quality Improvement initiatives.
	• Escalation Reports from the following subgroups were noted:
	  ○ Capital Planning and Space Utilisation Group
	  ○ DCH Subco Ltd and Q4 2022/23 Performance Report.
	• ICB Finance Committee Minutes were noted.

Decisions made by the Committee	The following items were approved by the committee: • Accommodation Lease in respect to 13 High East Street providing further staff accommodation. • Enabling Works – New Hospitals Programme – demolition of the West Annex was approved. • Delegated authority was given to the Chief Finance Officer and Deputy Chief Executive to approve spends up to £500k on further enabling works. • The CFO and Deputy CEO would sign the new Partnering Agreement with the New Hospitals Programme following receipt of legal advice.
Implications for the Corporate Risk Register or the Board Assurance Framework (BAF)	• Gaps in DCH Subco Ltd pharmacy provision reflected the national challenges and were reflected within the risk register.
Items / issues for referral to other Committees	• Nil new

Escalation Report

Executive / Committee: People and Culture Committee

Date of Meeting: Monday 17th April 2023

Presented by: Margaret Blankson (Chair)

Significant risks / issues for escalation to Board for action	• The following are recommended to the Board:
	  ○ Staff Sharing Agreement (Dorset MOU)
	  ○ Recruitment and Retention Strategy
	  ○ Equality Delivery System

Key issues / other matters discussed by the Committee	Divisional Report from Urgent and Integrated Care Division noting:
	• Oncology and pharmacy service challenges due to national staff shortages
	• New service models and roles to support cardiology services.
	• A reduction in staff sickness absence levels.
	
	The committee considered the following items:
	• People and Performance Report and Dashboard noting:
	  ○ Improved positions on sickness absence, appraisals and vacancies.
	  ○ The work of the Freedom to Speak Up Guardian to promote the role and raise awareness amongst staff.
	  ○ High sickness absence levels and low appraisal rates amongst Healthcare Scientists – additional support being provided.
	  ○ Recent and further planned industrial action by nurses and junior doctors.
	• Quarterly Education and Training Report noting the procurement of additional training places to ensure compliance with safeguarding children mandatory training requirements,
	• Workforce Planning and Insights Report noting an overall increase in staffing numbers over the previous year and ongoing international recruitment plans
	• Workforce Risk Report was deferred due to recent technical issues with Datix affecting the timely availability of data.

Decisions made by the Committee	• The following items were approved and are recommended to the Board:
	  ○ Staff Sharing Agreement (Dorset MOU)
	  ○ Recruitment and Retention Strategy
	  ○ Equality Delivery System

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

Items / issues for referral to other Committees	• None

Escalation Report

Executive / Committee: People and Culture Committee

Date of Meeting: Monday 22nd May 2023

Presented by: Margaret Blankson (Chair)

Significant risks / issues for escalation to Board for action	• The following are recommended to the Board:
	  ○ 2022/23 WRES and WDES Report.
	  ○ Bank and Agency Usage and Expenditure Report.
	  ○ Guardian of Safe Working Report.
	  ○ Freedom to Speak Up and Whistleblowing Report.

Key issues / other matters discussed by the Committee	The committee considered the following items:
	
	• People and Performance Report and Dashboard noting:
	  ○ April People Survey results were consistent with the national Staff Opinion Survey results, remaining above the national average but reflecting national pressures such as the cost of living crisis.
	  ○ The committee noted the staff perception of fear of detriment when reporting concerns.
	  ○ Improvements in appraisal rates for the Healthcare Scientist group of staff.
	• High Cost Agency Report noting a variety of actions to ensure sustainable workforce practices and deliver new workforce models in place.
	• Divisional Report from Family and Surgical Services Division noting:
	  ○ Development of transformational workforce plans
	  ○ Actions to address longstanding medical vacancies in Gastroenterology and Urology and gaps within the junior medical staff group.
	  ○ Slight reductions in the level of staff sickness absence
	  ○ Improvement in appraisal compliance rates.
	• The revised Equality, Diversity and Inclusion Strategy and Action Plan was deferred.
	• Guardian of Safe Working Report
	• 2023 WRES and WDES Report. An action plan would be returned to the committee by October.
	• Annual People Plan Update noting:
	  ○ Widening participation schemes in place.
	  ○ Management Matters programme launched
	  ○ Staff network activity and the Freedom to Speak Up Guardian role.
	  ○ Continued development of a ‘Just Culture’.
	  ○ Training, development and mentoring opportunities for staff.
	• 2022/23 Bank and Agency Usage and Expenditure Report noting:
	  ○ An increase in agency expenditure of 14% during the year. Senior medical expenditure was a feature.
	  ○ Development of the DCH Bank, enrolment and a consistent pay rate across the system to include all bands of staffing.

	• Bi-annual Freedom to Speak Up and Whistleblowing Report noting an increase in reporting following the appointment of the Guardian. • The Talent Management and Appraisal Report was deferred. • Ward Accreditation and Learning from Excellence Report. • Workforce Risk Report. • Bi-annual Communications Activity Report • ICB People Committee Minutes
Decisions made by the Committee	• The following items were approved and are recommended to the Board: ○ Guardian of Safe Working Report
Implications for the Corporate Risk Register or the Board Assurance Framework (BAF)	• Nil new
Items / issues for referral to other Committees	• None

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NHS
Dorset County Hospital
NHS Foundation Trust

Escalation Report

Committee: Quality Committee

Date of Meeting: 18th April 2023

Presented by: Sue Atkinson / Jo Howarth

Significant risks / issues for escalation to Board for action	• Impact of industrial action on elective care. No quality impacts noted during recent industrial action. • Continued disruption to the provision of oncology services, with acute patients being directed to Poole hospital. • Suspension of UKAS accreditation of microbiology. Some maternity tests are being sent to Bristol as a result. • Accreditation of the transfusion lab, histology, and endoscopy • Assurances received regarding the position of clinical coding and the SHMI

Key issues / matters discussed at the Committee	The committee received, discussed and noted the following reports:
	• Quality and Safety Performance Report noting:
	  ○ Sustained infection control thresholds and no never-events or medication incidents
	  ○ Continued work to address the high rate of falls
	  ○ Low VTE assessment rate due to a decision made during industrial action. No evidence to suggest patients had not received blood-thinners when required.
	• Industrial Action Impact Update
	• Divisional Exception Reports from Urgent and Integrated Care Division, noting improvements in transfusion lab now fully compliant with MHRA and histopathology reaccreditation with UKAS. Microbiology noted above. Family Services and Surgical Division noting the successful JAG reaccreditation of endoscopy.
	• Maternity Safety Report noting updates to main risks in the department.
	• Clinical Coding Update and Early Observations
	• PLACE Assessment Annual Review, requiring action on hospital food
	• Supporting Healthy Living – Treating Tobacco Dependency Annual Update
	• Escalation Reports from the following subgroups:
	  ○ Infection, Prevention and Control Group. Noting that face masks are no longer mandatory across the trust.
	  ○ Medicines Committee

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	• Nil

Escalation Report

Committee: Quality Committee

Date of Meeting: 23rd May 2023

Presented by: Eiri Jones / Jo Howarth

Significant risks / issues for escalation to Board for action	• A positive shift in focus throughout the committee away from the reactive position throughout the pandemic, to a proactive position focussing on reset and quality improvement. • Impact of digital challenges on the ability to deliver services. • HES data not submitted to NHS England on time, due to an issue at the external company who submits the data on the Trust's behalf. The Trust had submitted the data to the external company on time. The region is aware of the issue which has affected multiple Trusts. If the late data is not accepted by NHS Digital, it could impact the Trust's SHMI for the next 9 to 12 months. • Quality Account to be reviewed at 12th June Board meeting.

Key issues / matters discussed at the Committee	The committee received, discussed and noted the following reports:
	• Quality and Safety Performance Report noting:
	  ○ Revised format of the report now includes deeper analysis and will provide greater assurance once metrics are fully embedded.
	  ○ Review of governance processes continues.
	  ○ Medicines Optimisation Plan reviewed; noted to be a good template for other quality improvement work in the Trust.
	• Industrial Action Impact Update. The action had been well managed with no significant harms noted to date.
	• Learning from Deaths Q4 Report, noting the above issue with HES data. SHMI is falling and expected to be in range in the coming months.
	• Divisional Exception Reports from Urgent and Integrated Care Division, and Family Services and Surgical Division. Issues with the nurse call system were reprioritised in this year's capital plan due to the risks of safety. Positive achievements in sonography, decontamination, and fractured neck of femur. Challenges in the waiting times for ASD services. Work continues to regain the recently lost UKAS accreditation for microbiology. Request for assurance from Finance and Performance Committee in relation to quality impact of areas of challenging performance.
	• Maternity Safety Report outlining the national Three Year Delivery Plan for Maternity and Neonatal Services.
	• Annual Quality Account – Draft.
	• Quarterly Transformation Update, outlining their support to the divisions in aligning transformation work to the Trust's objectives.
	• Clinical Plan is in development and the Trust is contributing to alignment across the system.
	• Risk Management Strategy Update, noting that the strategy and policy are being fully re-written as part of the governance review and refresh.
	• Escalation Reports from the following subgroups:
	  ○ Safeguarding Group noting non-compliance with level-3 safeguarding training and delays in implementation of Oliver McGowan training, but with some mitigations in place.
	• ICB Quality Committee Minutes

Decisions made by the Committee	• Approval of the Annual Quality Account – Draft
Implications for the Corporate Risk Register or the Board Assurance Framework (BAF)	• Nil specific though consideration being given as part of the governance review.
Items / issues for referral to other Committees	• Nil

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Dorset County Hospital
NHS Foundation Trust

Escalation Report

Executive / Committee: Charitable Funds Committee

Date of Meeting: 23 May 2023

Presented by: Dave Underwood

Significant risks / issues for escalation to Committee / Board for action	• Nil
Key issues / matters discussed at the Committee	**DCHC Charitable Funds Committee (23.5.23)** • **DCH Charity Finance/Income 22/23** reports (M12 Mar 2023) received. Total income for 22/23 was £877,759 (Target £875K). Reserves at the end of March provided a surplus of £304,503 against the reserves target of £220k. • **Capital Appeal (ED/CrCU)** report received. £255K income/pledges to date as of April 2023. Public launch planned for 30th August 2023. New Capital Appeal Officer (12mth ftc) commenced in post 15.5.23. Appeal Board next meeting 7.6.23. Corporate engagement event planned for 28.6.23. Grants funding and donor engagement programme ongoing. • **DCH Charity Risk Register review** the committee agreed to maintain all risk ratings at current levels. Specific consideration of current economic conditions to be cited on the risk register. • **DCH Charity Policies** – have been submitted to Board (May) to be ratified.
Decisions made by the Committee	• Nil
Implications for the Corporate Risk Register or the Board Assurance Framework (BAF)	• Nil
Items / issues for referral to other Committees	• Nil

Learning from Deaths Report Q4 2022/23

1. Report Details			
Meeting Title:	Board of Directors		
Date of Meeting:	31st May 2023		
Document Title:	Learning from Deaths Q4 2022/23		
Responsible Director:	Prof Alastair Hutchison	Date of Executive Approval	
Author:	Prof Alastair Hutchison		
Confidentiality:	No		
Publishable under FOI?	Yes		
Predetermined Report Format?	No. However formatted in line with SW Regional guidance. Breadth of data presented is recognised as an exemplar within SW Region.		

2. Prior Discussion		
Job Title or Meeting Title	**Date**	**Recommendations/Comments**
Hospital Mortality Group	17th May 2023	Accepted
Quality Committee	23rd May 2023	Accepted

3. Purpose of the Paper	To inform the Quality Committee of the learning occurring from deaths being reported, investigated and appropriate findings disseminated throughout the Trust. To also outline additional measures put in place to assure the Trust that unnecessary deaths are not occurring at DCH despite the elevated SHMI. 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 (5 months in arrears) for DCH was above the 'Expected Range' for the rolling 12 months to October, November and December 2022 (page 7) but on a downward trend. No other local or national indicators suggest excess unexpected deaths are occurring at DCH, but SW Region acting through Dorset ICS, are seeking additional assurance from an external audit of Structured Judgment Reviews (SJRs). SJRs 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 independent DCH Medical Examiners review every death, speak to immediate relatives and highlight any obvious causes for concern. Prof Hutchison will commence an internal SJR audit during w/b 29th May, of 50 consecutive deaths occurring in September 2022 to look for unexpected events, and report to the quality Committee separately as soon as this is complete.							
5. Action recommended	The Quality Committee is recommended to: 1. **DISCUSS and NOTE** the findings of the report 2. **DISCUSS** the additional scrutiny occurring 3. **APPROVE** the report and escalate to Trust Board							

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 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 4 Report

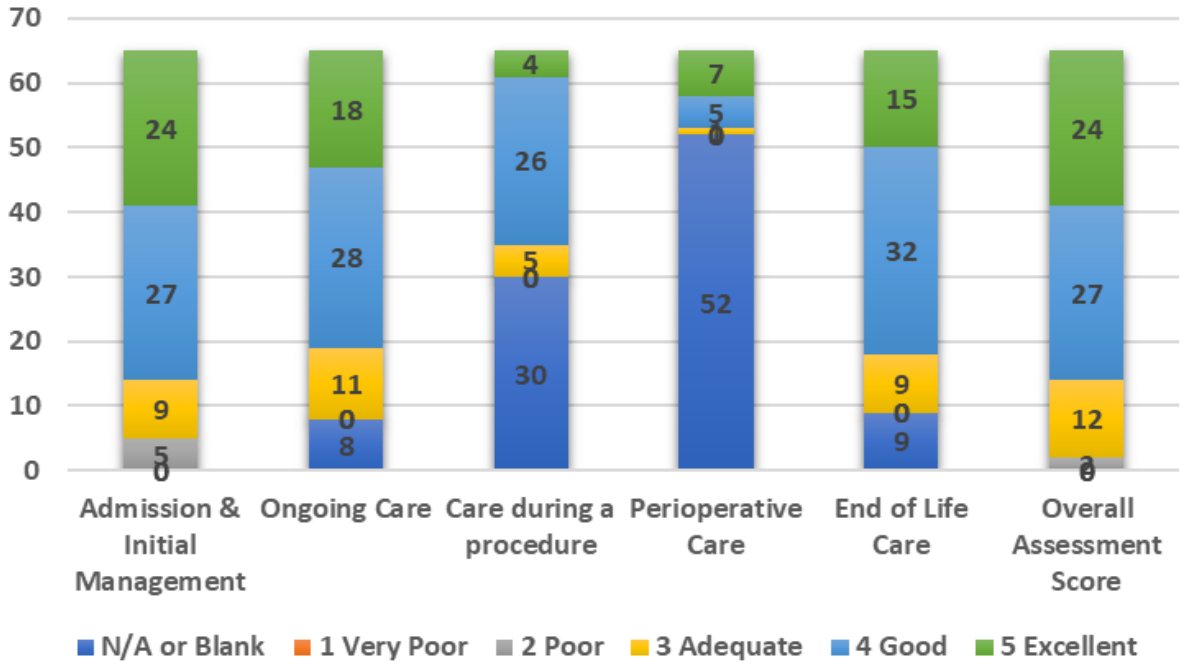
Structured Judgement Review Results: The Family Services & Division had 46 deaths in quarter 4, of which 41 that require SJR's to be completed. Of these 19 have had a SJR completed. Within quarter 4 an additional 46 SJR's have also been completed from previous months.

Outstanding SJR's: The Division have completed a large number of SJR's from previous quarters, reducing the overall backlog significantly. The backlog of outstanding SJR's (> 2 months) for the Division as at 30/04/2023 is 13:

October	November	December	January 23	February
2	3	3	1	4

Feedback from SJR's Completed in Quarter 4:

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	8	30	52	9	0
1 Very Poor	0	0	0	0	0	0
2 Poor	5	0	0	0	0	2
3 Adequate	9	11	5	1	9	12
4 Good	27	28	26	5	32	27
5 Excellent	24	18	4	7	15	24



Overall Quality of Patient Record:

Blank	Score 1 Very poor	Score 2 Poor	Score 3 Adequate	Score 4 Good	Score 5 Excellent
0	0	4	14	27	20

Comments:

- Clear and comprehensive documentation from admission through to patients death from the medical/surgical and anaesthetic teams, nurses and the MDT (dietician, physio etc).
- Consultant review not documented if it happened. Therefore over 48 hours from arrival.
- Difficult to follow Agyle notes and give impression of care.
- Unsure whether there are notes missing. Nothing available for review pre-ICU referral. Very poor surgical clerking.
- Notes loose and out of order but documentation, especially from medical reviews was clear.
- Some difficult handwriting.
- Whilst detailed contemporaneous documentation is difficult in hyper acute clinical scenarios such as this the scribe has missed key information from the trauma booklet which makes it difficult retrospectively to identify all present and have the full clinical picture from the time. Perhaps more experienced nurses/clinicians should fulfil this role.

Ongoing issue with patients' medical records being scanned to DPR before the SJR has been completed. There is a process in place 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). Quality Manager continues to monitor when the Mortuary have released the records to obtain them before they go to the scanning team to try and mitigate this.

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	4	12	49

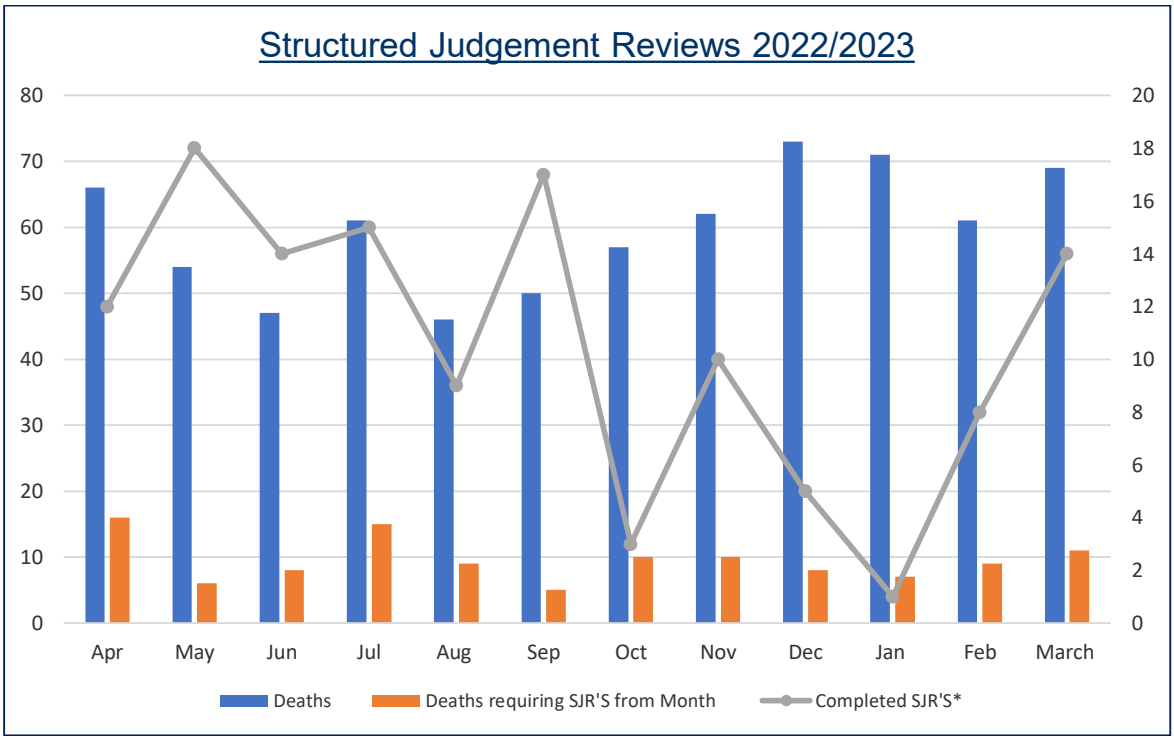
Report completed by: Richard Jee – Divisional Mortality Lead
Laura Symes – Quality Manager

1.2 Division of Urgent & Integrated Care – Quarter 4 Report

Structured Judgement Reviews: In quarter 4 there were 201 deaths, 27 SJR's requested from these deaths and 23 SJR's were completed in total (completed SJR's not necessarily from this quarter).

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total YTD
Deaths	66	54	47	61	46	50	57	62	73	71	61	69	717
Deaths requiring SJR'S from Month	16	6	8	15	9	5	10	10	8	7	9	11	114
Completed SJR'S*	12	18	14	15	9	17	3	10	5	1	8	14	126

Total outstanding SJR's (not including nosocomial) = **38 (29)**
Outstanding SJR's >2 months (prior to 30/11/2022) = **18 (20)**

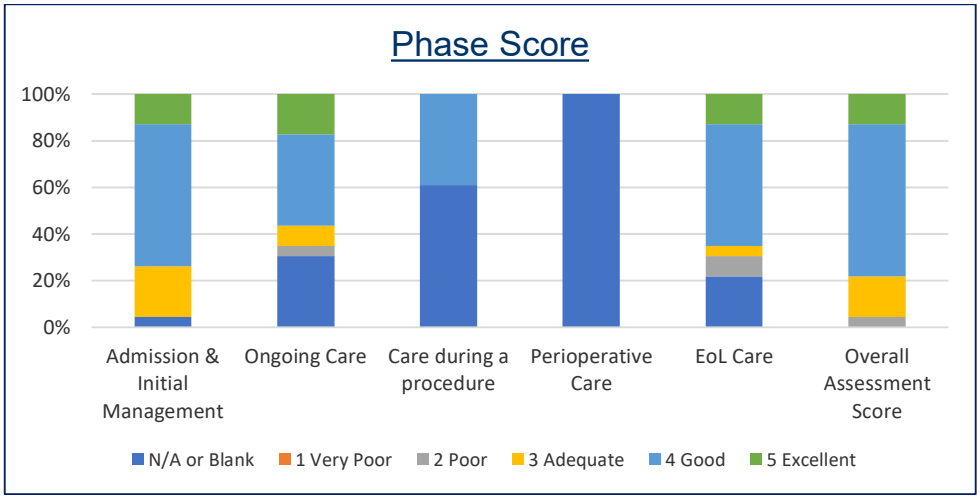


Nosocomial SJR Requests: 20 Nosocomial deaths that were to be reviewed by James Metcalfe (not included in above figures) (9 reviewed so far but Datix not updated as part of report rather than individual SJR's, 12 remaining from original list). 3 further Nosocomial SJR Trigger SJR's received (1 x Feb, 1 x March and 1 x April).

Phase score from 24 completed SJR's in Quarter 4:

Phase Score	Admission & Initial Management	Ongoing Care	Care during a procedure	Perioperative Care	EoL Care	Overall Assessment Score
N/A or Blank	1	7	14	23	5	0
1 Very Poor	0	0	0	0	0	0
2 Poor	0	1	0	0	2	1
3 Adequate	5	2	0	0	1	4
4 Good	14	9	9	0	12	15
5 Excellent	3	4	0	0	3	3

*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	14	5

Quality of patient record improved on last quarter with 19 of the 23 records reviewed scoring good or excellent.

Avoidability of Death Judgement Score

Score 1 Definitely avoidable	Score 2 Strong evidence of avoidability	Score 3 Probably avoidable (> 50:50)	Score 4 Possibly avoidable but not very likely (<50:50)	Score 5 Slight evidence of avoidability	Score 6 Definitely not avoidable
0	0	0	1	2	20

SJR with judgement score of 4, sent to Acute Medicine team beginning of February for sharing and discussing at their next M+M. I am pending minutes of this meeting for learning. Once minutes received, to be shared in divisional newsletter.

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

2.0 NATIONAL MORTALITY METRICS AND CODING ISSUES

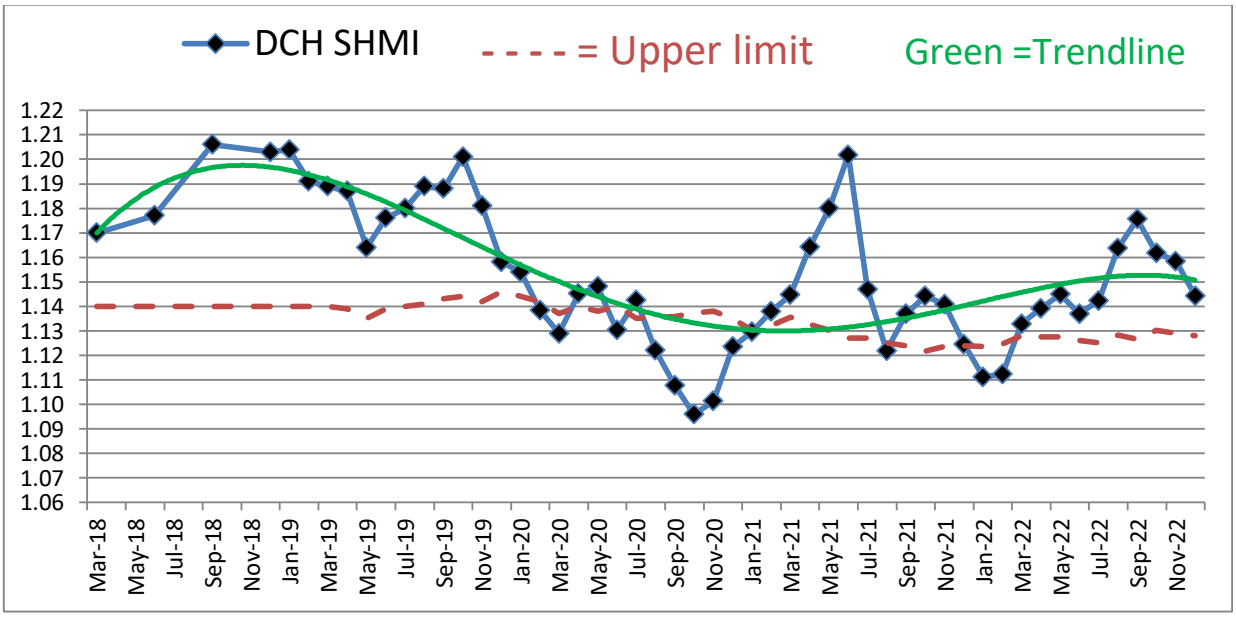
2.1 Summary Hospital-level Mortality Indicator (SHMI)

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 the rolling 12 months to October, November and December 2022 is reducing but remains 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 written medical record. NHS Digital continues to exclude all deaths related to covid from the reported data.

Victoria Stevens reports that the Clinical Coding Department has a coding backlog of more than 4,000 SPELLS with 2 vacancies for qualified coders, which may prevent us from reporting all SPELLS for this financial year. This is likely to continue to adversely influence the accuracy of DCH's SHMI data. 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.

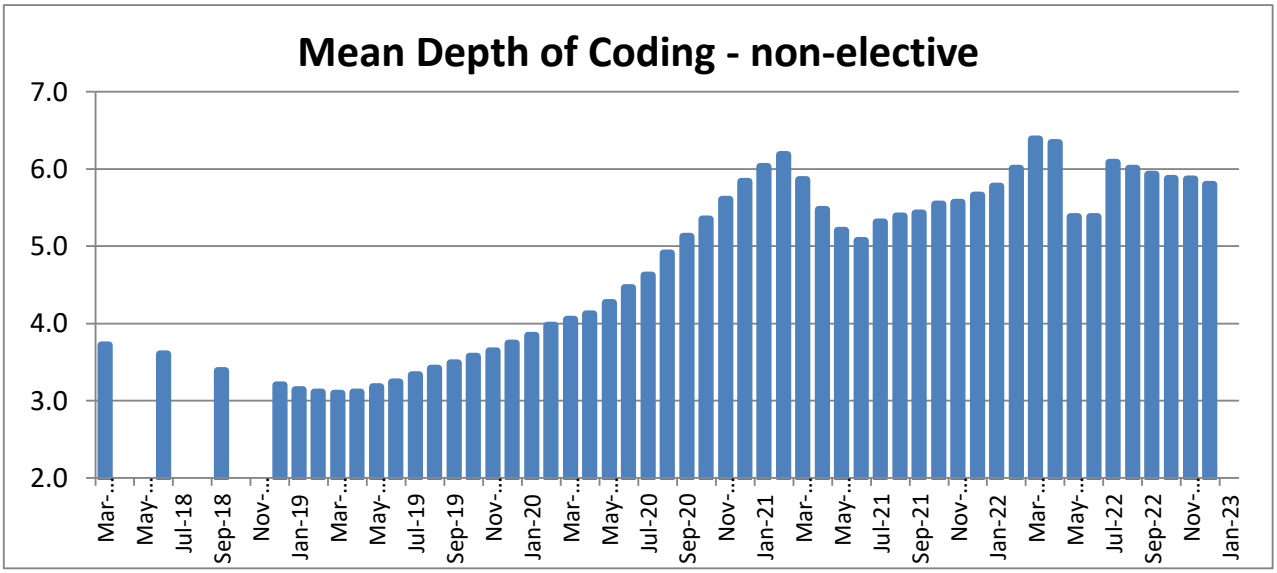
The latest published SHMI (rolling year to December 2022) is shown below:



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 focus on SJRs, M&M meetings and a full Medical Examiner service, plus investment in the coding department which resulted in more accurate coding returns to NHS Digital.

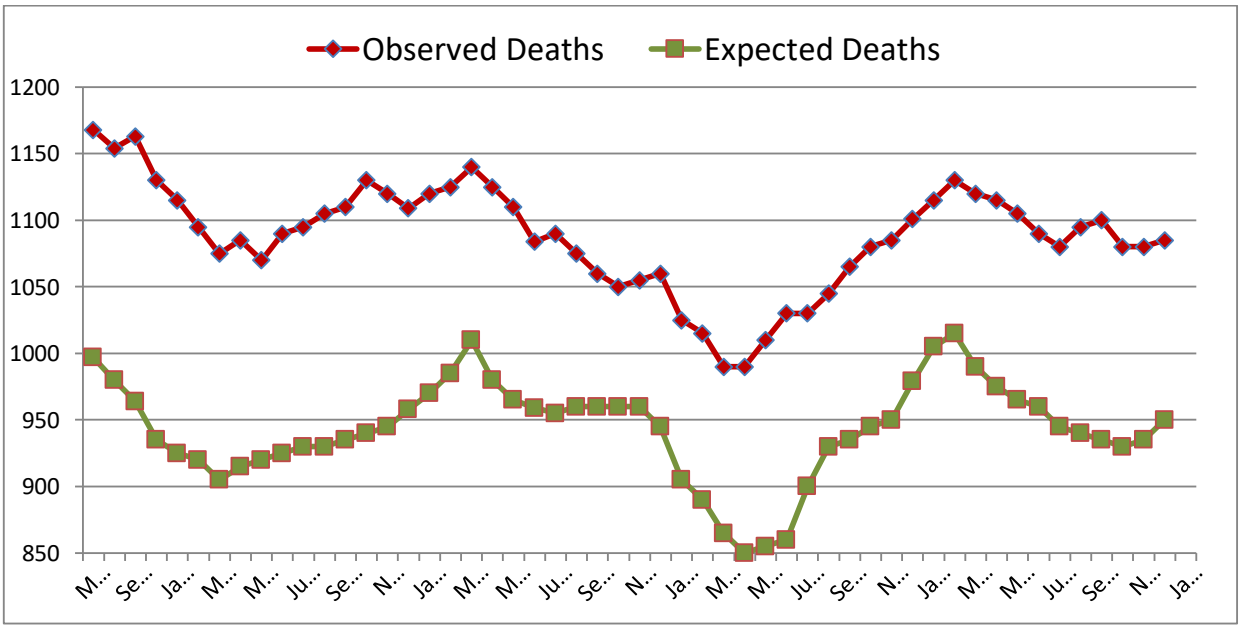
2.3 Depth of coding: NHS Digital states "*As well as information on the main condition the patient is in hospital for (the primary diagnosis), the SHMI data contain up to 19 secondary diagnosis codes for other conditions the patient is suffering from. This information is used to calculate the expected 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. 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 (calculated by NHS Digital) deaths over the past 4+ years (rolling years from March 18 to Dec 23), the numbers of which are directly influenced by the number of in-patients particularly during and immediately after the covid-19 pandemic. Whilst both observed and expected deaths tended to decrease over the 7 months to October 23 (as the total number of in-patients has tended to decrease), the expected deaths have recently increased back to their average of around 950 per 12 months.



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.

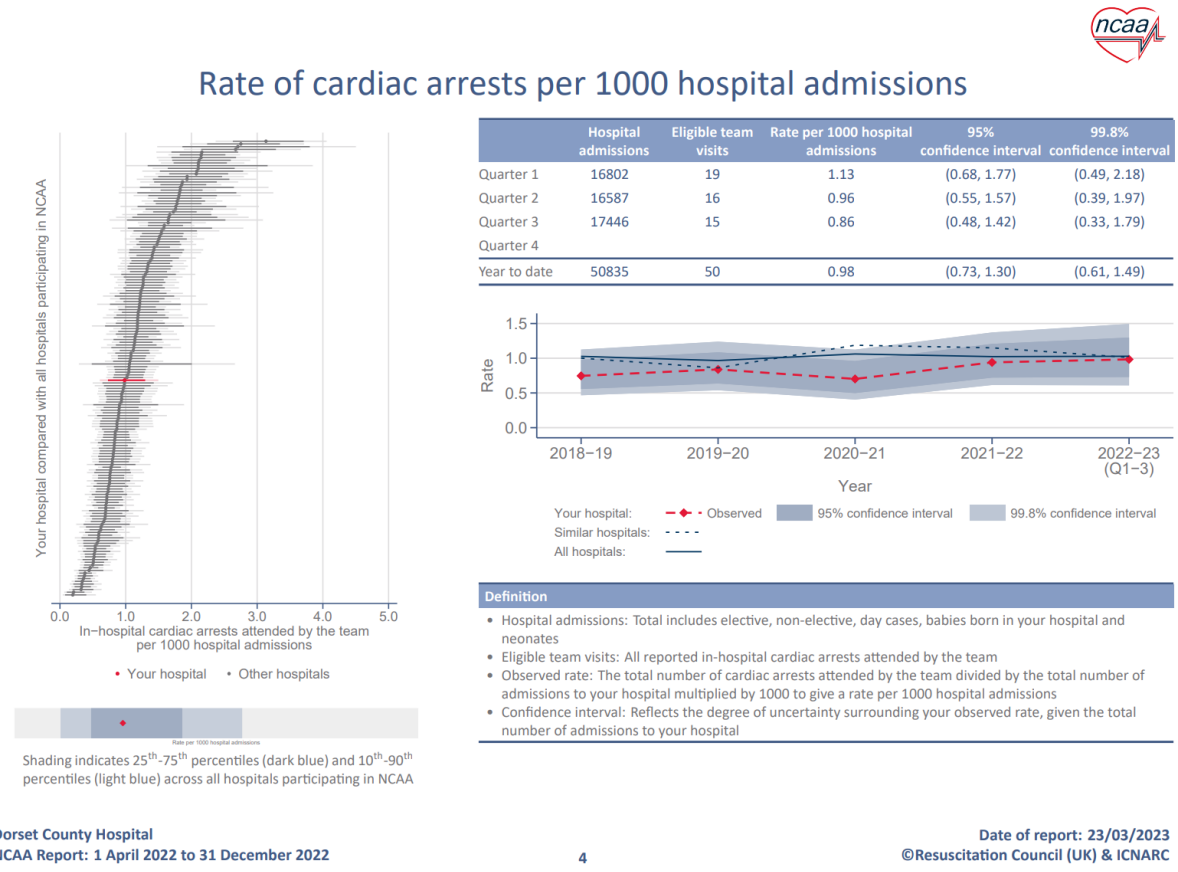
For other metrics of care including complaints responses, sepsis data, AKI, patient deterioration and DNACPR data and VTE assessment data please see the Quality Report presented on a monthly basis to Quality Committee by the Chief Nursing Officer.

In light of various issues related to maternity units and excess deaths of both children and mothers, NHS Digital has now published the first iterations of a "National Maternity Dashboard". This data is also contained within the monthly Quality report.

3.1 NCAA Cardiac Arrest data

The national Cardiac Arrest audit for DCH including data from April 2022 to December 2022 (quarters 1, 2 and 3) was published on 23/03/2023. Frequent cardiac arrest calls suggest unanticipated deterioration in a patient's condition, whereas fewer calls suggest higher standards of ward care, although this is unproven. A total of 50 cardiac arrest calls were recorded for this 9 month period, but not all were definite cardiac events since the cardiac arrest call is also used for any serious or unexpected patient event.

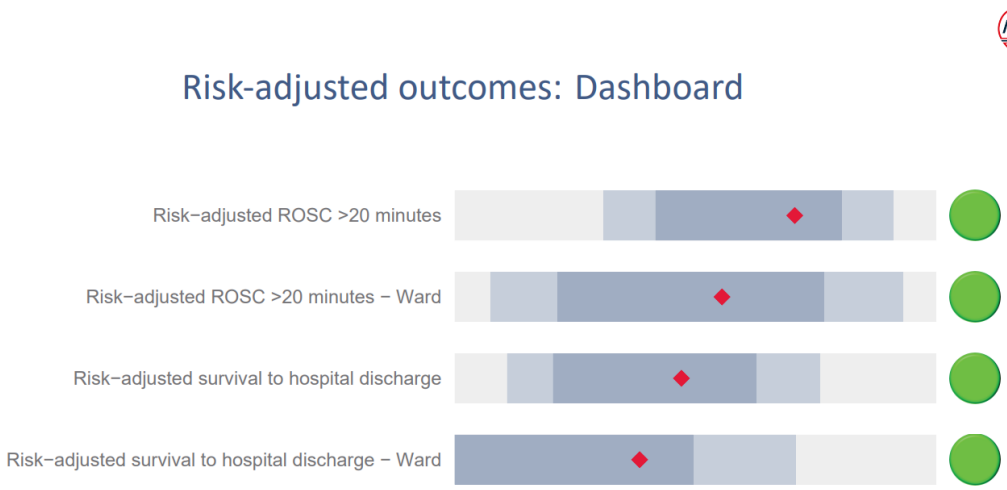
The graph below represents the number of in-hospital cardiac arrest calls attended by the team per 1,000 admissions for all adult, acute care hospitals in the NCA Audit. DCH is indicated in red, and lower on the chart is better. The table to the right gives more detail by quarter year, and the graph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



The dashboard below shows two important risk-adjusted outcome measures arising from a cardiac arrest:

a) Time to '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 and 3 (2022/23).

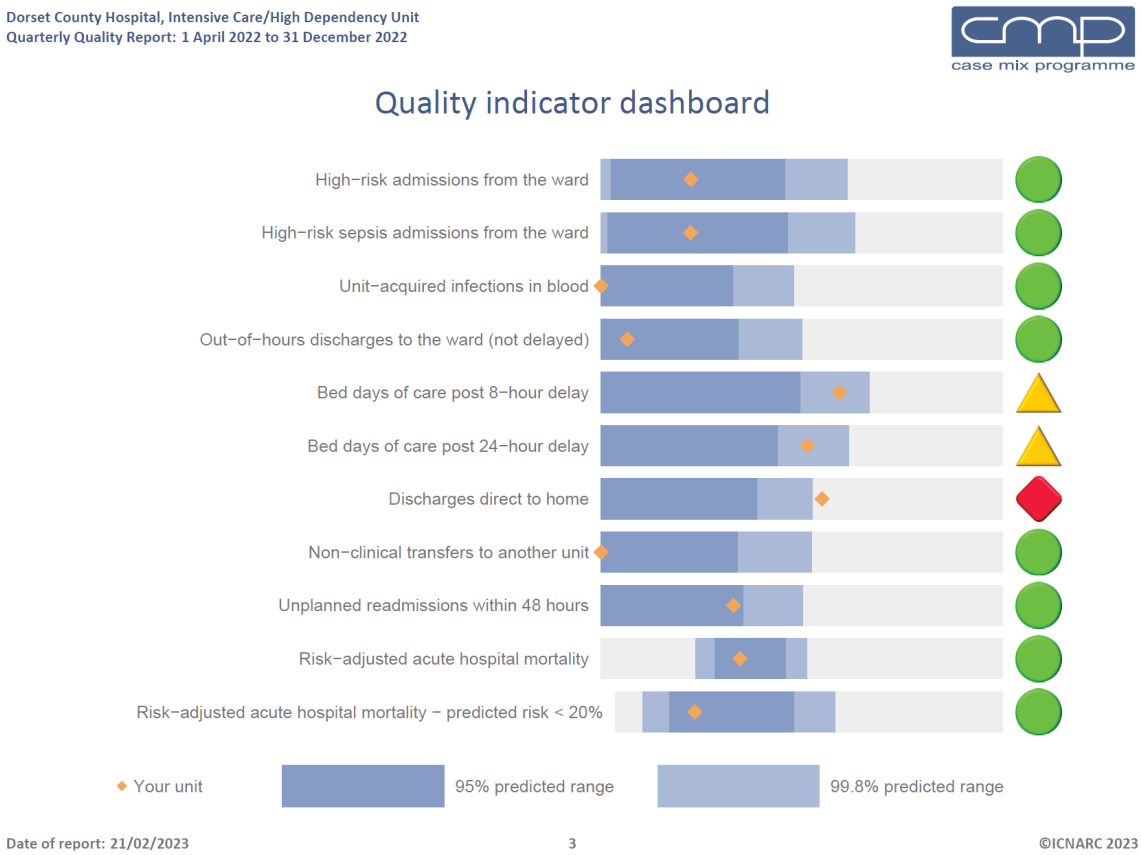


3.2 National Adult Community Acquired Pneumonia Audit latest data – last published Nov 2019 (see below), and not undertaken for either 2019/20 or 2020/21. Data collection restarted in Spring 2022 for publication in Summer this year.

3.3 ICNARC Intensive Care survival latest data for April to December 2022; published 21/02/2023; n = 491 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 (red indicator). This is an indication 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%). The combined result for Q1 + Q2 + Q3 is within the expected range.

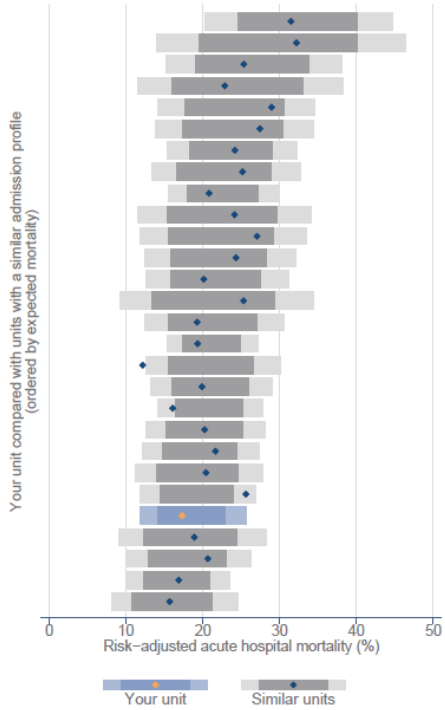


The charts below show the “risk-adjusted acute hospital mortality” following admission to the DCH Critical Care Unit in Q1, 2 and 3 2022/23. They compare observed and expected death rates in a similar fashion to SHMI. Lower is better.

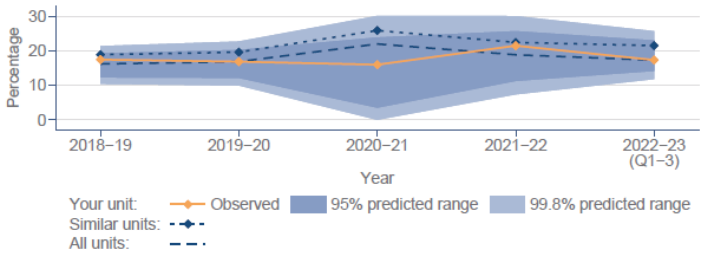
Dorset County Hospital, Intensive Care/High Dependency Unit
Quarterly Quality Report: 1 April 2022 to 31 December 2022

case mix programme

Risk-adjusted acute hospital mortality



	N	Eligible	Observed percentage	Expected percentage	95% predicted range	99.8% predicted range	
Quarter 1	146	134	14.2	18.1	(11.4, 24.5)	(8.2, 28.7)	
Quarter 2	166	158	16.5	18.9	(12.7, 24.9)	(9.6, 28.8)	
Quarter 3	179	170	20.6	18.7	(12.7, 24.5)	(9.7, 28.1)	
Quarter 4							
Year to date	491	462	17.3	18.6	(14.1, 23.0)	(11.8, 25.7)	



Definition

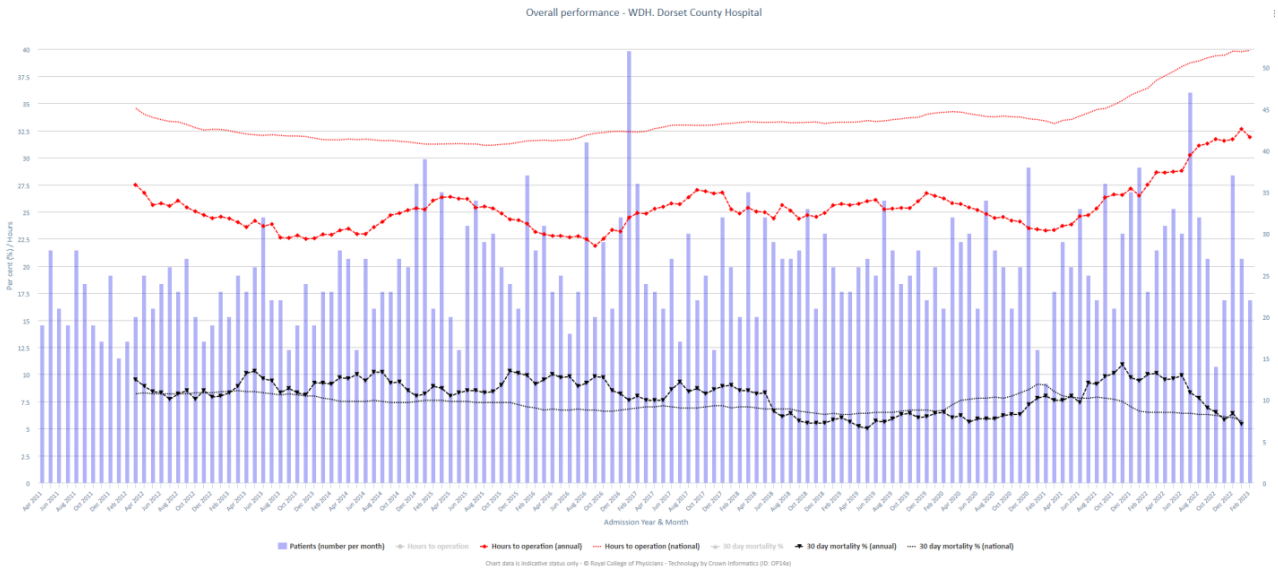
- Eligible: All critical care unit admissions, excluding readmissions, patients dead on admission and those admitted to facilitate organ donation
- Observed percentage: The percentage of eligible admissions that died before ultimate discharge from acute hospital
- Expected percentage: The expected percentage 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: 21/02/2023 13 ©ICNARC 2023

These results are well within the expected range.

3.5 National Hip Fracture database to April 2021

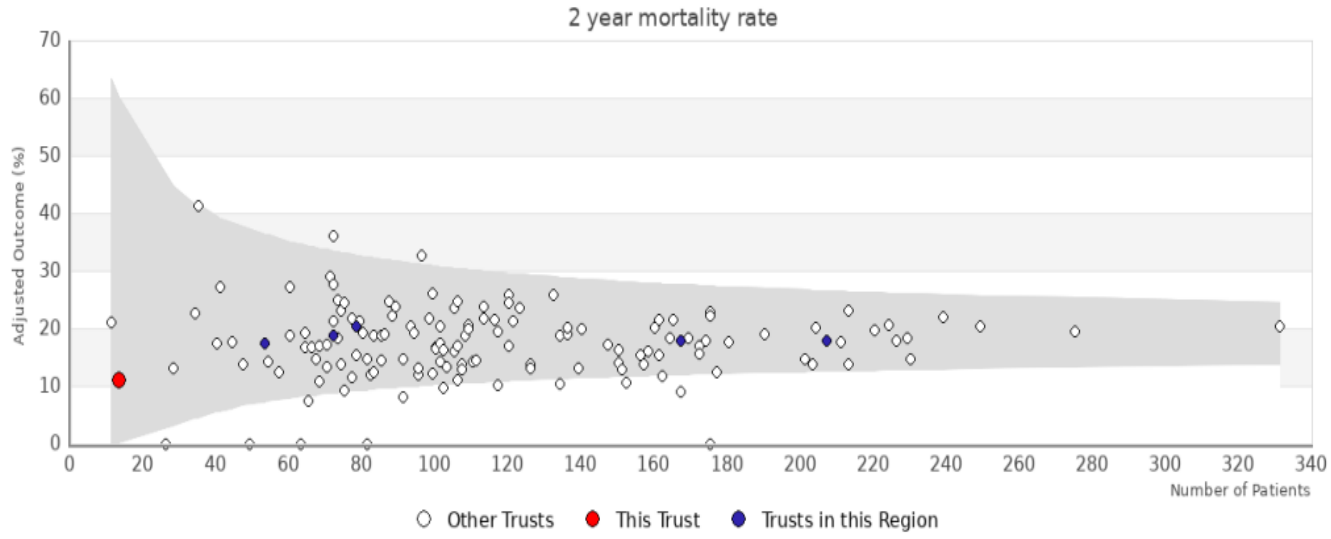
30 day mortality rose in 2021/22 but has now fallen below the national average once again (5.4 vs 5.7%).



'Hours to operation' remains significantly better than the national average for Q3 (31.9 vs 39.9 hours) but there has been a steady rise across the country post-covid.

3.6 National Bowel Cancer Annual audit

Data for 2 year survival after bowel cancer surgery for patients in England and Wales diagnosed with bowel cancer 1 April 2020 – 31 March 2021 was published earlier this year. 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.



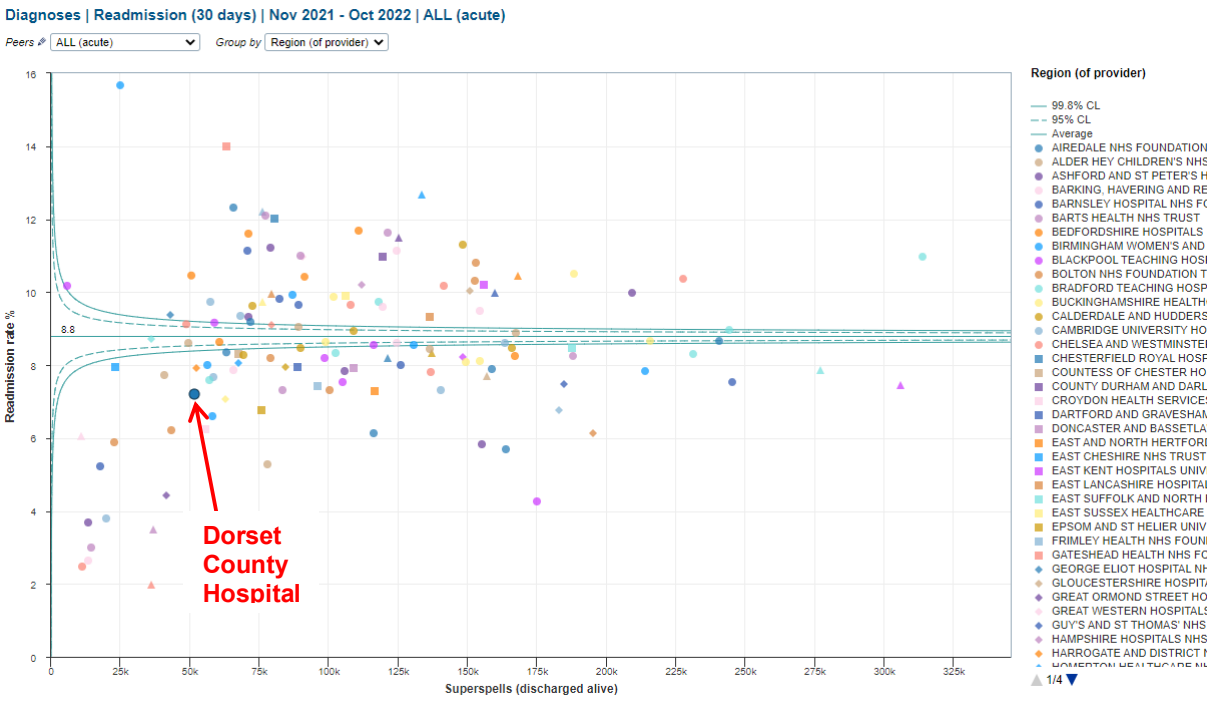
3.7 Getting it Right First Time; reviews in Qtr 4

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. None of these services have been reviewed during Q4.

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. The TARN website states that a data update will be available by 31st May 2023.

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 last year 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 but 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 June 2023 (strikes permitting) to re-examine the accuracy and quality of the SJR scrutiny, in association with the Dorset ICS Learning from Deaths committee.

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 4. 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, 0 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 was less good during covid-19 but is currently better than the national average again. 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:	31 May 2023		
Document Title:	**Annual Guardian Report of Safe Working report: Doctors in Training (April 2022 – March 2023)**		
Responsible Director:	Alastair Hutchinson, Chief Medical Officer	Date of Executive Approval	15/05/23 (EH)
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	22 May 2023	Approved

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 fourth quarterly report (this report) is also an annual report. 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 2022/2023.

Previous Guardian reports have noted the possibility of significant under reporting. The Medical Director, DME, GoSW, GMC regional liaison officer, and local BMA representatives have continued to encourage exception reporting. Whilst it is impossible to separate an increase in instances needing reporting, from an increased in engagement with the reporting mechanism, this year has seen an increase in the number of reports submitted, with the second highest number of reports since the mechanism began in 2017.

There has been a big increase in the number of reports highlighted as being of Immediate Safety Concern (ISC). These continue to be promptly escalated and resolved and there is generally excellent engagement with clinical leadership.

Clinical pressures in Trauma and Orthopaedics have been highlighted previously in the Guardian's Annual Report. Subsequent changes to staffing models were made and feedback from junior colleagues confirm these changes have had a very positive effect.

A part of the Guardian role, not directly related to Exception Reporting, is to provide oversight of a Junior Doctors' Forum (JDF). The Guardian is delighted to observe the return to a lively, well attended face-to-face JDF in the Junior Doctors' Mess with refreshments and is grateful to the Trust for the enthusiastic

	engagement of the Executive. Clinical pressures continue to exist, especially within medical specialties, that frequently require Junior Doctors to work above and beyond their contractual duties and this is documented in the form or Exception Reports. The Guardian has identified no breaches in the Trust's compliance with the contractual arrangements and no specific concerns regarding the safe working components of the 2016 Junior Doctors Contract. Progress has been made in several areas of concern previously highlighted by the Guardian, including successful recruitment towards a fuller establishment, and restructuring of the junior medical workforce to improve support for colleagues in Trauma & Orthopaedics and Gastroenterology/ Medical Outliers.
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	**22 May 2023**
Report Title	**Annual Guardian Report of Safe Working report: Doctors in Training (2022/2023)**
Author	**Mr Kyle Mitchell, Guardian of Safe Working (GoSW)**

1. Executive summary

- Junior Doctors must work flexibly, sometimes over and above their contracted hours, to ensure that the Trust can deliver safe patient care.
- A contractual mechanism exists which enables Junior Doctors to record, and receive remuneration for, these efforts, through the submission of *Exception Reports.*
- The same reporting mechanism also allows Junior Doctors to escalate immediate concerns for patient safety (ISCs); occasions when they work with inadequate service support; and when clinical workload causes them to miss their contracted educational opportunities.
- Junior Doctors continue to engage with Exception Reporting, with submission rates returning to pre-pandemic levels.
- Engagement and report submission allows identification of clinical areas of exceptional demand, helping resource allocation and improving patient safety.
- Trends in Exception Report clustering are not identical across quarterly and annual reports; changes to staffing models in Trauma and Orthopaedics - previously identified as being a recurrent high outlier in Exception Report submission rates - have obviated this tendency.
- Gastroenterology Junior Doctors have intermittently been exposed to exceptional clinical demand due to a variable demand placed on its junior doctors to support medical patients on outlying wards. Changes to medical outlier staffing have effectively dealt with this but this remains an area of vulnerability.
- Geriatric and respiratory medicine remain areas of significant clinical pressure.
- Pay restoration may have eclipsed working hours/ compliance with contractual safeguarding measures in terms of what is seen as a priority for the Junior Doctor workforce.
- This is the 4th Annual Report submitted to the Trust Board by the incumbent Guardian of Safe Working who considers it should therefore be the penultimate Annual Report before appointment of the next Guardian.

2. Introduction

All eligible doctors in training at the Trust in 2021/22 were working under the terms of the 2016 Junior Doctors Contract with 2019 Updates ("the 2016 Contract") and as such have had access to formally report occasions when their actual working pattern diverged from their contracted work schedules, as "Exception Reports", for review by the Trust's Guardian of Safe Working (GoSW).

All work schedules provided to doctors in training within 2021/22 complied with contractual commitments under the 2016 Contract.

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

3. High level data

Number of training post (total): 189 (from 185 in 21/22)

Number of doctors in training post (total): 173.5 (from 159.2 in 21/22)

Annual average vacancy rate among this staff group: 16.03 (24.75 in 21/22)

4. Exception reports

Exception reports by department				
Specialty	No. exceptions carried over from last report	No. exceptions raised	No. exceptions closed	No. exceptions outstanding (01/05/23)
Acute Medicine	0	7 (2 ISC)	7	0
Cardiology	0	16 (1 ISC)	16	0
Emergency Dept.	0	5	5	0
ENT	0	6 (1 ISC)	6	0
Gastroenterology	0	43 (3 ISC)	43	0
General Medicine	7	15 (8 ISC)	22	0
General Practice with medical on-call	1	2	3	0
General Surgery	2	15	17	0
Geriatric Medicine	3	43 (1 ISC)	45	1
Medical Oncology	0	10	10	0
Obstetrics & Gynaecology	0	10 (1 ISC)	10	0
Paediatrics	0	4	3	1
Renal	0	7	7	0
Respiratory Medicine	3	37 (1 ISC)	36	4
Trauma & Orthopaedics	5	14 (3 ISC)	19	0
Urology	0	7 (2 ISC)	7	0
Total	21	241 (23 ISCs)	256	6

Exception reports by grade				
Grade	No. exceptions carried over from last report	No. exceptions raised	No. exceptions closed	No. exceptions outstanding (01/04/23)
F1	13	122	129	6
F2	0	40	40	0
CT/ST1	8	65	73	0
CT2	0	5	5	0
CT3	0	7	7	0
ST3+	0	2	2	0
Total	21	241	256	6

Exception reports (response time) **this is a formal requirement of the annual report*			
	Addressed within 48 hours	Addressed within 7 days	Addressed in longer than 7 days
CT1	14	4	8
CT2	0	1	4
CT3	0	0	7
F1	34	30	47
F2	9	16	14
ST1	9	6	14
ST3+	2	0	0
Total	68	57	95

Total number of Exception Reports submitted	241	(from 117 in 20/21; 213 in 21/22)
Number of Immediate Safety Concerns	23	(from 5 in 20/21; 9 in 21/22)
Number of Work Schedule Reviews	19	(from 29 in 20/21; 28 in 21/22)

5. Work schedule reviews

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

Exception Reports taken to Level 1 Work Schedule Review

Specialty	F1	F2	CT1	ST3
Acute Medicine	2			
Cardiology				
ENT	2			
Gastroenterology		5		
General Medicine				2
General Practice				
General Surgery				
Geriatric Medicine	2			
Renal Medicine			2	
Respiratory Medicine	2			
Trauma & Orthopaedics	2			
Total	**10**	**5**	**2**	**2**

Rota	Total
2022 F1 Medical 03/08/2022 - 06/12/2022	3
2022 IMT 1/2 MED 03/08/2022 - 06/12/2022	2
2022 RG STR GASTRO - 07/09/2022 - 31/01/2023	2
2022 F2 MED 07/12/22-04/04/23	3
2022 F1 Medical 07/12/2022-04/04/23	2
AP 2021 F1 Medical 06/04/2022 - 02/08/2022	1
2022 F1 Ortho 03/08/22-06/12/22	2
2022 F2 MED 03/08/2022 - 06/12/2022	2
2022 GPST LY ENT 03/08/22-01/11/22	2
Total	**19**

Eight work schedule reviews remain open as of 01/04/23
- AP 2021 F1 Medical 06/04/2022 - 02/08/2022 x1
- 2022 F1 Ortho 03/08/22-06/12/22 x2
- 2022 F2 MED 03/08/2022 - 06/12/2022 x2
- 2022 GPST LY ENT 03/08/22-01/11/22 x2
- 2022 F1 Medical 03/08/2022 - 06/12/2022 x1

6. Vacancies

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

7. Fines

There were no fines levied during this period.

8. Qualitative information

8.1 Previous Guardian reports have noted the possibility of significant under reporting. The Medical Director, DME, GoSW, GMC regional liaison officer, and local BMA representatives have continued to encourage exception reporting. Whilst it is impossible to separate an increase in instances needing reporting, from an increased in engagement with the reporting mechanism, this year has seen an increase in the number of reports submitted, with the second highest number of reports since the mechanism began in 2017.

8.2 There has been a big increase in the number of reports highlighted as being of Immediate Safety Concern (ISC). These continue to be promptly escalated and resolved and there is generally excellent engagement with clinical leadership. The Guardian perceives a lowering of the threshold for submission of an ISC. Discussion about the role of ISCs will be included in future induction and Junior Doctors' Forums.

8.3 Clinical pressures in Trauma and Orthopaedics have been highlighted previously in the Guardian's Annual Report. Subsequent changes to staffing models now ensure an additional junior and middle-grade doctor is available for part of the weekend. Both in exception reporting (just 2 submitted during Q3 & Q4), and in informal feedback from junior colleagues, these changes have had a very positive effect.

8.4 Transiently, exception reports highlighted slow processing and reporting of inpatient laboratory blood tests as being a contributor. This delayed clinical decision making and sometimes necessitated time consuming hand-over of clinical information between shifts and increased activity out-of-hours. This did not persist and is no longer an issue.

8.5 A part of the Guardian role, not directly related to Exception Reporting, is to provide oversight of a Junior Doctors' Forum (JDF). As previously reported, social distancing had compromised the delivery of a meaningful and quorate JDF. The Guardian is delighted to observe the return to a lively, well attended face-to-face JDF in the Junior Doctors' Mess with refreshments and is grateful to the Trust for the enthusiastic engagement of the Executive.

9. Issues arising

Clinical pressures continue to exist, especially within medical specialties, that frequently require Junior Doctors to work above and beyond their contractual duties and this is documented in the form or Exception Reports.

10. Summary

An element of flexibility has always been part of how all doctors, including those in training, work. The 2016 Contract formalises arrangements to recognise, record and remunerate this. The Guardian has identified no breaches in the Trust's compliance with these contractual arrangements and no specific concerns regarding the safe working components of the 2016 Junior Doctors Contract.

Progress has been made in several areas of concern previously highlighted by the Guardian, including successful recruitment towards a fuller establishment, and restructuring of the junior medical workforce to improve support for colleagues in Trauma & Orthopaedics and Gastroenterology/ Medical Outliers.

11. Recommendation

The Guardian asks the committee to note this annual report, consider it to provide an assurance of compliance with the safeguarding aspects of the 2016 Junior Doctors Contract and approve its submission to the Trust Board.

APPENDICES

ANNUAL GUARDIAN REPORT ON SAFE WORKING HOURS: DOCTORS IN TRAINING – 2022/23

Appendix 1 – Trainee Vacancies within the Trust

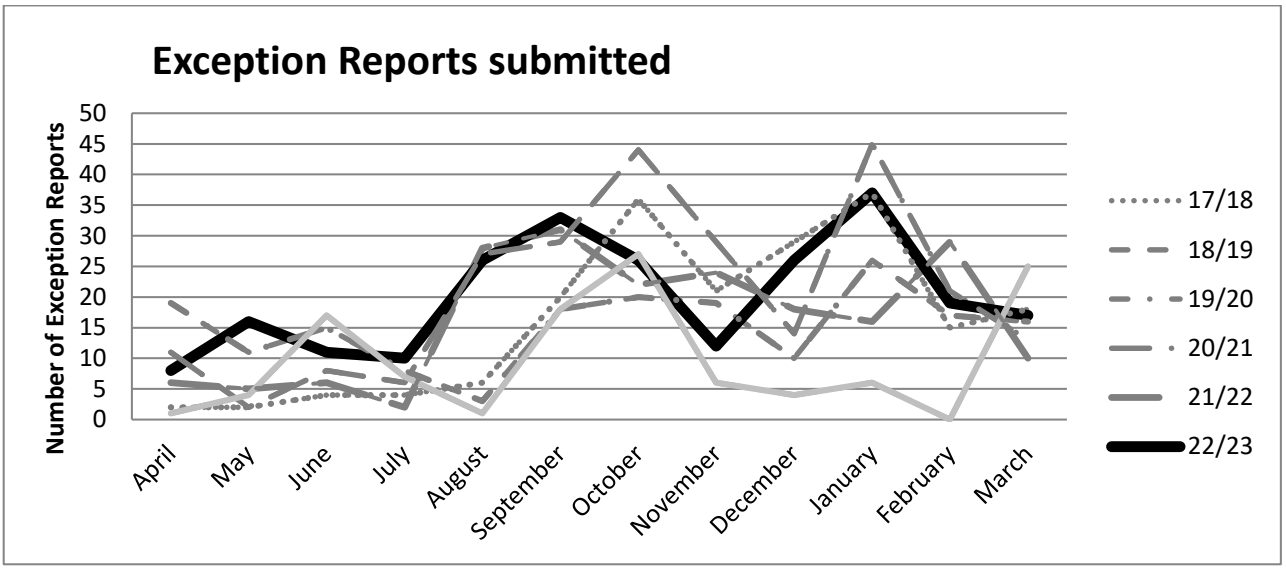
Department	Grade	Q1				Q2				Q3				Q4				Annual Average
	April 22 - March 23	Apr	May	June	Avr Q1	July	August	Sept	Avr Q2	Oct	Nov	Dec	Avr Q3	Jan	Feb	Mar	Avr Q4	
Paediatrics	ST3	0	0	0	0	0	0	0.2	0.1	0.2	0.2	0.2	0.2	0.2	0.2	0	0.1	0.4
Paediatrics	ST4+	0.4	0.4	0.4	0.4	0.4	0.4	1.8	0.9	1.8	1.8	1.8	1.8	1.8	1.8	0	1.2	4.3
O&G	ST1	0	0	0	0	0	0	0	0.0	0	0	0	0.0	0	0	0	0.0	0.0
O&G	ST3+	0	0	0	0	0	0	0	0.0	1.4	1.4	1.4	1.4	1.6	1.6	1.6	1.6	3.0
ED	ST3+	1	1	1	1	1	1	1	1.0	1.2	1.2	1.2	1.2	1.2	1.2	1.2	1.2	4.4
Surgery	CT1	0	0	0	0	0	0	0	0.0	0	0	0	0.0	0	0	0	0.0	0.0
Surgery	CT2	1	1	1	1	1	0	0	0.3	0	0	0	0.0	0	0	0	0.0	1.3
Surgery	ST3+	1	1	1	1	1	1	1	1.0	0	0	0	0.0	0	0	0	0.0	2.0
Orthopaedics	ST3+	1	1	1	1	1	1	1	1.0	1	1	1	1.0	1	1	1	1.0	4.0
Anaesthetics	CT1/2	1.2	1.2	1.2	1.2	1.2	1	1	1.1	1	1	1	1.0	1	0	0	0.3	3.6
Anaesthetics	ST3+	0.4	0.4	0.4	0.4	0.4	0.4	0.4	0.4	0.4	1.4	2.4	1.4	3.4	0.4	0.4	1.4	3.6
Medicine	CT1/2	3.8	3.8	3.8	3.8	3.8	3.4	3.4	3.5	3	3	3	3.0	3	3	3.8	3.3	13.6
Medicine COE	ST3+	0.4	0.4	0.4	0.4	0.4	0.4	0.4	0.4	0.4	0.4	0.4	0.4	0.4	0		0.1	1.3
Medicine Diab/Endo	ST3+	1	1	1	1	1	1	1	1.0	1	1	1	1.0	1	0	0	0.3	3.3
Medicine Gastro	ST3+	1	1	1	1	1	1	0	0.7	0	0	0	0.0	0	0	0	0.0	1.7
Medicine Resp	ST3+	1	1	1	1	0	0	0	0.0	0	0	0	0.0	0			0.0	1.0
Medicine Cardio	ST3+	1	1	1	1	0	0	0	0.0	0	0	0	0.0	0	0	0	0.0	1.0
Medicine Renal	ST3+	1	1	1	1	1	1	1	1.0	1	1	1	1.0	0	0	0	0.0	3.0
Haematology	ST3+	0	0	0	0	0	0	0	0.0	0	0	0	0.0	0	0	0	0.0	0.0
Med/Surg	FY1	1	1	1	1	1	0	0	0.3	0	0	0	0.0	0	0	0	0.0	1.3

Med/Surg	FY2	0	0	0	0	0	0	0	0.0	0	0	1	0.3	0	0	0	0.0	0.3
GPVTS	ST1	2	2	2	2	2	0.4	0.4	0.9	1.4	1.4	1.4	1.4	1.4	3.8	3.8	3.0	7.3
GPVTS	ST2	0.4	0.4	0.4	0.4	0.4	0.4	0.4	0.4	0.4	0.4	0.4	0.4	0	0	0	0.0	1.2
GPVTS	ST3	0	0	0	0	0	0	0	0.0	1.2	1.2	1.2	1.2	1.2	1.2	1.2	1.2	2.4
Orthodontics	ST3	0	0	0	0	0	0	0	0.0	0	0	0	0.0	0	0	0	0.0	0.0
Total		18.6	18.6	18.6	18.6	16.6	12.4	13	14.0	15.4	16.4	18.4	16.7	17.2	14.2	13	14.8	16.03

Trainees vacancies outside the Trust overseen by the LET guardian

General Practice	GPVTS	0.8	0.8	0.8	0.8	0.8	1.2	1.2	1.1	1.2	1.2	1.2	1.2	1.2	1.2	1.2	1.2	4.3
Public health trainees	FY1/2	0	0	0	0	0	0	0	0.0	0	0	0	0	0	0	0	0	0.0
Total		0.8	0.8	0.8	0.8	0.8	1.2	1.2	1.1	1.2	1.2	1.2	1.2				1.2	1.3

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



Report Front Sheet

1. Report Details			
Meeting Title:	Board Meeting		
Date of Meeting:	31st May 2023		
Document Title:	**Maternity Safety Report**		
Responsible Director:	Jo Howarth, CNO	Date of Executive Approval	
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	23rd May 2023	

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

3. Executive Summary

This report sets out the quality and safety activity covering the month of April 2023. This is to provide assurances of maternity quality and safety and effectiveness of patient care with evidence of quality improvements to the Trust Board.

- MNVP feedback not available as action plan not signed off by LMNS
- Data from Power BI provided
- Incident data provided. 12% submissions relating to poor staffing on the maternity unit. 8% relate to staff reallocated from mandatory study time to cover labour ward
- No complaints in April, one in March
- Training figures good but overall compliance not >90% - often due to one or two members of staff being out of date (for small staff groups)
- Risk register reviewed with updates
- Two cases reviewed for M&M
- F&F feedback positive. Two concerns raised about the quality and quantity of the food
- Detail provided of actions and expectations of three year maternity and neonatal delivery plan

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

May 2023 (April 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 April 2023.This is to provide assurances of maternity quality and safety and effectiveness of patient care with evidence of quality improvements to the Trust Board.

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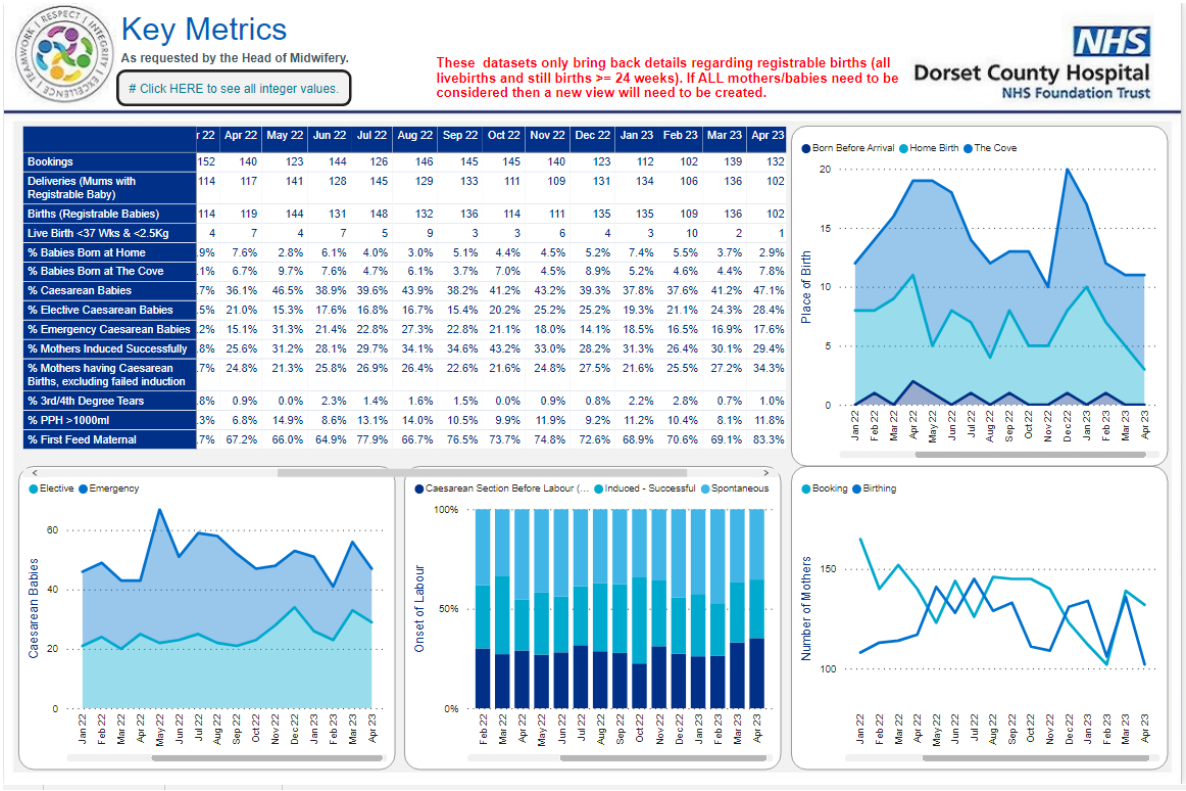
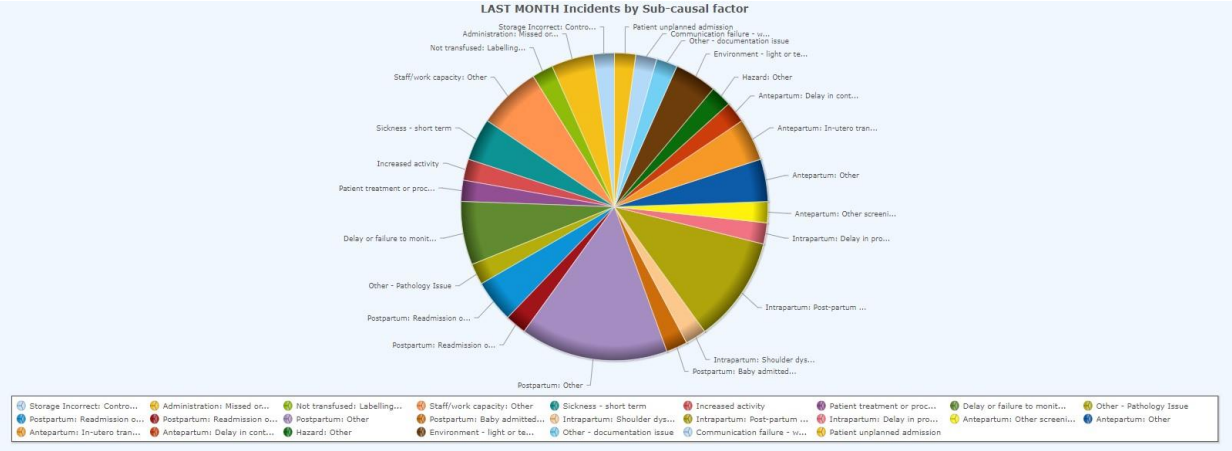
Activity



	r 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	Apr 23
Bookings	152	140	123	144	126	146	145	145	140	123	112	102	139	132
Deliveries (Mums with Registrable Baby)	114	117	141	128	145	129	133	111	109	131	134	106	136	102
Births (Registrable Babies)	114	119	144	131	148	132	136	114	111	135	135	109	136	102
Live Birth <37 Wks & <2.5Kg	4	7	4	7	5	9	3	3	6	4	3	10	2	1
% Babies Born at Home	9%	7.6%	2.8%	6.1%	4.0%	3.0%	5.1%	4.4%	4.5%	5.2%	7.4%	5.5%	3.7%	2.9%
% Babies Born at The Cove	1%	6.7%	9.7%	7.6%	4.7%	6.1%	3.7%	7.0%	4.5%	8.9%	5.2%	4.6%	4.4%	7.8%
% Caesarean Babies	7%	36.1%	46.5%	38.9%	39.6%	43.9%	38.2%	41.2%	43.2%	39.3%	37.8%	37.6%	41.2%	47.1%
% Elective Caesarean Babies	5%	21.0%	15.3%	17.6%	16.8%	16.7%	15.4%	20.2%	25.2%	25.2%	19.3%	21.1%	24.3%	28.4%
% Emergency Caesarean Babies	2%	15.1%	31.3%	21.4%	22.8%	27.3%	22.8%	21.1%	18.0%	14.1%	18.5%	16.5%	16.9%	17.6%
% Mothers Induced Successfully	8%	25.6%	31.2%	28.1%	29.7%	34.1%	34.6%	43.2%	33.0%	28.2%	31.3%	26.4%	30.1%	29.4%
% Mothers having Caesarean Births, excluding failed induction	7%	24.8%	21.3%	25.8%	26.9%	26.4%	22.6%	21.6%	24.8%	27.5%	21.6%	25.5%	27.2%	34.3%
% 3rd/4th Degree Tears	8%	0.9%	0.0%	2.3%	1.4%	1.6%	1.5%	0.0%	0.9%	0.8%	2.2%	2.8%	0.7%	1.0%
% PPH >1000ml	3%	6.8%	14.9%	8.6%	13.1%	14.0%	10.5%	9.9%	11.9%	9.2%	11.2%	10.4%	8.1%	11.8%
% First Feed Maternal	7%	67.2%	66.0%	64.9%	77.9%	66.7%	76.5%	73.7%	74.8%	72.6%	68.9%	70.6%	69.1%	83.3%

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 May 2022 to April 2023

May	June	July	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr
93	79	76	70	63	74	62	60	34	44	38	37
Number of incidents overdue: 9						Several overdue incidents closed recently					

Red Flag incidents: A midwifery red flag event is a warning sign that something may be wrong with midwifery staffing.

Red flag	Descriptor	Incidence for March and April
RF1	Escalation to divert of maternity services & poor staffing numbers, including medical staffing and SCBU	4/April and 5/March – none for SCBU
RF2	Missed medication	1
RF3	Delay in providing or reviewing an epidural in labour	1
RF4	Delay of more than 30 minutes between arrival and admission in ANDAU -	This is now being managed alongside
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

Claims

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 **April 2023** Service manager reviewed handover times and planned alignment **May 2023** To facilitate the attendance of the consultant at an 8pm handover, an extra session will be required which will necessitate an extra consultant being employed. Business care currently being written	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. **April 2023** Work is progressing well on the new ANDAU and training April 2023 • ANDAU has now moved into its now premises. • All ANDAU staff will complete their training by the end of April • The digital maternity team are poised to request BSOTS is “turned on” in the digital maternity system. This assists significantly with triaging as a paper-based system is time consuming and cumbersome • The particular challenges relating to DCH are as follows: 1) We do not currently have two midwives working over the weekend. However, BSOTS requires a minimum of two midwives working 2) Significantly larger services have a dedicated obstetric doctor for triage as this avoids delays. DCH does not have activity to justify a doctor allocated to ANDAU for the shift. 3) ANDAU is not open overnight as there is not the workload to justify this. Women arriving are admitted onto labour ward and triaged/seen very promptly, However, that process needs to be accurately reflected in the guideline **May 2023** There is a robust workplan for this but as our understanding of BSOTS increases, the expectations around it are seen to be more complex. All women must be triaged using BSOTS, including when ANDAU is closed – this requires all midwives and doctors to be trained in its use. The lead midwife has visited neighbouring Trusts where it is in use and there is a visit planned from one of the national BSOTS lead. Challenges are being discussed at regional level, with very few services reporting full compliance.	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 **April 2023** Work is ongoing but further repairs required so currently, only one room available on The Cove **May 2023** Leak now repaired – room requires decorating before use	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 **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: *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.* **April 2023** UHD have shared their SoP for using the bells in a maternity unit. It will require rewording for DCH but is very useful to ensure DCH have a similar document available. Awaiting confirmation from Estates about funding and a start date. Clarification sought 14/4 **May 2023** CFO requested update from Estates – awaiting a response which is anticipated will confirm start date for installation		high	divisional

	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 **Dec 2022** **T**his 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 **April 2023** The situation remains the same **May 2023** This remains on the risk register but no new incidents in April	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. **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 **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. **April 2023** Key action to improve CO at booking is a return to face-to-face bookings. This is possible in some community teams but not in Weymouth and Portland as staffing vacancies prevent face-to-face bookings being offered. Currently most bookings are processed over the phone. More CO testing kits planned so all community based staff have their own. Awaiting confirmation of money from the Maternity Incentive Scheme to contribute to improving this service **May 2023** Whilst staffing gaps remain, it has not been possible to return to face-to-face bookings for all women. However the system in Weymouth recently changed, all women are offerered a first point of contact appointment face to face which includes BMI, bloods and co reading	17/03/2022 Quarterly review	moderate	Care group

871	Levels of Entonox Exposure on the maternity unit	**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 **Jan 2023** Assessments completed on both rooms and awaiting results **Feb 2023** Awaiting results of assessment **Mar 2023** 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 The title of the paper is: *Guidance on minimising time weighted exposure to nitrous oxide in healthcare settings in England. 2nd March 2023* This is our current situation. • **Environmental ventilation** – there is environmental ventilation in every room Entonox is used I spoke to Estates department and we are supposed to be achieving 10 changes an hour as recommended in the report, however the unit was built before the current regulations and we cannot easily test the number of air changes. 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 • **Ensure that ventilation is turned on & 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	24/12/2019	High	Division

		to turn it off, all the switches have been covered so they cannot be tampered with • **Servicing the Entonox outlets** – All the Entonox outlets in use are serviced every 3 months to check for leaks and to ensure they are all working correctly. This is carried out by an external company. Any room on the Maternity Unit where there was an Entonox outlet that is not in use has had the regulation covers fitted so it cannot be used • **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. Entonox is on our risk register. I have forwarded the report to the Estates Department, so they are aware of the regulations and recommendations regarding Entonox levels in rooms. I have asked for a price for the ventilation system being installed in the two delivery rooms. We will be retesting all the rooms again this year. **April 2023** Estimates for the work to improve airflow changes in rooms 25 and 27 have been received and we await a start date for the work – anticipating very soon. **May 2023** Discussed at CPSUG and going out for tender to complete the work on rooms 25 and 27. This is the correct process but will delay completion until the Autumn. Extractor fans having mesh replaced very soon.			
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**	20/07/2021 Quarterly review	moderate	division

		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 **April 2023** Currently interviewing for newly qualified midwives and experienced midwives. Awaiting the decision from business planning in relation to funding for the maternity workforce. If this is agreed, the workforce plan can be signed off providing a robust basis for workforce planning including recruitment, retention, succession planning and developing future leaders **May 2023** Informal unpdate that business plan accepted, pending confirmation of external funding for some roles (submitted to DM). Some recent successful recruitment			

Complaints

Total informal and formal

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

C22748 This complaint concerns communication during a booking appointment	The DoM will be meeting with the midwife to discuss the complaint. A response will also be sent to the complainant and learning identified
C22459 This complaint relates to the provision of postnatal care to women with complex mental health and babies with extra needs	This complaint was noted in the February QC report but the response and learning is detailed below Maintaining a holistic view of all women – this must include their mental health as well as their physical health. This must be sensitively handed over from one team to another and reflected in the digital notes The impact of having a baby requiring a higher level of care. Inevitably, there will be a greater degree of anxiety for parents if their baby is premature or requires a more complex plan of care, for any other reason The correct way to escalate concerns to the paediatric team when an initial response has been unsatisfactory **Further update** This case is going to be presented at M&M in May

C21589 This complaint relates to an intrauterine death during the covid pandemic.	The DoM has asked for all documentation relating to this case for her review. The learning thus far relates to the way in which patients who were covid positive, were managed when admitted to hospital during the pandemic. **Update** Currently reviewing the documentation relating to this case

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 **Update** Recently discussed with programme lead for LMNS and acknowledged further input from MVP requires further funding for increased wte from the LMNS. MVP has recently contributed to two information leaflets for pregnant women **Update** Progress ongoing towards MNVP being involved with complaint responses
Opportunity to raise profile of safety champions		New safety champions board now displayed
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 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 **Update** Discussed with Programme Lead for LMNS and I have suggested a survey, lead by the newly appointed Digital Transformation lead for the LMNS as I suspect staff use, both at DCH and UHD has significantly improved. **Update**

		This action to be managed by the Digital Transformation Lead for the LMNS
To work with MVP to ensure review website and update as indicated		**Update** Discussed with Programme Lead for LMNS. This relates to the Maternity Matters Website, hosted by the LMNS. The information on the DCH page for maternity is intentionally brief, accurate and directs users to the Maternity Matters website for all other information
Review of Advanced Neonatal Nurse Practitioner clinical supervision		**Update** Discussed with Programme Lead for LMNS. Clarification from a tertiary NICU hasn't confirmed regular supervision for their ANNPs. This may relate to the fact that the DCH ANNP is a single employee. Her line manager will discuss what extra support would be helpful for her. However, currently, she had not raised any concerns about her role, the team she works with and she works closely with the lead consultant for neonatal care and the lead nurse for the service (who is also a very experienced ANNP)

Morbidity including M&M meetings

M&M Overview & Learning Joint Perinatal Meeting April 2023

Overview case 1	Overview case 2
Preterm birth at <37 weeks BW 5.4kg Current Type 1 diabetes, BMI >30. Arrived contracting. LSCS performed, EBL 500mls, BW >4kg Learning and Actions Due to poor control of blood sugars, large for gestational age and preterm at 36+2, a paediatrician or coordinator should have been at the birth due to risk of respiratory distress. **Action:** ongoing work with handovers in progress Documentation of resuscitation was not contemporaneous. **Action:** a digital system for SCBU is currently in the process of being created to improve this. **Action:** case to be reviewed by paediatric and obstetric staff regarding control of blood glucose immediately prior to birth to prevent initial neonatal hypoglycaemia.	Twin pregnancy. Anaemia, high risk VTE on Clexane. IOL LSCS due to slow progress. Both babies less than 2.5kg Learning and Actions Gaps in documentation make this case difficult to review. Escalation was timely following the discovery of the low O2 sats but attendance by paediatrician was delayed. **Action:** Digital escalation tools are currently being discussed.

Training

Maternity staff compliance for training

Training	Staff grade	Percentage of attendance
PROMPT (Practical Obstetric	**Obstetric Anaesthetists**	80% (5 non compliant)

Emergency Procedure Training)	**Obstetric Consultants** **Registrars** **ST1/F2** **Midwives** **MSW**	87.5% (1 non compliant) 75% (2 non compliant) 67% (1 due to attend) 92% (11 non compliant) 69.5% (11 non compliant)
NLS (4 yearly accredited course)	**Senior Midwives/Homebirth Midwives**	93%
NLS (yearly update)	**Midwives**	91%

Two new Registrars, both allocated to PROMPT in next couple of months. One allocated to 28/04/2023, One Registrar allocated 08/06/2023.

3 datix relating to staff reallocated from mandatory training to work on the ward – a total of 7 midwives reallocated

Maternity Staffing

Sickness absence over last 12 months	April 2023
midwives	6.23%

One midwife on LTS has now left the Trust, another LTS is poised to return in May.

Sickness absence	february 2023
MSW	5%

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

Date	Message	FFT score	Mood
	all staff were extremely good, kind and professional. They made the whole experience very calm and enjoyable	1	positive
	Absolutely fantastic friendly caring staff from having chats with the cleaners to all of the care I received at SCBU and maternity ward. Nothing was ever too much trouble and was reassured to use the bell as needed. The room we stayed in was beautiful and i really appreciated my partner being able to stay too. You are all super heroes - thank you	1	positive

	Amity went above and beyond to help keep me calm and make the whole process as smooth and stress free as possible. All the theatre staff were kind and lovely and Patsy on the ward was amazing. Mollie was attentive and professional and was great with my baby	1	positive
	Everyone of the staf has been very tentative, kind, caring supportive, froendly , calming during a difficult time. Cannot fault any of the staff who looked after me and our new arrival from the assessment unit team , theatre team and ward team. Thank you to everyone on shft	1	positive
		1	positive
	couldn't fault staff all so friendly and helpful. I don't envy their job even when short staffed everything was communicated well. They truly work so hard and always seem to have a smile on their faces! They deserve more than a pay rise	1	positive
	all the midwives and nurses are amazing and we couldn't do this without them	1	positive
	Everyone took very good care of me and my baby, wouldn't have changed a thing with all the lovely staff	1	positive
	we were in Weymouth for a family event when labour began early morning. The staff on the maternity ward were quick to action and incredibly supportive throughout. The level of guidance, support and kindness will stay with me forever. I was blown away by the professionalism and compassion of the midwives and cannot thank them enough. The care staff and support staff within the unit were equally amazing. They al went out of their way to be as supportive as possible	1	positive

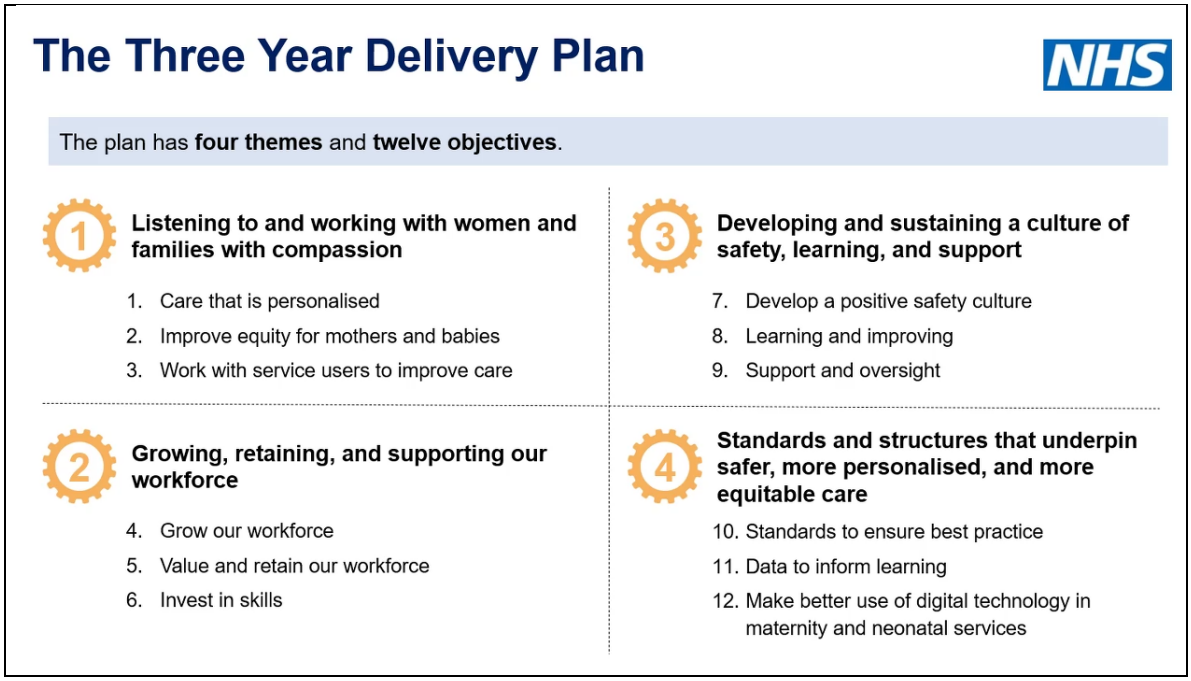
	Post natal - the experience has all depended on which shift - some shifts were so busy that I got left to deal with the unmanageable pain alone, then others have been amazing. I had gestational diabetes and the food available is appalling and embarrassing, GD is completely different to type 2 - I was told I could just take insulin to manage it ! Which when you have worked so so hard to manage it with diet isn't good enough. Paediatrician was too quick to push formula for low blood sugars in baby without listening to me and allowing breast milk to come in which it did a couple of hours later. Pre - Natal Birth wise went completely the way I didn't want it to go but I actually wouldn't change a thing. The care I received was briliant and I was kept very well informed and everything was my choice. so thank you to all of the team I saw which was about 20 people in the time I was in labour! Just a shame the food was so so bad	3	mixed
	All the staff have been lovely and helpful at all stages of my ante natal and post natal care. Everyone was amazing, thoughtful, and explained and helped with such care we can't thank everyone enough	1	positive
	We were really keen to have a home birth this time round. The last time my wife was in DCh was for an ectopic pregnancy and this was really triggering for her. We let you as a team know abut this and your approach and empathy around this was great. Than kyou from the bottom of our hearts for looking after us so well.	1	positive
	Every person that we met was kind considerate and treated us all with respect. Even though it was a challenging set of circumstances for us it felt that every decision was a considered one and done for the right reasons. I would recommend you to any future parents - A star ++	1	positive
	We have been in and out of the hospital for around 10 days. Every single member of staff have been brilliant looking after us giving advice and making us feel at ease. The hospital food is lovely there is so many staff we want to thank. Kerry, Sarah, the social worker and loads more. Thank you!	1	positive
	Felt attended to but food portions too small	2	mixed

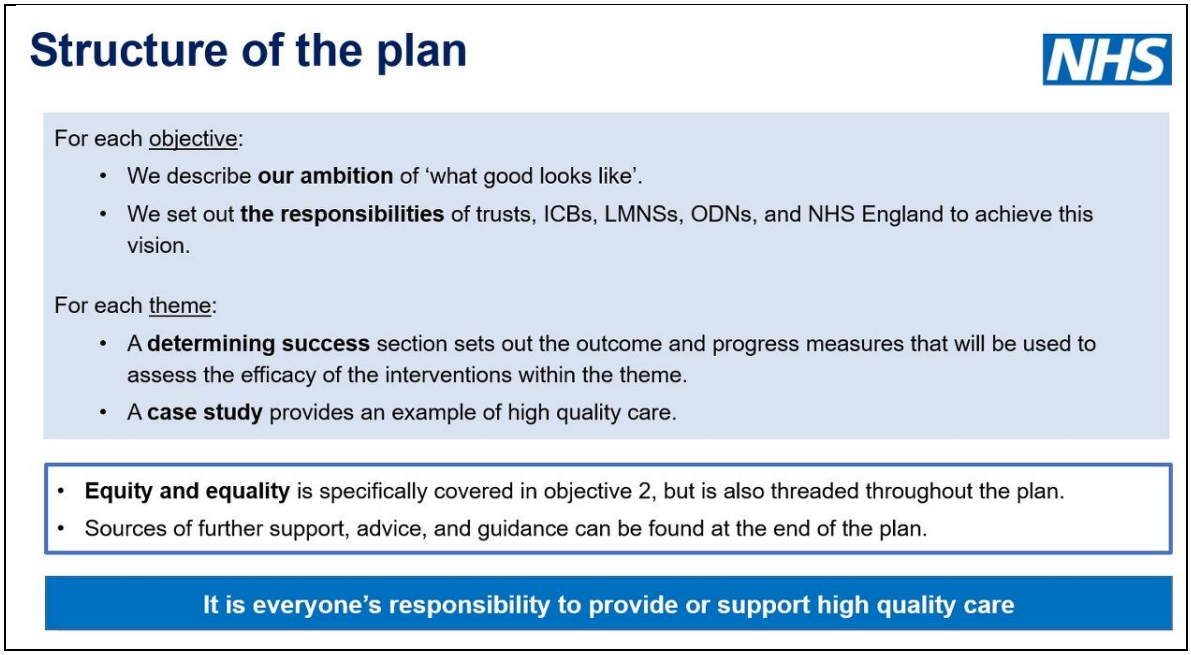
	We have sent probably longer than the average amount of time on the ward. Failed induction, c section, and poorly baby. But can honestly say that every midwife, nurse and everybody else working on the ward has gone above and beyond to make sure that we are comfortable while we were here. Everyone has been kind caring and understanding and just all round amazing people	1	positive
	A very good sweep by Melly in day assessment meant I did not require induction which I was really trying to avoid. Amazing care by Em Farmer she was an advocate for my preferences whilst ensuring both baby and I were safe. I cannot thank Em enough - she made my birth experience such a positive and somehow fun one. All midwives and support staff we have come across have been super helpful and we thank you for everything you have done for us.	1	positive
	All staff very lovely and caring	1	positive
	I couldn't have had a better experience throughout my pregnancy and labour. Everyone is so lovely and I felt well supported throughout labour and the following days spent in hospital.	1	positive
	All the staff were amazing couldn't be more helpful. Kerry was so helpful with all the feeding etc. Including her trainee, all the trainee midwives were amazing. Blonde lady with us A+ Sally and Allie Michelle, Kerry, Rachel thanks for everything in labour as well. Wish all the trainees all the best in your training. Would recommend you all at Dorchester to anyone	1	positive
	I've felt from start to finish everyone has listened to my needs. I was nervous going into my planned c section due to my previous fainting in pregnancy but was put at ease! After becoming unwell during surgery the whole team I felt calmness from and not worried. I would have never have known how much blood loss as there was no panic or change in voices. The midwives after care has been amazing again we have felt listened to and they have acted on anything we have said. So pleased I changed hospitals to Dorchester	1	positive
	Everyone is caring attentive and personable excellent experience from start to finish	1	positive

Three Year Delivery Plan for Maternity and Neonatal Services

On 30 March 2023 NHS England published its three year delivery plan for maternity and neonatal services. The plan sets out a series of actions for Trusts, ICBs and NHS England in order to improve the safety and quality of maternity and neonatal services with a focus on personalised care and equity and equality

Slides below courtesy of the Deputy Director of Maternity and Perinatal Services, ICB





- **Listening to women and families with compassion** which promotes safer care.
- All women will be offered personalised care and support plans. By 2024, every area in England will have specialist care including pelvic health services and bereavement care when needed; and, by 2025, improved neonatal cot capacity.

- During 2023/24, integrated care systems (ICSs) will publish equity and equality plans and take action to reduce inequalities in experience and outcomes.
- From 2023/24, integrated care boards (ICBs) will be funded to involve service users. National policy will be co-produced, keeping service users at the heart of our work

- **Supporting our workforce** to develop their skills and capacity to provide high-quality care.
- Trusts will meet establishment set by midwifery staffing tools and achieve fill rates by 2027/28, with new tools to guide safe staffing for other professions from 2023/24.
- During 2023/24, trusts will implement local evidence-based retention action plans to positively impact job satisfaction and retention.
- From 2023, NHS England, ICBs, and trusts will ensure all staff have the training, supervision, and support they need to perform to the best of their ability

- **Developing and sustaining a culture of safety** to benefit everyone.
- Throughout 2023, effectively implement the NHS-wide "PSIRF" approach to support learning and a compassionate response to families following any incidents.
- By 2024, NHS England will offer a development programme to all maternity and neonatal leadership teams to promote positive culture and leadership.
- NHS England, ICBs, and trusts will strengthen their support and oversight of services to ensure concerns are identified early and addressed.

- **Meeting and improving standards and structures** that underpin our national ambition.
- Trusts will implement best practice consistently, including the updated Saving Babies Lives Care Bundle by 2024 and new "MEWS" and "NEWTT-2" tools by 2025.
- In 2023, NHS England's new taskforce will report on how to better detect and act sooner on safety issues, arising from relevant data, in local services.
- By 2024, NHS England will publish digital maternity standards; services will progress work to enable women to access their records and interact with their digital plans.

Initial response to actions for the Trust

Care that is personalised

Empower maternity and neonatal staff to deliver personalised care so they the time, training, tools, and information, to deliver the ambition above.	Ockenden. 7 features of safety in maternity units.	Lindsey Burningham	Birthrights training roll out. Access to unbiased evidence based current information (staff & women). NBCP.	Care Quality Commission maternity survey results Patient reported experience measure (PREM)
Monitor the delivery of personalised care by undertaking regular audits and seeking feedback from women and parents.	Better Births. MTP.	Kate Nicholson & MNVP	PCSP part of the rolling audit programme	
Consider roll out midwifery continuity of carer in line with the principles NHS England set out in September 2022	Better Births. MTP.	Louise Kayles	1 WTE Lead MW for CoC since 2019. CoC teams well established and provided to approx. 20% women	
Achieve the standard of the UNICEF UK Baby Friendly Initiative (BFI) for infant feeding, or an equivalent initiative, by March 2027.		Emma Barrett	1 WTE BFI Lead + Senior MSW 0.4 WTE. Executive sponsorship. Organisational leadership. Training & education	

Grow our workforce

Undertake regular local workforce planning, using nationally standardised tools where available, to establish the workforce required for each profession at every stage of care. Where trusts do not yet meet the staffing establishment levels set by Birthrate+ or equivalent tools, do so by 2027/28, and in future meet the expectations from nationally recognised tools for for other professions.		Jo Hartley with Sara Collinson		NHS Staff Survey The National Education and Training Survey GMC National Training Survey: Doctors in training
Develop and implement a local plan to fill vacancies, which should include support for newly qualified staff and midwives who wish to return to practice.		Jo Hartley with Pawla Weekes		
Provide administrative support to free up pressured clinical time.		Jo Hartley Selina Willett		

Working with service users to improve care

Involve services users in quality, governance and co-production when planning the design and delivery of maternity and neonatal services	MNVP mandate. Better Births. MTP.		MNVP representative at governance meetings & other forums. Involvement in complaints process. Review of guidelines and leaflets through MNVP.	Care Quality Commission maternity survey results Patient reported experience measure (PREM)

Develop a positive safety culture

Make sure maternity and neonatal leads have the time, access to training and development, and lines of accountability to deliver the ambition above. Including time to engage stakeholders, including MNVP leads.			Governance Lead role 1 WTE. Safety Touchpoint bi monthly. .	NHS Staff Survey GMC National Training Survey: Doctors in training Perinatal Quality Surveillance model (PQSM)
Support all their senior leaders, including board maternity and neonatal safety champions, to engage in national leadership programmes (see below) by April 2024, identifying and sharing examples of best practice.			Momus training for B7 clinical leaders.	
At board level, regularly review progress and support implementation of a focused plan to improve and sustain maternity and neonatal culture.			Safety Champion walkabouts and meetings bi-monthly. Maternity & Neonatal safety & Quality report monthly at quality comittee	
Ensure staff are supported by clear and structured routes for the escalation of clinical concerns, based on frameworks such as the Each Baby Counts: Learn and Support escalation toolkit.				
Ensure all staff have access to Freedom to Speak Up training modules and a Guardian who can support them to speak up when they feel they are unable to in other ways.	PQSM			

Improve equity for mothers and babies

Provide services that meet the needs of their local populations, paying particular attention to health inequalities. This includes facilitating informed decision-making, for example choice of pain relief in labour, ensuring access to interpreter services, and adhering to the Accessible Information Standard in maternity and neonatal settings	RCOG 5X more. MBRRACE report. CDOP findings. Equity and equality Guidance for local maternity systems.	LMNS/Ellie Venton & Lindsey Burningham	Health inequalities Group membership. Wayfinding project. Language Line. BME Pathway. Health inequalities group membership within LMNS. Work with MNVP on service user engagement. Implicit bias training.	Care Quality Commission maternity survey results Patient reported experience measure (PREM)
Collect and disaggregate local data and feedback by population groups to monitor differences in outcomes and experiences for women and babies from different backgrounds and improve care. This data should be used to make changes to services and pathways to address any inequity or inequalities identified.	RCOG 5X more. MBRRACE report. CDOP findings.	Lindsey Burningham	Work with PALS, Power BI and Digital midwife to extrapolate available data. Work with MNVP on engagement initiatives as birth numbers of BME cohorts so low at DCH.	

Learn and improve

Understand 'what good looks like' to meet the needs of their local populations and learn from when things go well and when they do not.			
Respond effectively and openly to patient safety incidents using PSIRF.			Safety Team collaboration; PDM,
Ensure there is adequate time and formal structures to review and share learning, and ensure actions are implemented within an agreed timescale.	PMRT. HSIB. SIs.		Safety Team collaboration; PDM, FML, Audit Lead, Safety Lead. M&M, Gov forums

Further actions to be evaluated from the three year delivery plan

Learn and improve

Establish and maintain effective, kind, and compassionate processes to respond to families who experience harm or raise concerns about their care. This should include a single point of contact for ongoing dialogue with the trust.
Consider culture, ethnicity and language when responding to incidents (NHS England, 2021).
Act, alongside maternity and neonatal leaders, on outcomes data, staff and MNVP feedback, audits, incident investigations, and complaints, as well as learning from where things have gone well.

Value and retain workforce

Identify and address local retention issues affecting the maternity and neonatal workforce in a retention improvement action plan.
Implement equity and equality plan actions to reduce workforce inequalities.
Create an anti-racist workplace, acting on the principles set out in the combatting racial discrimination against minority ethnic nurses, midwives and nursing associates resource
Identify and address issues highlighted in student and trainee feedback surveys, such as the National Education and Training Survey
Offer a preceptorship programme to every newly registered midwife, with supernumerary time during orientation and protected development time. Newly appointed Band 7 and 8 midwives should be supported by a mentor.
Develop future leaders via succession planning, ensuring this pipeline reflects the ethnic background of the wider workforce.

Invest in skills

Undertake an annual training needs analysis and make training available to all staff in line with the core competency framework.
Ensure junior and SAS obstetricians and neonatal medical staff have appropriate clinical support and supervision in line with RCOG guidance and BAPM guidance, respectively.
Ensure temporary medical staff covering middle grade rotas in obstetric units for two weeks or less possess an RCOG certificate of eligibility for short-term locums.

Support and oversight

Maintain an ethos of open and honest reporting and sharing information on the safety, quality and experience of their services.
Regularly review the quality of maternity and neonatal services, supported by clinically relevant data including – at a minimum – the measures set out in the perinatal quality surveillance model and informed by the national maternity dashboard.
Appoint an executive and non-executive maternity and neonatal board safety champion to retain oversight and drive improvement. This includes inviting maternity and neonatal leads to participate directly in board discussions.
Involve the MNVP in developing the trust's complaints process, and in the quality safety and surveillance group that monitors and acts on trends.
At Board level listen to and act on Freedom to Speak Up data, concerns raised and suggested innovations in line with the FTSU Guide and improvement tool.

Standards to inform best practice

Implement version 3 of the Saving Babies' Lives Care Bundle by March 2024 and adopt the national MEWS and NEWTT-2 tools by March 2025
Regularly review and act on local outcomes including stillbirth, neonatal mortality and brain injury, and maternal morbidity and mortality to improve services.
Ensure staff are enabled to deliver care in line with NICE guidelines.
Complete the national maternity self-assessment tool if not already done and use the findings to inform maternity and neonatal safety improvement plans.
Review available data to draw out themes and trends and identify and address areas of concern including consideration of the impact of inequalities.
Ensure high-quality submissions to the Maternity Services Data Set and report information on incidents to NHS Resolution, the Healthcare Safety Investigation Branch and National Perinatal Epidemiology Unit.
Have and be implementing a digital maternity strategy and digital roadmap in line with the NHS England What Good Looks Like Framework.

Aim to ensure that any neonatal module specifications include standardised collection and extraction of neonatal national audit programme data and the neonatal critical care minimum data set.

INTEGRITY | RESPECT | TEAMWORK | EXCELLENCE

NHS
Dorset County Hospital
NHS Foundation Trust

Report Front Sheet

1. Report Details			
Meeting Title:	Board of Directors, Part 1		
Date of Meeting:	31 May 2023		
Document Title:	Workforce Race Equality Standard Report 2023		
Responsible Director:	Nicola Plumb – Chief People Officer Emma Hallett - Deputy Chief People Officer	Date of Executive Approval	14 May 2023 (EH)
Author:	Ebi Sosseh – Inclusion Lead		
Confidentiality:	No		
Publishable under FOI?	Yes		
Predetermined Report Format?	No		

2. Prior Discussion		
Job Title or Meeting Title	**Date**	**Recommendations/Comments**
People and Culture Committee	22 May 2023	Approval for data to be submitted to Board without the action plan

3. Purpose of the Paper	To note and approve the Dorset County Hospital (DCH) Workforce Race Equality Standard Report 2023.							
	Note (✓)	✓	*Discuss (✓)*		*Recommend (✓)*		*Approve (✓)*	✓
4. Key Issues	This summary provides an overview of our annual performance against the Workforce Race Equality Standard (WRES) metrics for 2022-23. The data will be published on our public website, along with our narrative and action plan, in line with regulatory requirements. Overall, there are nine indicators which make up the NHS WRES. These comprise workforce indicators from the ESR (1-4), Staff Survey indicators (5-8) and an indicator based on Board representation (9) around Band representation, values and behaviours, recruitment practices and training. Overall, we have seen improvements in five indicators and need further improvements in four - the data is attached at Annex A & B of the main report. The rolling WRES action plan has been incorporated into our trust-wide EDI action plan and will be complimented by a comprehensive suite of staff development activities and plans aimed at developing inclusive behaviours and practices across the organisation. This is shown at Annex C of the main report. The Board is recommended to note and approve the Workforce Race Equality Standard Report 2023.							
5. Action recommended	The Board is recommended to: 1. **NOTE** the Workforce Race Equality Standard Report 2023 2. **APPROVE** the Workforce Race Equality Standard Report 2023							

6. Governance and Compliance Obligations				
Legal / Regulatory Link		**Yes**		The general equality duty is set out in section 149 of the Equality Act 2010. Public organisations including NHS Trusts are subject to the general duty and must have due regard to the need to: eliminate unlawful: discrimination, harassment and victimisation. The Public Sector Equality Duty (PSED) requires public bodies to have due regard to the need to eliminate discrimination, advance equality of opportunity and foster good relations between different people when carrying out their activities.
Impact on CQC Standards		**Yes**		Development of fair and inclusive leadership, practice and culture contributes to the 'Well Led' CQC Domain. Inclusive workplaces report better staff health and wellbeing, which is linked to markedly higher patient satisfaction and better patient outcomes, meaning that there is potential for progress in EDI work to positively contribute to all CQC Domains
Risk Link		**Yes**		Non-compliance with the PSED would create risks for the organisation in terms of reputation and potential fines.
Impact on Social Value		**Yes**		Championing Equality, Diversity and Inclusion is a key ambition of 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	People, Place, Partnership – The Workforce Race Equality Standard Report 2023 signals our intention to truly value our ethnically diverse staff. Our people are our most important asset, and we want them to feel valued, welcomed, respected, they belong and matter. We recognise the link between high levels of staff satisfaction and improving patient experience and outcomes.		
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**		Target the focus on segmenting our population and providing bespoke outcomes for our patients
Tackling unequal outcomes and access		**Yes**		Deliver equitable services that are informed by engagement and involvement
Enhancing productivity and value for money		**Yes**		Avoids waste and enhance productivity through a better understanding of staff and patients' diverse needs
Helping the NHS to support broader social and economic development		**Yes**		Ensures equity in the allocation of resources towards our diverse population whether it is staff or patients
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**	

Workforce Race Equality Standard Report

2022-23

Introduction

This paper provides an overview of our annual performance against the Workforce Race Equality Standard (WRES) metrics for 2022-23. The data will be published on our public website, along with our action plan, in line with regulatory requirements.

The NHS Equality and Diversity Council (EDC) introduced WRES as a framework for NHS Trusts to focus specifically on race. This was in response to the 2014 study by Roger Kline titled 'The snowy white peaks of the NHS', which highlighted the link between good patient care and an NHS workforce that is representative of the local population it serves.

It is recognised that Dorset has a lower BME demographic (around 5%) than BME staff population at Dorset County Hospital Foundation Trust (15%). It is expected that the staff BME figure will continue to rise over the next few years due to increasing overseas recruitment needed to fill key posts.

The WRES came into effect on 1st April 2015. The standard is designed to improve the representation and experience of Black and Minority Ethnic (BME) staff at all levels of the organisation and to scrutinise and improve BME representation at senior levels. In the context of WRES, White staff comprises White British, White Irish and White Other (Ethnic codes A, B & C), whereas BME staff comprise all other categories except 'not stated'.

Overall, there are nine indicators which make up the NHS WRES. These comprise workforce indicators (1-4), Staff Survey indicators (5-8) and an indicator based on Board representation (9):

1	Percentage of BME staff
2	Relative likelihood of white applicants being appointed from shortlisting across all posts compared to BME applicants
3	Relative likelihood of BME staff entering the formal disciplinary process compared to white staff
4	Relative likelihood of white staff accessing non-mandatory training and continuous professional development (CPD) compared to BME staff
5	Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months
6	Percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months
7	Percentage of staff believing that their trust provides equal opportunities for career progression or promotion
8	Percentage of staff personally experiencing discrimination at work from a manager/team leader or other colleagues
9	BME board membership

The 2022-23 WRES data for Dorset County Hospital is based on staff who have an ethnicity recorded on the Trust's Electronic Staff Records. We currently have data on the ethnic origins of 95.37% of our workforce. We plan to contact the other 4.63% of staff to encourage them to disclose their ethnicity to improve the accuracy of our data by the end of 2023.

- **Indicator 1** is based on data recorded on ESR on a snapshot date: 31st March 2023.
- **Indicators 2 - 3** are based on known data from HR records for the period 1st April 2022 to 31st March 2023.
- **Indicator 4** is based on data recorded on ESR for the period 1st April 2022 – 31st March 2023
- **Indicators 5 – 8** are lifted from national NHS Survey data which was collected over a two-month period from early October – early December 2022 (the NHS Staff Survey Results were published 9h March 2023)

- **Indicator 9** is based on data recorded on ESR on a snapshot date: 31st March 2023

The rate of BME respondents for indicators 5-8 (from the national staff survey) averaged 168.

The WRES is now mandated as part of the standard NHS Contract and this supports closer scrutiny of the progress we make and outcomes we achieve. Non-compliance with the WRES would create risks for the organisation in terms of reputation, but more importantly, in terms of the wellbeing of the overall workforce.

Overview of changes since 2022/23 data

Developing an inclusive culture at DCH continues to be a key priority within our People Plan. During the last 12 months the programme of work supporting this has gained momentum. Training around intercultural communication for both L1 (speaker's first language) and L2 (speaker's second language) speakers has taken place. The onboarding package for overseas nurses has improved as well with supporting including a buddying system, a 'Letter of Guarantee' when seeking accommodation and pastoral support from the preceptorship team. The Dorset ICB-lead 'Beyond Difference' leadership programme aimed at ethnically diverse staff has also proven to be beneficial for those seeking to progress within their careers. The Reciprocal Mentoring programme matching senior leaders with members of our ethnic diverse DCH staff around creating change has continued and is gathering momentum.

Overall, the organisation has improved in five indicators and need to make more progress in four indicators. The data is attached at **Annex A**.

Narrative and Implication of the data

Key Indicator 1: *Percentage of staff in each of the AfC Bands 1-9 or Medical & Dental subgroups and VSM (including Executive Board members) compared with the % of staff in the overall workforce*

Ethnically diverse numbers have **increased** from 564 in 2021/22 to 679 at the end of March 2023 (2%). There are increased numbers in each of the clinical staff bandings especially within 5-7, with a 2% increase in Band 6 from the previous year, and 16 members of staff in Band 7 compared to 14, the previous year.

Key Indicator 2: *Relative likelihood of White staff being appointed from shortlisting compared to BME staff*

The gap between being appointed following shortlisting for jobs have slightly **widened** from 1.01 the previous year to white staff being 1.51 more likely to be appointed from shortlisting than their BME counterparts.

Key Indicator 3: *Relative likelihood of BME staff entering the formal disciplinary process compared to White staff (Note: This Indicator will be based on data from a two-year rolling average of the current year and the previous year)*

There is **no ratio difference** between white and BME staff into entering the formal disciplinary process this year. The figure stands at 0. This is positive bearing in mind the national trends of negative experiences of ethnically diverse staff within this indicator.

Key Indicator 4: *Relative likelihood of White staff accessing non-mandatory training & CPD compared to BME staff*

The likelihood ratio has slightly **increased** from 0.95 to 1.05. this means that White staff are more likely than BME colleagues to access non-mandatory training and CPD.

Key Indicator 5: *Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months*

The percentage of ethnically diverse staff who have experienced bullying from patients, relatives or the public has **decreased** by 4% from last year to 29.8%. the difference between white and BME staff has narrowed to 5% as well.

Key Indicator 6: Percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months

The percentage has **increased** by over 3% from the previous year (29.1% to 32.4%) but is still significantly lower than in 2020.The gap between white and BME staff for this indicator is getting wider and is now 7.5%.

Key Indicator 7: Percentage of staff believing that the Trust provides equal opportunities for career progression and promotion

The % of staff who believe that the Trust provides equal opportunities for career progression and promotion **reduced** by 8% from the previous year compared to a decrease of 2% from white members of staff.

Key Indicator 8: *In the last 12 months have you personally experienced discrimination at work from any of the following? Manager/Team Leader or other colleagues.*

16.6 % of ethnically diverse staff have felt discriminated by their managers/leaders and the rates have **decreased** by 2.1% from the previous year (18.7%). We have to be mindful though that this figure is still 10.5% more than for white counterparts.

Key Indicator 9: *Percentage difference between the organisation's Board voting membership & its overall workforce*

There is one member of the board who is from an ethnically diverse background. The **overall % difference** between the organisation's Board voting membership & its overall workforce by ethnicity is -4%.

Next steps

Not all the narrative around our ethnically diverse staff is captured within the WRES framework and data. The number of respondents to the 2022 Staff Survey accounts for just one third of the 2022 BME group. Our next steps will be to continue developing the opportunities for our staff to share their views around civility, career progression and development and for us to record and monitor concerns and progress on a more consistent basis. Notwithstanding we will continue to focus on the following as well:

- Increase Communication and Engagement about the WRES to all staff
- Encourage more staff to fill in the staff survey and declare their ethnicity status
- More visible campaigns around dignity and respect across departments and teams
- Include the WRES indicators into the Workforce Business Partners dashboard so as to increase its visibility
- Recommend the development of a panel to investigate reported incidents of bullying and harassment

Achieving inclusion and equity remains central to our mission to deliver outstanding care, support staff development, and reduce health inequalities.

Annex A

WRES Indicators	2019/20	2020/21	2021/22	2022/23
Indicator 1 Percentage of staff in each of the AfC Bands 1-9 or Medical & Dental subgroups and VSM (including Executive Board members) compared with the % of staff in the overall workforce **See Annex B for detailed breakdown for 2021/22**	White: 3365 BME: 364 Unknown: 170 Total staff: 3903 **Overall BME%: 9.33**	White: 3474 BME: 380 Unknown: 196 Total staff: 4052 **Overall BME %: 9.38**	White: 3486 BME: 564 Unknown: 199 Total staff: 4249 **Overall BME %: 13.27**	White: 3564 BME: 679 Unknown: 186 Total staff: 4429 **Overall BME %: 15.33**
Indicator 2 Relative likelihood of being appointed from shortlisting across all posts ***Relative likelihood of White staff being appointed from shortlisting compared to BME staff***	White: 216 (25.06%) BME: 18 (11.18%) **Difference: 14%** ***Likelihood ratio: 2.24***	White: 382 (53%) BME: 83 (47%) **Difference: 6%** ***Likelihood ratio: 1.12***	White: 1324 (69%) BME: 427 (68%) **Difference: 1%** ***Likelihood ratio: 1.01***	White: 1122(44%) BME: 263 (29%) **Difference: 15%** ***Likelihood ratio: 1.51***
Indicator 3 The relative likelihood of staff entering the formal disciplinary process, as measured by entry into a formal disciplinary investigation ***Relative likelihood of BME staff entering the formal disciplinary process compared to White staff***	White: 26 (0.77%) BME: 0 (0.00%) **Difference: 0%** ***Likelihood ratio: 0.00***	White: 19 (0.55%) BME: 3 (0.79%) **Difference: 0.24%** ***Likelihood ratio: 1.44***	White: 17 (1%) BME: 3 (1%) **Difference: 0%** ***Likelihood ratio: 1***	White: 17 0.4%) BME: 6(0.8%) **Difference: 0%** ***Likelihood ratio: 0***
Indicator 4 Relative likelihood of staff accessing non-mandatory training and CPD ***Relative likelihood of White staff accessing non-mandatory training & CPD compared to BME staff***	White: 188 (5.59%) BME: 33 (9.07%) ***Likelihood ratio: 0.62***	White: 379 (10.91%) BME: 46 (12.11%) ***Likelihood ratio: 0.90***	White: 1573 (57%) BME: 316 (60%) ***Likelihood ratio: 0.95***	White: 2779 (77%) BME: 503 (74%) **Difference: 3%** ***Likelihood ratio: 1.05***

Indicator 5 % of staff experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months	White: 24.3% BME: 25.3% **Difference: 1.0%**	White: 21.4% BME: 27.5% **Difference: 6.1%**	White: 24.5% BME: 34% **Difference: 9.5%**	White: 25% BME: 29.8% **Difference: 4.8%**
Indicator 6 % of staff experiencing harassment, bullying or abuse from staff in the last 12 months	White: 23.0% BME: 36.8% **Difference: 13.8%**	White: 26.2% BME: 40.4% **Difference: 14.2%**	White: 26.0% BME: 29.1% **Difference: 3.1%**	White: 24.9% BME: 32.4% **Difference: 7.5%**
Indicator 7 % of staff believing that the Trust provides equal opportunities for career progression and promotion	White: 91.8% BME: 84.3% **Difference: 7.5%**	White: 90.5% BME: 67.2% **Difference: 23.3%**	White: 62.6% BME: 55% **Difference: 7.6%**	White: 60.7% BME: 47% **Difference: 13.7%**
Indicator 8 In the last 12 months have you personally experienced discrimination at work from any of the following? Manager/Team Leader or other colleagues	White: 4.7% BME: 18.6% **Difference: 13.9%**	White: 6.6% BME: 20.0% **Difference: 13.4%**	White: 5.6% BME: 18.7% **Difference: 13.1%**	White: 6.1% BME: 16.6% **Difference: 10.5%**
Indicator 9 % **difference** between the organisation's Board voting membership & its **overall workforce**	White: 90.9% **Difference: 5.4%** BME: 9.1% **Difference: -1.0%**	White: 86.7% **Difference: 0.9%** BME: 13.3% **Difference: 4.0%**	White: 93% **Difference: 13%** BME: 7% **Difference: -8%**	White: 91% **Difference: 10%** BME: 8.3% **Difference: -4.2%**

Annex B Workforce Metrics – Indicator 1

2022-23 Workforce data

ow cells which turn white when filled. alculated. Blue cells are for notes.		Snapshot of data as at 31st MARCH 2023						
		White staff		BME staff		Ethnicity Unknown		Overall
	Measure	# White	% White	# BME	% BME	# Unknown	% Unknown/ Null	Total
1a) Non Clinical Staff								
Under Band 1	Headcount	0	0.0%	0	0.0%	0	0.0%	0
Bands 1	Headcount	14	87.5%	2	12.5%	0	0.0%	16
Bands 2	Headcount	1027	88.5%	104	9.0%	30	2.6%	1161
Bands 3	Headcount	471	92.2%	24	4.7%	16	3.1%	511
Bands 4	Headcount	199	76.8%	50	19.3%	10	3.9%	259
Bands 5	Headcount	91	90.1%	8	7.9%	2	2.0%	101
Bands 6	Headcount	50	92.6%	3	5.6%	1	1.9%	54
Bands 7	Headcount	46	86.8%	4	7.5%	3	5.7%	53
Bands 8a	Headcount	36	92.3%	1	2.6%	2	5.1%	39
Bands 8b	Headcount	20	87.0%	0	0.0%	3	13.0%	23
Bands 8c	Headcount	6	75.0%	0	0.0%	2	25.0%	8
Bands 8d	Headcount	6	85.7%	1	14.3%	0	0.0%	7
Bands 9	Headcount	3	100.0%	0	0.0%	0	0.0%	3
VSM	Headcount	0	0.0%	0	0.0%	0	0.0%	0
Other. Please specify in notes.	Headcount	12	80.0%	2	13.3%	1	6.7%	15
Cluster 1: AfC Bands <1 to 4	Auto-Calculated	1711	87.9%	180	9.2%	56	2.9%	1947
Cluster 2: AfC bands 5 to 7	Auto-Calculated	187	89.9%	15	7.2%	6	2.9%	208
Cluster 3: AfC bands 8a and 8b	Auto-Calculated	56	90.3%	1	1.6%	5	8.1%	62
Cluster 4: AfC bands 8c to VSM	Auto-Calculated	15	83.3%	1	5.6%	2	11.1%	18
Total Non-Clinical	Auto-Calculated	1981	88.0%	199	8.8%	70	3.1%	2250
1b) Clinical Staff								
Under Band 1	Headcount	0	0.00%	0	0.00%	0	0.00%	0
Bands 1	Headcount	0	0.00%	0	0.00%	0	0.00%	0
Bands 2	Headcount	0	0.00%	0	0.00%	0	0.00%	0
Bands 3	Headcount	1	100.00%	0	0.00%	0	0.00%	1
Bands 4	Headcount	11	100.00%	0	0.00%	0	0.00%	11
Bands 5	Headcount	388	61.30%	197	31.12%	48	7.58%	633
Bands 6	Headcount	458	87.07%	55	10.46%	13	2.47%	526
Bands 7	Headcount	290	91.77%	16	5.06%	10	3.16%	316
Bands 8a	Headcount	67	90.54%	3	4.05%	4	5.41%	74
Bands 8b	Headcount	18	100.00%	0	0.00%	0	0.00%	18
Bands 8c	Headcount	4	100.00%	0	0.00%	0	0.00%	4
Bands 8d	Headcount	4	100.00%	0	0.00%	0	0.00%	4
Bands 9	Headcount	0	0.00%	0	0.00%	0	0.00%	0
VSM	Headcount	0	0.00%	0	0.00%	0	0.00%	0
Other. Please specify in notes.	Headcount	0	0.0%	0	0.0%	0	0.0%	0
Cluster 1: AfC Bands <1 to 4	Auto-Calculated	12	100.0%	0	0.0%	0	0.0%	12
Cluster 2: AfC bands 5 to 7	Auto-Calculated	1136	77.0%	268	18.2%	71	4.8%	1475
Cluster 3: AfC bands 8a and 8b	Auto-Calculated	85	92.4%	3	3.3%	4	4.3%	92
Cluster 4: AfC bands 8c to VSM	Auto-Calculated	8	100.0%	0	0.0%	0	0.0%	8
Total Clinical	Auto-Calculated	1241	78.2%	271	17.1%	75	4.7%	1587
Medical & Dental Staff, Consultants	Headcount	122	62.56%	47	24.10%	26	13.33%	195
Medical & Dental Staff, Non-Consultants career grade	Headcount	51	51.00%	40	40.00%	9	9.00%	100
Medical & Dental Staff, Medical and dental trainee grades	Headcount	184	54.93%	124	37.01%	27	8.06%	335
Total Medical and Dental	Auto-Calculated	357	56.67%	211	33.49%	62	9.84%	630
Number of staff in workforce	Auto-Calculated	3579	80.12%	681	15.25%	207	4.63%	4467

Report Front Sheet

1. Report Details			
Meeting Title:	Board of Directors, Part 1		
Date of Meeting:	31 May 2023		
Document Title:	Workforce Disability Equality Standard Report 2023		
Responsible Director:	Nicola Plumb –Chief People Officer Emma Hallett - Deputy Chief People Officer	Date of Executive Approval	14 May 2023 (EH)
Author:	Ebi Sosseh – Inclusion Lead		
Confidentiality:	No		
Publishable under FOI?	Yes		
Predetermined Report Format?	No		

2. Prior Discussion		
Job Title or Meeting Title	**Date**	**Recommendations/Comments**
People and Culture Committee	22 May 2023	Approval for data to be submitted to Board without the action plan

3. Purpose of the Paper	To note and approve the Dorset County Hospital (DCH) Workforce Race Equality Standard Report 2023.							
	Note (✓)	✓	*Discuss (✓)*		*Recommend (✓)*		*Approve (✓)*	✓
4. Key Issues	The WDES is a data-based standard and uses a series of ten measures (metrics) to improve the experiences of disabled staff in the NHS. The ten key metrics comprise workforce metrics (1-3), Staff Survey metrics (4-9a), narrative evidence of actions taken (9b) and a metric based on Board representation (10). The WDES is mandated by the NHS Standard Contract and applies to all NHS Trusts and Foundation Trusts. The data and narrative will be published on our public website, along with our action plan, in line with regulatory requirements. Annex A of attached report provides detail of the WDES National Metrics and Annex B is the Action Plan. The WDES actions have also been included in the overarching EDI Strategy Action Plan. Overall, we have seen improvements in four metrics/sub-metrics and declines in all other metrics. Action is already underway to target areas of concern. The Board is recommended to note and approve the Workforce Disability Equality Standard Report 2023.							
5. Action recommended	The People and Culture Committee is recommended to: 1. **NOTE** the Workforce Disability Equality Standard Report 2023 2. **APPROVE** the Workforce Disability Equality Standard Report 2023							

6. Governance and Compliance Obligations				
Legal / Regulatory Link		**Yes**		The general equality duty is set out in section 149 of the Equality Act 2010. Public organisations including NHS Trusts are subject to the general duty and must have due regard to the need to: eliminate unlawful: discrimination, harassment and victimisation. The Public Sector Equality Duty (PSED) requires public bodies to have due regard to the need to eliminate discrimination, advance equality of opportunity and foster good relations between different people when carrying out their activities.
Impact on CQC Standards		**Yes**		Development of fair and inclusive leadership, practice and culture contributes to the 'Well Led' CQC Domain. Inclusive workplaces report better staff health and wellbeing, which is linked to markedly higher patient satisfaction and better patient outcomes, meaning that there is potential for progress in EDI work to positively contribute to all CQC Domains
Risk Link		**Yes**		Non-compliance with the PSED would create risks for the organisation in terms of reputation and potential fines.
Impact on Social Value		**Yes**		Championing Equality, Diversity and Inclusion is a key ambition of 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	People, Place, Partnership – The Workforce Disability Equality Standard Report 2023 signals our intention to truly value our disabled staff. Our people are our most important asset, and we want them to feel valued, welcomed, respected, they belong and matter. We recognise the link between high levels of staff satisfaction and improving patient experience and outcomes.		
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**		Target the focus on segmenting our population and providing bespoke outcomes for our patients
Tackling unequal outcomes and access		**Yes**		Deliver equitable services that are informed by engagement and involvement
Enhancing productivity and value for money		**Yes**		Avoids waste and enhance productivity through a better understanding of staff and patients' diverse needs
Helping the NHS to support broader social and economic development		**Yes**		Ensures equity in the allocation of resources towards our diverse population whether it is staff or patients
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**	

Workforce Disability Equality Standard Report

2022-23

Introduction

This paper provides an overview of our annual performance against the Workforce Disability Equality Standard (WDES) metrics for 2022-23. The data will be published on our public website, along with our action plan, in line with regulatory requirements.

The WDES is mandated by the NHS Standard Contract and applies to all NHS Trusts and Foundation Trusts. This supports closer scrutiny of the progress we make and outcomes we achieve. Non-compliance with the WDES would create risks for the organisation in terms of reputation, but more importantly, in terms of the wellbeing of the overall workforce. In the spirit of transparency and continuous improvement, national health organisations adopted the WDES in autumn 2020.

The WDES is a data-based standard and uses a series of ten measures (metrics) to improve the experiences of Disabled staff in the NHS. All the metrics draw from existing data sources (recruitment dataset, staff records, NHS Staff Survey, local HR data) with the exception of one; metric 9b asks for narrative evidence of actions taken, to be written into the Trust's WDES annual report.

The ten key metrics comprise workforce metrics (1-3), Staff Survey metrics (4-9a) and a metric based on Board representation (10).

	The NHS Workforce Disability Equality Standard Metrics
1	Percentage of staff in each of the AfC Bands 1-9 or Medical & Dental subgroups and VSM (including Executive Board members) compared with the % of staff in the overall workforce
2	Relative likelihood of non-Disabled staff compared to Disabled staff being appointed from shortlisting across all posts
3	Relative likelihood of Disabled staff compared to non-disabled staff entering the formal capability process, as measured by entry into the formal capability procedure.
4	Percentage of Disabled staff compared to non-disabled staff experiencing harassment, bullying or abuse *I. From patients/service users, their relatives or other members of the public* II. *From Managers* III. *From other colleagues*
5	Percentage of Disabled staff compared to non-disabled staff believing that the Trust provides equal opportunities for career progression and promotion
6	Percentage of Disabled staff compared to non-disabled staff saying they have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties
7	Percentage of Disabled staff compared to non-disabled staff saying that they are satisfied with the extent to which their organisation values their work
8	Percentage of Disabled staff saying that their employer has made adequate adjustment(s) to enable them to carry out their work
9	NHS Staff Survey and the engagement of Disabled Staff *Part (a): The engagement score for Disabled staff, compared to non-disabled staff* *Part (b): Has your Trust taken action to facilitate the voices of Disabled staff in your organisation to be heard?*
10	Percentage difference between the organisation's Board voting membership and its organisation's overall workforce, disaggregated: *(a) By Voting Membership of the Board* (b) *By Executive membership of the Board*

The 2022-23 WDES data for Dorset County Hospital is based on staff who have a disability recorded on the Trust's Electronic Staff Records and we currently have data indicating 4.28% of our workforce have a disability, which is an improvement in disclosure from the previous year.

- **Indicator 1** is based on data recorded on ESR on a snapshot date: 31st March 2023.
- **Indicators 2 - 3** are based on known data from HR records for the period 1st April 2022 to 31st March 2023

- **Indicator 4-9** are based on the NHS Survey data which was collected over a two-month period from early October – early December 2022 (the NHS Staff Survey Results were published 30th March 2023)
- **Indicator 10** is based on data recorded on ESR on a snapshot date: 31st March 2023

Overview of changes since 2021/22 data

Developing an inclusive culture at DCH continues to be a key priority within our People Plan. During the last 12 months the programme of work supporting this has gained momentum. The disability staff support network has made good progress in raising awareness about disability issues including the design of a health passport for staff and helping to implement the Accessible Information Standard. Training has also been provided to line managers around how to best support staff with disabilities and around autism.

To improve the experience of people with disabilities, we need to encourage more disabled staff to share that they have a long-term condition or disability so that we can appreciate the numbers and track our progress via a number of parameters.

It is important to continue the improvement seen in the relative likelihood of disabled staff being recruited into the organisation compared to non-disabled staff. However, engagement survey results for disabled employees show a need for improved opportunities for career development, better experience of feeling valued, greater access to workplace adjustments and amplification of the disability and neurodiversity networks' profile.

Narrative – the implications of the data

The data is attached at Annex A and the WDES Action Plan is shown at Annex B. These actions have been incorporated into the EDI Action Plan which supports the implementation of our EDI strategy.

Metric 1: *Percentage of staff in each of the AfC Bands 1-9 or Medical & Dental subgroups and VSM (including Executive Board members) compared with the % of staff in the overall workforce*

The number of staff identifying as having a disability has **increased** from 3.67% in 21/22 to 4.28% in 22/23- an increase of 0.67% across the overall workforce. The clinical staff numbers at bands 5-7 have remained very similar to last year's figures.

We know from our 2022 Staff Survey that 25.9% of respondents stated they have a physical or mental health condition or disability which is expected to last more than 12 months. Our EDI Plan & actions will support increased disclosure over time to improve accuracy of ESR data.

Due to low ESR disclosure numbers, no conclusions can be drawn from this data. A breakdown of workforce data for 2022-23 is shown at Annex A.

Metric 2: *Relative likelihood of non-Disabled staff compared to Disabled staff being appointed from shortlisting across all posts*

Our likelihood ratio of 0.38 in 2020/21 has **increased** to 1.14 in 2022/23 in regard to the likelihood of non-Disabled staff compared to Disabled staff being appointed from shortlisting across all posts.

Metric 3: *Relative likelihood of Disabled staff compared to non-disabled staff entering the formal capability process, as measured by entry into the formal capability procedure.*

Our likelihood percentage of 1.85% in 2021/22 has **increased** to 4.24% in 2022/23. High relative likelihoods can be obtained due to the small proportion of the workforce that has declared a disability on ESR. If the number of Disabled staff in the capability process is small (say less than 10), **it is highly unlikely there are any fundamental issues. This year there were two cases within the Trust.**

Metric 4a: *Percentage of Disabled staff compared to non-disabled staff experiencing harassment, bullying or abuse*
(i) From patients/service users, their relatives or other members of the public

This data shows a **decrease** of 3.9% for disabled staff for the year, with 28.8% of disabled staff reporting this behaviour. There is a 4.3% difference with non-disabled staff.

(ii) From Managers

This data shows a **decrease** of 1.2% from last year, with 16% of disabled staff saying they had experienced harassment, bullying or abuse from managers. The disparity between Disabled and non-disabled staff has narrowed down to 6%, a 2% improvement on last year. This remains an area of focus for attention and the Trust welcomes the fact that more staff feel able to express their views.

It is worth reminding ourselves that whilst our ESR shows that 4.28% of staff have a disability, metrics 4-9a are taken from our Staff Survey where 25.9% of staff have declared themselves to be Disabled (or to have a long-term condition), so these figures represent a significant number of staff reporting unacceptable behaviour.

(iii) From other colleagues

This data shows an **increase** of 2.3% from last year, with 28.8% of disabled staff saying they had experienced harassment, bullying or abuse from other colleagues. This figure is in line with the national average of 26.5%. This also resulted in the disparity between disabled and non-disabled staff increasing to 9.9%, which shows some progress but remains an area of focus.

Metric 4b: *Percentage of Disabled staff compared to non-disabled staff saying the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it*

52% of disabled staff said that they reported incidents – this is a 2% **increase** from the previous year and is a positive trend over consecutive years. All staff will continue to be encouraged to report incidents to help us target action accordingly.

Metric 5: *Percentage of Disabled staff compared to non-disabled staff believing that the Trust provides equal opportunities for career progression and promotion*

59.1% of disabled staff reported on this metric, showing a 1.8% **decrease** from the previous year. The Trust's Staff Survey results for this metric for disabled and non-disabled staff remain higher than the national average for Acute Trusts. This is consistent with staff with non-disabled staff (58.6%).

Career planning and development discussions are included in the new shortened appraisal process and skills training for managers is underway as part of the Management Matters programme. A tailored career development programme for disabled staff (similar to that in place for internationally educated nurses) will be considered.

Metric 6: *Percentage of Disabled staff compared to non-disabled staff saying they have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties*

The data shows a slight **increase** for disabled staff of 1.2% resulting in 28.6% saying they have felt pressurised to come to work. The difference is 10.6% in contrast to non-disabled staff.

Metric 7: *Percentage of Disabled staff compared to non-disabled staff saying that they are satisfied with the extent to which their organisation values their work*

Satisfaction has **decreased** by 3.3% to 36.5% for Disabled staff and also shows a 9.9% gap with non disabled staff.

Metric 8: *Percentage of Disabled staff saying that their employer has made adequate adjustment(s) to enable them to carry out their work*

This shows a 2.2% **reduction** on last year, but the current score of 71.9% is still just above the national average for Acute Trusts.

Metric 9: *NHS Staff Survey and the engagement of Disabled Staff*

Part (a): The engagement score for Disabled staff, compared to non-disabled staff

This metric has **declined** for disabled and decreased for non-disabled staff, resulting in a **negative** disparity gap of **-0.5%.**

Part (b): Has your Trust taken action to facilitate the voices of Disabled staff in your organisation to be heard?

We answered **'yes'** to this question. We have a 'Without Limits ' Staff Support Network who meet regularly to advocate for their members to have the necessary adjustments and supportive environment at work. The network chair has a standing agenda item at the EDI steering group.

The network has already made positive strides towards improving the experience of disabled staff. Examples include:

(a) Raising awareness about autism across the trust.
(b) Co-designing a Health Passport for all staff
(c) Supporting the delivery of the Accessible Information Standard

Metric 10: *Percentage difference between the organisation's Board voting membership and its organisation's overall workforce, disaggregated:*

(c) By Voting Membership of the Board (8.33%)
(d) By Executive membership of the Board (7.14%)

This is a total difference of + 2.86% compared to the overall disabled workforce, a positive increase from previous year.

Next steps

Next steps will be to align the following activities to the WDES indicators with a view to showing improvements over the next 12-18 months:

- Campaign to encourage more disclosure of disability status on ESR.
- Participate in the NHS Employers Equality and Inclusion Partners Programme
- Develop an Equality Diversity Representatives programme at each stage of the recruitment process.
- Review the system for making Reasonable Adjustments requests.

More is shown at Annex B.

The EDI strategy and action plan are regularly reviewed and refined as we measure impact using quantitative and qualitative data as part of the monthly People Dashboard.

The WDES findings will be shared with the Without Limits Staff Network and EDI steering group to test if there is anything missing from our Action Plan, to further improve the experience of Disabled staff across the Trust.

Annex A - WDES National Metrics Report

Detailed below is the organisation's WDES data which will be submitted in May 2023 covering the period 1 April 2022 – 31 March 2023.
Where data is available, year-on-year comparisons have been made.

Metric 1: Percentage of staff in AfC pay bands or medical and dental subgroups and very senior managers (including Executive Board members) compared with the percentage of staff in the overall workforce. (Data source: ESR)

N.B. Due to the low percentage of staff recorded with a disability on ESR (4.28%), it was not possible to draw any conclusions from this. This low percentage also presented a risk of identifying individuals at particular grades, so the majority of the data for Metric 1 has had to be presented as overall figures.

calculated. Blue cells are for notes.

	Measure	Disabled staff		Non-disabled staff		Disability Unknown or Null		Overall
		# Disabled	% Disabled	# Non-disabled	% Non-disabled	# Unknown/ Null	% Unknown/ Null	Total
1a) Non Clinical Staff								
Under Band 1	Headcount	0	0.0%	0	0.0%	0	0.0%	0
Bands 1	Headcount	0	0.0%	9	56.3%	7	43.8%	16
Bands 2	Headcount	56	4.8%	990	85.3%	115	9.9%	1161
Bands 3	Headcount	30	5.9%	426	83.4%	55	10.8%	511
Bands 4	Headcount	13	5.0%	213	82.2%	33	12.7%	259
Bands 5	Headcount	4	4.0%	85	84.2%	12	11.9%	101
Bands 6	Headcount	4	7.4%	41	75.9%	9	16.7%	54
Bands 7	Headcount	2	3.8%	44	83.0%	7	13.2%	53
Bands 8a	Headcount	1	2.6%	34	87.2%	4	10.3%	39
Bands 8b	Headcount	0	0.0%	18	78.3%	5	21.7%	23
Bands 8c	Headcount	0	0.0%	6	75.0%	2	25.0%	8
Bands 8d	Headcount	1	14.3%	6	85.7%	0	0.0%	7
Bands 9	Headcount	0	0.0%	2	66.7%	1	33.3%	3
VSM	Headcount	0	0.0%	0	0.0%	0	0.0%	0
Other. Please specify in notes.	Headcount	0	0.0%	12	80.0%	3	20.0%	15
Cluster 1: AfC Bands <1 to 4	Auto-Calculated	99	5.1%	1638	84.1%	210	10.8%	1947
Cluster 2: AfC bands 5 to 7	Auto-Calculated	10	4.8%	170	81.7%	28	13.5%	208
Cluster 3: AfC bands 8a and 8b	Auto-Calculated	1	1.6%	52	83.9%	9	14.5%	62
Cluster 4: AfC bands 8c to VSM	Auto-Calculated	1	5.6%	14	77.8%	3	16.7%	18
Total Non-Clinical	Auto-Calculated	111	4.9%	1886	83.8%	253	11.2%	2250
1b) Clinical Staff								
Under Band 1	Headcount	0	0.00%	0	0.00%	0	0.00%	0
Bands 1	Headcount	0	0.00%	0	0.00%	0	0.00%	0
Bands 2	Headcount	0	0.00%	0	0.00%	0	0.00%	0
Bands 3	Headcount	0	0.00%	1	100.00%	0	0.00%	1
Bands 4	Headcount	1	9.09%	10	90.91%	0	0.00%	11
Bands 5	Headcount	25	3.95%	520	82.15%	88	13.90%	633
Bands 6	Headcount	24	4.56%	428	81.37%	74	14.07%	526
Bands 7	Headcount	11	3.48%	246	77.85%	59	18.67%	316
Bands 8a	Headcount	0	0.00%	61	82.43%	13	17.57%	74
Bands 8b	Headcount	0	0.00%	14	77.78%	4	22.22%	18
Bands 8c	Headcount	1	25.00%	3	75.00%	0	0.00%	4
Bands 8d	Headcount	0	0.00%	3	75.00%	1	25.00%	4
Bands 9	Headcount	0	0.00%	0	0.00%	0	0.00%	0
VSM	Headcount	0	0.00%	0	0.00%	0	0.00%	0
Other. Please specify in notes.	Headcount	0	0.0%	0	0.0%	0	0.0%	0
Cluster 1: AfC Bands <1 to 4	Auto-Calculated	1	8.3%	11	91.7%	0	0.0%	12
Cluster 2: AfC bands 5 to 7	Auto-Calculated	60	4.1%	1194	80.9%	221	15.0%	1475
Cluster 3: AfC bands 8a and 8b	Auto-Calculated	0	0.0%	75	81.5%	17	18.5%	92
Cluster 4: AfC bands 8c to VSM	Auto-Calculated	1	12.5%	6	75.0%	1	12.5%	8
Total Clinical	Auto-Calculated	62	3.9%	1286	81.0%	239	15.1%	1587
Medical & Dental Staff, Consultants	Headcount	1	0.51%	128	65.64%	66	33.85%	195
Medical & Dental Staff, Non-Consultants career grade	Headcount	5	5.00%	71	71.00%	24	24.00%	100
Medical & Dental Staff, Medical and dental trainee grades	Headcount	12	3.58%	277	82.69%	46	13.73%	335
Total Medical and Dental	Auto-Calculated	18	2.86%	476	75.56%	136	21.59%	630
Number of staff in workforce	Auto-Calculated	191	4.28%	3648	81.67%	628	14.06%	4467

Metric 2: Relative likelihood of non-Disabled staff compared to Disabled staff being appointed from shortlisting across all posts

(Data source: Trust's recruitment & ESR data)

Relative likelihood of non-Disabled staff compared to Disabled staff being appointed from shortlisting	**Relative likelihood in 2021-22**	**Relative likelihood in 2022-23**	A figure below 1.00 indicates that Disabled staff are more likely than non-Disabled staff to be appointed from shortlisting
	0.38	**1.14**	

Metric 3: Relative likelihood of Disabled staff compared to non-disabled staff entering the formal capability process, as measured by entry into the formal capability procedure.

(Data source: Trust's HR data)

Relative likelihood of Disabled staff compared to non-Disabled staff entering	**Relative likelihood in 2021-22**	**Relative likelihood in 2022-23**	A figure above 1.00 indicates that Disabled staff are more likely than non-Disabled staff to enter the formal capability process
	1.85	**4.24**	

Metric 4: Percentage of Disabled staff compared to non-disabled staff experiencing harassment, bullying or abuse

(Data source: Q.13a-d, NHS Staff Survey)

4a: % of Disabled staff compared to non-disabled staff experiencing harassment, bullying or abuse from:	**2020**			**2021**			**2022**		
	Disabled staff	Non-disabled staff	% points difference (+/-)	Disabled staff	Non-disabled staff	% points difference (+/-)	Disabled staff	Non-disabled staff	% points difference (+/-)
(i) Patients/service users, their relatives or other members of the public	23.5	21.5	-2.0	32.4	23.4	-9	**28.8**	24.5	-4.3
(ii) Managers	20.7	8.7	-12.0	17.2	9.2	-8	**16.0**	9.9	6.1
(iii) Other colleagues	32.1	19.1	-13.0	26.5	20.4	-6.1	**28.8**	18.9	9.9
4b: % of Disabled staff compared to non-disabled staff saying the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it	44.1	43.3	**+0.8**	**50.8**	**44.2**	**-6.6**	**52.0**	**42.0**	**10.0**

Metric 5: Percentage of Disabled staff compared to non-disabled staff believing that the Trust provides equal opportunities for career progression and promotion

(Data source: Q.14, NHS Staff Survey)

2020			2021				2022	
Disabled Staff	**Non-disabled staff**	**Difference (+/-)**	**Disabled Staff**	**Non-disabled staff**	**Difference (+/-)**	**Disabled Staff**	**Non-disabled staff**	**Difference (+/-)**
56.0	60.6	-4.6	60.7	61.7	-1	**59.1**	58.6	0.5

Metric 6: Percentage of Disabled staff compared to non-disabled staff saying they have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties

(Data source: Q11e, NHS Staff Survey)

2020			2021				2022	
Disabled Staff	**Non-disabled staff**	**Difference (+/-)**	**Disabled Staff**	**Non-disabled staff**	**Difference (+/-)**	**Disabled Staff**	**Non-disabled staff**	**Difference (+/-)**
30.8	21.4	-9.4	27.8	19.6	- 8.2	**28.6**	18.0	10.6

Metric 7: Percentage of Disabled staff compared to non-disabled staff saying that they are satisfied with the extent to which their organisation values their work

(Data source: Q5f, NHS Staff Survey)

2020			2021				2022	
Disabled Staff	**Non-disabled staff**	**Difference (+/-)**	**Disabled Staff**	**Non-disabled staff**	**Difference (+/-)**	**Disabled Staff**	**Non-disabled staff**	**Difference (+/-)**
37.8	49.4	-11.6	39.8	47.0	-7.2	**36.5**	46.4	9.9

Metric 8: Percentage of Disabled staff saying that their employer has made adequate adjustment(s) to enable them to carry out their work

(Data source: Q.26b, NHS Staff Survey – *this question only includes the responses of Disabled staff*)

2020	2021	2022
75.5	74.1	**71.9**

Metric 9: NHS Staff Survey and the engagement of Disabled Staff

Part (a): The engagement score for Disabled staff, compared to non-disabled staff. The score for disabled staff has **declined** this year with a **negative** difference of -0.5 compared to non-disabled staff.

2020			2021				2022	
Disabled Staff	**Non-disabled staff**	**Difference (+/-)**	**Disabled Staff**	**Non-disabled staff**	**Difference (+/-)**	**Disabled Staff**	**Non-disabled staff**	**Difference (+/-)**
6.9	7.3	-0.4	6.9	7.2	- 0.3	6.6	7.1	**- 0.5**

(Data source: NHS Staff Survey)

Part (b): Has your Trust taken action to facilitate the voices of Disabled staff in your organisation to be heard? **Yes.**

We were asked to provide at least one practical example of current action being taken in the last 12 months to engage with Disabled staff:

We have a 'Without Limits ' Staff Support Network who meet regularly to advocate for their members to have the necessary adjustments and supportive environment at work. The network chair has a standing agenda item at the EDI steering group.

(Data source: WDES Submission, May 2023)

Part (b): Has your Trust taken action to facilitate the voices of Disabled staff in your organisation to be heard? **Yes.**

We were asked to provide at least one practical example of current action being taken in the last 12 months to engage with Disabled staff:

The Without Limits staff network group have been co-creating a Health Passport for staff to be able to declare any support needs that they may have.

(Data source: WDES Submission, May 2023)

Metric 10: Percentage difference between the organisation's Board voting membership and its organisation's overall workforce, disaggregated).

Snapshot as at 31/3/23	**Disabled %**	**Non-disabled %**	**Disability unknown %**
Total Board members	7.14	85.71	7.14
By Voting Membership of the Board	8.33	91.67	0.00
By Non-Voting Membership of the Board	0.00	50.00	50.00
By Executive Membership of the Board	7.14	85.71	7.14
By Non-Executive Membership of the Board	0.00	71.43	28.57
Difference (Total Board – Overall Workforce)	**-4.28**	81.67	-14.06
Difference (Voting membership – Overall Workforce)	**-4.05**	10	-14.06
Difference (Executive membership – Overall workforce)	**2.86**	4.04	-6.92

(Data source: WDES Submission, May 2023)

Freedom to Speak Up & Whistleblowing Report Q3 & Q4 2022/23
Front Sheet

1. Report Details			
Meeting Title:	Board of Directors Part 1		
Date of Meeting:	31 May 2023		
Document Title:	Freedom to Speak Up & Whistleblowing Report Q3 & Q4		
Responsible Director:	Nicola Plumb – Chief People Officer Emma Hallett – Deputy Chief People Officer	Date of Executive Approval	14 May 2023 (EH)
Author:	Lynn Paterson - Freedom to Speak Up Guardian Catherine Youers- Head of People Services		
Confidentiality:	No		
Publishable under FOI?	Yes		
Predetermined Report Format?	No		

2. Prior Discussion		
Job Title or Meeting Title	**Date**	**Recommendations/Comments**
People and Culture Committee	22 May 2023	Noted

3. Purpose of the Paper	To provide a bi-annual update on the Freedom to Speak Up cases and activities and formal whistleblowing disclosures made in Quarter 3 and 4 (October 2022-March 2023) and outline plans moving forward.							
	Note (✓)	***X***	*Discuss (✓)*		*Recommend (✓)*		*Approve (✓)*	

4. Executive Summary

This is the first report which covers the Whistleblowing Arrangements and the bi-annual Freedom to Speak Up (FTSU) activity report. The update provides a summary of the activities of the FTSU work & formal Whistleblowing disclosures between October 2022 and March 2023 (Q3 and 4). **There were 35 cases reported to the guardian during this period and no formal whistleblowing disclosures.**

We welcome concerns raised as part of our commitment to a culture of speaking out safely. The number of concerns raised through the FTSU process in Q3 and 4 was significantly higher than the previous two quarters. However, as previously discussed with the committee, the increase in activity is likely due to having a dedicated FTSU Guardian (FTSUG) now in place.

Concerns involving elements that indicate a risk of adverse impact of worker wellbeing was the most prominent theme. These are mainly in relation to repeated incivility towards staff. Elements of bullying featured in over 50% of cases received in Q3 and Q4.

Around 95% of concerns have been escalated within the timeframe set for action (3 weeks) and 91% of the cases have been resolved and/or an improvement plan put into place.

Development activities such as the Trust's Dignity & Respect at Work (DRW) workshops and the Inclusive Leadership Programme have raised awareness

	about acceptable and unacceptable behaviour. The weekly Organisational Development (OD) bulletin is regularly used to reiterate the messages about Speaking Up as well as signposting staff to training opportunities. Next steps include more robust triangulation of intelligence, improving the culture of 'psychological safety' in terms of challenging and speaking up, to be more visible in the messaging about the Trust values in terms of civility and compassionate leadership and to continue to drive the Speak Up culture through attendance at team meetings, via the Champions Network and ESR training modules.
5. Action recommended	The Board is recommended to: 1. **NOTE** the update

6. Governance and Compliance Obligations				
Legal / Regulatory Link		**Yes**		Contractual requirement to have FTSUG. Reporting follows national guidelines.
Impact on CQC Standards		**Yes**		Links to well-led leadership & management promoting open & fair culture.
Risk Link			**No**	
Impact on Social Value		**Yes**		Recognised as a Good Employer, ensuring employees have a positive & fulfilling experience.
Trust Strategy Link		Looking after and investing in our staff, developing our workforce to support outstanding care and equity of access and outcomes. Creating an environment where everyone feels they belong.		
Strategic Objectives	People	look after and invest in our staff, developing our workforce to support outstanding care and equity of access and outcomes.		
	Place	create an environment where everyone feels they belong, they matter, and their voice is heard.		
	Partnership	continue to create collaborative and multidisciplinary professional team working to maximise skills, knowledge, and respect.		
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**		Information and insight provided can contribute to this ecology of improving population health and healthcare
Tackling unequal outcomes and access		**Yes**		Information and insight provided can result in improvements for patient safety and the staff experience.
Enhancing productivity and value for money		**Yes**		Information and insight provided could result in improvements
Helping the NHS to support broader social and economic development		**Yes**		Information and insight provided could foster better understanding amongst staff members.
Assessments		**Have these assessments been completed?** *If yes, please include the assessment in the appendix to the report..* *If no, please state the reason in the comment box below.* *(Please delete as appropriate)*		
Equality Impact Assessment (EIA)			**No**	n/a
Quality Impact Assessment (QIA)			**No**	n/a

Bi-annual Freedom to Speak Up and Whistleblowing Report

Executive Summary

The new Freedom to Speak Up Guardian (FTSUG) Lynn Paterson has been in post since January 2023. The FTSUG's key role is to support the creation of a positive, open learning culture where our people feel listened to, and feedback is welcomed, and acted on. We welcome concerns raised as part of our commitment to a culture of speaking out safely.

There were 35 cases/concerns reported to the guardian during Quarter 3 and 4 (1 October 2022 to 31 March 2023), Q4 was significantly higher with 28 cases. This is higher than the previous two quarters. The increase in activity is likely due to having a dedicated FTSUG now in place with heightened visibility across the Trust. Concerns have been raised mainly by individuals, including several staff members from the same area in two separate departments.

Concerns involving elements of risk to worker wellbeing are the highest indicator with bullying and fear of detriment equally present in 16 of the cases. Other issues raised include poor work culture and incivility.

Development activities such as the Trust's Dignity and Respect at Work (DRW) workshops and the Inclusive Leadership programme have raised awareness about acceptable and unacceptable behaviour. The weekly OD bulletin is regularly used to reiterate the messages about Speaking Up as well as signposting staff to training opportunities. Whilst DRW workshops highlight ways to respectfully challenge the perpetrator, it is recognised that some staff may not yet have the confidence to do so. Therefore, during the workshops staff are signposted to a variety of routes to speaking up and other sources of support.

Over the past year the groundwork has been laid to develop a 'speaking up culture'. Despite significant staffing challenges, approaches and activities have started to gather momentum to take the Trust to the next level.

The Committee is recommended to note this update.

1.0 Introduction

1.1 It is a contractual requirement for all NHS provider Trusts to have a FTSUG. The guardian's key role is to support the creation of a positive, open learning culture where our people feel listened to, and feedback is welcomed, and acted on. 'Every Voice Counts' is one of the principles outlined in the People Plan/Promise (2020/21) which advocates for all staff to feel safe and confident to speak up with an expectation to be listened to and for appropriate action to be taken.

1.2 The FTSUG provides bi-annual updates to the Trust Board, as recommended by the National Guardian Office (NGO).

1.3 The FTSUG is supported by a network of FTSU Champions, which have now increased to 16 in total. Champions work to ensure colleagues understand and can access routes to speaking up and provide a confidential source of signposting. This model follows the recommendations of the NGO and CQC.

1.4 This report also covers whistleblowing activity. To date, an annual review of whistleblowing arrangements has been provided to the People and Culture Committee; this will now be bi-annual. The review provides a summary of the formal whistleblowing disclosures made within the previous 6 months and the lessons learned.

1.5 The relevant policy to follow for those wishing to make a formal whistleblowing disclosure is the Freedom to Speak Up: Raising Concerns (Whistleblowing) policy (EM63). The policy signposts individuals to those who can support them to raise informal concerns, including their line manager, or where this is not possible, the FTSU Guardian, any other senior manager, Staff Governor, Clinical Lead, Clinical Director, Executive Director or Non-Executive Director within the Trust. The process for making a formal whistleblowing disclosure is documented within the policy. The policy was revised and ratified by Partnership Forum last year and policy aligns to the NHS standard integrated whistleblowing policy produced by NHSEI.

2.0 Reporting Speaking Up Cases

2.1 The FTSUG submits Quarterly DCH Speaking Up data online via the NGO Portal. This is published nationally by the NGO alongside all other NHS Trusts' data.

2.2 Quarter 3 and Quarter 4 saw a 59% increase in cases from the last reporting period (22 to 35), as such, an in-depth comparison between Q1 and Q2 with Q3 and Q4 may be erroneous. This increase is likely attributed to the recruitment and communications launch for the newly appointed FTSUG.

2.3 FTSU data for Q3 and Q4:

Total concerns raised	**Q3**	**Q4**
	7	28
Raised anonymously	0	0
Elements of bullying	3	16
Elements of patient safety	4	11
Detriment for speaking up	3	13
Element of work safety/wellbeing	2	22
Other	1	11

2.4 Around 95% of concerns have been escalated within the timeframe set for action (3 weeks) and through signposting to routes of support and supporting individuals to raise concerns directly with their line managers. 91% of the cases have been resolved and/or an improvement plan put into place.

2.5 The remaining concerns are in the process of resolution. Progress has been delayed in some cases due to absence of the relevant staff members to discuss the issues.

2.6 This is the first review of Whistleblowing Arrangements report to be merged with the bi-annual FTSU report; previously these have been separate reports.

2.7 **No formal whistleblowing disclosures have been made in the period covering this review**. The last formal whistleblowing disclosure made within the Trust was in

July 2020. This is mirrored within the Dorset region with no formal disclosures made during Q3 and Q4. Whilst there have been no formal whistleblowing disclosures made in this period, there has been an increase in issues raised via the FTSUG. It is positive that staff are feeling able to raise issues using this mechanism rather than the formal whistleblowing process.

3.0 Emerging Themes

3.1 There has been a 300% increase in cases between the two quarters which sounds significant, but this is most likely attributed to the recruitment and communications launch following employment of a dedicated postholder.

3.2 The main themes involved uncivil behaviour and poor communication/feedback/action primarily from Line Managers. Due to lack of timely feedback/action, staff report things are 'being swept under the carpet'. Additionally, a poor culture and staff not feeling valued was a recurring theme.

3.3 Elements that indicate a risk of adverse impact of worker wellbeing was the most prominent theme. These are mainly in relation to repeated incivility towards staff. In these cases, staff wellbeing support information is given, and the Trust's mandatory DRW Programme recommended.

3.4 Elements of risk of bullying featured in over 50% of cases received in Q3 and Q4. Incidents include incivility, staff feeling victimised and in turn, lack of learning opportunities. The need to reiterate the messages around 'zero tolerance' for such behaviours in line with the Trust values continues.

This echoes the importance of the ongoing engagement and development activities such as the Trust's DRW Programme, Inclusive Leadership Programme, induction talks and promotion of the agenda through the OD bulletin and roadshows.

3.5 Whilst the DRW programme highlights ways to respectfully challenge unacceptable behaviour directly with the perpetrator, it is recognised that some staff may not yet have the confidence to do so. Therefore, as part of the programme, staff are signposted to a variety of routes to speaking up and other sources of support.

3.6 Q3 and Q4 has shown a decrease of 100% in concerns raised anonymously which is encouraging as staff feel able to raise a concern either confidentially or openly.

4.0 Next Steps

4.1 The culture around 'Psychological safety' to speak up is in the process of development. The fear of 'detriment' as a result of speaking up still features as a theme. Further questions are now being asked when dealing with a case to try to gain more understanding around staffs fear of detriment.

4.2 The Champions Network is increasing with monthly meetings scheduled from May to share ideas for promotional activities which include raising money for DCH Charity and to encourage staff to access the FTSU training materials on ESR. The training is also highlighted on the weekly OD bulletin.

4.3 The FTSUG continues to drive a stronger 'speaking up' culture by attending team/department meetings, Staff Networks, Induction and preceptorship training. She

is also developing a Speak Up/Listen Up session to feed into the vision for raising concerns within the NHS.

4.4 More robust triangulation of data is planned, to help identify hotspots, particularly in relation to patient safety and staff turnover/retention. Weekly Patient Safety Huddles now take place with attendance from FTSUG and relevant stakeholders. Local Intelligence meetings between HR, Workforce Business Partners (WBPs) and the OD Team commence in May. This collaboration will be very helpful in providing initial context around the issues and then highlighting who to progress matters to.

4.5 Discussions will continue in identifying and tackling barriers to speaking up, informing organisational development, and learning to achieve improvements. A question will be incorporated into the FTSUG feedback survey to further support work in this area.

4.6 Contact has already been established with the FTSUG at DHC who has been very generous in sharing ideas and the potential to collaborate on future board reports and activities has been discussed.

5.0 Conclusion

5.1 The FTSU Guardian role supports the creation of a positive culture and environment for raising concerns. It helps protect patient safety and quality of care, improve staff experience and promote learning and development leading to continuous improvement.

5.2 As a system, we need to be more visible in terms of messaging about our values around civility, improve communications around any challenges and ensure that we have people with the right expertise to tackle some issues in this report. Encouragingly, staff mainly appear to be employed in a role they enjoy; however wellbeing is being impacted by incivility and their concerns not being acted upon. Managers should be role models, setting a good example by being the flagship for the Trusts values. DRW is mandatory for all staff and the Management Matters Programme is now operational. This will invariably help managers with issues such as Conflict Resolution, motivating and maintaining morale within their teams and give staff the confidence to challenge uncivil and unprofessional behaviour as it arises.

6. Recommendation

The Committee is recommended to note this update and the ongoing work of the Freedom to Speak Up Guardian.

Report Front Sheet

1. Report Details			
Meeting Title:	DCHFT Board		
Date of Meeting:	31 May 2023		
Document Title:	DCH Social Value Programme Report (6 month)		
Responsible Director:	Nicholas Johnson, Deputy Chief Executive	Date of Executive Approval	23/05/2023
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**
Senior Leadership Group	30.3.23	IMPACT Social Value platform presentation
DCHFT Board Development session	26.4.23	IMPACT Social Value platform presentation

3. Purpose of the Paper	Progress report for DCH Social Value programme (6 month)							
	Note (✓)	✓	*Discuss (✓)*		*Recommend (✓)*		*Approve (✓)*	
4. Executive Summary	This paper highlights the progress and key developments for the DCH Social Value programme. Key elements in the report include: • **DCH Social Value Pledge:** copy attached for information. • **IMPACT Social Value reporting platform:** online repository for key DCH social value projects, activities and goals. Summary of key social value metrics. • **Embedding Social Value across DCH:** Social value to be incorporated in the Board Assurance Framework. • **Living Wage accreditation:** the Trust aims to become a Living Wage employer, accredited through the Living Wage Foundation. • **Estate Capital Projects:** Tilbury Douglas Social Value Plans for the new Emergency Department and Critical Care Unit and clinics at South Walks House. • **Sustainability activities:** including funding bid for DCH Decarbonisation plan; new Green Theatres group; and DCH Sustainability Day (6.6.23) • **DCHFT Annual Report 22/23:** social value is reported in the Annual Report including procurement, workforce and sustainability. • **Dorset ICS - Dorset Anchors Network:** Our Dorset Anchor Institutions Maturity Matrix to capture baseline information relating to four key anchor institution impact themes-Employment/Procurement/Estate/Environment.							

5. Action recommended	DCHFT Board is recommended to: 1. **NOTE** the progress of the DCH Social Value programme.

6. Governance and Compliance Obligations			
Legal / Regulatory Link		**No**	*If yes, please summarise the legal/regulatory compliance requirement.* *(Please delete as appropriate)*
Impact on CQC Standards		**No**	*If yes, please summarise the impact on CQC standards.* *(Please delete as appropriate)*
Risk Link		**No**	*f yes, please state the link to Board Assurance Framework and Corporate Risk Register risks (incl. reference number). Provide a statement on the mitigated risk position.* *(Please delete as appropriate)*
Impact on Social Value	**Yes**		Supports Social Value Pledge as reports on delivery of DCH Social Value programme
Trust Strategy Link	**How does this report link to the Trust's Strategic Objectives?** *Please summarise how your report will impact one (or multiple) of the Trust's Strategic Objectives (positive or negative impact). Please include a summary of key measurable benefits or key performance indicators (KPIs) which demonstrate the impact.*		
Strategic Objectives – People	Social value commitments to local employment; good employer and EDI.		
Strategic Objectives – Place	Social value contributes to the social and economic health of our local communities.		
Strategic Objectives – Partnership	Social value pledge aims to work with Dorset anchors across the ICS system.		
Dorset Integrated Care System (ICS) Objectives	**Which Dorset ICS Objective does this report link to / support?** *Please summarise how your report contributes to the Dorset ICS key objectives.* *(Please delete as appropriate)*		
Improving population health and healthcare	**Yes**		Addressing social determinants of health.
Tackling unequal outcomes and access	**Yes**		Addressing social determinants of health.
Enhancing productivity and value for money	**Yes**		Local investment and employment.
Helping the NHS to support broader social and economic development	**Yes**		Social value contributes to the social and economic health of our local communities, through provision of local employment and local investment in Dorset economy.
Assessments	**Have these assessments been completed?** *If yes, please include the assessment in the appendix to the report..* *If no, please state the reason in the comment box below.* *(Please delete as appropriate)*		
Equality Impact Assessment (EIA)	**Yes**	**No**	N/A
Quality Impact Assessment (QIA)	**Yes**	**No**	N/A

DCH Social Value Programme: Progress Report (6 month) May 2023

Our Social Value Pledge

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

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

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

- **IMPACT Social Value platform**:

This online platform is a repository for key DCH social value projects, activities and goals for the DCH social value programme.
IMPACT platform was presented to Senior Leadership Group on 30.3.23 and Board on 26.4.23.

Key social value metrics: the following provide examples of some of the key metrics recorded on the IMPACT platform.

Social Value pledge	Social Value activity	Measure
Maximise Local Investment	Regional Supplier spend 22/23	£11,853,845
Maximise Local Investment	Local Supplier (DT) spend 22/23	£7,279,833
Maximise Local Investment	Local Supplier-Catering spend 22/23	£288,049
Maximise Local Investment	3rd Sector spend 22/23	£144,581
Maximise Local Investment	Multi-storey car park (SROI) – Wilmott Dixon social return on investment report	£4,124,136
Greener & Sustainable	DCH Net Zero carbon by 2040 (emissions we control) - NHSE figs. estimate DCH CO2e baseline (2019/20)	33,998 tonnes CO2e
Greener & Sustainable	EcoEarn: staff app promoting green actions	143 DCH participants t/d
Greener & Sustainable	Liftshare: staff car-share app	57 DCH participants t/d
Involve our Community	DCH Volunteers (total) 22/23	203
Involve our Community	DCH Young Volunteers 22/23	59 *(incl. in fig above)*
Civic Partnerships	DCH Charity income 22/23	£878,000

The Social Value Programme Group workstream leads will now continue to populate the IMPACT platform as DCH's social value programme moves forward.

- **Embedding Social Value:**

  Board Assurance Framework: Social value to be incorporated in the Board Assurance Framework to monitor delivery of social value programme.
  Divisions: IMPACT Social Value platform presentations to be planned with Divisional management teams.
  SLG Working Group: DCH Social Value lead now attends these meetings to provide oversight/advisory from social value perspective.

- **Living Wage Employer accreditation:** the Trust aims to become a Living Wage employer, accredited through the Living Wage Foundation. (https://www.livingwage.org.uk/) This requires consideration of the financial implications and other matters prior to a final decision to apply for accreditation. Dorset ICB have included Living Wage accreditation in their People Plan, which was due to be signed off on 5.5.23. It is a Year One priority for them.

- **Estate Capital Projects:** Tilbury Douglas have produced their Social Value Plans for the new Emergency Department and Critical Care Unit and clinics at South Walks House. These were provided to DCHFT Board on 26.4.23.

  They also produce monthly social value activity reports for their community engagement activities including working with local education providers, providing careers advice and supporting charitable initiatives. We have uploaded their social value plans and reports to the Social Value IMPACT platform. Tilbury Douglas are now working on measuring the social value return on investment delivered by these capital projects respectively. These reports will be presented to Board once received.

- **DCH Net Zero Carbon:** DCH Energy Efficiency group submitted an application on 26.4.23 to the Low Carbon Skills Fund for a £160K grant to fund development of a DCH Decarbonisation Plan. Currently awaiting outcome.

- **Green Theatres group**: now established as part of DCH Sustainability Working Group to implement green initiatives in DCH theatres including reducing anaesthetic gases and waste recycling. The first Green Theatres sub working group has met and the waste strategy was reviewed. Waste separation is being looked at and will be promoted by theatre champions.

- **NHS Greener Exhibition:** this exhibition has been touring the country and has recently been on display at DCH; together with DCH-specific photographs representing our Green Plan related activities across the Trust.

- **DCH Sustainability Day (6.6.23):** DCH Sustainability Manager, Bev Lagden is planning a 'Sustainability Day' on 6 June, the theme will be active travel plus wider sustainability activities.

- **DCHFT Annual Report 2022/23 (draft):** DCH's commitment to deliver social value is reported through the DCHFT Annual Report including procurement, workforce and sustainability.

- **Dorset ICS – Dorset Anchors Network:** Dorset Anchors Network lead has developed an Our Dorset Anchor Institutions Maturity Matrix to capture baseline information relating to four key anchor institution impact themes – Employment/Procurement/Estate/Environment. The DCH Social Value Programme Group are completing this for DCH's anchor activities. This information will be collated from all Dorset Anchor Network partners. The network lead will advise of next steps in due course.

Simon Pearson MCIOF
Head of Charity & Social Value

Dorset County Hospital
NHS Foundation Trust

Social Value Pledge

Our Commitments as an Anchor Institution

DCHFT & Social Value

What is Social Value?

Increasingly, organisations are considering their activities holistically, taking account of the wider economic, social and environmental effects of their actions.

Social Value serves as an umbrella term for these broader effects, and organisations which make a conscious effort to ensure that these effects are positive can be seen as adding social value by contributing to the long-term wellbeing and resilience of individuals, communities and society in general.

Dorset County Hospital Foundation Trust, as an anchor institution, commits to maximise the positive social value impact we have on our local communities, contributing to improving the economic, social and environmental well-being of the community we serve. An anchor institution is one that, alongside its main function, plays a significant and recognised role in a locality by making a strategic contribution to the local economy.

Our Social Value Pledge

Dorset County Hospital commits, through its approach to delivering social value as an Acute Trust, to reduce avoidable inequalities and improve health and wellbeing across its community.

Up to 90% of a person's health is determined not by the quality of healthcare they receive but by a host of other social, environmental and economic factors such as housing, isolation, green space, employment and access to food. As a hospital we provide quality care, treating people when they are sick, but we also have a broader role, as an organisation with a vested interest in people being healthy and as a major employer in our area, to directly and indirectly help improve the social, environmental and economic circumstances of our communities.

Our Social Value Pledge presents our commitments to helping to improve the overall well-being of our community.

Our Social Value Principles

- Working together across DCH and with our Dorset system partners to improve health and well-being and reduce avoidable inequalities across our community – linked to the Marmot Principles:

  - Giving every child the best start in life;
  - Enabling all children, young people and adults to maximise their capabilities and have control over their lives;
  - Creating fair employment and good work for all;
  - Ensuring a healthy standard of living for all; throughout the life course;
  - Creating and developing sustainable places and communities;
  - Strengthening the role and impact of ill-health prevention;
  - Protecting health and social care services for future generations.

- Social Value will be embedded as core practice, behaviours and the way that we operate across DCH.
- Our Social Value commitments will be embedded in and contribute to delivery of DCHFT strategic priorities (including current, medium and longer term).
- We will make every penny count, improving local health, wealth and our environment.
- We are inclusive in our approach so that Social Value benefits everyone.
- Our Social Value approach will facilitate shared learning, encouraging innovation through a culture of quality improvement, which creates positive change and delivers best practice.
- Our Social Value approach will deliver Social Impact. We will understand and measure Social Impact - the change and difference that we make locally.
- Social Value will be delivered sustainably and ethically, in terms of 'how' (process) and 'what' (outcomes).
- Our Social Value approach will create a lasting, positive social impact and legacy for the community we serve.

Our Social Value Commitments:

Develop Anchor Networks across the Dorset System

There is an increasing policy focus on reducing avoidable inequalities, prevention and population health and the move towards 'place based' models of care focusing on communities and populations. There is growing synergy between the place-based lens of the NHS and broader policy emphasising localism in shaping the environments where we live.

Dorset County Hospital NHS Foundation Trust commits as an anchor institution to build social value objectives into its planning for the delivery of the NHS Long Term Plan; and in partnership across the Dorset ICS system.

With our system partners, we will develop Our Dorset's social value vision and pledge in order to maximise our contribution to the wider health and well-being of our local communities.

Working with Dorset Council, NHS Trusts, CCG, Large Education Providers, VCSE sector, Arts and Cultural organisations and Business and Industry to deliver our social value ambition.

Maximise Local Investment
Dorset County Hospital NHS Foundation Trust will be compliant with the requirements of The Public Services (Social Value) Act 2012 which will be used to inform how we can derive social value from our activities. The Act requires public authorities to have regard to economic, social and environmental wellbeing in connection with public services contracts.

We commit to maximise local investment which is financially generative to the local economy, retaining and recirculating wealth locally.

We will take account of the social, economic and environmental impacts of buying locally when procuring goods and services.

Our commitment to local investment includes:

- Our largest investment in the local economy is our workforce.
- Support the local economy by choosing suppliers close to the point of service delivery, where possible.
- Increase accessibility and improve opportunities for local businesses and social enterprises to bid for contracts throughout the supply chain. Develop local supply chains which will impact on local economic growth for the longer term.
- Commit to sourcing our raw materials locally, where possible.
- Ensure our major capital infrastructure investments deliver measurable social value. Recognise and communicate these social value benefits.
- Provide advertising and promotional opportunities (free of charge) on site for appropriate local businesses.
- Work with third sector organisations to deliver services and contracts, where appropriate.

Recognised as a Good Employer
As a Good Employer to provide outstanding careers, ensuring our employees have a positive and fulfilling experience. We will create opportunities for our people to develop skills and further their careers. We will work together in line with our Trust values – Integrity, Respect, Teamwork and Excellence, and empower staff to deliver outstanding services, sustainably, every day.

Our commitment to be a good employer includes:

- Comply with working hours legislation and sector standards.
- To support fair employment by considering/providing a range of employment contracts.

- To support flexible working by considering/providing a range of flexible working options.

- Work towards paying the Living Wage, within the context of Agenda for Change.

- Ensure zero hours contracts do not discriminate or disadvantage individuals in the workplace/market.

- We will provide in-work training opportunities for our people to develop skills and further their careers.

- Understand the different needs of our workforce and implement policies that support their health and wellbeing.

- Foster a loyal and motivated workforce. Work to ensure recruitment practices for new applicants and opportunities for career progression are inclusive of all. Ensure that equality strands are supported through transparent and fair employment processes.

- Ensure we are a Leaderful organisation, recognising that leaders exist at all levels contributing to the success of our hospital.

- Develop workforce volunteering programmes.

- Commitment to the NHS People Plan promise that the NHS is best place to work for all – where we are part of one team that brings out the very best in each other.

Increase Local Employment

We will commit to increase employment and training opportunities for local people, especially from areas of high deprivation and unemployment, including people with disabilities and learning disabilities, Black, Asian and Minority Ethnic communities, LGBT communities and young people; supporting people into work, apprenticeships and work experience placements.

Our commitment to employment for local people includes:

- Commit to create employment and training opportunities for local residents; including opportunities which contribute to improved social mobility and enable career progression.

- Seek opportunities to work with education and training providers to help ensure young people are equipped with the right skills to match the requirements of the NHS labour market.

- Seek to provide employment opportunities for all ages including those older age groups and those seeking a late stage career change.

- Promoting improvement and provision of local employment and training opportunities.

- Support the local economy to create jobs and apprenticeships, by adopting procurement strategies that remove barriers to local businesses.

- Work with local third sector organisations to ensure people facing barriers to employment are supported.

- Support volunteering to provide routes into employment.

Champion Equality, Diversity & Inclusion
Dorset County Hospital NHS Foundation Trust is committed to becoming a truly inclusive organisation. We recognise that we must value the contribution of people of all backgrounds, abilities and experiences in order to deliver outstanding services. We will work to ensure that our organisation is a place where all our staff and patients feel safe, listened to, and that they belong.

We will work closely with local partners and community organisations to ensure that all voices are heard and every member of DCH and our wider community has equitable access to the benefits that our Social Value programme will bring.

Our overarching EDI goals include:

- Better Health Outcomes for All
- Improved Patient Access and Experience
- Empowered, Engaged and Well Supported Staff
- Inclusive Leadership at All Levels

Our objectives for achieving these goals are detailed in our Equality, Diversity & Inclusion Action Plan 2019 – 2021.

Greener & Sustainable
We commit to our Sustainable Development Management Plan (SDMP to become DCH Green Plan) to deliver long term improvements to the sustainability performance of the hospital. We recognise the impact we have on the environment and our responsibility to improve our sustainability and contribute to better health and well-being of our local community.

We will work towards the Greener NHS Net-Zero objectives committing to protecting the environment, minimising waste, water and energy consumption and using other resources efficiently within our organisation and supply chains.

Our commitment to being Greener and Sustainable includes:

- In line with ‘Delivering a ‘Net Zero’ National Health Service’ (1 October 2020) UK Government and DCHFT are committed to reaching net zero by 2050.

- For the emissions controlled directly by the NHS Carbon Footprint plans are to reach net zero by 2040, with an ambition to reach an 80% reduction by 2028 to 2032. DCHFT will be assessing and promoting to staff and general public how as a partnership we can reduce our Carbon Footprint.
- For the emissions we can influence (our NHS Carbon Footprint Plus), we will reach net zero by 2045, with an ambition to reach an 80% reduction by 2036 to 2039.
- Plans continue for reduction of our energy and water consumption. (NB. due to Covid-19 and the guidance for staff, patients and visitors 'Wash Your Hands' is anticipated to raise the use of water consumption.)
- Eliminate unnecessary waste by continuing to "reduce, reuse, recycle" and improve the infrastructure to enable people to do so.
- With sources of NHS carbon footprint highlighting Medicines, Medical Equipment and other Supply Chain as the highest ratio to address, DCHFT is now addressing Anaesthetics, Medical Devices, Nursing and Pharmacy to be included in the new Green Plan.
- Promote the DCH Green Travel Plan for sustainable transport (public transport/electric vehicles/cycling/walking/car share)
- Improve green areas (e.g. biodiversity, visual attractiveness)
- Ensure that sustainability is thoroughly communicated throughout the Trust and ensure that appropriate employees receive relevant training as part of induction.
- To work in partnership with local groups and key stakeholders in order to support sustainable development within our community.
- Contributing to a sustainable local economy.

Promote Civic Partnerships

To build on and coordinate effective links between DCH and our civic community including VCSE organisations, arts and culture sector, large education providers, religious organisations and other civic bodies. To develop joint initiatives and programmes and implement local activities which contribute to reducing inequalities and improving health and well-being for all.

Our commitment to promoting Civic Partnerships includes:

- DCH Charity builds relationships with supporters across our community including patients, families and organisations; delivering funding which enhances patient care and staff welfare at DCH.

- DCH Volunteers provide valued and essential services for our hospital; in addition to the social, skills and other benefits achieved from volunteering. The DCH Young Volunteers programme also exemplifies this approach.

- DCH Arts in Hospital programme engages with local artists and arts/cultural organisations from our local community. Research demonstrates the benefit arts deliver in contributing to people's well-being, particularly mental health.

- Through existing and new partnerships with local civic bodies we will develop initiatives which contribute to improving our community's social, economic and environmental well-being, particularly as our local community works to recover from the Covid pandemic.

Involve Our Community
A key principle of delivering social value is engagement with our stakeholders. We will play an active role in engaging with our local community by listening to them, involving them and acknowledging their contributions to our social value commitments.

Our commitment to involving our community includes:

- Engage with local residents and service users.

- To promote opportunities for gathering views, including those not heard or voiced.

- To provide feedback to the local community so they can see the results of their involvement. Ensure communities receive timely and appropriate information and communication.

Monitor & Report
We will monitor and demonstrate our commitment to delivering social value by:

- Implementing recognised procedures for measuring and reporting on our Social Value outcomes and Social Return on Investment.

- Embedding tools for monitoring, measuring and reporting on social value outcomes as part of our organisational processes.

- Communicate our Social Value commitments and outcomes internally and externally.

- Reporting on our Social Value commitments, through an annual Social Impact report and in the DCHFT Annual Report.

By signing this Pledge, we commit to delivering social value as an anchor institution through the provision of our services, contributing to reducing avoidable inequalities and improving the social, economic and environmental well-being of the community we serve.

Signed:
Name: Mark Addison
Designation: Chairman
Organisation: Dorset County Hospital NHS Foundation Trust
Date: 04December 2020

Signed:
Name: Patricia Miller
Designation: Chief Executive
Organisation: Dorset County Hospital NHS Foundation Trust
Date: 04December 2020

Report Front Sheet

1. Report Details			
Meeting Title:	DCHFT Board		
Date of Meeting:	31 May 2023		
Document Title:	DCH Charity – Policies Review 2023		
Responsible Director:	Nicholas Johnson, Deputy Chief Executive	Date of Executive Approval	Charitable Funds Committee 21.3.23
Author:	Simon Pearson, Head of Charity & Social Value		
Confidentiality:			
Publishable under FOI?	Yes		
Predetermined Report Format?	No		

2. Prior Discussion		
Job Title or Meeting Title	**Date**	**Recommendations/Comments**
Charitable Funds Committee	21.3.23	Policies approved for Corporate Trustee (Board) to ratify.

3. Purpose of the Paper	Three-year review of DCH Charity Policies. Adoption and approval of new Policies.							
	Note (✓)	✓	*Discuss (✓)*		*Recommend (✓)*		*Approve (✓)*	✓
4. Key Issues	DCH Charitable Funds Committee carried out three-year review and approval of existing DCH Charity Policies, for ratification by Corporate Trustee (Board). The committee also adopted and approved two new policies, for ratification by Corporate Trustee (Board). These Policies (as enclosed with this report) include: **Existing DCH Charity Policies:** - Standing Financial Instructions - Fundraising Policy - Income Policy - Expenditure Policy - Investment Policy There were no material changes to the existing policies. **New DCH Charity Policies:** - Grants Policy - Ethical Statement These policies will be implemented once ratified by the Corporate Trustee.							
5. Action recommended	The DCHFT Board is recommended to: 1. **NOTE** the reviewed and new DCH Charity Policies 2. **APPROVE** Ratify the reviewed and new DCH Charity Policies							

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 contributes through Civic Partnership to DCH'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	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) 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**		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)			**No**	N/A
Quality Impact Assessment (QIA)			**No**	N/A

Policy Title	**CHARITABLE FUND STANDING FINANCIAL INSTRUCTIONS**		
Procedure Number		**Version number**	
Applicable to	**Corporate Trustee, Charitable Funds Committee, Fundraising Team, Fund Representatives**		
Date issued	**21 March 2023**		
Review date	**21 March 2026**		
Author's name and title	**James Claypole, Deputy Financial Controller**		
Development group/committee	**Charitable Funds Committee**		
Stakeholders	**Charitable Funds Committee; DCH Charity Team; DCH Finance**		
Approved by	**Charitable Funds Committee**		
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Ratified on	**31 May 2023**		
Keywords			

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Previous policy number		**Previous version number**	
Changes requested or dictated by			
Description of changes since last version			

CHARITABLE FUND (Registered Charity 1056479)

STANDING FINANCIAL INSTRUCTIONS (SFI)

CONTENTS

1. FOREWORD

1. The Charity was originally constituted as West Dorset General Hospitals NHS Trust Charitable Fund on 10 May 1996 by a declaration of trust following the Charity Commission's model format. It was entered on the Central Register of Charities on 28 June 1996 as registered Charity No. 1056479. Following the change of the beneficiary hospital to Foundation Trust status from 1 June 2007, the Charity altered its name on 15 December 2008 to Dorset County Hospital NHS Foundation Trust Charitable Fund (the Charity).

2. At 31 December 2022, the Charity comprised 67 individual funds including both restricted and unrestricted income and balances. Each of the funds has been established by a Deed of Declaration that includes a clause setting out the objects of the fund and the purposes under which expenditure from the fund is permitted.

3. The Charity has a single corporate trustee, which is Dorset County Hospital NHS Foundation Trust (DCHFT), in the form of the Board of Directors of that organisation. Responsibility for the management and administration of the Charity has been delegated to the Charitable Funds Committee, comprised of members of the Board, including the Chief Financial Officer.

4. The Charity comprises a Head of Fundraising and fundraising team members as its staff members. Though technically employed by the Foundation Trust and recharged to the Charity, these individuals report to the Trustees and are primarily responsible for income generation.

5. Additionally, the Charity makes use of administrative and accounting services provided by the Foundation Trust, mainly by staff within the Financial Services function.

6. These Standing Financial Instructions (SFIs), together with the Charity's various statements of Policy, provide a business and financial framework within which all members of the Charitable Funds Committee, the wider Foundation Trust Board, and other the hospital staff involved with the activities of the Charity are expected to work. The Committee Members and all hospital staff having frequent involvement with the charity's activities must be aware of the existence of these documents and, where necessary, be familiar with the detailed provisions and more specific guidance contained in various policy documents in force from time to time.

7. These combined documents are intended to provide an operational framework to assist in protecting the Charity's interests. Additionally, by providing guidance and structural information to individuals involved with activities of the charity, they should if followed minimise the risks of such individuals falling under suspicion of acting improperly.

8. Further general guidance may be obtained from the offices of the Charity Commission, Fundraising Regulator and from various Department of Health and National Health Service organisations dealing specifically with charitable operations.

2 INTRODUCTION

2.1 General

1. These SFIs detail the financial responsibilities, policies and procedures to be adopted by the Charity. They are designed to ensure that its financial transactions are carried out in accordance with the law and other regulatory guidance applicable to charities in order to achieve probity, accuracy, efficiency and effectiveness in the application of funds for properly authorised purposes.
2. The SFIs identify the financial responsibilities and obligations that apply to everyone operating for or on behalf of the Charity. They do not provide detailed procedural advice. These statements should therefore be read in conjunction with the Charity's strategic policy documents, financial policies and any detailed procedural instructions. The Committee must approve all financial procedures.
3. The Charity obtains administrative and accounting services from the Foundation Trust. Foundation Trust staff involved with the provision of such services are also required to comply with the SFIs, financial and administrative policies, and procedures of that organisation.
4. Should any questions arise regarding the interpretation or application of any of the SFIs then the advice of the Committee or the Chief Financial Officer must be obtained before proceeding. Users of these SFIs should also be aware of, and where necessary comply with the provisions of the Foundation Trust's own financial policies and procedures.

2.2 Terminology

1. Any expression to which a meaning is given in the Charities Acts in force, or in regulatory guidance issued by the Charity Commission and Fundraising Regulator, shall have the same meaning in these instructions; and
   a) "Foundation Trust" means the Dorset County Hospital NHS Foundation Trust;
   b) "Board" means the Board of Directors of the Foundation Trust as set out in its Constitution;
   c) "Trustee" means the Board acting in its capacity as the representative body of the Foundation Trust as corporate trustee of the Charity
   d) "Committee" means the Charitable Funds Committee appointed by the Board and delegated with responsibility for operations of the Charity.
   e) "Chief Financial Officer" means the person so appointed and holding that position within the Board;
   f) "SFIs" means Standing Financial Instructions;
2. Where the title Chair/Chairperson, Chief Financial Officer, or other nominated officer is used in these instructions, it shall be deemed to include any employee of the Foundation Trust or other person duly authorised by the Board or Trustee as "deputy" or "acting" or "interim" to represent that position.

2.3 Responsibilities and Delegation

1. The Trustee has delegated authority for routine operations of the Charity to the Committee, which exercises financial supervision and control by:

a) formulating the financial strategy necessary to fulfil the objects of the various funds;

b) preparing periodic budgets and forecasts so that planned expenditure remains within income levels over time;

c) defining and approving essential features in respect of important procedures and financial systems.

2. The Committee has resolved that certain powers and decisions may only be exercised by the Committee in formal session.

3. The committee has permitted the approval of lower value transactions to be undertaken according to the following Expenditure authorisation limits:

- Up to £2,000 - Deputy Director of Finance;
- From £2,001 to £10,000 - Chief Financial Officer and Chair of Committee;
- Above £10,000 - Committee as a whole.

4. Within the SFIs, it is acknowledged that the Committee is accountable to the Trustee for ensuring that the Charity fulfils its objectives as set out in the authorising documents of the various funds and has responsibility for the Charity's system of internal control.

5. The Committee is responsible for:

a) formulating the Charity's administrative and financial policies and for coordinating any corrective action necessary to further these policies;

b) establishing and maintaining an effective system of internal control including ensuring that detailed financial procedures and systems are documented to supplement these instructions;

c) ensuring that sufficient records are maintained to show and explain the Charity's transactions in order to disclose, with reasonable accuracy, the financial position of the Charity at any time; and

d) ensuring that good financial practice is followed in accordance with accepted accounting standards and guidance issued by the Charity Commission and other relevant bodies.

6. Members of the Committee and the Board, singularly and collectively, are responsible for:

a) the security of the property of the Charity;
b) avoiding loss;
c) exercising economy and efficiency in the use of resources;
d) conforming with the requirements of Standing Financial Instructions, Policies, and Financial Procedures; and

e) reporting any suspected theft or fraud or breach of the Charity's objects to the Trustee.

7. Any delegation of authority by the Trustee to the Committee or to any other body or individual does not in any way remove or diminish the overriding responsibility of the Trustee for the proper and secure administration of the Charity in pursuance of its objectives as set out in the establishing Deeds of Declaration.
8. The Committee has by informal arrangement delegated the undertaking of routine accounting transactions and the preparation of financial reports to the finance department of the Foundation Trust. An annual fee is paid by the Charity for the provision of these services and therefore the Foundation Trust is required to ensure that staff involved are adequately trained and experienced. All transactions undertaken on behalf of the Charity are recorded accurately and promptly and in full compliance with standard accounting practice and all applicable control and security procedures operated by the Foundation Trust in its own accounting processes.
9. No employee of the Foundation Trust is empowered by the Charity to commit the Charity to expenditure except in strict accordance with the authorisation limits set out above. It is the responsibility of the Committee to ensure that all such persons are aware of this restriction.

3 AUDIT

3.1 Foundation Trust processes

1. As noted above, the Foundation Trust provides the Charity with accounting and administrative services, for which a fee is payable to offset the incremental costs incurred in the provision of these services.
2. In providing such services, the Foundation Trust shall apply the same level and standard of care to transactions relating to the Charity as it does to its own transactions and operations. This includes, so far as they are relevant to transactions of the Charity, the application of any and all internal control, internal audit, security, and anti-fraud controls and processes that are set out in the Foundation Trust's own Standing Financial Instructions, Policies, and Procedures.

3.2 Fraud and Corruption

1. The function and operation of the Foundation Trust's Counter-Fraud processes shall be applied equally to transactions of the Charity at the discretion of those operating such controls.
2. If any matter arises which involves, or is thought to involve, irregularities concerning transactions of the Charity is discovered during Counter-Fraud controls, then the specified investigation and reporting processes of the Foundation Trust shall be followed and the Chairperson of the Committee and the Chief Financial Officer must be notified immediately.

3.3 Internal Audit

1. The function and operation of the Foundation Trust's Internal Audit processes may be applied equally to transactions of the Charity at the discretion of those operating such controls.
2. If any matter arises which involves, or is thought to involve, irregularities concerning transactions of the Charity is discovered during Internal Audit reviews, then the specified investigation and reporting processes of the Foundation Trust shall be followed and the Chairperson of the Committee and the Chief Financial Officer must be notified immediately.

3.4 External Audit

1. Generally, the regulations determining whether charities are required to have their accounts subjected to an audit or external examination are contained in the Charities Act 2016 and the Charities (Accounts and Reports) Regulations 2008. The Regulatory Reform (NHS Charitable and Non-Charitable Trust Accounts and Audit) Order 2005 amended s43 of the Charities Act 1993 this defined the Charity as an English National Health Service Charity, which are excluded from the exemption from audit on the basis of gross income limits.
2. The Committee will appoint an appropriately qualified and experienced auditor, and will obtain any consent required from the Charity Commission, Department of Health, or other body. The Committee will ensure that the Charity provides such information and facilities as are necessary for the auditor to fulfil their responsibilities under the 2016 Act.

4 FINANCIAL TARGETS

1. The Trustee has overall responsibility for the Charity's activities and in this capacity is responsible for ensuring that the Charity maintains its financial viability and complies with the objects contained in the establishing Deeds of Declaration.

2. There are no specific targets regarding overall financial performance in charities, but the Trustee and its delegated Committee is required to ensure the continuation of the Charity for the benefit of the beneficiaries defined in the objects.

3. Since the income of the Charity is primarily derived from voluntary donations it may be subject to considerable fluctuations from year to year. The Committee is required to manage levels of expenditure within income over time.

4. The Charity shall have a Reserves Policy that defines a target level of Reserves to ensure the sustainability of its operations. The target will be set by the Committee and actual levels of reserves regularly measured and compared to the target.

5 BUSINESS PLANNING AND BUDGETARY CONTROL

5.1 Preparation and Approval of Strategic Business Plan and Budget

1. The Committee will prepare a Business Plan for the Charity that sets out its key strategic objectives and annual financial forecasts for a future period of between three and five years. The Business Plan will include a detailed financial budget for the first (next) full financial year within the plan period. The strategic business plan will include:

   a) a statement of the grant objectives on which the plan is based; and
   b) details of the expected changes in income and other resources necessary to achieve the plan.

2. The Committee will submit the plan to the full Board, as Corporate Trustee, for approval.
3. The Business Plan will be reviewed and the period covered by it extended annually in advance of the new financial year. The review and period extension shall include a detailed financial budget for a further year. The review will take into consideration actual performance against the previous plan and any changes to grant objectives and future income forecasts.

5.2 Budgetary Control and Reporting

1. The Chief Financial Officer will devise and maintain a system of financial reporting that will be subject to periodic review, and if necessary, amendment. The system will include financial reports to the Committee on at least a quarterly basis containing:
   a) actual income and expenditure to date compared to budget;
   b) actual balance sheet position compared to budget;
   c) explanations of any material variances from plan
2. The Committee will review the financial reports presented to it and consider the financial consequences of variances from the budgeted and planned outcome. The review will include changes in policy and may result in any necessary alterations to the amount or timing of proposed grant awards and other events previously planned by the Charity.
3. The Committee will report its findings to the Trustee. If significant alterations to proposed grant awards or other events are necessary, the Committee will also notify the Board (as representative of the primary beneficiary) or any other proposed beneficiaries of the Charity of the likely effect of such changes.

6 ANNUAL ACCOUNTS AND REPORTS

1. The accounting and reporting framework for charities is provided by Part 8 of the Charities Act 2011. This and the regulations derived from it primarily provide for:

   a) The content of the Charity's annual reports;
   b) The form and content of the Charity's accounts;

c) The methods and principles adopted in preparing the Charity's accounts; and,
d) Information to be provided by way of notes to the Charity's accounts.

2. Additional regulations that must be complied with include:

a) the Charities Act 2011
b) the Charities Act 2016 fundraising rules,
c) the Charities Act 2022
d) The Charities (Accounts and Reports) Regulations 2008,
e) Accounting and Reporting By Charities: Statement of Recommended Practice FRS102 (2019),
f) Charity Reporting and Accounting, issued by the Charity Commission in November 2016.

3. The Committee will ensure that the annual accounts and reports of the Charity are prepared promptly after the financial year-end following all appropriate generally accepted accounting practices and in compliance with all applicable statutes and other regulations. With regard to their style and format, consideration will be given to recommendations or guidance from the Charity Commission, Department of Health, and current best practice. The annual accounts and reports shall be presented to the Trustee for approval and shall be signed as required by the applicable statutes and other regulations as evidence of that approval.

4. The Committee will arrange for the annual accounts and all accounting and other records of the Charity to be made available to the appointed auditor to carry out the audit of the accounts the report thereon. The auditor will present the report to the Trustee.

5. The Committee shall arrange for the audited annual accounts and reports to be published locally and to be lodged with the Charity Commission and any other necessary regulatory body.

7 BANK ACCOUNTS

7.1 General

1. The Committee is responsible for establishing and managing the Charity's banking arrangements and for advising the Charity on the provision of banking services and operation of accounts.

7.2 Bank Accounts

1. The Committee will agree and define detailed instructions on the operation of bank accounts which will include:
   a) Selection of the Charity's bankers
   b) The type of account and the conditions under which each bank account is to be operated;
   c) Limits and combinations of signatories for cheques or other orders drawn on the Charity's accounts.
2. The Chief Financial Officer, by virtue of membership of the Committee, is responsible for:
   a) Day-to-day operating of the bank accounts;
   b) ensuring that payments made from bank accounts do not exceed the amount credited to the account; and

c) reporting to the Committee all arrangements made with the Charity's bankers for accounts to be overdrawn.

3. No officer other than the Chief Financial Officer will open any bank account in the name of the Charity or relating to any activities of the Charity, or issue instructions to the Charity's bankers.
4. The Committee will agree and define detailed instructions on the operation of bank accounts which will include:

   a) the conditions under which each bank account is to be operated;
   b) the limit to be applied to any overdraft; and
   c) those authorised to sign other orders drawn on the Trust's accounts.

7.3 Banking Procedures

1. Accounting and administrative procedures including banking are carried out by staff of the Foundation Trust on behalf of the Charity.
2. In doing so, all of the normal procedures and controls used when banking for the Foundation Trust are also undertaken when banking for the Charity.

7.4 Tendering and Review

1. The Committee will review the banking arrangements of the Charity at regular intervals to ensure they reflect best practice and represent best value for money by periodically seeking competitive tenders for the Charity's banking business.
2. The Charity Bank account is currently a Government Bank account.

8 INCOME, AND SECURITY OF CASH, CHEQUES AND OTHER NEGOTIABLE INSTRUMENTS

8.1 Income

1. The Committee will define and operate an Income Policy for the Charity that will be subject to periodic review, and if necessary, amendment.
2. The Committee is responsible for establishing and maintaining suitable systems for the proper recording, invoicing, collection and coding of all monies due to the Charity.
3. Accounting and administrative procedures including banking are carried out on behalf of the Charity by the Foundation Trust and its staff. Where practical the Foundation Trust and its staff will adopt the same policies and procedures when dealing with income of the Charity.

8.2 Security of Cash, Cheques and Other Negotiable Instruments

1. The established systems, procedures and controls operated by staff of the Foundation Trust when dealing with income of the Charity are intended to ensure the proper recording and handling of cash and cheques. These include:
   a) approved forms of receipt books, agreement forms, or other means of officially acknowledging or recording monies received;
   b) secure ordering and control of such stationery;

c) the provision of adequate facilities and systems for employees whose duties include collecting and holding cash, including the provision of safes or lockable cash boxes; and
d) systems and procedures for handling cash and negotiable securities on behalf of the Charity.

2. Charity funds shall not under any circumstances be used for the encashment of private cheques.

3. All cheques, postal orders, cash etc. received shall be banked intact. Disbursements shall not be made from cash received, except under arrangements approved by the Chief Financial Officer.

9 EMPLOYEES

9.1 Recruitment and Appointments

1. No recruitment or appointment of employees shall be made except with the prior agreement of the Committee.

2. Wherever possible the same policies and procedures for the recruitment of staff as are followed by the Foundation Trust shall be used by the Charity.

3. For the Fundraising Team, the Head of Fundraising shall lead the interview and selection process. Members of the Committee, along with Director of Strategy and Business Development shall be involved in the interview and selection process for Senior Charity Staff and any other staff that the Charity seeks to employ. The Committee as a group shall make the final decision as to the selection and terms and conditions of employment of any successful applicant. Terms and conditions of employment shall include rate of pay, hours of work, any other benefits, and notice periods, and shall comply in all respects with any relevant employment law.

9.2 Processing of Payroll

1. Subject to the agreement of the Foundation Trust, the Charity will arrange for processing of payroll by that organisation as part of the accounting and administration services provided by it.

2. Regardless of the arrangements for providing the payroll service, the Chief Financial Officer shall ensure that the chosen method is supported by appropriate contracted terms and conditions, adequate internal controls and audit review procedures and that suitable arrangement is made for the collection of payroll deductions and payment of these to appropriate bodies.

9.3 Contracts of Employment

1. The Committee shall:
   a) ensure that all employees are issued with a Contract of Employment in a form approved by the Committee and which complies with employment legislation; and
   b) deal with variations to, or termination of, contracts of employment.

c) ensure that so far as possible, the terms and conditions will not be incompatible with those of the Foundation Trust.
d) deal with variations to, or termination of, contracts of employment.

10 EXPENDITURE

10.1 General

1. The Committee will define and operate an Expenditure Policy for the Charity that will be subject to periodic review, and if necessary, amendment.
2. The Committee is responsible for establishing and maintaining suitable systems for the proper recording, ordering, invoicing, payment and coding of all expenditure incurred by the Charity.
3. Accounting and administrative procedures including ordering, receiving of goods, and payment of invoices are carried out on behalf of the Charity by the Foundation Trust and its staff. Where practical the Foundation Trust and its staff will adopt the same policies and procedures when dealing with income of the Charity.

10.2 Governance and administrative costs

1. As noted above, the Foundation Trust provides accounting and administrative services to the Charity. In consideration of the provision of these services the Charity agrees to pay an annual fee to the Foundation Trust. The amount of the fee is intended to cover the incremental cost to the Foundation Trust of the provision of these services by existing Foundation Trust staff. It may not cover the full economic cost that would otherwise be incurred by the Charity if it had to provide all of the services itself.
2. The fee will be agreed annually between the Committee and the Board. The Foundation Trust will issue an invoice from time to time in respect of the agreed fee due which will be paid by the Charity in accordance with the standard terms and conditions of the Foundation Trust.
3. The Chief Financial Officer, as a member of the Board and not as a member of the Committee, shall ensure that the Foundation Trust has adequate staff time and other resources available as are necessary to provide the services to the Charity.
4. Expenditure for administrative or fundraising purposes shall be approved by the Committee in accordance with the agreed detailed financial forecast process described in section 5 above.
5. The Committee may delegate authorisation for certain types of expenditure to specified individuals within clearly defined limits. Any such expenditure shall be notified to the Committee by way of a report submitted for each monthly accounting period.

10.3 Grant Expenditure and Payments for Goods and Services

1. The Expenditure Policy and any associated process documentation shall set out the procedures to be followed by directors or staff of the

Foundation trust, and my staff and Committee members of the Charity regarding grant expenditure.

2. The Charity may make grant expenditure for goods or for services to or on behalf of appropriate beneficiaries. Expenditure on goods may include items of a capital or fixed nature, or of a revenue or consumable nature. At all times, expenditure must only be made for charitable purposes in accordance with the objects of the establishing Declaration of Trust.
3. In selecting the item to be supplied (or the service to be performed) the Charity may take into consideration any requests or proposals received from beneficiaries. At all times the Committee or its delegates retains the final right of decision in such matters and shall always seek obtain the best value for money for the Charity.
4. Where appropriate, the Charity will make use of the services of the Supplies or Procurement department of the Foundation Trust. When this occurs the Committee shall ensure that any agreed terms and conditions of supply, including credit payment terms, are complied with in full.
5. No employee of the Foundation Trust is empowered by the Charity to commit the Charity to expenditure except in strict accordance with the authorisation limits set out above. It is the responsibility of the Committee to ensure that all such persons are aware of this restriction.

10.4 Ownership and Title

1. Ownership or title in any goods acquired as a result of expenditure by the Charity may be transferred absolutely to a beneficiary or remain with the Charity.
2. Where ownership or title remains with the Charity but possession or control passes to a beneficiary, details of ownership shall be confirmed in writing between the Charity and the beneficiary, including details of any responsibility for its maintenance and upkeep. The item concerned shall be adequately labelled or marked to clearly identify ownership.

11 INVESTMENTS

1. The Committee will define and operate an Investment Policy for the Charity that will be subject to periodic review, and if necessary, amendment.

12 STORES AND RECEIPT OF GOODS

1. If the Charity has any trading activities requiring the purchase of items for use or resale, it will ensure that suitable controls and procedures are in place for the security of assets. Where practical, it will adopt the same policies and procedures as are used by the Foundation Trust for the same purposes, including records for receipt of goods, issues, and returns to stores, and losses.

2. Where necessary, stocktaking arrangements shall be agreed with the Chief Financial Officer and there shall be a physical check covering all items in store at least once a year.

13 ACCEPTANCE OF GIFTS AND HOSPITALITY

1. It is recognised that though most donations to the Charity will be in monetary form, whether as cash or cheque or other payment method, from time to time goods or services may be donated. When this occurs, a receipt or other written acknowledgement must be issued and appropriate procedures followed to ensure security of the donated item. A member of the Committee must be advised of the donation and should be consulted regarding disposition of the item. The value of a non-monetary donation should be disclosed in the Annual Report and Accounts as an in-kind benefit.

2. The personal acceptance by employees of gifts, hospitality or consideration of any kind from contractors and other suppliers of goods or services as an inducement or reward is not permitted under the Corruption Acts 1906 and 1916. The Foundation Trust has guidance on Standards of Business Conduct and this should be followed by all employees and Committee members of the Charity.

14 DECLARATION OF INTERESTS

1. The Trustee shall be advised of any declared pecuniary interests of members of the Board of Directors or employees that might officers, for recording in the register to be maintained for that purpose.

15 RETENTION OF DOCUMENTS

1. The Committee shall be responsible for the security of all documents that are required to be retained in accordance with Charity Commission and Department of Health guidelines and best business practice.

2. Documents held in archives shall be capable of retrieval by authorised persons.

3. Archived documents shall only be destroyed under authorisation of the Committee. A record will be kept of destroyed documents.

16 RISK MANAGEMENT & INSURANCE

1. The Committee will ensure that the Charity has a programme of risk assessment and management, in accordance with current controls assurance guidance from the Charity Commission, Department of Health, NHS Improvement and best practice.

2. The programme of risk management shall include:
   a) a process for identifying and quantifying risks and potential liabilities;

b) management processes to ensure all significant risks and potential liabilities are addressed including effective systems of internal control, cost effective insurance cover, and decisions on the acceptable level of retained risk;
c) a policy to promote awareness among Foundation Trust staff involved with the Charity about the control of risk;
d) contingency plans to offset the impact of adverse events;
e) audit arrangements;
f) arrangements for regular reviews of the risk management programme.

3. The Committee will assess whether it is appropriate to implement insurance cover against the occurrence of identified risks.

4. The value of all assets of the Charity and any insured risks shall be reviewed annually by the Committee.

Policy Title	**CHARITABLE FUND FUNDRAISING POLICY**		
Procedure Number		**Version number**	
Applicable to	**Corporate Trustee, Charitable Funds Committee and Fundraising Team**		
Date issued	**21 March 2023**		
Review date	**21 March 2026**		
Author's name and title	**Simon Pearson, Head of Charity and James Claypole, Deputy Financial Controller**		
Development group/committee	**Charitable Funds Committee**		
Stakeholders	**Charitable Funds Committee; DCH Charity Team; DCH Finance**		
Approved by	**Charitable Funds Committee**		
Date approved	**21 March 2023**		
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Ratified on	**31 May 2023**		
Keywords			

Document Management Section (if applicable)			
Previous policy number		**Previous version number**	
Changes requested or dictated by			
Description of changes since last version			

CHARITABLE FUND (Registered Charity 1056479)

FUNDRAISING POLICY

1. INTRODUCTION

1.1 Dorset County Hospital NHS Foundation Trust Charitable Fund (the Charity) has a single corporate trustee, which is Dorset County Hospital NHS Foundation Trust (DCHFT), in the form of the Board of Directors of that organisation. Responsibility for the management and administration of the Charity has been delegated to the Charitable Funds Committee, comprised of members of the Board, including the Chief Financial Officer.

1.2 These responsibilities include ensuring that:

- Fund raising is properly carried out;
- Expenditure is properly validated;
- All funds raised are properly accounted for.

1.3 Fundraising is a legitimate means of improving patient care, by enabling the purchase of additional goods, equipment or services, which are not available within NHS capital or revenue budgets. For the public, donating cash or equipment, or actively raising funds is seen as a positive way of supporting local health services.

2. PURPOSE

2.1 It is considered good practice for all charities to prepare and publish a Fundraising Policy. The existence of clear guidance assists the Trustee in meeting its responsibilities and for those involved in fundraising activities to do so in full compliance with all applicable regulations.

2.2 The primary aim of the policy is to ensure that the Charity complies with its own establishing Declarations of Trust, which includes specific details about how and on what received funds may be expended.

2.3 The charity is registered with the Fundraising Regulator to comply with all recognised fundraising standards including those of the Code of Fundraising Practice.

3. SCOPE OF RESPONSIBILITY

3.1 The Charity employs staff in its Fundraising Team and makes use of administrative and accounting services provided by the Foundation Trust, mainly by staff within the Financial Services function.

3.2 This policy applies to members of the Charitable Funds Committee, the wider Foundation Trust Board of directors, and all DCHFT staff involved with the fundraising activities on behalf of the Charity.

4. APPROVAL OF FUNDRAISING

4.1 Fundraising activities will be recognised so long as they are generally within the strategic direction of the Charity. Fundraising by hospital staff must be approved in advance (see Section 5 below). Other fundraising by external bodies will be recognised, although such bodies will be encouraged to advise the Charity of their intentions in advance and be guided by the Charity.

4.2 If funds are raised or donated to the Charity, the Charitable Funds Committee may decline to accept the donation, but will encourage the donor/organiser to allow the donation to be used for more appropriate general purposes. The Trustee can also decline the donation if it is felt that the conditions attached to the donation are not in the interests of the Charity, or are too onerous to adhere to. Donations with conditions attached are likely to create restricted funds for accounting purposes. The Charity would prefer donations to be granted as a wish without an obligation attached to it.

4.3 All fundraising by Foundation Trust staff must be approved before it commences.

4.4 The Head of Charity, regardless of the sum involved, must approve all fundraising outside the Foundation Trust, e.g. collections outside of Foundation Trust premises, appeals to the media or industry. The Head o Fundraising will report such approvals to the Charitable Funds Committee.

4.5 If a member of the Foundation Trust's staff becomes aware of an external body fund raising on behalf of the Charity, he/she must notify the Head of Charity so that the fundraising can be approved (if this has not already occurred) and the Charity can formally accept the donated cash or equipment.

4.6 Proposals for approval of major fundraising appeals or projects (whether by members of staff or external bodies) must include the following details:

- Scheme for which funds are to be raised;
- How the funds will be raised (collections, raffles, appeal, etc);
- Capital cost of the scheme;
- Revenue cost of the scheme;
- Where relevant should be supported by Trust service business case;
- Proposed source of funding if any cost additional to that covered by fundraising;
- For equipment, proposed source of eventual replacement and timescale.

5. METHODS OF FUNDRAISING

5.1 Many Health Service bodies raise funds on a regular basis through appeals (both large and small), trusts and foundations, individuals, community events, lotteries, sponsored events, companies etc. We must be careful however, about inadvertently moving from charitable fund raising to non-charitable trading (e.g. income from training courses held in Foundation Trust's time on Foundation Trust premises cannot be considered as a charitable donation). The Charities Act gives health bodies the power to engage in activities

intended to stimulate the giving of money but does not give a general license to trade. The Charity might consider registering a trading company if relevant opportunities arise to support fundraising further.

Lotteries

5.2 The Charity is registered for lotteries with West Dorset District Council Small Society Lottery Licence No SL0135), which covers the Charity for lottery ticket sales less than £20,000 and the Charity does not make total lottery sales of over £250,000 from all lottery sales in any financial year. Information and advice about lotteries must be obtained from the Foundation Trust's Charitable Accounts staff.

Special Appeals

5.3 The Charity has a number of existing funds for special purposes, known as restricted funds, which are separately registered with the Charity Commission.

5.4 If fundraising is planned for one of these funds, it is important that the purpose is clearly stated so that the public knows precisely for what they are contributing.

5.5 Generally appeals would be a restricted fund as a donor would get the impression that their donation was to pay for the purpose of the appeal and not for any other purpose. Unrestricted funds could include the proceeds of an appeal but only provided the trustees have added a disclaimer to the effect that the appeal proceeds may be used for other purposes of the charity in the event that the appeal purposes cannot be fulfilled.

Fundraising by other bodies

5.6 Where the Charity becomes aware of fundraising by other bodies it will:

- Try to bring the fundraising initiative within the ambit of existing strategy;
- Liaise with the fundraiser to ensure there are no misrepresentations;
- Take all reasonable steps to ensure consultation prior to any fundraising to avoid being asked to accept assets we do not want or cannot afford to maintain;
- The Foundation Trust can take steps (including legal steps) to prevent unauthorised fundraising, and ensure that all donations from unauthorised fundraising are passed to the charity. The Foundation Trust can allow the unauthorised fundraising to continue with written agreement of the terms and conditions.

Gift Aid tax relief

5.7 The Charity participates in a scheme operated by HM Revenue & Customs that permits the claim of basic rate tax relief where donors have competed and provided necessary information about their tax status. An example of the form is given below at Appendix 3. All donors should be encouraged to donate in this way.

Public Collections

5.8 The Charity needs to obtain a Public Collections Licence from the Local Council if it wishes to carry out door-to-door or street collection fundraising.

Any public collections that are conducted where the public has free access (eg: shopping centres, football clubs, etc), are not regulated but do require permission from the landlord.

6. REVENUE CONSEQUENCES OF DONATED ASSETS

6.1 Fundraising is normally for the capital cost and there is usually not a requirement to raise the maintenance costs. Therefore fundraising would be approved as long as the Trust is satisfied that its revenue budgets can support any on-going maintenance, consumables and any other recurring running cost of procuring the asset. The Chief Financial Officer has authority to waive this requirement if they are satisfied that alternative arrangements are in place.

7. SPONSORSHIP

7.1 Sponsorship from personal or corporate sources is a potential source of funding for a variety of purposes.

7.2 In general sponsorship is a corporate issue and the Director of Strategy, Transformation & Partnerships must approve all proposals. Each proposal will be dealt with on an individual basis and will be considered on its merits, fit with the Business Plan, and the appropriateness of the sponsor to the area or service to be sponsored.

8. ACCOUNTING FOR FUNDRAISING AND SPONSORSHIP

8.1 When a fundraising event or a sponsorship has been agreed according to the above procedure the Foundation Trust's Charitable Accounts staff must be informed immediately of the funds received.

8.2 Separate accounts will be set up within the Charitable Fund pool to which all income and expenditure will be posted. The Foundation Trust's Charitable Accounts staff will inform the fundraiser of the number of the account to be used.

8.3 Any cash donations received against the fund must be receipted and deposited in accordance with the financial procedures for the receipt of donations detailed in section 9 below.

8.4 If goods of an estimated value greater than £100 have been received rather than money, then the donation form must still be completed, crossing out sum of and instead writing in the description of the goods received. The donor will be given his/her copy of the form and a copy being retained by the Charity through the Fundraising Team.

Auction of Goods

8.5 On occasions donation of goods may be auctioned. Where this occurs, the date, time, and place of the auction will be set by the Charity Fundraising Team. ***All auctions must be agreed with the Head of Charity and promoted and managed in line with fundraising guidelines***.

8.6 Wards may have small sales at different times of the year, particularly around Christmas.

8.7 Common sense should prevail as it is clearly impracticable to list and receipt all items donated e.g. cakes, second hand toys, etc, and then give receipts for all sales.

8.8 Each stall should, however, be manned by two people at all times and, at the end of the event, the money counted by both, a donation form completed and the money taken immediately to the cash office.

8.9 Any goods not sold on the day, depending on their nature, should:

- be listed by two people;
- if desired kept in a secure environment until the next event;
- where a consumable item (e.g. cake) disposed of;
- if no further event is likely to occur, the goods will be taken to a charity shop, which should provide a receipt that the goods as listed have been received.

8.10 It is not considered reasonable to try and return items to their previous owner who may take offence at such an action.

9. RECEIPT OF DONATIONS

9.1 To ensure that donations are spent as the donor wishes, and so that the Charity has documentary evidence of the donor's wishes, an official receipt will be provided to the donor, in a timely manner.

9.2 The receipts are two part numbered stationery. One copy of the receipt is given to the donor, one copy sent to cash office with the donation.

9.3 Receipt books are available from the Cash Office and will be issued to each ward/area.

9.4 Since the books are serially numbered, voided receipts will also be returned to the Cash Office with the receipt clearly marked as to why it has been made void. Gaps in returned serial numbers will be examined by cash office/audit. Trust staff are reminded that all donations must be immediately banked via the cash office into DCHFT accounts and not into private accounts of any description or kept in drawers. The Fundraising Team also have a safe to help cover the cash office when it is closed. Cash donations must not be used to offset expenditure when received but sent to cash office.

10. FAILED APPEALS

10.1 The Charity could be subject to a failed appeal for funds for a specific project that has been approved by the Trustee.

10.2 Where the appeal has raised insufficient funds for the project (an initial failure), the Charity is required to offer to return donations to the donors where they can be reasonably identified, unless the original appeal documentation stated what would happen to any unused donations.

11. SUCCESSFUL APPEALS

11.1 Where the appeal has raised surplus funds for the project donors will not be entitled to a refund of their donation, if the original appeal documentation stated what would happen to any unused donations.

Chris Hearn

Chief Financial Officer

21 March 2023

Appendix 1

FUNDRAISING POLICY FOR LOTTERIES, RAFFLES & OTHER FORMS OF GAMING

1. INTRODUCTION

1.1 This policy has been developed to provide guidance for employees of Dorset County Hospital NHS Foundation Trust on how to register fund raising activities in line with the requirements of the legislation referred to below.

1.2 The purpose of this policy is to affirm the Charity's commitment to comply with the requirements of the Act and to set out the procedural arrangements, which must be applied internally to ensure compliance.

1.3 Failure to comply with the requirements of the Gambling Act may be a criminal offence and therefore it is imperative that the procedure is followed in all cases.

1.4 This policy must be adhered to by any member of staff wishing to conduct any form of gaming including lotteries and raffles as a means of raising funds. Any member of staff who conducts a raffle, lottery or other form of gaming without adherence to this procedure will be liable to disciplinary action.

2. LEGISLATION AND GUIDANCE

2.1 The Gambling Act 2005 places upon the Charity a duty to ensure that any forms of gaming, e.g. raffles, lotteries, etc which involve the participation of individuals who are not employees of the Foundation Trust, i.e. patients, residents, visitors, members of the public, must comply with both the registration and operational requirements of the Act. This is done to ensure the interests of those individuals are protected by statute.

3. AIMS AND OBJECTIVES

3.1 The objective of this policy is to ensure that all staff understand how to register fundraising activities.

3.2 The aims of this policy are to: -

- To ensure the Charity complies with current legislation;
- Define the individual responsibilities for registering fundraising activities;
- Describe the arrangements for registering fundraising activities.

4. ACCOUNTABILITIES AND RESPONSIBILITIES

4.1 The Head of Charity is responsible for organising the "Licence registration under the Gambling Act 2005" with Dorset Council to cover all Foundation Trust staff and approved activities. For the purposes of this policy the registration address is Dorset County Hospital NHS Foundation Trust,

Williams Avenue, Dorchester, Dorset DT1 2JY. This address must be used on all tickets produced. The promoter is responsible for:

- The conduct of the lottery, raffle, etc, and to describe both the purpose and the operational arrangements which will apply;
- Formally registering the intention to conduct a raffle, lottery or any other form of gaming.

4.2 The Head of Charity is responsible for sending the Deputy Financial Controller a quarterly "Schedule of Returns" for approval and signature.

5. TRAINING

5.1 It is recognised that this is an area with which staff will not necessarily be familiar. Further advice and information may therefore be obtained from the Charity, at Dorset County Hospital NHS Foundation Trust.

6. PROCEDURE

6.1 In order to conduct a raffle, lottery of other form of gaming the pro-forma attached at Appendix 1 must be completed by the organiser and authorised by the Promotor (DCH Charity).

6.2 The completed proforma will be forwarded to the Head of Charity who will complete the authorisation (section 2) and return it to the nominated organiser.

6.3 Any raffle, lottery, etc not properly registered will not be covered by the Charity's registration and may be illegal. Retrospective approval cannot be given.

6.4 Once the lottery, raffle, etc has been conducted the organiser will be required to complete section 3 of the proforma detailing the financial aspects and return it to the Head of Charity within 7 days of the fundraising event.

6.5 The Head of Charity will then complete the required return to the Council in line with the required timescales and regulations; retaining a copy for the Charity's records.

Appendix 2

GAMBLING ACT 2005 (SOCIETIES LOTTERIES REGISTRATION No. LA7360)
FUND RAISING RETURN – RAFFLES, LOTTERIES AND OTHER FORMS OF GAMING

Section 1:
To be completed by the 'promoter' and forwarded to the Chief Financial Officer at Dorset County Hospital NHS Foundation Trust for authorisation prior to the sale of tickets.

Name of Promoter / Organiser:
Ward / Department:
Date tickets will be on sale From: To
Date the prize winner will be drawn:
Purpose of Lottery:
Number of tickets to be sold:
To whom will tickets be sold (tick): Staff Patients Visitors Public

Section 2:
To be completed by the Chief Financial Officer at Dorset County Hospital NHS Foundation Trust.

Authorisation:

Dorset County Hospital NHS Foundation Trust Charitable Fund approves this application to run a raffle to commence on: _____

Chief Financial Officer: _____

Date: _____

Section 3:
To be completed by the 'promoter' and returned to the Deputy Financial Controller within 7 days of the prizewinners being drawn.

Total cash received from sale of tickets: £
Expenses incurred raffle ticket sale etc. £
Cost of prizes: £
Total cost: £
Balance paid into fund: £
Fund Code:
Signature of Promoter: Date:

Appendix 3

Charity Gift Aid Declaration – multiple donations

Boost your donation by 25p of Gift Aid for every £1 you donate
Gift Aid is reclaimed by the charity from the tax you pay for the current tax year. Your address is needed to identify you as a current UK taxpayer.

In order to Gift Aid your donation you must tick the box below:
I want to Gift Aid my donation of £_____ and any donations I make in the future or have made in the past 4 years to:

Dorset County Hospital Charity

I am a UK taxpayer and understand that if I pay less Income Tax and/or Capital Gains Tax than the amount of Gift Aid claimed on all my donations in that tax year it is my responsibility to pay any difference.

My Details
Title _____ First name or initial(s) _____

Surname _____

Full Home address _____

_____

Postcode _____ Date _____ _

Signed _____

Please notify Dorset County Hospital Charity if you:

- want to cancel this declaration
- change your name or home address
- no longer pay sufficient tax on your income and/or capital gains

If you pay Income Tax at the higher or additional rate and want to receive the additional tax relief due to you, you must include all your Gift Aid donations on your Self-Assessment tax return or ask HM Revenue and Customs to adjust your tax code.

Thank you for your support. Please return this form to Dorset County Hospital Charity.

Policy Title	**CHARITABLE FUND INCOME POLICY**		
Procedure Number		**Version number**	
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Author's name and title	**James Claypole, Deputy Financial Controller**		
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Stakeholders	**Head of Charity and Fundraising Team Members, Cashiers.**		
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CHARITABLE FUND (Registered Charity 1056479)

INCOME POLICY

1. INTRODUCTION

1.1 Dorset County Hospital NHS Foundation Trust Charitable Fund (the Charity) has a single corporate trustee, which is Dorset County Hospital NHS Foundation Trust (DCHFT), in the form of the Board of Directors of that organisation. Responsibility for the management and administration of the Charity has been delegated to the Charitable Funds Committee, comprised of members of the Board.

1.2 These responsibilities include: Ensuring that funds are spent efficiently and promptly in furthering the fund's objectives.

1.3 This document sets out the policies of the Charity for receiving income donated to it.

1.4 Income may be received from a range of sources including donations or legacies.

2. PURPOSE

2.1 It is considered good practice for all charities to prepare and publish an Income Policy. This policy should be prepared in line with current regulations contained in the Charities Act 2016, the Statement of Recommended Practice FRS102 (2019) and the NHS Act 2006.

2.2 The primary aim of the income policy is to ensure that the Charity complies with its own establishing Declarations of Trust, which include specific details about how and on what received funds may be expended.

2.3 Specific restrictions may be placed by the donor on the expenditure of donated funds, and in these cases amounts received will be allocated to one of the Charity's restricted funds.

2.4 Where a donor makes an indication of preference that does not impose a legal obligation, amounts received may be allocated to one of the Charity's designated funds, or may be allocated to general funds at the discretion of the Charitable Funds Committee.

2.5 Where no restriction or indication of preferences is made, income will be allocated to general funds.

3. SCOPE OF RESPONSIBILITY

3.1 The Charity employs staff within its Fundraising Team and also makes use of administrative and accounting services provided by the Foundation Trust, mainly by staff within the Financial Services function.

3.2 This policy applies to members of the Charitable Funds Committee, the wider Foundation Trust Board of directors, and all other DCHFT staff involved with the receipt of Charitable Funds.

4. INCOME RECEIVED BY DONATION OR LEGACY

4.1 From time to time Patients and/or their relatives and other supporters wish to make a donation to the Charity, often as an expression of appreciation for their care. Dorset County Hospital Charity would normally want to accept these, either into the general purpose fund or into one of the other restricted funds, designated or unrestricted funds if the preference is indicated. However the following matters must be considered:

- Patients and/or their relatives or others must never be made to feel under any pressure that a donation is expected;
- Donors may express a preference for a particular specialty or department to benefit from the donation, and such expression may constitute a legally binding restriction on use of the funds by the Charity. If an expression of preference is made, it should not be finally accepted without further information and advice being obtained from the Foundation Trust's Charitable Accounts staff;
- All donors should be provided with, and encouraged to complete and return, a Gift Aid form (see Appendix 1) to enable the Charity to reclaim income tax and thereby increase its total income. All those participating in a sponsored event, should be encouraged to complete a 'Sponsorship And Gift Aid Declaration Form' to reclaim income tax.
- Where donations are received in cash, the donation should be logged on the Fundraising Database and then taken to the cash office where it is logged on the Harlequin Debtors System and a cash sheet created. A receipt should be issued to the donor along with a thank you letter.
- Donations by cheque should be made payable to Dorset County Hospital Charity.
- Money received should be kept safely and banked as quickly as possible, clearly identified as a trust fund donation using the code issued for this purpose;
- A Legacies register is maintained by Financial Services, which records the legacy value, legacy description, type of legacy and executors.

4.2 There may be circumstances in which a gift made by legacy under the terms of the will of a deceased former patient or relative or other supporter may impose legally binding restrictions that are not acceptable to the Charity or its Trustee. In such cases it may not be advisable to accept the legacy without further consultation, and cheques must not be banked or accepted without the approval of the Charitable Funds Committee. A scheme of the Charity Commission may be used to remove any restrictions. Any enquiries, correspondence, or cheques received relating to legacies must be forwarded to the Head of Charity (regulations dealing with legacies are located in the NHS Act 2006 Section 218).

4.3 Income is banked into the Charity's bank account and is identified and coded to the relevant funds. Cheques must be made payable only to the Charity, banked in accordance with the Foundation Trust's Financial Procedure for Cashiering.

4.4 An example of the Gift Aid form received from an individual donor is shown at Appendix 1.

4.5 Income from donations or grants is recognised when there is evidence of entitlement to the gift, receipt is probable and its amount can be measured reliably.

4.6 In the case of a grant, evidence of entitlement will usually exist when the formal offer of funding is communicated in writing to the charity.

4.7 In the case of a donation, entitlement usually arises immediately on its receipt.

4.8 Receipt of a legacy must be recognised when it is probable that it will be received. Receipt is normally probable when:

- There has been grant of probate;
- The executors have established that there are sufficient assets in the estate, after settling any liabilities, to pay the legacy;
- Any conditions attached to the legacy are either within the control of the charity or have been met.
- The value of the legacy due can be reliably measured.

5. INCOME FROM INVESTMENTS

5.1 Policy regarding Income from investments is included in the separate Investment Policy document.

6. INCOME FROM FUNDRAISING ACTIVITIES

6.1 Policy regarding Income from Fundraising Activities is included in the separate Fundraising Policy document and includes donations, events, sponsorship and trading activities.

7. POLICY REVIEW

7.1 Application of the policy will be monitored at each meeting of the Charitable Funds Committee, reviewing:

- Income details against the Charitable Funds;

7.2 The Committee will formally review the Income Policy and consider if any changes are required at the policy review date.

Chris Hearn
Chief Financial Officer 21 March 2023

Appendix 1

Gift Aid Declaration Form

Key criteria for Gift Aid – please note we can only accept your **home address**

Title * First Name * Surname *

Home Address *

Postcode *

Email

Phone

Date of Declaration *

***mandatory fields**

If you are a UK taxpayer, you can boost your donation by 25p for every £1 you donate. giftaid it

Please tick the box below.

☐ I am a UK taxpayer. Please treat all donations I make or have made to Dorset County Hospital Charity for the past 4 years as Gift Aid donations until further notice.

I am a UK taxpayer and understand that if I pay less Income Tax and/or Capital Gains Tax than the amount of Gift Aid claimed on all my donations in that tax year, it is my responsibility to pay any difference.

Please let us know if you want to cancel this declaration, change your home address, or no longer pay sufficient tax.

It may be that, having read the information on this form, you feel that your donation does not qualify for Gift Aid. If this is the case please tick the relevant box below and return this form to us. This will ensure you are not asked to complete a Gift Aid form in the future, should you choose to support us again.

I cannot complete the Gift Aid form because:

☐ I am not a UK taxpayer ☐ I do not pay enough tax each year to cover the tax on the gift

☐ Other (please state)

Keep in Touch

Hear about our latest news and campaigns, and how you can support our work.

Can we send you emails?	Yes ☐	No ☐
Can we send you mail?	Yes ☐	No ☐
Can we phone you?	Yes ☐	No ☐
Can we send you text messages?	Yes ☐	No ☐
I give my consent to receiving news, appeals and ways to get involved	Yes ☐	No ☐

How would you prefer us to get in touch with you? Mail ☐ Phone ☐ Email ☐

Gift Aid Key Facts

When Dorset County Hospital Charity receives a donation from a UK taxpayer, we are entitled to claim an amount of tax (calculated at the basic rate of income tax in that year) paid on that donation. Once you have given your permission for us to do this on your behalf (by filling in this Gift Aid form), there is no need for you to do anything else.

All that is required is that you must be a taxpayer and that you would have paid or will pay sufficient Income and/or Capital Gains Tax to cover all the Gift Aid claimed on all your donations in that tax year. Please note that it is your responsibility to pay any difference.

The amount of tax we claim will be 25% of the total value of your donations in that tax year. Furthermore, if you are a higher rate taxpayer you are also entitled to claim the difference between the basic rate which we will claim and the amount of tax you have actually paid. For further details on how you can do this, please contact your tax office.

If your tax situation changes and your gifts will no longer be eligible for the Gift Aid scheme, please contact us and we will amend your record accordingly.

Dorset County Hospital Charity, Williams Avenue, Dorchester, Dorset, DT1 2JY
www.dchcharity.org.uk
01305 253215

Registered Charity 1056479

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CHARITABLE FUND (Registered Charity 1056479)

EXPENDITURE POLICY

1. INTRODUCTION

1.1 Dorset County Hospital NHS Foundation Trust Charitable Fund (the Charity) has a single corporate trustee, which is Dorset County Hospital NHS Foundation Trust (DCHFT), in the form of the Board of Directors of that organisation. Responsibility for the management and administration of the Charity has been delegated to the Charitable Funds Committee, comprised of members of the Board.

1.2 These responsibilities include: Ensuring that funds are spent effectively, efficiently and promptly in furthering the fund's objectives.

1.3 The Charity has a duty to spend funds donated to it in a timely manner unless the fund's governing document gives it power to accumulate income to ensure the sustainability of the Charity or there is an agreed specific application in mind. Simply to allow the funds to accumulate without good reason could be considered a breach of Trust but the Reserves Policy has to be considered in conjunction with the Expenditure Policy.

1.4 This document sets out the policies of the Charity for spending from funds donated to it and is restricted to funds relating to services provided by DCHFT, mainly at its Dorset County Hospital location.

2. PURPOSE

2.1 It is considered good practice for all charities to prepare and publish an Expenditure Policy. The Expenditure Policy should be prepared in accordance with the regulations contained in the Charities Act 2011, The Statement of Recommended Practice (FRS102 SORP 2019) and the NHS Act 2006.

2.2 The primary aim of the expenditure policy is to ensure that the Charity complies with its own establishing Declarations of Trust, which includes specific details about how and on what received funds may be expended.

2.3 Where specific restrictions are placed by the donor on the expenditure of donated funds, amounts received will be allocated to one of the Charity's restricted funds. Where a donor makes an indication of preference, which does not impose a legal obligation, amounts may be allocated to one of the Charity's designated funds.

3. SCOPE OF RESPONSIBILITY

3.1 The Charity employs fundraising staff and uses administrative and accounting services provided by the Foundation Trust, mainly by staff within the Financial Services function, to provide support to the processing of charitable applications.

3.2 This policy applies to members of the Charitable Funds Committee, the wider Foundation Trust Board of directors, and all other DCHFT staff involved with the expenditure of Charitable Funds.

4. USE OF FUNDS

4.1 The funds will be utilised only in line with the objectives of the funds for the benefit of patients and staff to purchase goods and services that would not be ordinarily funded by revenue or capital resources available to the Foundation Trust.

4.2 Given the varying nature of the Charitable Funds and the differing purposes for which they were donated it is not practical to provide specific examples of items that would, or would not be, permissible uses of funds. There is a general presumption be that it would not ordinarily be expected to purchase goods or services for which the Foundation Trust has an existing budget, or where it might be considered reasonable that such a budget should exist. Any purchase of items from the Charitable Funds, that does not comply with the objects of the particular fund (or the funds in general), the Corporate Trustees, as a corporate body, could be liable to repay the funds used to the Charitable Funds.

4.3 For each of the Restricted, General Purpose, and Designated funds, the Charitable Funds Committee appoints a Fund Representative to act as a liaison point between the hospital departments/specialties, the Charity, and the Foundation Trusts finance staff that deal with accounting on behalf of the Charity. Where a Fund Representative has not been appointed, this function will be provided temporarily by the Committee or a member of the Committee.

4.4 The Charitable Funds Committee encourages the use of funds for appropriate causes but recognises the possibility that not all funds will be utilised in the short-term. The Charity has adopted a Reserves Policy, intended to ensure that it has sufficient funds available for unrestricted use to sustain donation expenditure for a reasonable time during periods of fluctuating income. Where surplus funds temporarily exist, an investment approach that minimises risk and maximises return on investment will be adopted, as per the Investment Policy.

4.5 Where the immediate benefit of expenditure is for staff welfare or development, there should be a clear evidence of how this will improve services for patients and service users, for example through enhancing relevant staff skills or encouraging staff innovation.

4.6 The Charitable Funds Committee recognises that all expenditure incurred in the pursuit of the Charitable Funds objects, should meet the Public Benefit Test as defined in the NHS Regulations recognised by the Charity Commission.

4.7 Retirement buffets and departmental meals can lead to tax implications as these may be seen as benefit in kind and as such are not supported.

4.8 When considering using Charitable Funds, thinking from a public perception point of view, a person should ask themselves:

- Would someone who puts a pound in a collection tin be happy for it to be spent in this way?
- Would you be proud to tell a donor about this expenditure and the difference this is making?
- Would you be confident in defending this as a charitable purchase or should it have come from an NHS budget?

5. LISTING OF FUND OBJECTS

The Charity comprises a number of funds, each established by a declaration of trust that includes a clause setting out the objects of the fund. Listed below are the object clauses for each of the funds. The heading sets out the name of the fund, its date of formation, and (where applicable) the current cost centre details within the hospital's accounting system.

5.1 General Purpose Fund (Umbrella Fund) - 10 August 1996 - Cost Centre ZZA

The trustees shall hold the trust fund upon trust to apply income and at their discretion, so far as may be permissible, the capital, for any charitable purpose or purposes relating to the National Health Service, wholly or mainly for relief of sickness and the promotion of health of patients who are or have been treated at the Dorset County Hospital NHS Foundation Trust.

5.2 Staff General Purpose Fund - 6 August 1996 - Cost Centre ZZB

The trustees shall hold the trust fund upon trust to apply income and at their discretion, so far as may be permissible, the capital for the relief of sickness by promoting the efficient performance of their duties by the staff of the Dorset County Hospital NHS Foundation Trust.

5.3 Patients General Purpose Fund - 6 August 1996 - Cost Centre ZZC

The trustees shall hold the trust fund upon trust to apply income and at their discretion, so far as may be permissible, the capital for the relief of sickness and the promotion of health of patients who are or have been treated at the Dorset County Hospital NHS Foundation Trust.

5.4 Children's Services Fund - 6 August 1996 - Cost Centre ZYB

The trustees shall hold the trust fund upon trust to apply income and at their discretion, so far as may be permissible, the capital for any charitable purpose or purposes relating to the National Health Service wholly or mainly for Children's Services administered by Dorset County Hospital NHS Foundation Trust.

5.5 Special Care Baby Unit - 6 August 1996 - Cost Centre ZYC

The trustees shall hold the trust fund upon trust to apply income and at their discretion, so far as may be permissible, the capital for any charitable purpose or purposes relating to the provision of health care wholly or mainly for the Special Care Baby Unit.

5.6 Arts in Hospital - 6 August 1996 - Cost Centre ZYD

The trustees shall hold the trust fund upon trust, to apply income and at their discretion, so far as may be permissible, the capital to help relieve the sickness of patients at Dorset County Hospital NHS Foundation Trust by enhancing the environment of the hospitals by the provision and development of therapeutic programmes connected with the arts and the provision of art work.

5.7 Diabetic Fund - 26 August 1997

The trustees shall hold the trust fund upon trust to apply income and at their discretion, so far as may be permissible, the capital for any charitable purpose or purposes relating to the National Health Service wholly or mainly for the Diabetic Specialty administered by Dorset County Hospital NHS Foundation Trust.

5.8 Renal Fund - 26 August 1997 - Cost Centre ZYF

The trustees shall hold the trust fund upon trust to apply income and at their discretion, so far as may be permissible, the capital for any charitable purpose or purposes relating to the National Health Service wholly or mainly for the Renal Department/Services administered by Dorset County Hospital NHS Foundation Trust.

5.9 The Lillian Martin Ophthalmology Fund - 20 December 2001 - Cost Centre ZYL

The trustees shall hold the trust fund upon trust to apply income and at their discretion, so far as may be permissible, the capital for the provision of facilities and equipment in connection with Ophthalmology services at Dorset County Hospital NHS Foundation Trust.

5.10 West Dorset Medical Society for Postgraduate Education and Research - 4 February 2004 - Cost Centre ZYN

The trustees shall hold the trust fund upon trust to apply income and at their discretion, so far as may be permissible, the capital for any charitable purpose or purposes relating to the National Health Service wholly or mainly for the Dorset County Hospital NHS Foundation Trust which will further the following aims:

a) To promote and advance the study and general knowledge of medicine and science and all matters relating to the progress and development of medicine;
b) To foster post-graduate medical and dental education for and research by consultants, practitioners and hospital staff;
c) To assist in bringing general practitioners within the hospital sphere and thereby to provide improved service to the community by greater co-operation between the various branches of medicine or dentistry;

5.11 DCHFT Cancer Services Charity - 19 May 2004 - Cost Centre ZYM

The trustees shall hold the trust fund upon trust to apply income and at their discretion, so far as may be permissible, the capital for any charitable purpose or purposes relating to Cancer Services administered by Dorset County Hospital NHS Foundation Trust.

6. AUTHORISATION LEVELS

6.1 Applications for expenditure of Charity funds may be initiated by hospital staff but must be made using the specified Charitable Funds Application Form. A copy of the specified Charitable Funds Application Form can be obtained from the Charity Fundraising Team. If necessary, further information and advice may be obtained from the Charity Fundraising Team or Deputy Financial Controller.

6.2 Applications for expenditure should be submitted initially to the relevant Divisional Manager and Fund Representative, and must be fully approved at the appropriate level before any purchase order or other commitment to expenditure are issued.

6.3 Requests for expenditure will be considered for approval, providing sufficient funds are available within the appropriate fund, or general resources. Expenditure authorisation levels are set out in the Standing Financial Instructions (SFIs) and are as follows:

Up to £2,000 – Deputy Director of Finance & Resources;

From £2,001 to £10,000 – Chief Financial Officer plus chair of Charitable Funds Committee;

Above £10,000 – Charitable Funds Committee

7. POLICY REVIEW

7.1 Application of the policy will be monitored at each meeting of the Charitable Funds Committee, reviewing:

- Expenditure details against the Charitable Funds;

7.2 The Committee will formally review the Expenditure Policy in line with the policy review date, and consider if any changes are required.

Chris Hearn

Chief Financial Officer

21 March 2023

Policy Title	**CHARITABLE FUND INVESTMENT POLICY**		
Procedure Number		**Version number**	
Applicable to	**Corporate Trustee and Charitable Funds Committee**		
Date issued	**21 March 2023**		
Review date	**21 March 2026**		
Author's name and title	**James Claypole, Deputy Financial Controller**		
Development group/committee	**Charitable Funds Committee**		
Stakeholders	**Charitable Funds Committee; DCH Finance**		
Approved by	**Charitable Funds Committee**		
Date approved	**21 March 2023**		
Ratified by	**DCHFT Board (Corporate Trustee)**		
Ratified on	**31 May 2023**		
Keywords			

Document Management Section (if applicable)			
Previous policy number		**Previous version number**	
Changes requested or dictated by			
Description of changes since last version			

CHARITABLE FUND (Registered Charity 1056479)

INVESTMENT POLICY

1. INTRODUCTION

1.1 Dorset County Hospital NHS Foundation Trust Charitable Fund (the Charity) has a single corporate trustee, which is Dorset County Hospital NHS Foundation Trust (DCHFT), in the form of the Board of Directors of that organisation. Responsibility for the management and administration of the Charity has been delegated to the Charitable Funds Committee, comprised of members of the Board.

1.2 These responsibilities include: Investing funds in accordance with the requirements of the Trustee Act 2000.

1.3 In order to fulfil these responsibilities, trustees should have in place an Investment Policy.

1.4 The Trustee Act 2000 allows trustees to place funds in any kind of investment, excluding land, as though the Trustees were the absolute owners of those funds. The rules also introduced a requirement to take proper advice and the need to consider the suitability of the investment in relation to the charity e.g. ethical considerations.

1.5 The Charity includes the Dorset County Hospital NHS Trust (Expendable Funds) Common Investment Fund, approved by the Charity Commission on 10 June 1998 and listed on its website. The trustee may combine the investments and money belonging to the charities and representing expendable funds into one pooled fund, and the fund is a common investment fund within the meaning of section 24 of the Charities Act 1993.

2. PURPOSE

2.1 Under the Charities Act, all charities are required to prepare and publish an Investment Policy. This policy ensures that funds are invested in accordance with the Trustee Act 2000.

2.2 The aim of the Investment Policy is to give clear guidelines to the Trustee in the managing of the funds of the Charity and to ensure proper and timely review and monitoring of investment performance. The strategy is to:

- adopt a low risk approach;
- avoid unethical investments;
- maximise the return from the investment of the funds; and
- protect income from inflationary increases and increase capital growth.

3. SCOPE OF RESPONSIBILITY

3.1 The Charitable Funds Committee is responsible for the routine management of charitable funds and the implementation and monitoring of this investment strategy.

3.2 In furtherance of the Charity's objects but not otherwise, the trustee may exercise the power to permit any investments comprised in the charitable funds to be held in the name of any clearing bank and the UK Debt Management Agency Deposit Facility (Bank of England).

3.3 The Trustee has a duty to properly manage and protect the funds of their Charity. In particular, the Trustee should ensure the following:

- Invest money not immediately needed, or place it on deposit to earn interest if expenditure is expected in the near future;
- Invest the funds in a way which will both preserve their capital value and produce a proper return consistent with prudent investment;
- Not place the funds at risk by speculative investment;
- Diversification of investments to reduce risk, or hold in low risk investment;
- Follow legal requirements should anyone be appointed to manage investments on the Charity's behalf;
- The Trustee must be aware of any tax implications that affect the Charity from any investments made.

4. INVESTMENT POLICY

4.1 Cash deposits are placed with approved banks with suitable credit ratings as per the Dorset County Hospital NHS FT Treasury Management Policy.

4.2 The trustees have set out a framework of parameters of discretionary asset allocation as set out below:

- Fixed Interest 50 - 100%;
- Absolute return (long deposit only over 1 month) 0 - 50% (low risk);

4.3 Donated monies are currently held in 1 charitable fund bank account as appointed by the Charity:

- Royal Bank of Scotland (Government Banking Services for overnight deposit and payments;

4.4 Investment income after administrative expenses shall be allocated to funds pro-rata to average balances.

5. POLICY REVIEW

5.1 The policy will be monitored by the Charitable Funds Committee at each meeting, reviewing:

- Performance of the investments;

5.2 The Charitable Funds Committee will formally review the Investment Policy at the policy review date.

Chris Hearn
Chief Financial Officer

21 March 2023

NHS
Dorset County Hospital
NHS Foundation Trust

DCH CHARITABLE FUND GRANTS POLICY

Policy Title	**DCH CHARITABLE FUND GRANTS POLICY**		
Policy Number	**XXXX**	**Policy Version Number**	**1**
Applicable to	Corporate Trustee, Charitable Funds Committee, DCH Finance and DCHC Fundraising Team		
Aim of the Policy	This purpose of this policy is to set out the principles, criteria and processes that govern how DCH Charity makes grants to Dorset County Hospital across all fund types.		
Next Review Due Date	21 March 2026		
Author/ Reviewer	Simon Pearson, Head of Charity & Social Value		
Policy Sponsor	Chris Hearn, Chief Financial Officer		
Expert Group	Charitable Funds Committee		
Date Approved	21 March 2023		
Primary Specialty	DCH Charity		
Secondary Specialties	DCH Finance		

Document Version Management	
Previous Version Number: N/A	
Changes Requested/ Dictated by: N/A	Year:
Description of Changes Since Last Version: N/A	

Content

1. INTRODUCTION

1.1 Dorset County Hospital NHS Foundation Trust Charitable Fund (the Charity) registered charity 1056479 has a single corporate trustee, which is Dorset County Hospital NHS Foundation Trust (DCHFT), in the form of the Board of Directors of that organisation. Responsibility for the management and administration of the Charity has been delegated to the Charitable Funds Committee, comprised of members of the Board, including the Chief Financial Officer.

1.2 These responsibilities include ensuring that:

- Grant-making is properly carried out;
- Expenditure is properly validated/authorised;
- All funds granted are properly accounted.

1.3 Fundraising is a legitimate means of enhancing patient care and staff welfare, by supporting capital projects and enabling the purchase of beneficial goods, equipment or services, which are not available within NHS capital or revenue budgets. For the public, donating funds, goods, or actively raising funds is seen as a positive way of supporting local health services.

1.4 Charitable funds should not be used as a substitute for statutory funding. Health bodies are required to provide a basic level of care from government funding. Charitable funds can be used to enhance this level of care, but not replace it.

2. AIM AND OBJECTIVES

2.1 It is considered good practice for all charities to prepare and publish a Grants Policy. The existence of clear guidance assists the Trustee in meeting its responsibilities and for those involved in grant-making activities to do so in full compliance with all applicable regulations. This purpose of this policy is to set out the principles, criteria and processes that govern how the Charity makes grants across all fund types.

2.2 To ensure funds are spent in accordance with the charity's charitable objects and supporters' wishes, to the greatest benefit for patients and staff.

2.3 A primary aim of the policy is to ensure that the Charity complies with its own establishing Deeds of Trust (where relevant), which include details about how specific DCHC funds may be expended.

3. WHO IS THE POLICY FOR?

3.1 This policy applies to DCHFT Board (Corporate Trustee), Charitable Funds Committee members, DCH Finance, Fund representatives and DCH Charity team.

3.2 The Charity employs staff in its Fundraising Team and makes use of administrative and accounting services provided by the Foundation Trust, mainly by staff within the Financial Services function.

4. DEFINITIONS, LEGISLATION, POLICIES, GUIDELINES AND REFERENCES

DEFINITIONS

4.1 A grant is defined as a financial award made by the Charity from its charitable funds to support the beneficiary activities, primarily Dorset County Hospital NHS Foundation Trust.

LEGAL

4.2 The charity must apply suitable due diligence and grant conditions, ensuring grants made to the NHS body are for a specific charitable purpose that provides sufficient public benefit in accordance with Charity Commission guidance on grants to non-charities, which includes NHS bodies. While the activities of NHS bodies will ordinarily be within the charitable purposes of an NHS charity, these actions must be demonstrable.

5. EQUALITY IMPACT ASSESSMENT

5.1 Equality Impact Assessment completed (see Appendix 1 below). The policy does not unfairly affect certain staff or groups of staff.

6. DATA PROTECTION IMPACT ASSESSMENT

6.1 Data Protection Impact Assessment completed (see Appendix 2 below).

7. STAKEHOLDERS AND CONSULTATION

7.1 Charitable Funds Committee, DCH Finance, DCH Charity Team

8. ROLES AND RESPONSIBILITIES

8.1 Charity Team for advising on grant application process and processing charitable fund grant applications.

8.2 DCH Finance representative/s for grant funding authorisation and payments to applicants.

9. DISSEMINATION

9.1 This policy has been reviewed by the Chief Financial Officer (sponsor) and approved by the Charitable Funds Committee (expert group/committee). Disseminated to staff via the Trust StaffNet.

9.2 This approved policy will be uploaded to the Trust Policies and Clinical Guidance database and published via the Trust StaffNet.

10. MONITORING AND REVIEWING ARRANGEMENTS

10.1 To be reviewed every three years, unless agreed otherwise, in accordance with the Policy for the Management of Policies and Guidance (Ref 1126).

11. POLICY APPROVAL

11.1 The policy has been approved in accordance with the Policy for the Management of Policies and Guidance (Ref 1126) and Procedure for the Development of Policies (Ref 1909).

12. POLICY CONTENT

STATEMENT OF PRINCIPLES

The principles which underpin the Trustee governance of the Charity's grant-making take into account the value of grant-related activity balancing direct involvement in decision-making where required, with efficient, responsive service for applicants. The governance principles are as follows:

12.1 The Corporate Trustee has ultimate responsibility for all grant-making decisions in line with the Charity's charitable purposes and any restrictions agreed with donors and funding partners.

12.2 The Corporate Trustee may delegate certain decision-making responsibilities to members of the Charitable Funds Committee and/or Charity staff within its framework of delegation.

12.3 The Corporate Trustee or those with delegated authority reserve the right not to approve any recommendation or nomination, if they determine that the resulting grant would not be charitable or would conflict with the Charity's stated policies or damage its or the Charity's reputation.

12.4 The Charitable Fund enhances the provision of healthcare services that are provided to the population served by Dorset County Hospital NHS Foundation Trust. This encompasses the provision of medical equipment, furniture and fittings, improvement of the environment and facilities, enhancement of staff and patient education and the welfare of staff and patients.

12.5 The Corporate Trustee sets grant-making criteria, the aim of which is to provide clear information for those administering and applying for grant funding. The Charitable Funds Committee will review these criteria every three years and, if necessary, amend or update them accordingly.

GRANTS PROCEDURES

12.6 **Grant application process**

Applications can be submitted at any time. Charitable funding application forms and guidance will be provided by the Head of Charity. A current list of funds and fund representatives can be obtained from the Charity team. All

applications must follow the DCH Charity funding guidance in relation to the nature of their specific bid accordingly.

12.7 All applicants from Dorset County Hospital must ensure funding will benefit of patients at the hospital or staff welfare.

12.8 Applications must clearly demonstrate how the project proposal will improve patient care, services, experience or staff welfare.

12.9 All applications must be endorsed by respective Fund Representative and Divisional Manager. Applicants will need to discuss with the endorsers in advance of their intention to submit an application, to ensure they will be willing to support it.

12.10 Any proposal for funding of on-going staff posts must state how it is intended the post will be funded from other sources beyond the grant period. The Trust will be expected to fund all costs other than direct salary and employer NI and pension contributions eg paid leave of absence etc.

12.11 Application assessment

Applications are received and initially assessed by the Head of Charity and Deputy Financial Controller. Thereafter, qualifying applications will be submitted to representatives of the Charitable Funds Committee for consideration/authorisation for funding according to the limits outlined in 12.12 below.

12.12 The Charitable Funds Committee will approve bids to the charitable funds on the following basis:

Limit	**Delegation**
Under £2,000	Deputy Chief Financial Officer or Chief Financial Officer.
£2,001 to £10,000	Deputy Chief Financial Officer or Chief Financial Officer and Chair of Charitable Funds Committee.
£10,000 +	Charitable Funds Committee (members only).
Emergency powers	The Chief Financial Officer and Trust Chair may approve expenditure in excess of CFC delegated limits for matters of urgency having contacted one other member for approval. All approvals on this basis will be reported retrospectively to the Board of Directors (Corporate Trustee) for ratification.

12.13 Advice may be sought from clinical representatives on the committee including the Chief Nursing Officer; or clinical staff specialising in the field of care relevant to the application.

12.14 Approval and support will be required from the Divisions if there are any on-going revenue costs that Dorset County Hospital NHS Foundation Trust will incur as a consequence of a charitable application, prior to the application being approved by the Charity.

12.15 Applicants will receive a decision on their application within two weeks of receipt; or following the subsequent meeting of the Charitable Funds Committee for applications above £10,000.

Grant award

12.16 Grant payments
Payments from grant awards are made against fully evidenced grant applications submitted to the Charity by the Trust. Grant payments are administered by DCH Finance department and procurement processes set out in the grant award confirmation.

12.17 Impact Reporting

For large project grants (£10K+) - as part of the grant application process, reporting expectations will be communicated in the guidelines to the grant applicant.

Reports must enable the assessment of:
- The progress made by the project
- Whether project risks are being addressed
- Whether the expected impact has been achieved

Outcome measures agreed at the outset of the project must be as SMART as possible:
- Specific
- Measurable
- Achievable
- Realistic
- Time-framed

An interim report must be submitted to the Charitable Funds Committee, to enable monitoring of project progress. At the end of the project a detailed end-of-project report must also be completed.

12.18 Promotion
Impactful projects will be showcased through the Charity's communications channels, including website and social media. Case studies of examples of the impact the Charity's funding makes will be developed with the grant holder's permission and input.

Appendix 1

EQUALITY IMPACT AND COMPLIANCE ASSESSMENT

1. General	
Title of document	**DCH CHARITABLE FUND GRANTS POLICY**
Purpose of document	To set out the principles, criteria and processes that govern how DCH Charity makes grants to Dorset County Hospital across all fund types.
Intended scope	DCHFT Board (Corporate Trustee), Charitable Funds Committee members, DCH Finance and DCH Charity team.

2. Consultation	
Which groups/associations/bodies or individuals were consulted in the formulation of this document?	DCH Charitable Funds Committee DCH Finance DCH Charity team
What was the impact of any feedback on the document?	Supported
Who was involved in the approval of the final document?	DCH Charitable Funds Committee
Any other comments to record?	

3. Equality Impact Assessment	
Does the document unfairly affect certain staff or groups of staff? If so, please state how this is justified.	No
What measures are proposed to address any inequity?	N/A
Can the document be made available in alternative format or in translation?	YES

4. Compliance Assessment	
Does the document comply with relevant employment legislation? **Please specify.**	N/A

5. Document assessed by:	
Name	Simon Pearson

Post Title/ Position	Head of Charity & Social Value
Date	July 2022

Appendix 2

Data Protection Impact Assessment (DPIA) Screening Questionnaire

Project/Policy/Procedure Title: **DCH CHARITABLE FUND GRANTS POLICY**

Project Lead: Simon Pearson, Head of Charity & Social Value Date: July 2022

Question		Yes	No	Unsure	Comments
1	Are privacy-intrusive[1] technologies being used?		No		
2	Are new and untested technologies being used?		No		
3	Are the purposes of data processing unclear?		No		
4	What is the lawful basis for processing data?				Internal processing of charitable funding applications.
5	Are new or substantially different identification authentication requirements needed?		No		
6	Will there be a significant amount of new data about each person, or a significant change in the current data-holdings?		No		
7	Will there be new data about a significant number of people?		No		
8	Will there be a new link of personal data with another data-holding?		No		
9	Are the data collection procedures new, changed, unclear or intrusive?		No		
10	Will there be a new or changed data quality process?		No		
11	Will there be new or changed data security arrangements?		No		
12	Are there new or changed data access or disclosure arrangements?		No		

[1] Intrusion can come in the form of collection of excessive personal information, disclosure of personal information without consent and misuse of such information. It can include the collection of information through surveillance or monitoring of how people act in public or private spaces and through the monitoring of communications whether by post, phone or online and extends to monitoring the records of senders and recipients as well as the content of messages.

13	Are there new or changed data retention arrangements?		No		
14	Has any external data sharing been identified on the departments data flow map?		No		
15	Is the personal data likely to raise privacy concerns with the individuals? e.g. health records, criminal records		No		
16	Is there any use of highly sensitive or biometric data? e.g. protected characteristics or finger print recognition		No		
17	Will personal data be disclosed to organisations or people who have not previously had access to the data?		No		
18	Will data collection and processing result in automated decision making which will have a significant impact on the individuals concerned?		No		
19	Will individuals be compelled to provide information about themselves?		No		
20	Is there a contract or data sharing agreement in place with all third parties?		N/A		

If you have answered 'Yes' or 'Unsure' to any of the above, please consult with the Information Governance and Data Protection Officer. You may need to complete the full DPIA.

If all answers are 'No' or the Information Governance and Data Protection Officer has been consulted and approves, this Screening Questionnaire can be signed off by the Project Lead and responsible Information Asset Owner.

Name	**Job Title**	**Date**
Simon Pearson	Head of Charity & Social Value	July 2022

Dorset County Hospital Charity

Ethical Fundraising statement

Dorset County Hospital Charity's (DCHC) purpose is to raise funds to enhance patient care at Dorset County Hospital providing support through grants for purposes that are over and above what the NHS would normally provide and/or above and beyond the NHS budget.

Purpose
To ensure DCHC can guarantee the availability of funds to serve its charitable purpose, the charity is continuously engaged in maintaining and growing a broad base of funding sources. The purpose of DCHC's ethical fundraising statement is to guide DCHC's ability to accept voluntary gifts and other forms of support.

By adhering to our ethical statement, we are striving to minimise any risk of bringing the charity into disrepute. As such, this statement is designed as a due diligence tool to ensure the needs of the organisation are balanced against its organisational principles.

Ethical fundraising
We abide by the law which requires us, in deciding whether to accept or refuse a donation, to consider which action is in the Charity's best overall interest.
DCHC actively engages in fundraising activities in collaboration with external organisations and individuals. In doing so, we adopt set criteria guiding the following:

1. Acceptance of donations or other forms of support
2. Avoidance criteria identifying the conditions under which we will not accept a gift or other forms of voluntary support
3. Fundraising initiatives involving corporate partnerships

When accepting any particular donation, DCHC's Corporate Trustee have a duty to demonstrate to the Charity Commission that they have acted in the best interest of the Charity, and that association with any particular donor does not compromise DCHC's ethical position, harm the charity's reputation or put future funding at risk. DCHC strives to comply with all relevant legislation as set out in the Fundraising Regulator's Code of Fundraising Practice and by following Charity Commission guidance.

1. Acceptance criteria
DCHC accepts voluntary donations and other forms of voluntary support, such as volunteering or gifts in kind, from individuals, companies and other organisations on the following conditions:

1.1. There are strong grounds for believing it will result in benefit to patients or staff welfare at Dorset County Hospital.
1.2. If a gift is offered for a specific purpose then this must be a charitable purpose that is within DCHC's objects.
1.3. It is feasible to apply the donation in a way that is consistent with donor's wishes, given the operational constraints and strategic priorities of Dorset County Hospital.
1.4. DCHC will accept the donation together with any reasonable obligations attached, for example requirements to report back to donors on public benefit achieved as a consequence of the gift.

2. Avoidance/refusal criteria
DCHC will not accept voluntary donations and other forms of voluntary support where any of the following criteria apply:

2.1. The support is known, suspected to be or derives from the proceeds of crime.
2.2. The support derives from a source conflicting with DCHC's objectives and/or the work of Dorset County Hospital, for example a possible gift from a tobacco manufacturer.
2.3. The supporting source is known or suspected to be closely associated with a regime known or suspected to be in violation of human rights.
2.4 The supporting source manufacturers or exports Arms.
2.5. Acceptance is likely to deter actual or potential supporters from future support.
2.6. Acceptance would involve onerous obligations, for example the upkeep of an unsuitable building, the cost of which might outweigh the benefit.
2.7. Support is offered in an attempt to procure privileged access to treatment for the donor or persons linked to the donor.
2.8. Support is offered in an attempt to procure privileged access to NHS contracts.
2.9. Acceptance would be in contravention of the Bribery Act 2010.
2.10 Acceptance would be in contravention of the Modern Day Slavery Act 2015.

3. Fundraising initiatives involving corporate partnerships
DCHC welcomes cooperative relationships with companies from a wide range of sectors and industries and our collaboration could consist of one or several of the following:

- Staff fundraising
- Supplier fundraising and fundraising from other stakeholders
- Cause related marketing (i.e. a commercial activity by which the business and the charity form a partnership with each other to market an image, product or service for mutual benefit)

- Sponsorship (i.e. cash or in kind paid in return for access to exploitable commercial potential)
- Payroll Giving
- Donations/matched giving
- Secondments
- Employee involvement and volunteering
- Gifts in Kind
- Royalties
- Events
- Recycling

All potential partnerships and initiatives need to be looked at on a case-by-case basis. DCHC's overarching principles for corporate partnerships are:

- Integrity and openness
- Maintenance of independence
- Mutual benefit for all parties

General corporate partnership guidelines

Where required (ie. Cause-related marketing) a written agreement/contract between the company and DCHC will be produced for each joint initiative/partnership.

DCHC will retain full editorial control and maintain copyright over all materials sponsored by a company, offline and online.

Approval must be sought from DCHC whenever its brand (name or logo/s) is used for any internal or external communications.

All initiatives and partnerships will be regularly reviewed against agreed success criteria.

Where appropriate, DCHC will consult with Dorset County Hospital's Chief Executive and/or Communications Manager, to ensure there is no risk of reputational or other damage to Dorset County Hospital or the wider NHS.

Implementation

DCHC's ethical statement must be followed by all DCHC staff, and those officially acting on behalf of the Charity. Where the decision regarding acceptance or avoidance of a donation or another form of support requires a balancing of the financial benefits versus exposure to financial or reputational risk, DCHC's Charitable Funds Committee are responsible for ensuring that the decision is made in the best interest of DCHC's objectives. In some cases it may be necessary to obtain authorisation from the Charity Commission before refusing a donation.

Conflicts procedure

Should potential conflicts be identified an internal conflicts procedure will be followed to assess and make a final decision. The Head of Charity will advise the Chair, Charitable Funds Committee and provide a report for members of this committee to consider accordingly. The Head of Charity will provide an annual summary of any conflicts to the Charitable Funds Committee.

Report Front Sheet

1. Report Details			
Meeting Title:	Board of Directors		
Date of Meeting:	31st May 2023		
Document Title:	New NHS Provider License		
Responsible Director:	Nick Johnson, Deputy Chief Executive	Date of Executive Approval	10.5.23
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**
Executive Management Team	21.11.22	
Board of Directors	30.11.22	Noted

3. Purpose of the Paper	This document informs the Board about the new NHS Provider License issued by NHS England in March 2023 following their consultation on proposed changes in autumn 2022 which were discussed by the Board at their meeting in November 2022.							
	Note (✓)	✓	*Discuss (✓)*		*Recommend (✓)*		*Approve (✓)*	
4. Key Issues	The NHS provider license forms part of the oversight arrangements for the NHS. It sets out conditions that providers of NHS-funded healthcare services in England must meet to help ensure that the health sector works for the benefit of patients, now and in the future. The NHS provider license has been updated to reflect the requirements of the Health and Care Act 2022 promoting integrated service provision and co-operation alongside the need to address health inequalities, promote digital maturity and remove obsolete conditions. Discussion of the proposed changes to license was had by the Board at their meeting in November 2022. The new license was issued to the NHS in March 2023. Dorset County Hospital received the new license at the end of March 2023 with standard conditions applied.							
5. Action recommended	The Board of Directors is asked to: 1. **NOTE** the receipt of the new Provider License with standard conditions.							

6. Governance and Compliance Obligations				
Legal / Regulatory Link		**Yes**		The NHS provider license forms part of the oversight and enforcement arrangements for the NHS.
Impact on CQC Standards			**No**	
Risk Link			**No**	
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	Amendments to the Fit and Proper Persons requirement have been made.		
	Place	See ICS goals below.		
	Partnership	See ICS goals below.		
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**	Changes reflect requirements of the Health and Care Act 2022 and the move to greater collaboration and co-operation to improve population health. There are also requirements to tackle climate change
Tackling unequal outcomes and access		**Yes**	**No**	Changes to the NHS Provider License also reflect the Triple Aim requirement, having regard to health inequalities.
Enhancing productivity and value for money		**Yes**	**No**	Changes remove the competition condition and reflect personalised care in patient choice. Reporting arrangements have been streamlined.
Helping the NHS to support broader social and economic development		**Yes**	**No**	Changes reframe the integrated care condition as a positive obligation to integrate service provision and reduce inequalities.
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		**Yes**		NHS England has completed an impact assessment

Assessment (EIA)			as part of the statutory consultation process.
Quality Impact Assessment (QIA)	**Yes**		NHS England has completed an impact assessment as part of the statutory consultation process.

The New NHS Provider License

Executive Summary

The NHS provider license forms part of the oversight arrangements for NHS organisations and provides the legal framework for enforcement or regulatory intervention in the NHS. NHS England published a statutory notification of its intent to publicly consult on changes to the NHS Provider License general conditions on 24th October 2022. The consultation period took place between 28th October 2022 and 9th December 2022.

The consultation proposed changes to the NHS Provider License to reflect the requirements of the Health and Care Act 2022 that aims to promote greater collaboration between providers, reflect the Triple Aim and to reduce health inequalities. For the first time, license conditions have also been applied to NHS Trusts in addition to Foundation Trusts and new requirements to reflect digital obligations are included.

The New Provider License

Changes to the NHS Provider License reflect the requirements of the Health and Care Act 2022 and are summarised as:

- Expectations around collaboration and co-operation.
- The Triple Aim.
- Obligations to reduce health inequalities.
- Promoting patient choice.
- Removal of competition conditions.
- Expanded scope of the Continuity of Services Condition.
- Enhanced oversight of key services provided by the independent sector.
- Addressing climate change.
- Shifting the focus of costing and pricing conditions to reflect national policy.
- Streamlined reporting.
- Application to NHS Trusts
- Removal of obsolete conditions
- Amendment to the Fit and Proper Persons condition and to include Governors.

Appendix 1 provides further detail of the changes to the provider license.

Conclusion

The NHS provider license has been updated to reflect the requirements of the Health and Care Act 2022 promoting integrated service provision and co-operation alongside the need to address health inequalities, promote digital maturity and remove obsolete conditions. The DCH license has been issued with standard conditions.

Recommendation
The Board is asked to note the changes to the provider license as set out in Appendix 1 and note that the DCH License has been issued and received with standard conditions.

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Date: May 2023

Appendices

The full NHS England consultation documents are appended as follows:
Appendix 1 – Summary of changes to the NHS provider License
Appendix 2 – Cover sheet to Provider License indicating standard conditions apply.
Appendix 3 – The new Provider License

Provider License Changes 'On a Page'

License Ref:		Current License	Proposed Change	Nature of Change
Old	**New**			
Section 1 Integrated Care				
IC1	**IC1**	**Provision of Integrated Care**	Amended	Reframed to create a positive duty to participate in providing integrated care Improving quality of health and reducing inequalities.
IC2	**IC2**	**The rights of patients to make choices**	Amended	Amended to include new provisions for providing personalised care. Updated and strengthened requirement
Section 2 Trusts Working in Systems				
	WS 1	**Cooperation**	New	New condition to ensure that NHS trusts and FTs cooperate with other NHS providers and local authorities to develop system plans, deliver NHS services, improve NHS services, deliver financial objectives and workforce plans.
	WS 2	**Triple Aim**	New	New condition that requires trusts and FTs give regard to the Triple Aim.
	WS 3	**Digital transformation**	New	New condition that requires trusts and FTs to comply with the required levels of digital maturity and compliance with s250 of the 2012 Act (updated by the 2022 Act) standards.
Section 3 General Conditions				
G1	**G1**	**Provision of Information**	Retained	
G2	**G2**	**Publication of Information**	Retained	
G3			Removed	Removed as NHS England does not intend to charge fees to licensees.
G4	**G3**	**Fit and Proper Persons**	Amended	Renamed condition G3 and rewritten to include Fit and Proper Persons Regulations and Test changes consulted on in 2021 but not

				implemented and which includes the need for Governors to meet this requirement.
G5	**G4**	**NHSE Guidance**	Retained	Renamed condition G4.
G6	**G5**	**Systems for compliance with License conditions**	Amended	Renamed condition G5. Removal of the requirement to provide a certificate of compliance as this information is captured elsewhere.
G7	**G6**	**CQC Registration**	Retained	Renamed condition G6.
G8	**G7**	**Patient Eligibility and selection criteria**	Retained	Renamed condition G7.
G9	**G8**	**Application of Continuity of Service**	Amended	Renamed condition G8. Amended to better define and reflect the current system for identifying a Commissioner Requested Service and adds a process for Hard to Replace Providers.
Section 4 Trust Conditions				
FT1	**NHS1**	**Information to Update the Register**	Renamed	
FT2		**Payment of Fees to Monitor**	Removed	Removed as NHS England does not intend to charge fees to licensees.
FT3		**Provision of information to a governor advisory panel**	Removed	The FT governor advisory panel no longer exists.
FT4	**NHS2**	**Governance Arrangements**	Renamed and amended	Amended to reflect the legal status of NHS Trusts and include reference to NHS climate goals, and digital maturity. Updated to remove corporate governance statement as this reduces unnecessary duplication.

Section 5 NHS Controlled Providers				
	CP1	**Governance Arrangements for NHS Controlled Providers**	Amended	Amended to include climate goals and digital maturity requirements. Removes the Corporate Governance statement as this removes duplication.
Section 6 Continuity of Services				
	CoS1	**Continuing Provision of Commissioner Requested Services**	Retained	
	CoS2	**Restriction on the disposal of assets**	Retained	
	CoS3	**Standards of corporate governance, and financial management and quality governance**	Amended	To Introduce a requirement for quality governance standards for Commissioner Requested services and Hard to Replace providers and providing safeguards are in place to ensure service delivery when there is quality stress.
	CoS4	**Undertaking from the ultimate controller**	Retained	
	CoS5	**Risk Pool Levy**	Retained	
	CoS6	**Cooperation in the event of financial or quality stress**	Amended	Application of Continuity of service conditions to hard to replace providers. Amended to ensure cooperation when there is quality or financial stress.
	CoS7	**Availability of resources**	Amended	Amended to include definitions for hard to replace services and to ensure that quality governance resources. Application of Continuity of service conditions to hard to replace

				providers
Section 7 Costing				
P1	**C1**	**Submission of costing information**	Amended	Replaced with updated costing condition 1 requiring providers to record and submit data in line with Approved Costing Guidance
P2	**C2**	**Provision of costing and costing related information**	Amended	Replace P2 with a requirement to submit data in condition 1 to NHSE
P3	**C3**	**Assurance on Accuracy of costing and pricing Information**	Amended	Places a requirement to have processes in place to comply with C1 and C2
Section 8 Pricing				
P4	**P1**	**Compliance with the NHS payment scheme**	Amended	Renamed as Pricing Condition 1. Updated to reflect that the national tariff has been replaced with the NHS Payment Scheme
P5		**Constructive engagement regarding local tariff modifications**	Removed	This condition is removed as it no longer reflects the current process for pricing.
Section 9 Interpretation and Definition				
	D1	**Interpretation And Definitions**	Amended	
Other Conditions				
C2		**Competition Oversight**	Removed	Removed to reflect collaboration and legislation removing NHSE/I's functions relating to competition
FT2		**Payment to Monitor**	Removed	Removed as NHSE does not charge fees to administer the License

		of registration fees		
FT3		**Provision of information to advisory panel**	Removed	Removed as advisory panel never established, condition never used.
FT4		**Governance arrangements**	Amended	Renamed NHS2

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Licence number: 110036

Date of issue	**Version number**
1 April 2023	3

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Version History

Version number	Date	Comments
1.0	26 March 2013	Created
2.0	04 April 2013	Formatting changes
3.0	31 March 2023	Modified licence standard conditions

Classification: Official

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NHS England

NHS Provider Licence

Standard Conditions

31 March 2023

Version History

Version number	Date	Comments
1.0	26 March 2013	Created
2.0	04 April 2013	Formatting changes
3.0	27 October 2022	Draft updated licence for consultation
4.0	31 March 2023	Updated licence conditions

Contents

NHS Provider Licence Standard Conditions

Section 1 – Integrated Care

IC1: Provision of Integrated care

1. The Licensee shall act in the interests of the people who use health care services by ensuring that its provision of health care services for the purposes of the NHS:
    i) is integrated with the provision of such services by others, and
    ii) is integrated with the provision of health-related services or social care services by others and
    iii) enables co-operation with other providers of health care services for the purposes of the NHS

    where this would achieve one or more of the objectives referred to in paragraph 2.
2. The objectives are:
    a. improving the quality of health care services provided for the purposes of the NHS (including the outcomes that are achieved from their provision) or the efficiency of their provision,
    b. reducing inequalities between persons with respect to their ability to access those services, and
    c. reducing inequalities between persons with respect to the outcomes achieved for them by the provision of those services.
3. The Licensee shall have regard to guidance as may be issued by NHS England from time to time for the purposes of paragraphs 1 and 2 of this Condition.
4. Nothing in this licence condition requires the licensee to take action or share information with other providers of health care services for the purposes of the NHS if the action or disclosure of the information would materially prejudice its commercial or charitable interests.

IC2: Personalised Care and Patient Choice

1. The Licensee shall support the implementation and delivery of personalised care by complying with legislation and having due regard to guidance on personalised care.
2. Subsequent to a person becoming a patient of the Licensee, and for as long the person remains a patient, the Licensee must ensure people who use their services are offered information, choice and control to manage their own health and well-being to best meet their circumstances, needs and preferences, working in partnership with other services where required.
3. Subsequent to a person becoming a patient of the Licensee, and for as long the person remains a patient, the Licensee shall ensure that at every point where that person has a choice of provider under the NHS Constitution or a choice of provider conferred locally by Commissioners, the person is notified of that choice and told where information about that choice can be found.
4. Information and advice about patient choice of provider made available by the Licensee shall not be misleading.
5. Without prejudice to paragraph 2, information and advice about patient choice of provider made available by the Licensee shall not unfairly favour one provider over another and shall be presented in a manner that, as far as reasonably practicable, assists patients in making well informed choices between providers of treatments or other health care services.
6. In the conduct of any activities, and in the provision of any material, for the purpose of promoting itself as a provider of health care services for the purposes of the NHS the Licensee shall not offer or give gifts, benefits in kind, or pecuniary or other advantages to clinicians, other health professionals, Commissioners or their administrative or other staff as inducements to refer patients or commission services.

Section 2 – Trusts Working in Systems

WS1: Cooperation

1. This condition shall apply if the Licensee is an NHS trust NHS foundation trust or NHS controlled provider of healthcare services for the purposes of the NHS.
2. The Licensee shall carry out its legal duties to co-operate with NHS bodies and with local authorities.
3. Without prejudice to the generality of paragraph 2, the Licensee shall:
   a. consistently co-operate with:
   - other providers of NHS services; and
   - other NHS bodies, including any Integrated Care Board of which it is a partner;
     i. as necessary and appropriate for the purposes of developing and delivering system plan(s).
     ii. as necessary and appropriate for the purposes of delivering their individual or collective financial responsibilities including but not limited to contributing to the delivery of agreed system financial plans in each financial year
     iii. as necessary and appropriate for the purposes of delivering agreed people and workforce plans

   b. consistently co-operate with:
   - other providers of NHS services;
   - other NHS bodies, including any Integrated Care Board of which it is a partner; and
   - any relevant local authority in England
     i. as necessary and appropriate for the purposes of delivering NHS services.
     ii. as necessary and appropriate for the purposes of improving NHS services.
4. The Licensee shall have regard to such guidance concerning co-operation as may be issued from time to time by either:

a. the Secretary of State for Health and Social Care; or
b. NHS England.

For the purposes of this condition, cooperation is considered synonymous to collaboration.

WS2: The Triple Aim

1. This condition shall apply if the Licensee is an NHS trust, NHS foundation trust or NHS controlled provider of healthcare services for the purposes of the NHS.
2. When making decisions in the exercise of its functions which relate to the provision of health care for the purposes of the NHS, the Licensee shall comply with its duty relating to the triple aim.
3. The Licensee shall have regard to the triple aim and to any guidance published by NHS England under section 13NB of the 2006 Act.
4. In this condition, "the triple aim" refers to the aim of achieving:
    a. better health and wellbeing of the people of England (including by reducing inequalities with respect to health and wellbeing)
    b. better quality of health care services for the purposes of the NHS (including by reducing inequalities with respect to the benefits obtained by individuals from those services)
    c. more sustainable and efficient use of resources by NHS bodies,

and "duty relating to the triple aim" means, in relation to an NHS trust, its duty under section 26A of the 2006 Act, and in relation to an NHS foundation trust, its duty under section 63A of the 2006 Act.

WS3: Digital Transformation

1. This condition shall apply if the Licensee is an NHS trust, NHS foundation trust or NHS controlled provider of healthcare services for the purposes of the NHS.
2. The Licensee shall comply with information standards published under section 250 of the 2012 Act where they pertain to one or more of the requirements set out in the cooperation condition (WS1) and the Triple Aim condition (WS2).
3. The Licensee shall comply with required levels of digital maturity as set out in guidance published by NHS England from time to time where they pertain to one or more of the requirements set out in the cooperation condition (WS1) and the Triple Aim condition (WS2).

Section 3 – General Conditions

G1: Provision of information

1. The Licensee shall provide NHS England with such information, documents and reports (together 'information') as NHS England may require for any of the purposes set out in section 96(2) of the 2012 Act. This requirement is in addition to specific obligations set out elsewhere in the licence. If requested by NHS England, the Licensee shall prepare or procure information in order to comply with this condition.
2. Information shall be provided in such manner, in such form, and at such place and times as NHS England may require.
3. The Licensee shall take all reasonable steps to ensure that information is:
    a. in the case of information or a report, it is accurate, complete and not misleading;
    b. in the case of a document, it is a true copy of the document requested.
4. This Condition shall not require the Licensee to provide any information which it could not be compelled to produce or give in evidence in civil proceedings before a court because of legal professional privilege.

G2: Publication of information

1. The Licensee shall comply with any instruction by NHS England, issued for any of the purposes set out in section 96(2) of the 2012 Act, to publish information about the health care services it provides for the purposes of the NHS. The Licensee shall publish the information in such manner as NHS England may instruct.
2. For the purposes of this Condition, “publish” includes making available to the public at large, to any section of the public or to particular individuals.

G3: Fit and proper persons as Governors and Directors (also applicable to those performing the functions of, or functions equivalent or similar to the functions of, a director)

1. The Licensee must ensure that a person may not become or continue as a Governor of the Licensee if that person is:
   a. a person who has been made bankrupt or whose estate has been sequestrated and (in either case) has not been discharged;
   b. a person in relation to whom a moratorium period under a debt relief order applies (under Part 7A of the Insolvency Act 1986);
   c. a person who has made a composition or arrangement with, or granted a trust deed for, that person's creditors and has not been discharged in respect of it;
   d. a person who within the preceding five years has been convicted in the British Islands of any offence if a sentence of imprisonment (whether suspended or not) for a period of not less than three months (without the option of a fine) was imposed on that person.

2. The Licensee must not appoint or have in place a person as a Director of the Licensee who is not fit and proper.

3. For the purposes of paragraph 2, a person is not fit and proper if that person is:
   a. an individual who does not satisfy all the requirements as set out in paragraph (3) and referenced in paragraph (4) of regulation 5 (fit and proper persons: directors) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (S.I. 2014/2936); or
   b. an organisation which is a body corporate, or a body corporate with a parent body corporate:
      i. where one or more of the Directors of the body corporate or of its parent body corporate is an individual who does not meet the requirements referred to in sub-paragraph (a);
      ii. in relation to which a voluntary arrangement is proposed, or has effect, under section 1 of the Insolvency Act 1986;

iii. which has a receiver (including an administrative receiver within the meaning of section 29(2) of the 1986 Act) appointed for the whole or any material part of its assets or undertaking;

iv. which has an administrator appointed to manage its affairs, business and property in accordance with Schedule B1 to the 1986 Act;

v. which passes any resolution for winding up;

vi. which becomes subject to an order of a Court for winding up; or

vii. the estate of which has been sequestrated under Part 1 of the Bankruptcy (Scotland) Act 1985.

4. In assessing whether a person satisfies the requirements referred to in paragraph 3(a), the Licensee must take into account any guidance published by the Care Quality Commission.

G4: NHS England guidance

1. Without prejudice to specific obligations in other Conditions of this Licence, the Licensee shall at all times have regard to guidance issued by NHS England for any of the purposes set out in section 96(2) of the 2012 Act.
2. In any case where the Licensee decides not to follow the guidance referred to in paragraph 1 or guidance issued under any other Conditions of this licence, it shall inform NHS England of the reasons for that decision.

G5: Systems for compliance with licence conditions and related obligations

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

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

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

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

G6: Registration with the Care Quality Commission

1. The Licensee shall at all times be registered with the Care Quality Commission in so far as is necessary in order to be able to lawfully provide health care services for the purposes of the NHS.
2. The Licensee shall notify NHS England promptly of:
    a. any application it may make to the Care Quality Commission for the cancellation of its registration by that Commission, or
    b. the cancellation by the Care Quality Commission for any reason of its registration by that Commission.
3. A notification given by the Licensee for the purposes of paragraph 2 shall:
    a. be made within 7 days of:
        i. the making of an application in the case of paragraph (a), or
        ii. becoming aware of the cancellation in the case of paragraph (b), and
    b. contain an explanation of the reasons (in so far as they are known to the Licensee) for:
        i. the making of an application in the case of paragraph (a), or
        ii. the cancellation in the case of paragraph (b).

G7: Patient eligibility and selection criteria

1. The Licensee shall:
    a. set transparent eligibility and selection criteria,
    b. apply those criteria in a transparent way to persons who, having a choice of persons from whom to receive health care services for the purposes of the NHS, choose to receive them from the Licensee, and
    c. publish those criteria in such a manner as will make them readily accessible by any persons who could reasonably be regarded as likely to have an interest in them.
2. “Eligibility and selection criteria” means criteria for determining:
    a. whether a person is eligible, or is to be selected, to receive health care services provided by the Licensee for the purposes of the NHS, and
    b. if the person is selected, the manner in which the services are provided to the person.

G8: Application of section 6 (Continuity of Service)

1. The Conditions in Section 6 shall apply:
   a. whenever the Licensee is subject to a contractual obligation to provide a service to a Commissioner which is contractually agreed to be a Commissioner Requested Service,
   b. whenever the Licensee is subject to a contractual obligation to deliver a service which is subsequently designated as a Commissioner Requested Service by virtue of the process set out in paragraph 2,
   c. where the circumstances set out in paragraph 6 apply (expiry of contract without renewal or extension),
   d. where the circumstances set out in paragraph 7 apply (instruction by NHS England that the Licensee must continue to deliver a service as a Commissioner Requested Service),
   e. whenever the Licensee is determined by NHS England to be a Hard to Replace Provider.
2. A service is designated as a Commissioner Requested Service if:
   a. it is a service which the Licensee is required to provide to a Commissioner under the terms of a contract which has been entered into between them, and
   b. the Commissioner has made a written request to the Licensee to provide that service as a Commissioner Requested Service, and either
   c. the Licensee has failed to respond in writing to that request by the expiry of the 28th day after it was made to the Licensee by the Commissioner, or
   d. the Commissioner, not earlier than the expiry of the 28th day after making that request to the Licensee, has given to NHS England and to the Licensee a notice in accordance with paragraph 4, and NHS England, after giving the Licensee the opportunity to make representations, has issued an instruction in writing in accordance with paragraph 4.
3. A notice in accordance with this paragraph is a notice:
   a. in writing,
   b. stating that the Licensee has refused to agree to a request to provide a service as a Commissioner Requested Service, and

c. setting out the Commissioner's reasons for concluding that the Licensee is acting unreasonably in refusing to agree to that request to provide a service as a Commissioner Requested Service.

4. An instruction in accordance with this paragraph is an instruction that the Licensee's refusal to provide a service as a Commissioner Requested Service in response to a request made under paragraph 2(b) is unreasonable.

5. The Licensee shall give NHS England not less than 28 days' notice of the expiry of any contractual obligation pursuant to which it is required to provide a Commissioner Requested Service to a Commissioner for which no extension or renewal has been agreed.

6. If any contractual obligation of a Licensee to provide a Commissioner Requested Service expires without extension or renewal having been agreed between the Licensee and the Commissioner who is a party to the contract, the Licensee shall continue to provide that service on the terms of the contract (save as agreed with that Commissioner), and the service shall continue to be a Commissioner Requested Service, for the period from the expiry of the contractual obligation until NHS England issues either:

a. an instruction of the sort referred to in paragraph 7, or
b. a notice in writing to the Licensee stating that it has decided not to issue such a instruction.

7. If, during the period of a contractual or post contractual obligation to provide a Commissioner Requested Service, NHS England issues to the Licensee an instruction in writing to continue providing that service for a period specified in the instruction, then for that period the service shall continue to be a Commissioner Requested Service.

8. A service shall cease to be a Commissioner Requested Service if:

a. all current Commissioners of that service as a Commissioner Requested Service agree in writing that there is no longer any need for the service to be a Commissioner Requested Service, and NHS England has issued a determination in writing that the service is no longer a Commissioner Requested Service, or
b. NHS England has issued a determination in writing that the service is no longer a Commissioner Requested Service; or

c. the contractual obligation pursuant to which the service is provided has expired and NHS England has issued a notice pursuant to paragraph 6(b) in relation to the service; or
d. the period specified in an instruction by NHS England of the sort referred to in paragraph 7 in relation to the service has expired.

9. The Licensee shall make available free of charge to any person who requests it a statement in writing setting out the description and quantity of services which it is under a contractual or other legally enforceable obligation to provide as Commissioner Requested Services.

10. Within 28 days of every occasion on which there is a change in the description or quantity of the services which the Licensee is under a contractual or other legally enforceable obligation to provide as Commissioner Requested Services, the Licensee shall provide to NHS England in writing a notice setting out the description and quantity of all the services it is obliged to provide as Commissioner Requested Services.

11. In this condition, a provider is a Hard to Replace Provider if it has been identified as such by NHS England based on criteria set out and managed through guidance published by NHS England and NHS England has issued a determination in writing.

12. A provider will cease to be a Hard to Replace provider if it no longer meets the criteria set out and managed through guidance published by NHS England and NHS England has issued a determination in writing that the provider is no longer a Hard to Replace Provider.

13. In this Condition “NHS contract” has the meaning given to that term in Section 9 of the 2006 Act.

Section 4 – Trust Conditions

NHS1: Information to update the register

1. The obligations in the following paragraphs of this Condition apply if the Licensee is an NHS foundation trust, without prejudice to the generality of the other conditions in this Licence.
2. The Licensee shall make available to NHS England written and electronic copies of the following documents:
    a. the current version of Licensee's constitution;
    b. the Licensee's most recently published annual accounts and any report of the auditor on them, and
    c. the Licensee's most recently published annual report,

and for that purpose shall provide to NHS England written and electronic copies of any document establishing or amending its constitution within 28 days of being adopted and of the documents referred to in sub-paragraphs (b) and (c) within 28 days of being published.
3. Subject to paragraph 4, the Licensee shall provide to NHS England written and electronic copies of any document that is required by NHS England for the purpose of NHS foundation trust register within 28 days of the receipt of the original document by the Licensee.
4. The obligation in paragraph 3 shall not apply to:
    a. any document provided pursuant to paragraph 2;
    b. any document originating from NHS England; or
    c. any document required by law to be provided to NHS England by another person.
5. The Licensee shall comply with any instruction issued by NHS England concerning the format in which electronic copies of documents are to be made available or provided.
6. When submitting a document to NHS England for the purposes of this Condition, the Licensee shall provide to NHS England a short written statement describing the document and specifying its electronic format and advising NHS England that the

document is being sent for the purpose of updating the register of NHS foundation trusts maintained in accordance with section 39 of the 2006 Act.

NHS2: Governance arrangements

1. This Condition shall apply if the Licensee is an NHS trust or NHS foundation trust, without prejudice to the generality of the other conditions in this Licence.
2. The Licensee shall apply those principles, systems and standards of good corporate governance which reasonably would be regarded as appropriate for a provider of health care services to the NHS.
3. Without prejudice to the generality of paragraph 2 and to the generality of General Condition 5, the Licensee shall:
    a. have regard to such guidance on good corporate governance as may be issued by NHS England from time to time
    b. have regard to such guidance on tackling climate change and delivering net zero emissions as NHS England may publish from time to time, and take all reasonable steps to minimise the adverse impact of climate change on health
    c. have corporate and/or governance systems and processes in place to meet any guidance issued by NHS England on digital maturity; and
    d. comply with the following paragraphs of this Condition.
4. The Licensee shall establish and implement:
    a. effective board and committee structures;
    b. clear responsibilities for its Board, for committees reporting to the Board and for staff reporting to the Board and those committees; and
    c. clear reporting lines and accountabilities throughout its organisation.
5. The Licensee shall establish and effectively implement systems and/or processes:
    a. to ensure compliance with the Licensee's duty to operate efficiently, economically and effectively;
    b. for timely and effective scrutiny and oversight by the Board of the Licensee's operations;
    c. to ensure compliance with health care standards binding on the Licensee including but not restricted to standards specified by the Secretary of State, the Care Quality Commission, NHS England and statutory regulators of health care professions;

d. for effective financial decision-making, management and control (including but not restricted to appropriate systems and/or processes to ensure the Licensee's ability to continue as a going concern);
e. to obtain and disseminate accurate, comprehensive, timely and up to date information for Board and Committee decision-making;
f. to identify and manage (including but not restricted to manage through forward plans) material risks to compliance with the Conditions of its Licence;
g. to generate and monitor delivery of business plans (including any changes to such plans) and to receive internal and where appropriate external assurance on such plans and their delivery; and
h. to ensure compliance with all applicable legal requirements.

6. The systems and/or processes referred to in paragraph 5 should include but not be restricted to systems and/or processes to ensure:

a. that there is sufficient capability at Board level to provide effective organisational leadership on the quality of care provided;
b. that the Board's planning and decision-making processes take timely and appropriate account of quality of care considerations;
c. the collection of accurate, comprehensive, timely and up to date information on quality of care;
d. that the Board receives and takes into account accurate, comprehensive, timely and up to date information on quality of care;
e. that the Licensee including its Board actively engages on quality of care with patients, staff and other relevant stakeholders and takes into account as appropriate views and information from these sources; and
f. that there is clear accountability for quality of care throughout the Licensee's organisation including but not restricted to systems and/or processes for escalating and resolving quality issues including escalating them to the Board where appropriate.

7. The Licensee shall ensure the existence and effective operation of systems to ensure that it has in place personnel on the Board, reporting to the Board and within the rest of the Licensee's organisation who are sufficient in number and appropriately qualified to ensure compliance with the Conditions of this Licence.

Section 5 – NHS Controlled Providers Conditions

CP1: Governance arrangements for NHS-controlled providers

1. This condition shall apply if the Licensee is an NHS-controlled provider of healthcare services for the purposes of the NHS without prejudice to the generality of the other conditions in this Licence.
2. The Licensee shall apply those principles, systems and standards of good corporate governance which reasonably would be regarded as appropriate for a provider of health care services to the NHS.
3. Without prejudice to the generality of paragraph 2 and to the generality of General Condition 5, the Licensee shall:

a. have regard to such guidance on good corporate governance as may be issued by NHS England from time to time
b. have regard to such guidance on tackling climate change and delivering net zero emissions as NHS England may publish from time to time, and take all reasonable steps to minimise the adverse impact of climate change on health
c. have corporate and/or governance systems and processes in place to meet any guidance issued by NHS England on digital maturity; and
d. comply with the following paragraphs of this Condition.

4. The Licensee shall establish and implement:

a. effective board and committee structures;
b. clear responsibilities for its Board, for committees reporting to the Board and for staff reporting to the Board and those committees; and
c. clear reporting lines and accountabilities throughout its organisation and to the NHS body by which it is controlled (as defined below).

5. The Licensee shall establish and effectively implement systems and/or processes:

a. to operate efficiently, economically and effectively;

b. for timely and effective scrutiny and oversight by the Board of the Licensee's operations;
c. to ensure compliance with health care standards binding on the Licensee including but not restricted to standards specified by the Secretary of State, the Care Quality Commission, NHS England and statutory regulators of health care professions;
d. for effective financial decision-making, management and control (including but not restricted to appropriate systems and/or processes to ensure the Licensee's ability to continue as a going concern);
e. to obtain and disseminate accurate, comprehensive, timely and up to date information for Board and Committee decision-making;
f. to identify and manage (including but not restricted to manage through forward plans) material risks to compliance with the Conditions of its Licence;
g. to generate and monitor delivery of business plans (including any changes to such plans) and to receive internal and where appropriate external assurance on such plans and their delivery; and
h. to ensure compliance with all applicable legal requirements.

6. The systems and/or processes referred to in paragraph 5 should include but not be restricted to systems and/or processes to ensure:

a. that there is sufficient capability at Board level to provide effective organisational leadership on the quality of care provided;
b. that the Board's planning and decision-making processes take timely and appropriate account of quality of care considerations;
c. the collection of accurate, comprehensive, timely and up to date information on quality of care;
d. that the Board receives and takes into account accurate, comprehensive, timely and up to date information on quality of care;
e. that the Licensee including its Board actively engages on quality of care with patients, staff and other relevant stakeholders and takes into account as appropriate views and information from these sources; and

f. that there is clear accountability for quality of care throughout the Licensee's organisation including but not restricted to systems and/or processes for escalating and resolving quality issues including escalating them to the Board where appropriate.

7. The Licensee shall ensure the existence and effective operation of systems to ensure that it has in place personnel on the Board reporting to the Board and within the rest of the Licensee's organisation who are sufficient in number and appropriately qualified to ensure compliance with the Conditions of this Licence.

Section 6 – Continuity of Services

CoS 1: Continuing provision of Commissioner Requested services

1. The Licensee shall not cease to provide, or materially alter the specification or means of provision of, any Commissioner Requested Service otherwise than in accordance with the following paragraphs of this Condition.
2. If, during the period of a contractual or other legally enforceable obligation to provide a Commissioner Requested Service, or during any period when this condition applies by virtue of Condition G8(1)(b), NHS England issues to the Licensee a direction in writing to continue providing that service for a period specified in the direction, then the Licensee shall provide the service for that period in accordance with the direction.
3. The Licensee shall not materially alter the specification or means of provision of any Commissioner Requested Service except:
    a. with the agreement in writing of all Commissioners to which the Licensee is required by a contractual or other legally enforceable obligation to provide the service as a Commissioner Requested Service; or
    b. at any time when this condition applies by virtue of Condition G8(1)(b), with the agreement in writing of all Commissioners to which the Licensee provides, or may be requested to provide, the service as a Commissioner Requested Service; or
    c. if required to do so by, or in accordance with the terms of its authorisation by, any body having responsibility pursuant to statute for regulating one or more aspects of the provision of health care services in England and which has been designated by NHS England for the purposes of this condition and of equivalent conditions in other licences granted under the 2012 Act.
4. If the specification or means of provision of a Commissioner Requested Service is altered as provided in paragraph 3 the Licensee, within 28 days of the alteration, shall give to NHS England notice in writing of the occurrence of the alteration with a summary of its nature.

5. For the purposes of this Condition an alteration to the specification or means of provision of any Commissioner Requested Service is material if it involves the delivery or provision of that service in a manner which differs from the manner specified and described in:

a. the contract in which it was first required to be provided to a Commissioner at or following the coming into effect of this Condition; or
b. if there has been an alteration pursuant to paragraph 3, the document in which it was specified on the coming into effect of that alteration; or
c. at any time when this Condition applies by virtue of Condition G8(1)(b), the contract, or NHS contract, by which it was required to be provided immediately before the commencement of this Licence or the Licensee's authorisation, as the case may be.

CoS 2: Restriction of the disposal of assets

1. The Licensee shall establish, maintain and keep up to date, an asset register which complies with paragraphs 2 and 3 of this Condition ("the Asset Register")
2. The Asset Register shall list every relevant asset used by the Licensee for the provision of Commissioner Requested Services.
3. The Asset Register shall be established, maintained and kept up to date in a manner that reasonably would be regarded as both adequate and professional.
4. The obligations in paragraphs 5 to 8 shall apply to the Licensee if NHS England has given notice in writing to the Licensee that it is concerned about the ability of the Licensee to carry on as a going concern.
5. The Licensee shall not dispose of, or relinquish control over, any relevant asset except:
    a. with the consent in writing of NHS England, and
    b. in accordance with the paragraphs 6 to 8 of this Condition.
6. The Licensee shall provide NHS England with such information as NHS England may request relating to any proposal by the Licensee to dispose of, or relinquish control over, any relevant asset.
7. Where consent by NHS England for the purpose of paragraph 5(a) is subject to conditions, the Licensee shall comply with those conditions.
8. Paragraph 5(a) of this Condition shall not prevent the Licensee from disposing of, or relinquishing control over, any relevant asset where:
    a. NHS England has issued a general consent for the purposes of this Condition (whether or not subject to conditions) in relation to:
        i. transactions of a specified description; or
        ii. the disposal of or relinquishment of control over relevant assets of a specified description, and the transaction or the relevant assets are of a description to which the consent applies and the disposal, or relinquishment of control, is in accordance with any conditions to which the consent is subject; or
    b. the Licensee is required by the Care Quality Commission to dispose of a relevant asset.

9. In this Condition:

“disposal”	means any of the following: (a) a transfer, whether legal or equitable, of the whole or any part of an asset (whether or not for value) to a person other than the Licensee; or (b) a grant, whether legal or equitable, of a lease, licence, or loan of (or the grant of any other right of possession in relation to) that asset; or (c) the grant, whether legal or equitable, of any mortgage, charge, or other form of security over that asset; or (d) if the asset is an interest in land, any transaction or event that is capable under any enactment or rule of law of affecting the title to a registered interest in that land, on the assumption that the title is registered, and references to “dispose” are to be read accordingly;
“relevant asset”	means any item of property, including buildings, interests in land, equipment (including rights, licenses and consents relating to its use), without which the Licensee’s ability to meet its obligations to provide Commissioner Requested Services would reasonably be regarded as materially prejudiced;
“relinquishment of control”	includes entering into any agreement or arrangement under which control of the asset is not, or ceases to be, under the sole management of the Licensee, and “relinquish” and related expressions are to be read accordingly.

10. The Licensee shall have regard to such guidance as may be issued from time to time by NHS England regarding:

a. the manner in which asset registers should be established, maintained and updated, and
b. property, including buildings, interests in land, intellectual property rights and equipment, without which a licensee’s ability to provide

Commissioner Requested Services should be regarded as materially prejudiced.

CoS 3: Standards of corporate governance, financial management and quality governance

1. The Licensee shall at all times adopt and apply systems and standards of corporate governance, quality governance and of financial management which reasonably would be regarded as:
   a. suitable for a provider of the Commissioner Requested Services, provided by the Licensee, or a Hard to Replace Provider,
   b. providing reasonable safeguards against the risk of the Licensee being unable to carry on as a going concern, and
   c. providing reasonable safeguards against the licensee being unable to deliver services due to quality stress.
2. In its determination of the systems and standards to adopt for the purpose of paragraph 1, and in the application of those systems and standards, the Licensee shall have regard to:
   a. such guidance as NHS England may issue from time to time concerning systems and standards of corporate governance, financial management and quality governance;
   b. the Licensee's ratings using the risk rating methodologies published by NHS England from time to time, and
   c. the desirability of that rating being not less than the level regarded by NHS England as acceptable under the provisions of that methodology.

CoS 4: Undertaking from the ultimate controller

1. The Licensee shall procure from each company or other person which the Licensee knows or reasonably ought to know is at any time its ultimate controller, a legally enforceable undertaking in favour of the Licensee, in the form specified by NHS England, that the ultimate controller ("the Covenantor"):

a. will refrain for any action, and will procure that any person which is a subsidiary of, or which is controlled by, the Covenantor (other than the Licensee and its subsidiaries) will refrain from any action, which would be likely to cause the Licensee to be in contravention of any of its obligations under the NHS Acts or this Licence, and

b. will give to the Licensee, and will procure that any person which is a subsidiary of, or which is controlled by, the Covenantor (other than the Licensee and its subsidiaries) will give to the Licensee, all such information in its possession or control as may be necessary to enable the Licensee to comply fully with its obligations under this Licence to provide information to NHS England.

2. The Licensee shall obtain any undertaking required to be procured for the purpose of paragraph 1 within 7 days of a company or other person becoming an ultimate controller of the Licensee and shall ensure that any such undertaking remains in force for as long as the Covenantor remains the ultimate controller of the Licensee.

3. The Licensee shall:

a. deliver to NHS England a copy of each such undertaking within seven days of obtaining it;

b. inform NHS England immediately in writing if any Director, secretary or other officer of the Licensee becomes aware that any such undertaking has ceased to be legally enforceable or that its terms have been breached, and

c. comply with any request which may be made by NHS England to enforce any such undertaking.

4. For the purpose of this Condition, subject to paragraph 5, a person (whether an individual or a body corporate) is an ultimate controller of the Licensee if:

a. directly, or indirectly, the Licensee can be required to act in accordance with the instructions of that person acting alone or in concert with others, and
b. that person cannot be required to act in accordance with the instructions of another person acting alone or in concert with others.

5. A person is not an ultimate controller if they are:
   a. a health service body, within the meaning of section 9 of the 2006 Act;
   b. a Governor or Director of the Licensee and the Licensee is an NHS foundation trust;
   c. any Director of the Licensee who does not, alone or in association with others, have a controlling interest in the ownership of the Licensee and the Licensee is a body corporate; or
   d. a trustee of the Licensee and the Licensee is a charity.

CoS 5: Risk pool levy

1. The Licensee shall pay to NHS England any sums required to be paid in consequence of any requirement imposed on providers under section 135(2) of the 2012 Act, including sums payable by way of levy imposed under section 139(1) and any interest payable under section 143(10), by the dates by which they are required to be paid.
2. In the event that no date has been clearly determined by which a sum referred to in paragraph 1 is required to be paid, that sum shall be paid within 28 days of being demanded in writing by NHS England.

CoS 6: Cooperation in the event of financial or quality stress

1. The obligations in paragraph 2 shall apply if NHS England has given notice in writing to the Licensee that it is concerned about:
   a. the ability of the Licensee to continue to provide commissioner requested services due to quality stress
   b. the ability of a Hard to Replace Provider being able to continue to provide its NHS commissioned services due to quality stress, or
   c. the ability of the Licensee to carry on as a going concern.
2. When this paragraph applies the Licensee shall:
   a. provide such information as NHS England may direct to Commissioners and to such other persons as NHS England may direct;
   b. allow such persons as NHS England may appoint to enter premises owned or controlled by the Licensee and to inspect the premises and anything on them, and
   c. co-operate with such persons as NHS England may appoint to assist in the management of the Licensee's affairs, business and property.

CoS 7: Availability of resources

1. The Licensee shall at all times act in a manner calculated to secure that it has, or has access to, the Required Resources.
2. The Licensee shall not enter into any agreement or undertake any activity which creates a material risk that the Required Resources will not be available to the Licensee.
3. The Licensee, not later than two months from the end of each Financial Year, shall submit to NHS England a certificate as to the availability of the Required Resources for the period of 12 months commencing on the date of the certificate, in one of the following forms:
    a. “After making enquiries the Directors of the Licensee have a reasonable expectation that the Licensee will have the Required Resources available to it after taking account distributions which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate.”
    b. “After making enquiries the Directors of the Licensee have a reasonable expectation, subject to what is explained below, that the Licensee will have the Required Resources available to it after taking into account in particular (but without limitation) any distribution which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate. However, they would like to draw attention to the following factors which may cast doubt on the ability of the Licensee to have access to the required resources”.
    c. “In the opinion of the Directors of the Licensee, the Licensee will not have the Required Resources available to it for the period of 12 months referred to in this certificate”.
4. The Licensee shall submit to NHS England with that certificate a statement of the main factors which the Directors of the Licensee have taken into account in issuing that certificate.
5. The statement submitted to NHS England in accordance with paragraph 4 shall be approved by a resolution of the board of Directors of the Licensee and signed by a Director of the Licensee pursuant to that resolution.

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

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

8. In this Condition:

"distribution" includes the payment of dividends or similar payments on share capital and the payment of interest or similar payments on public dividend capital and the repayment of capital;

"Financial Year" means the period of twelve months over which the Licensee normally prepares its accounts;

"Required Resources" means such:

a. management resources including clinical leadership,
b. appropriate and accurate information pertinent to the governance of quality
c. financial resources and financial facilities,
d. personnel,
e. physical and other assets including rights, licences and consents relating to their use,
f. subcontracts , and
g. working capital as reasonably would be regarded as sufficient for a Hard to Replace Provider and/or to enable the Licensee at all times to provide the Commissioner Requested Services.

Section 7 – Costing Conditions

C1: Submission of costing information

1. Whereby NHS England, and only in relation to periods from the date of that requirement, the Licensee shall:

    a. obtain, record and maintain sufficient information about the costs which it expends in the course of providing services for the purposes of the NHS and other relevant information,
    b. establish, maintain and apply such systems and methods for the obtaining, recording and maintaining of such information about those costs and other relevant information, as are necessary to enable it to comply with the following paragraphs of this Condition.

2. Licensee should record the cost and other relevant information required in this condition consistent with the guidance in NHS England's Approved Costing Guidance. The form of data collected, costed and submitted should be consistent with the technical guidance included in the Approved Costing Guidance (subject to any variations agreed and approved with NHS England) and submitted in line with the nationally set deadlines.

3. If the Licensee uses sub-contractors in the provision of health care services for the purposes of the NHS, to the extent that it is required to do so in writing by NHS England the Licensee shall procure that each of those sub-contractors:

    a. obtains, records and maintains information about the costs which it expends in the course of providing services as sub-contractor to the Licensee, and establishes, maintains and applies systems and methods for the obtaining, recording and maintaining of that information, in a manner that complies with paragraphs 2 and 3 of this Condition, and
    b. provides that information to NHS England in a timely manner.

4. Records required to be maintained by this Condition shall be kept for not less than six years.

5. In this Condition:

“the Approved Guidance”	means such guidance on the obtaining, recording and maintaining of information about costs and on the breaking down and allocation of costs published annually by NHS England.
“other relevant information”	means such information, which may include quality and outcomes data, as may be required by NHS England for the purpose of its functions under Chapter 4 (Pricing) in Part 3 of the 2012 Act and material costs funded through other public sector entities which impact on the accuracy of costing information.

C2: Provision of costing and costing related information

1. Subject to paragraph 3, and without prejudice to the generality of Condition G1, the Licensee shall submit the mandated information required per Costing Condition 1 consistent with the approved costing guidance in the form, manner and the timetable as prescribed.
2. In furnishing information documents and reports pursuant to paragraph 1 the Licensee shall take all reasonable steps to ensure that:
    a. in the case of information (data) or a report, it is accurate, complete and not misleading;
    b. in the case of a document, it is a true copy of the document requested;
3. This Condition shall not require the Licensee to furnish any information, documents or reports which it could not be compelled to produce or give in evidence in civil proceedings before a court because of legal professional privilege.

C3: Assuring the accuracy of pricing and costing information

1. Providers are required to have processes in place to ensure itself of the accuracy and completeness of costing and other relevant information collected and submitted to NHS England is as per the Approved Costing Guidance.
2. This may include but is not limited to
    a. Regular assessments by the providers internal and/or external auditor
    b. specific work by NHS England or NHS England nominated representative on costing related issues and
    c. use of tools or other information or assessments of costing information produced by NHS England on costing and other relevant information.
    d. Evidence of the assurance process (including work by the internal or external auditor of the provider) should be maintained and submitted as and when requested by NHS England and may be subject to follow up by NHS England. NHS England reserves the right to undertake specific work at a provider where issues are identified which may be undertaken by a nominated representative.

Section 8 – Pricing Conditions

P1: Compliance with the NHS payment scheme

1. Except as approved in writing by NHS England, the Licensee shall comply with the rules, and apply the methods, concerning charging for the provision of health care services for the purposes of the NHS contained in the NHS Payment Scheme published by NHS England in accordance with section 116 of the 2012 Act, wherever applicable.

Section 9 – Interpretation and Definitions

Condition D1: Interpretation and Definitions

1. In this Licence, except where the context requires otherwise, words or expressions set out in the left-hand column of the following table have the meaning set out next to them in the right hand column of the table.

“the 2006 Act”	the National Health Service Act 2006 c.41;
“the 2008 Act”	the Health and Social Care Act 2008 c.14;
“the 2009 Act”	the Health Act 2009 c.21;
“the 2012 Act”	the Health and Social Care Act 2012 c.7;
“the 2022 Act”	The Health and Care Act 2022;
“the Care Quality Commission”	the Care Quality Commission established under section 1 of the 2008 Act;
“Commissioner Requested Service”	a service of the sort described in paragraph 2 of condition G8 which has not ceased to be such a service in accordance with paragraph 8 of that condition;
“Commissioners”	NHS England and any Integrated Care Board and includes any bodies exercising commissioning functions pursuant to a delegation from NHS England or an ICB;
“Director”	includes any person who, in any organisation, performs the functions of, or functions equivalent or similar to those of, a director of: (i) an NHS foundation trust, (ii) an NHS Trust or (iii) a company constituted under the Companies Act 2006;

“Governor”	a Governor of an NHS foundation trust;
“Hard to replace provider”	has the meaning given in condition G8 of the licence;
“Integrated Care Board”	a body corporate established by NHS England by virtue of section 14Z25 of the 2006 Act;
“the NHS Acts”	the 2006 Act, the 2008 Act, the 2009 Act; the 2012 Act and the 2022 Act;
NHS Controlled provider	An organisation which is not an NHS trust or NHS foundation trust but is ultimately controlled by one or more NHS trusts and/or foundation trusts, where ‘control’ is defined on the basis of IFRS 10;
“NHS England”	the body named as NHS England in section 1 of the 2022 Act;
“NHS foundation trust”	a public benefit corporation established pursuant to section 30 of, and Schedule 7 to, the 2006 Act;
“NHS Trust”	an NHS trust established under section 25 of the 2006 Act;
“Relevant bodies”	NHS England, Integrated Care Boards, NHS trusts and NHS foundation trusts in accordance with section 96(2B) of the 2012 Act;
“Trusts”	means NHS foundation trusts and NHS trusts.

2. Any reference in this Licence to a statutory body shall be taken, unless the contrary is indicated, to be a reference also to any successor to that body.
3. Unless the context requires otherwise, words or expressions which are defined in the NHS Acts shall have the same meaning for the purpose of this Licence as they have for the purpose of that Act.

4. Any reference in the Licence to any provision of a statute, statutory instrument or other regulation is a reference, unless the context requires otherwise, to that provision as currently amended.

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DCH Subco Ltd Escalation Report to

DCHFT Finance and Performance Committee

Date of Meeting: 2nd May 2023

Presented by: Stephen Tilton

Significant risks / issues for escalation to Committee / Board for action	• The Annual Work Plan was approved. • The Terms of Reference were reviewed and approved. • The Board approved an 80% share profits from 2022/23 to be donated to the DCH Charity. • The Going Concern Statement was approved as the basis for preparation of the DCH Subco Ltd Accounts • The 2023/24 Budget was approved. • The proposal for a 5% additional staff remuneration was approved. • Risks relating to limited operating space and staff availability.

Key issues / matters discussed at the Committee	• Finance Report noting that at the end of March 2023:
	  ○ profit was £119k
	  ○ The Cash balance was £600k verses the planned position of £412k.
	• The Performance report noted:
	  ○ Performance Indicators were RAG rated Green with the exception of one indicator relating to the availability of a responsible pharmacist for a 60-minute period.
	  ○ There had been no dispensing errors.
	  ○ There had been no complaints.
	  ○ Service activity levels remained consistent.
	• Contract Review Feedback
	• Review of Risks, Incidents and Complaints.
	• Discussion of the DCH Strategy was deferred to the autumn.

Decisions made by the Committee	• The Annual Work Plan was approved. • The Terms of Reference were reviewed and approved. • The Board approved an 80% share profits from 2022/23 to be donated to the DCH Charity. • The Going Concern Statement was approved as the basis for preparation of the DCH Subco Ltd Accounts • The 2023/24 Budget was approved. • The proposal for a 5% additional staff remuneration was approved.
Implications for the Corporate Risk Register or the Board Assurance Framework (BAF)	• The Pharmacy staffing and operational space risks were noted.

Items / issues for referral to other Committees	• None

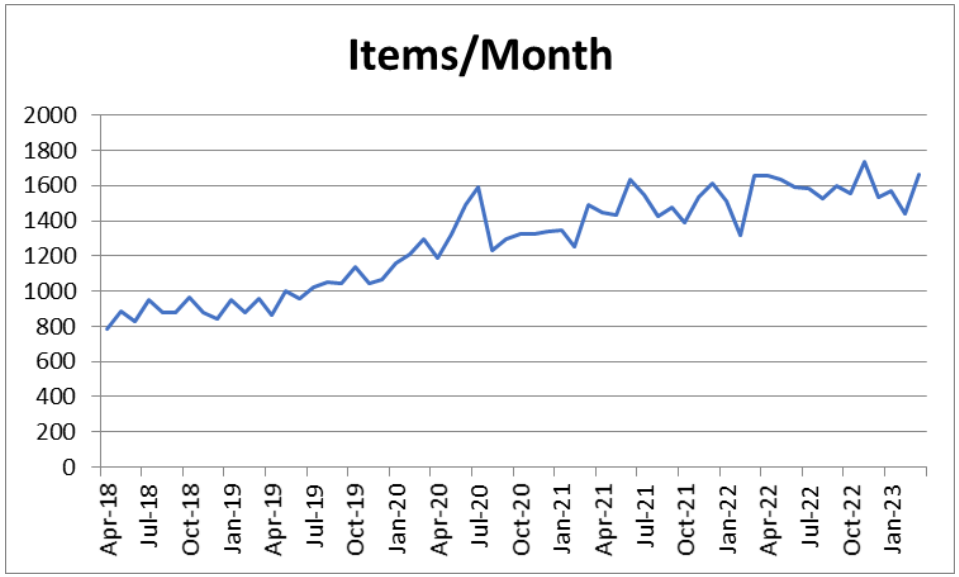
Performance Report

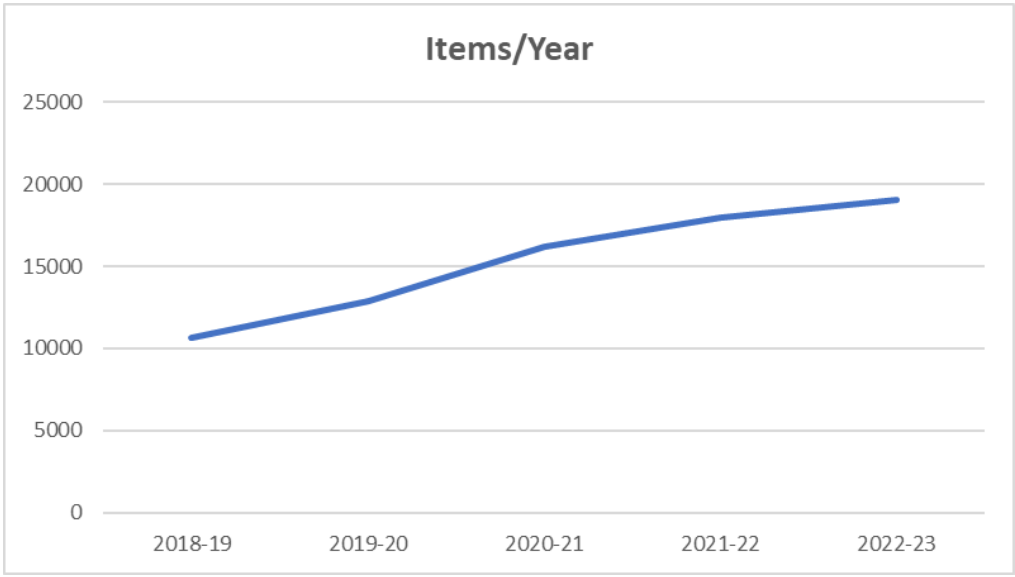
Andrew Harris
Superintendent Pharmacist
Apr 2023

Key Performance Indicators (KPIs)

	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 Number of Customers per Month	151	211	178	201	196	217	186	240	184	228	174	232
Total Items Dispensed	1656	1635	1588	1582	1524	1595	1558	1735	1532	1566	1437	1660
Average Items/day	87.2	77.9	79.4	75.3	69.3	72.5	74.2	78.9	76.6	74.6	71.9	72.2
No. of same day Prescriptions	442	364	376	331	323	348	377	361	331	362	315	336
No. of Advance Prescriptions	330	401	390	458	444	421	432	505	408	441	409	513

Activity levels from April 2018 to current:





Fortuneswell Pharmacy has returned to cancer only related activity which is reflected in the reduced activity from August 2020, though cancer related activity is now climbing.

All contractual KPIs year to date are green, with one exception:
On Friday 2nd December, Pharmacy were unable to provide a responsible pharmacist for the full day to cover annual leave. No responsible pharmacist was signed in for the period 09:00-10:00, which had been discussed in advance with the SubCo Board.

Performance measure	Key Performance Indicator	Target performance	Green	Amber	Red	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep–22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
Rate of dispensing errors detected post issue	Number of errors made per total volume of prescriptions dispensed that have LEFT the department	<2.0%	<1.0%	1.0-2.0%	>2.0%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Near Miss Monitoring	Number of errors made per total volume of prescriptions dispensed that have NOT LEFT the department	<2.0%				0.91%	0.92%	0.88%	0.85%	0.82%	0.76%	0.71%	0.86%	0.91%	1.02%	0.77%	0.96%
Availability of service	Responsible Pharmacist Availability	0	0 to 45 mins	45 to 90 mins	> 90 mins	0	0	0	0	0	0	0	0	60 mins	0	0	0
Availability of medicines	The % of prescription items dispensed in full at the first time of presentation excluding manufacturer can't supply	98%	100% - 98%	97.9% - 96%	< 95.9%	99.64%	99.20%	99.43%	99.43%	99.54%	99.56%	99.55%	99.37%	99.67%	99.43%	99.03%	99.16%
MHRA Recall Assurance	100% of all SABs alerts, MHRA and Company-Led recalls are managed in accordance with Class status	100%				100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%

All Mosaiq advance prescription preparedthe day in advance of collection	The completion time should bethe day in advance of collection/ delivery to chemotherapy nurses.	>90%	100% - 90%	89.9% - 80%	<80 %	90.1%	96.3%	91.8%	97.6%	97.3%	98.1%	92.1%	96.6%	91.2%	96.8%	90.7%	97.9%
The waiting time for dispensing prescriptions, during a monthly period shall be: (i) 30 minutes or less in respect of 95% of all prescriptions; and (ii) 20 minutes or less in respect of 80% of all prescriptions	The time taken for a patient to wait for their prescription from the time they present it to the Pharmacy.	(i) 30 minutes or less in respect of 95% of all prescriptions (ii) 20 minutes or less in respect of 80% of all prescriptions	For (i) Greater than or equal to 95% For (ii) Greater than or equal to 80%	For (i) 80% - 94.9% For (ii) 65% - 79.9%	For (i) Less than 80% For (ii) Less than 65%	(i) 99.6% (ii) 95.6%	(i) 99.2% (ii) 96.2%	(i) 99.1% (ii) 97.3%	(i) 100% (ii) 98.7%	(i) 100% (ii) 98.8%	(i) 99.2% (ii) 97.1%	(i) 99.6% (ii) 97.6%	(i) 100% (ii) 97.3%	(i) 99.1% (97.3%	(i) 100% (ii) 97.8%	(i) 99.6% (ii) 96.9%	(i) 99.6% (ii) 96.5%
Index of customer satisfaction	The patient overall satisfaction level		100% of Customers to be offered Customer Feedback Survey Monthly Reporting on KPIs to record; Total Number of Customers per Month Completion / Uptake Rate (%)			100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Number of complaints	The number of upheld complaints		1 or fewer complaints per quarter	2 or fewer complaints per quarter	Over 2 complaints per quarter	0	0	0	0	0	0	0	0	0	0	0	0

Number of non-agreed non-formulary items supplied	Number of items that appear on total non-formulary supply report	0%	0% - 0.049%	0.05% - 0.099%	> 0.1%	0	0	0	0	0	0	0	0	0	0	0	0
Controlled drug management	Correct procedure against SOPs followed at all times	100%	No Tolerance			100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Provision of financial, clinical and management information	financial, clinical and management information to be provided within 5 working days following the end of the previous month	100%	100% - 99%	98.9% - 97.5%	< 97.5 %	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Waste/Expiry management *	Waste Costs below £200 per month - Stock waste to be managed	<£200	<£200			£0.00	£14.36	£0.00	£16.23	£2.23	£11.24	£4.32	£0.00	£5.01	£0.03	£26.10	£21.11

Incidents

No dispensing errors have left Fortuneswell Pharmacy in financial year 2022/23

Complaints

Nil

Keys Risks

- The original business was for a dedicated Cancer Services Outpatient Pharmacy with an estimated dispensing activity of ~700 items per month. Activity has steadily increased over the two year period and is now 1,400 per month, double the anticipated level of activity in the original business case. There is now a risk the Outpatient Pharmacy would no longer meet the General Pharmaceutical Council (GPhC) premises standards if re-inspected.
- Significant level of vacancies within the DCH Clinical Pharmacy Service impacting on ability of Superintendent Pharmacist to take Annual Leave. This also poses a potential for service disruption (reduced opening hours) in the absence of the superintendent pharmacist (both planned and unplanned).
- HM Treasury commenced a consultation in August 2020 on “VAT and the Public Sector: Reform to VAT refund rules”. This has significant implications for the Public sector including the NHS which if the recommendation is implemented, would permit full refunds of the VAT incurred on all goods and services during the course of non-business activities (full refund model). This represents a significant risk to the long term sustainability of the subsidiary company.

Report Front Sheet

1. Report Details			
Meeting Title:	Board of Directors, Part 1		
Date of Meeting:	31 May 2023		
Document Title:	Communications Activity Report		
Responsible Director:	Nick Johnson, Deputy Chief Executive and Director of Strategy, Transformation and Partnerships	Date of Executive Approval	
Author:	Susie Palmer, Head of Communications		
Confidentiality:	No		
Publishable under FOI?	Yes		
Predetermined Report Format?	No		

2. Prior Discussion		
Job Title or Meeting Title	**Date**	**Recommendations/Comments**
People and Culture Committee	22 May 2023	Noted

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

6. Governance and Compliance Obligations				
Legal / Regulatory Link			**No**	*If yes, please summarise the legal/regulatory compliance requirement. (Please delete as appropriate)*
Impact on CQC Standards			**No**	*If yes, please summarise the impact on CQC standards. (Please delete as appropriate)*
Risk Link			**No**	*f yes, please state the link to Board Assurance Framework and Corporate Risk Register risks (incl. reference number). Provide a statement on the mitigated risk position. (Please delete as appropriate)*
Impact on Social Value		**Yes**		**Our comms activities highlight the Trust's contribution to Social Value**
Trust Strategy Link		**How does this report link to the Trust's Strategic Objectives?** *Please summarise how your report will impact one (or multiple) of the Trust's Strategic Objectives (positive or negative impact). Please include a summary of key measurable benefits or key performance indicators (KPIs) which demonstrate the impact.*		
Strategic Objectives	People	A significant amount of our comms resource goes into keeping staff well informed and supporting recruitment and retention initiatives		
	Place	Supporting the comms and engagement for the site development		
	Partnership	The comms team works closely with system comms leads to coordinate key messages		

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

Communications Activity Report

Quarters 3 and 4: October 2022 – March 2023

1. Introduction

This report gives an overview of communications activity for the Trust. It is by no means an exhaustive account of what the communications team has been involved in but it covers some key areas of our work and a summary of activity.

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

One member of the three-person comms team is on maternity leave until August 2023 and was not replaced to make a CIP saving. This has of course increased pressure on the team to maintain a comprehensive comms service, so we have been focusing on the highest priorities.

To manage the ever-increasing requests for comms support, we have further developed our Comms Portal on the intranet to offer colleagues guidance, advice and practical tips to enable them to promote their service or initiative.

2. Key Campaigns, Initiatives, Events and Developments

New E-newsletter Tool – e-Shot

We are very excited to have secured funding, thanks to the support of the People Division, for an e-newsletter platform which will transform how we present and analyse our staff e-bulletins.

e-Shot will allow us to create engaging and accessible e-newsletter templates for all our regular staff comms – including the Staff Bulletin, CEO Brief, OD Bulletin, Education Bulletin and Celebrating Success.

The platform will also give us valuable insights into how many staff are reading the bulletins, and which articles they access – allowing us to better tailor content for our audience and maximise our reach.

Staff App Refresh and Relaunch

The introduction of our e-newsletter platform will be complemented by a refresh of our DCH Staff App.

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

Current users clearly value the app as they downloaded the new version promptly, and we have picked up new users as well. At the time of writing this report, we have logged 3,344 downloads. The app is promoted at staff induction so we add to our download numbers each month. We have also worked with our Freedom to Speak Up Guardian to encourage more staff without regular access to a Trust device to download the app.

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

We have added two new sections to the app recently – 'Bank Staff' and 'Noticeboard'. The Bank Staff section brings together useful information for bank staff in one place and we will develop this further with the temporary staffing team.

The new noticeboard function allows staff to post information to colleagues – such as items for sale and events. The functionality is similar to the intranet noticeboard, which is a legacy system we have been looking to replace, so this offers us a good alternative. We've already had positive feedback from staff and will continue to raise awareness and encourage more staff to download the app.

Wayfinding Signage Project
The comms team have taken the lead on a project to update the wayfinding signs throughout the hospital as the current directional signs are woefully out of date and causing much confusion.

Funding has been secured for the first phase of the project to replace the existing signs in corridors, stairwells and outside lifts with new signs designed according to NHS guidelines. Each sign has been reviewed and updated, and will incorporate references to new developments such as the new Discharge Lounge and the Mary Anning Unit.

Consideration has been given to future updates required and the materials used will be far cheaper to update and replace than the current signs.

Outside signs (which were replaced as part of the multi-storey car park build) are also being updated to reflect recent changes, and updated site maps will be used on outside and inside signs as a supporting wayfinding tool. Patient and staff feedback was incorporated into the sign design, colours and wording for the outside signs, which has been reflected in the design for the internal signs. Further feedback will be sought from the Patient Voice group and hospital volunteers who act as guides when draft signs are available to share.

If additional funding can be secured, the second phase of the project will be to review the signage on department entrance doors to adopt a more consistent and clean approach.

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

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

Strike Comms
Clear, consistent and coordinated comms has been required internally and externally through periods of industrial action.

We set up a dedicated section of our intranet to keep staff updated with rapidly changing guidance, and issued regular updates.

We created a suite of social media assets and website content for our DCH channels to keep patients informed and updated about the impact, while also coordinating with system partners to ensure messages were consistent.

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

We are now working together to agree a comprehensive comms and engagement plan to ensure staff in both organisations are informed and involved as collaboration work progresses.

Strategy Work
The People Plan and the Clinical Plan have been published alongside the Trust Strategy.

We developed a visual identity for all the related documents to illustrate how these plans link together and worked with NHS Creative on the design to give them a professional look and feel. The documents can be read in the strategy section of the intranet.

Recruitment Comms
We continue to support recruitment activity, but without a dedicated recruitment marketing resource we are limited in the impact we can make. The comms team is not resourced for planning and delivering a comprehensive recruitment marketing service.

Replacing the recruitment microsite with a dedicated section on our Trust website has proved positive, with the new landing page consistently one of our most visited pages.

Dedicated sections have been created to highlight key job roles, such as healthcare support workers and Emergency Department vacancies.

We worked with a professional video production company and the Education Team to create a series of videos to support recruitment to healthcare support workers, highlighting DCH's unique offering around support and career development through real staff stories.

We have received positive feedback about the videos and the engagement on social media has been high.

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

Staff Flu and COVID-19 Vaccination Campaign
We took a different approach this year by combining both flu and COVID vaccinations at each session rather than running separate campaigns.

Our comms materials supported the national focus on getting 'doubly protected'. The staff campaign we ran was well received with good levels of engagement on our channels – but there was a lower take-up of vaccinations overall this time, which reflected the situation across the country.

Your Future Hospital Comms
We continue to support strategic estates to communicate with staff, communities and other stakeholders about the major building projects happening across the Trust. This has included a presentation to local councillors and updates for MPs. The dedicated area on our website continues to be updated with new schemes and our progress.

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

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

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

We have been responding to local media enquiries and keeping local reporters informed, and media coverage has been largely positive.

At the time of writing this report, the most recent barrier testing had gone well and we have lined up comms to re-launch the Staff Parking Portal so staff can register their cars for number plate recognition which will allow the barriers to become operational. Comms are also prepared to inform the public about how the barriers and new payment system will operate.

South Walks House - The comms team have been closely involved in the project to develop South Walks House, supporting the strategic estates team with internal comms for the teams moving from the West Annex, including a briefing document for managers.

We secured front page coverage for our successful Targeted Funding Bid and helped to inform staff, patients and the wider community about the Outpatient Assessment Centre temporarily moving to South Walks House.

Discharge Lounge - There was a quick turnaround for both securing funding for this – and communicating the project with staff, visitors and key stakeholders. Activity has included:

- Writing and delivering a letter to residents on Bridport Road to give them the heads-up about the scheme and the timetable of construction works;
- Announcing the Trust successfully securing the £2million funding;
- Messages for staff and local communities explaining how the modular building was to be delivered on site, including the disruption this would cause and the mitigations in place.

We filmed the delivery of the building to share on our social media channels, receiving more than 2,000 views.

Emergency Department Expansion (ED15) - In December, we helped the Trust mark completion of the ED15 project. We supported the team with a celebration event for staff and key stakeholders, publicised the scheme with photos of the refurbishment in internal comms, on our website and within the local media.

New Hospital Programme (NHP) - In January we informed staff and wider stakeholders that we had secured outline planning permission. We were also featured in the New Hospital Programme's national bulletin.

Nationally the scheme is under scrutiny, and we carefully manage ongoing media interest about the programme, working closely with our system partners and the national NHP scheme.

In February we promoted the first half of a £2million donation from the HELP Appeal charity for our new rooftop helipad.

We are now preparing communications for the decommissioning of the existing helipad, the demolition of the West Annex and sharing updated plans as part of our Reserved Matters application once it is submitted.

We are also supporting the strategic estates team to participate in a series of system-wide roadshows across Dorset to talk to local residents more about our plans.

3. Social Media

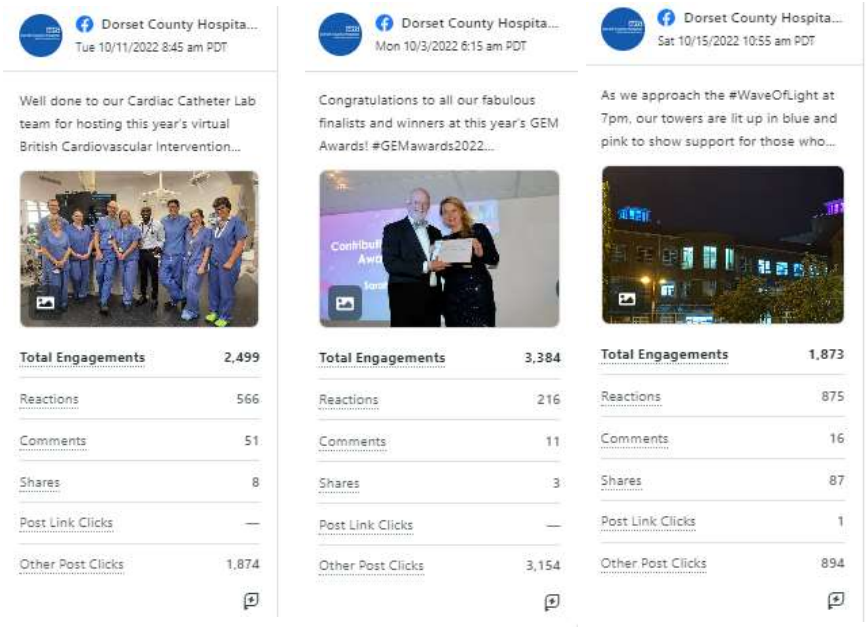
The statistics below demonstrate how many people we are reaching each quarter through each channel. Also included is a small selection of the most popular posts for each month.

Facebook Analytics – www.facebook.com/DCHFT

The organic reach of FB posts (how many people see your post without paid advertising) is cut after reaching 10,000 followers.

	Q1 April-June 2022	Q2 July-Sept 2022	Q3 Oct-Dec 2022	Q4 Jan-March 2023
Number of posts	137	131	204	142
Engaged users	95,826	100,586	157,716	117,087
Number of followers	11,816	12,184	12,339	12,451

Facebook Highlights for October 2022



Dorset County Hospita...
Tue 10/11/2022 8:45 am PDT

Well done to our Cardiac Catheter Lab team for hosting this year's virtual British Cardiovascular Intervention...

Total Engagements	2,499
Reactions	566
Comments	51
Shares	8
Post Link Clicks	—
Other Post Clicks	1,874

Dorset County Hospita...
Mon 10/3/2022 6:15 am PDT

Congratulations to all our fabulous finalists and winners at this year's GEM Awards! #GEMawards2022...

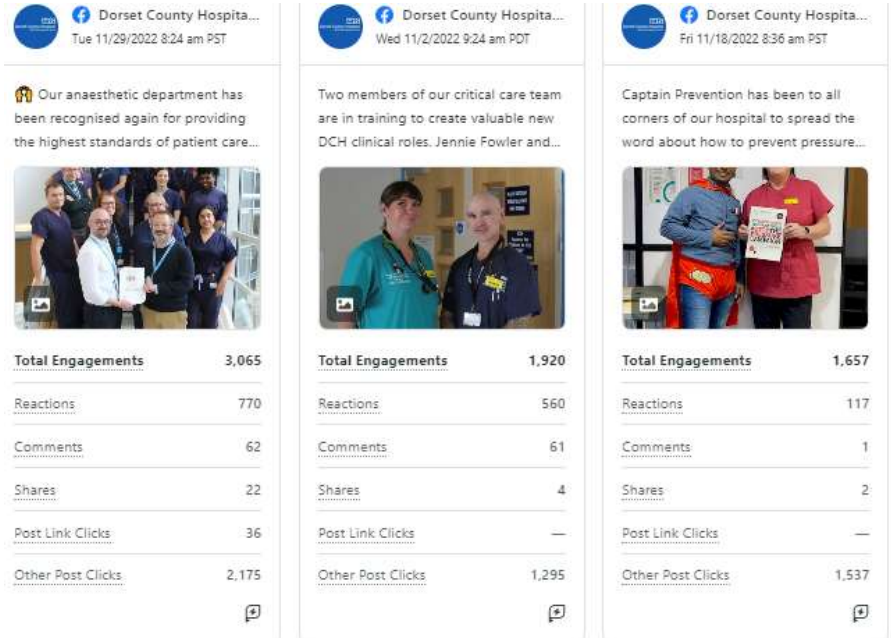
Total Engagements	3,384
Reactions	216
Comments	11
Shares	3
Post Link Clicks	—
Other Post Clicks	3,154

Dorset County Hospita...
Sat 10/15/2022 10:55 am PDT

As we approach the #WaveOfLight at 7pm, our towers are lit up in blue and pink to show support for those who...

Total Engagements	1,873
Reactions	875
Comments	16
Shares	87
Post Link Clicks	1
Other Post Clicks	894

Facebook Highlights for November 2022



Dorset County Hospita...
Tue 11/29/2022 8:24 am PST

Our anaesthetic department has been recognised again for providing the highest standards of patient care...

Total Engagements	3,065
Reactions	770
Comments	62
Shares	22
Post Link Clicks	36
Other Post Clicks	2,175

Dorset County Hospita...
Wed 11/2/2022 9:24 am PDT

Two members of our critical care team are in training to create valuable new DCH clinical roles. Jennie Fowler and...

Total Engagements	1,920
Reactions	560
Comments	61
Shares	4
Post Link Clicks	—
Other Post Clicks	1,295

Dorset County Hospita...
Fri 11/18/2022 8:36 am PST

Captain Prevention has been to all corners of our hospital to spread the word about how to prevent pressure...

Total Engagements	1,657
Reactions	117
Comments	1
Shares	2
Post Link Clicks	—
Other Post Clicks	1,537

Facebook Highlights for December 2022

Dorset County Hospita...
Thu 12/29/2022 3:36 am PST

⚠ Dorset County Hospital has declared a critical incident due to the extreme operational pressures...

Total Engagements	9,271
Reactions	523
Comments	189
Shares	604
Post Link Clicks	53
Other Post Clicks	7,902

Dorset County Hospita...
Wed 12/14/2022 8:15 am PST

The refurbishment of our existing Emergency Department (ED) is complete! It offers improved facilities...

Total Engagements	5,713
Reactions	576
Comments	50
Shares	40
Post Link Clicks	26
Other Post Clicks	5,021

Dorset County Hospita...
Thu 12/15/2022 5:19 am PST

Please note that staff at Dorset County Hospital are not included in the Royal College of Nursing industrial action ...

Total Engagements	2,916
Reactions	586
Comments	66
Shares	186
Post Link Clicks	39
Other Post Clicks	2,039

Facebook Highlights for January 2023

Dorset County Hospita...
Fri 1/13/2023 9:14 am PST

Congratulations to our Maternity Service for their high scores in a national patient survey published by...

Total Engagements	4,853
Reactions	1,011
Comments	124
Shares	50
Post Link Clicks	64
Other Post Clicks	3,604

Dorset County Hospita...
Tue 1/17/2023 4:41 am PST

Visiting times on our general wards are being extended on Wednesday 18 January and Thursday 19 January. Fo...

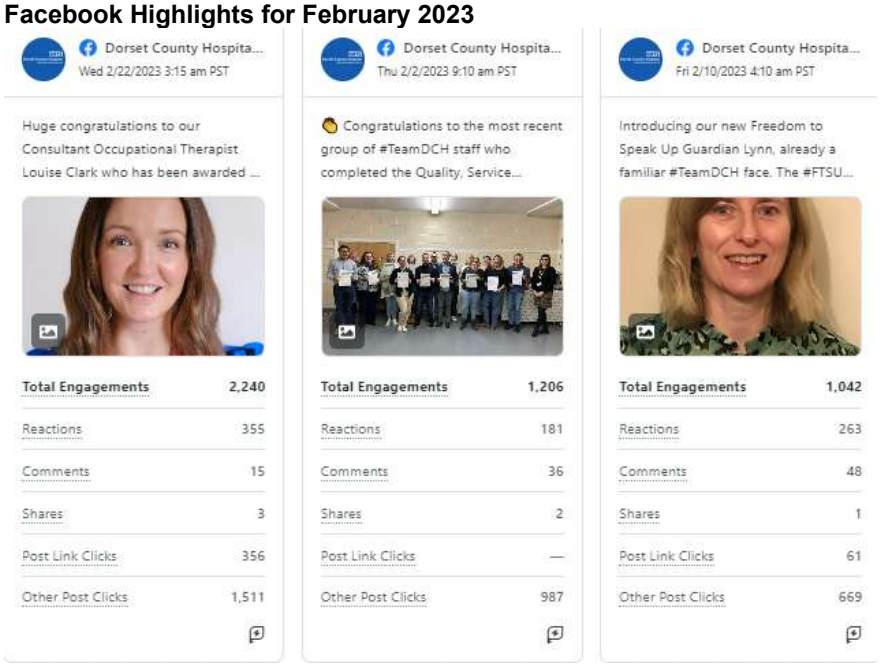
Total Engagements	2,336
Reactions	277
Comments	44
Shares	92
Post Link Clicks	22
Other Post Clicks	1,901

Dorset County Hospita...
Mon 1/16/2023 9:22 am PST

We're delighted that outline plans to develop our hospital, including building a new Emergency...

Total Engagements	1,981
Reactions	340
Comments	21
Shares	16
Post Link Clicks	272
Other Post Clicks	1,332

Facebook Highlights for February 2023



Dorset County Hospita...
Wed 2/22/2023 3:15 am PST

Huge congratulations to our Consultant Occupational Therapist Louise Clark who has been awarded ...

Total Engagements	2,240
Reactions	355
Comments	15
Shares	3
Post Link Clicks	356
Other Post Clicks	1,511

Dorset County Hospita...
Thu 2/2/2023 9:10 am PST

Congratulations to the most recent group of #TeamDCH staff who completed the Quality, Service...

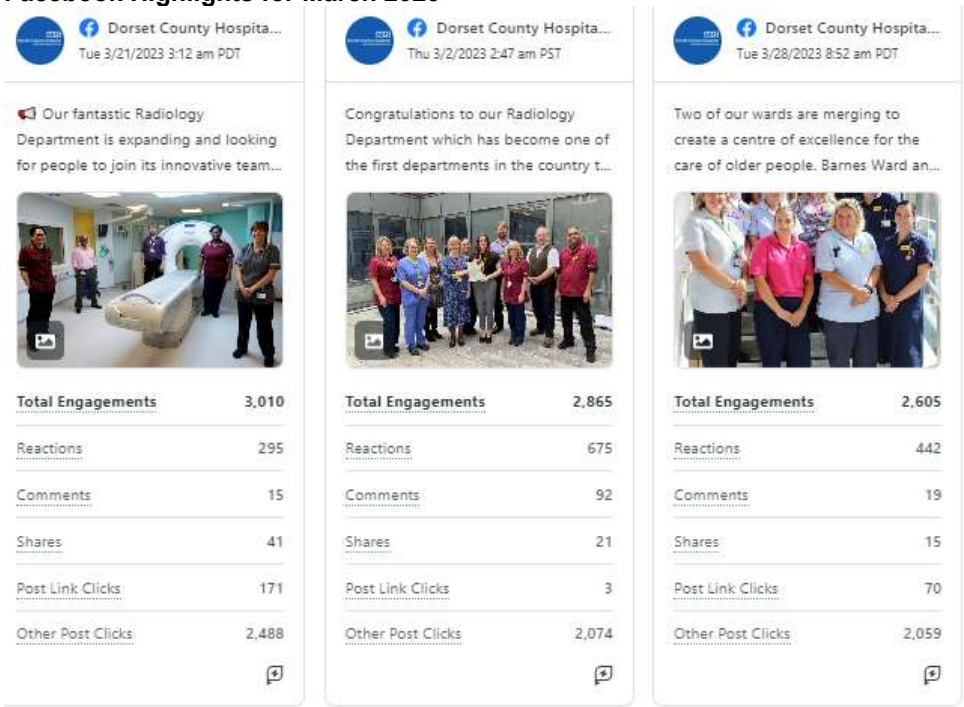
Total Engagements	1,206
Reactions	181
Comments	36
Shares	2
Post Link Clicks	—
Other Post Clicks	987

Dorset County Hospita...
Fri 2/10/2023 4:10 am PST

Introducing our new Freedom to Speak Up Guardian Lynn, already a familiar #TeamDCH face. The #FTSU...

Total Engagements	1,042
Reactions	263
Comments	48
Shares	1
Post Link Clicks	61
Other Post Clicks	669

Facebook Highlights for March 2023



Dorset County Hospita...
Tue 3/21/2023 3:12 am PDT

Our fantastic Radiology Department is expanding and looking for people to join its innovative team...

Total Engagements	3,010
Reactions	295
Comments	15
Shares	41
Post Link Clicks	171
Other Post Clicks	2,488

Dorset County Hospita...
Thu 3/2/2023 2:47 am PST

Congratulations to our Radiology Department which has become one of the first departments in the country t...

Total Engagements	2,865
Reactions	675
Comments	92
Shares	21
Post Link Clicks	3
Other Post Clicks	2,074

Dorset County Hospita...
Tue 3/28/2023 8:52 am PDT

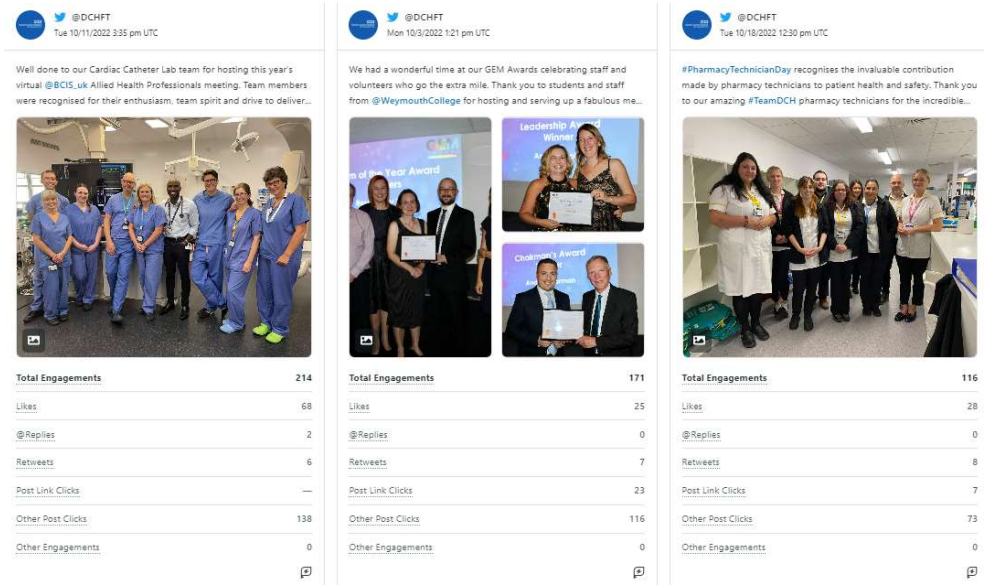
Two of our wards are merging to create a centre of excellence for the care of older people. Barnes Ward an...

Total Engagements	2,605
Reactions	442
Comments	19
Shares	15
Post Link Clicks	70
Other Post Clicks	2,059

Twitter Analytics - @DCHFT www.twitter.com/DCHFT

	Q1 April-June 2022	Q2 July-Sept 2022	Q3 Oct-Dec 2022	Q4 Jan-March 2023
Number of Tweets	219	188	233	176
Tweet impressions (how many times our tweets were seen)	178,024	152,724	190,776	139,982
Engagement (likes, replies, clicks, retweets)	6,105	5,532	7,408	3847
Number of followers	6,663	6,800	6,958	7,131

Twitter Highlights for October 2022



Twitter Highlights for November 2022

@DCHFT
Tue 11/29/2022 4:21 pm UTC

Our anaesthetic department has been recognised again for providing the highest standards of patient care. Our staff received the prestigious Anaesthesia Clinical Services Accreditation from the Roya...

Total Engagements	533
Likes	97
@Replies	8
Retweets	9
Post Link Clicks	19
Other Post Clicks	400
Other Engagements	0

@DCHFT
Thu 11/17/2022 11:13 am UTC

Is it a bird? Is it a plane? No, it's Captain Prevention spreading the word about how to avoid pressure ulcers and injuries as part of World Stop the Pressure Day. Here he is on our Kingfisher Children's Ward...

Total Engagements	155
Likes	30
@Replies	2
Retweets	5
Post Link Clicks	—
Other Post Clicks	118
Other Engagements	0

@DCHFT
Tue 11/8/2022 2:00 pm UTC

Our Orthotics Department has been recognised for its innovative work to treat patients with knee osteoarthritis during the pandemic. The team won the Safe Restoration of Elective Care Services Award a...

Total Engagements	79
Likes	26
@Replies	2
Retweets	8
Post Link Clicks	12
Other Post Clicks	31
Other Engagements	0

Twitter Highlights for December 2022

@DCHFT
Thu 12/15/2022 11:30 am UTC

We are pleased to announce that, following a robust recruitment process, Dorset County Hospital and @DorsetHealth have appointed Matthew Bryant to the role of joint Chief Executive Officer. Matthew...

Total Engagements	379
Likes	61
@Replies	5
Retweets	6
Post Link Clicks	150
Other Post Clicks	157
Other Engagements	0

@DCHFT
Thu 12/29/2022 11:46 am UTC

⚠ We have declared a critical incident as we continue to face extreme operational pressures. Our focus is making sure our patients are safe and that we keep our critical services running. Read more....

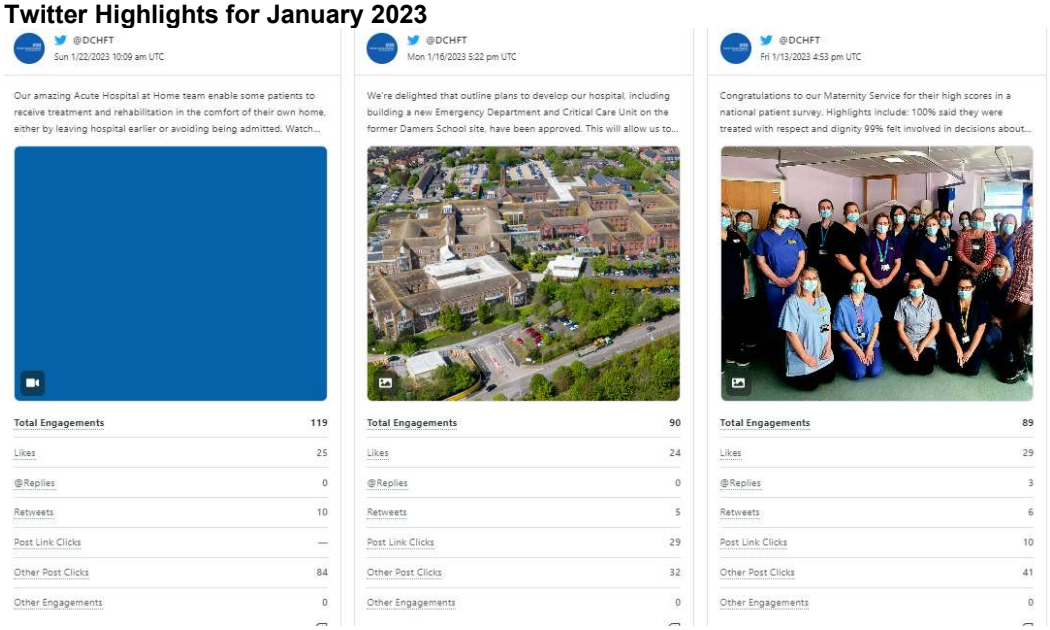
Total Engagements	247
Likes	33
@Replies	0
Retweets	24
Post Link Clicks	109
Other Post Clicks	81
Other Engagements	0

@DCHFT
Wed 12/14/2022 4:04 pm UTC

The refurbishment of our existing Emergency Department (ED) is complete! It offers improved facilities and additional spaces for patients, staff and visitors, and paves the way for a brand new ED an...

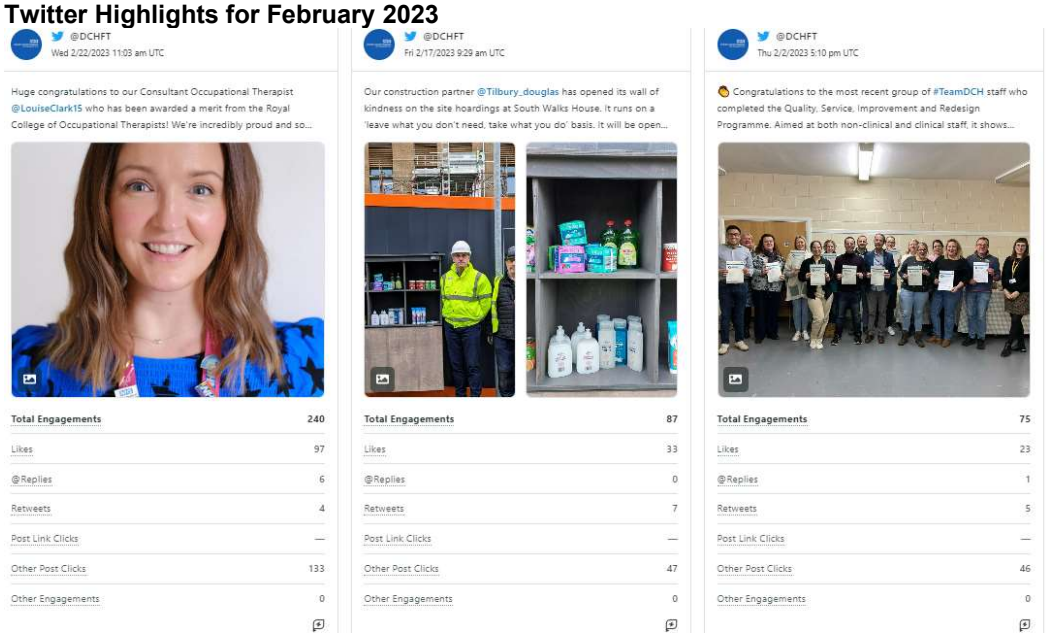
Total Engagements	125
Likes	27
@Replies	0
Retweets	7
Post Link Clicks	10
Other Post Clicks	81
Other Engagements	0

Twitter Highlights for January 2023



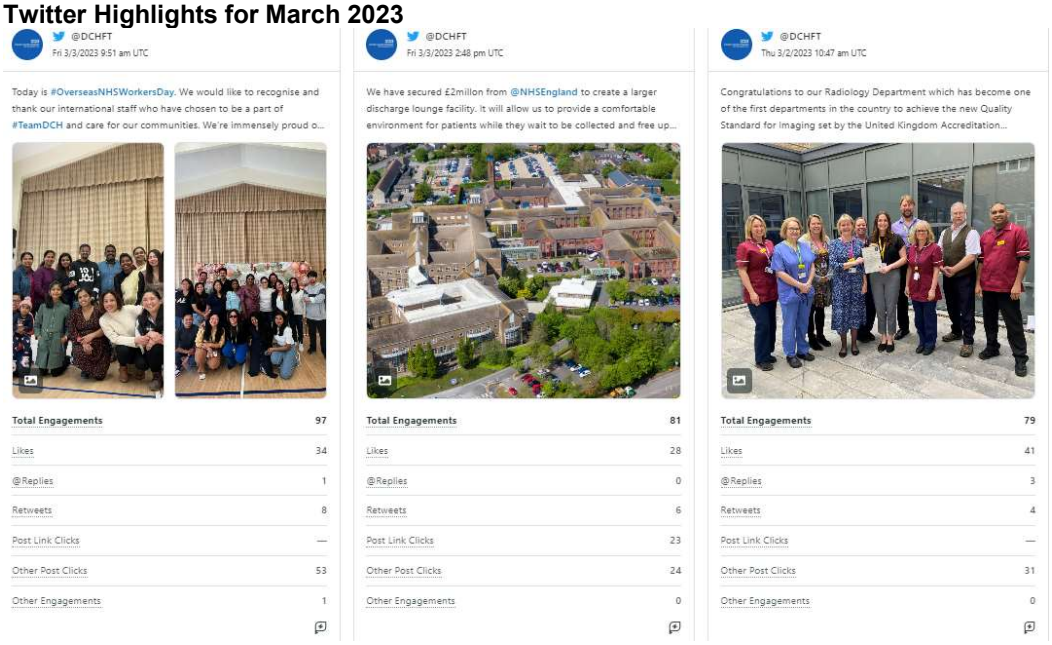
	@DCHFT Sun 1/22/2023 10:09 am UTC	@DCHFT Mon 1/16/2023 5:22 pm UTC	@DCHFT Fri 1/13/2023 4:53 pm UTC
	Our amazing Acute Hospital at Home team enable some patients to receive treatment and rehabilitation in the comfort of their own home, either by leaving hospital earlier or avoiding being admitted. Watch...	We're delighted that outline plans to develop our hospital, including building a new Emergency Department and Critical Care Unit on the former Damers School site, have been approved. This will allow us to...	Congratulations to our Maternity Service for their high scores in a national patient survey. Highlights include: 100% said they were treated with respect and dignity 99% felt involved in decisions about...
Total Engagements	119	90	89
Likes	25	24	29
@Replies	0	0	3
Retweets	10	5	6
Post Link Clicks	—	29	10
Other Post Clicks	84	32	41
Other Engagements	0	0	0

Twitter Highlights for February 2023



	@DCHFT Wed 2/22/2023 11:03 am UTC	@DCHFT Fri 2/17/2023 9:29 am UTC	@DCHFT Thu 2/2/2023 5:10 pm UTC
	Huge congratulations to our Consultant Occupational Therapist @LouiseClark15 who has been awarded a merit from the Royal College of Occupational Therapists! We're incredibly proud and so...	Our construction partner @Tilbury_douglas has opened its wall of kindness on the site hoardings at South Walks House. It runs on a 'leave what you don't need, take what you do' basis. It will be open...	Congratulations to the most recent group of #TeamDCH staff who completed the Quality, Service, Improvement and Redesign Programme. Aimed at both non-clinical and clinical staff, it shows...
Total Engagements	240	87	75
Likes	97	33	23
@Replies	6	0	1
Retweets	4	7	5
Post Link Clicks	—	—	—
Other Post Clicks	133	47	46
Other Engagements	0	0	0

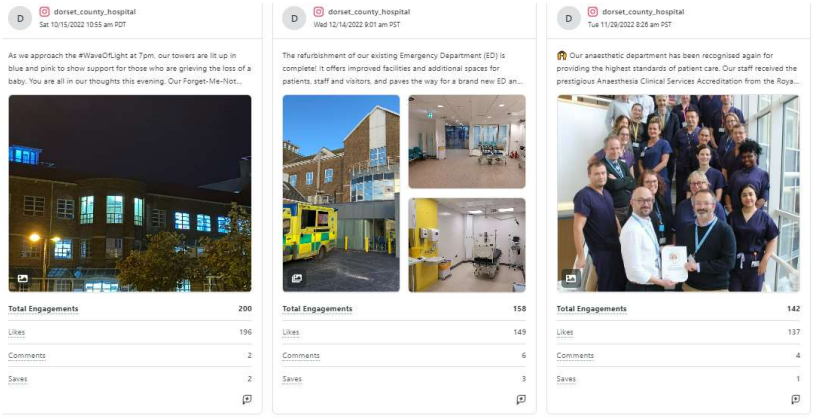
Twitter Highlights for March 2023



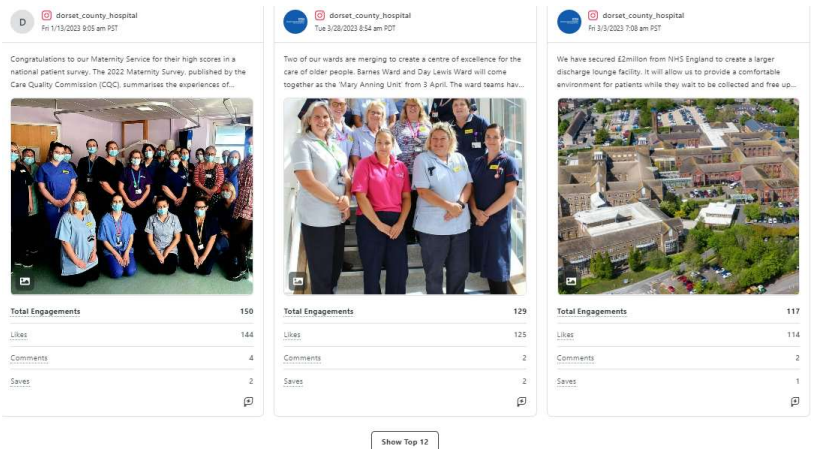
Instagram Analytics - www.instagram.com/dorset_county_hospital/

	Q1 April-June 2022	Q2 July-Sept 2022	Q3 Oct-Dec 2022	Q4 Jan-Feb 2023
Number of posts	39	53	67	68
Total impressions	28,896	52,008	77,875	79,406
Average impressions (number of times the post was shown) per day	318	565	846.47	882.29
Average daily reach per profile (unique views)	231	390	509.71	529.97
Number of followers	2,619	2,673	2,755	2,845

Instagram Highlights – October to December 2022



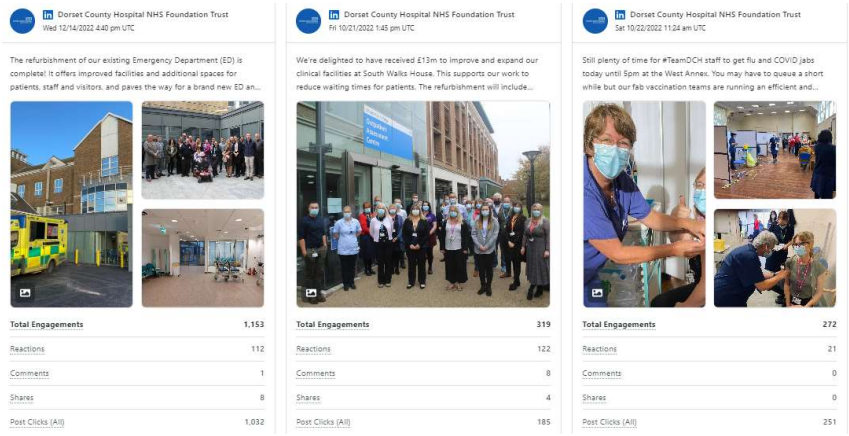
Instagram Highlights – January to March 2023



LinkedIn Analytics - www.linkedin.com/company/dorset-county-hospital-foundation-trust

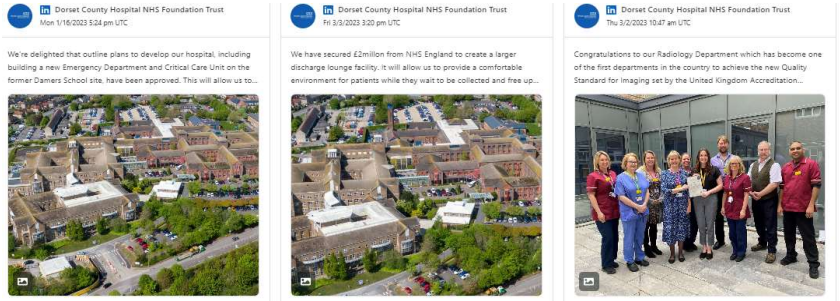
	Q1 April-June 2022	Q2 July-Sept 2022	Q3 Oct-Dec 2022	Q4 Jan-March 2023
Number of posts	29	36	55	47
Total impressions (number of views)	48,993	33,207	57,561	49,914
Total engagements (clicks, likes, replies and shares)	3,424	2,272	4,974	3,220
Organic followers gained	380	314	333	404
Number of followers	3,720	4,000	4,315	4,664

LinkedIn Highlights – October to December 2022



Total Engagements	1,153	319	272
Reactions	112	122	21
Comments	1	8	0
Shares	8	4	0
Post Clicks (All)	1,032	185	251

LinkedIn Highlights – January to March 2023



Total Engagements	472	211	189
Reactions	214	112	69
Comments	5	2	3
Shares	2	3	4
Post Clicks (All)	251	94	113

4. Public Website

The analytics below show general usage of the website and the most visited pages:

Website Analytics – www.dchft.nhs.uk

	Q1 April-June 2022	Q2 July-Sept 2022	Q3 Oct-Dec 2022	Q4 Jan-March 2023
Sessions	52,999	108,218	127,744	194,178
Page Views	88,365	175,213	204, 213	312, 974
Users	40,405	88,275	98,124	145,145
Average Session Duration	00:00:51	00:00:40	00:00:46	00:00:47

**We saw a significant drop in visits to the website due to an issue with Google search. This was resolved in September 2022 and, as you can see, we are seeing an increase in visitors again.

Most Popular Webpages (October 2022 to March 2023)

Page	Page Views	Average Time on Page
https://www.dchft.nhs.uk/	71,440	00:00:48
http://www.dchft.nhs.uk/working-for-us/join-team-dch/vacancies/	66,730	00:00:51
http://www.dchft.nhs.uk/patients-and-visitors/a-z-of-services/	16,826	00:01:15
http://www.dchft.nhs.uk/working-for-us/e-rostering-links/	15,012	00:00:49
http://www.dchft.nhs.uk/patients-and-visitors/visiting-guidance/	12,886	00:00:47
http://www.dchft.nhs.uk/working-for-us/join-team-dch/	12,338	00:00:55
http://www.dchft.nhs.uk/about-us/contact-us/	8,876	00:00:33
http://www.dchft.nhs.uk/patients-and-visitors/getting-here/	3,933	00:00:57

5. News Releases

A round-up of the news releases issued by the communications team with links to the full releases on our website. While news releases and media relations are still an important part of our comms approach, we are increasingly prioritising using our own channels to reach our audiences directly:

Ward teams create new centre of excellence for the care of older patients - 28 March 2023
Two wards at Dorset County Hospital are merging to create a centre of excellence for the care of older people.

Flooding at Dorset County Hospital - 24 March 2023
There has been a flood in our hospital overnight. The Emergency Department has been affected and the incident is being managed with the support of our partner hospitals - University Hospitals Dorset, Dorset Healthcare, Yeovil Hospital and Salisbury District Hospital.

New discharge lounge building to be delivered next week - 23 March 2023
People coming to Dorset County Hospital next week are being advised to allow for extra time, as sections of the new modular discharge lounge will arrive on site from Monday (27 March).

Industrial action update - 9 March 2023
Dorset is one of a number of areas affected by planned industrial action on 13, 14 and 15 March 2023. Our priority is to keep people safe and well.

Join the DCH Activity Squad and help support patients' wellbeing - 6 March 2023
Could you spend as few hours a week playing games or doing puzzles with patients at Dorset County Hospital (DCH)?

Dorset County Hospital secures £2million to improve its discharge facilities - 3 March 2023
Dorset County Hospital (DCH) has secured £2millon to help free up hospital beds by creating a new, larger discharge lounge facility.

DCH staff deployed to help people in Ukraine - 24 February 2023
We recently welcomed home two members of #TeamDCH from Lviv in Ukraine following a deployment with frontline medical aid charity UK-Med. Biomedical Scientist Andy Walbridge and Physiotherapist Lauren Eve voluntarily registered with the charity and were asked to go and help provide medical care, training and support to the people of Ukraine.

Response to CQC report on services for children and young people with mental health issues, learning disabilities or autism - 17 February 2023
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.

Dorset County Hospital receives £2million donation for a new helipad - 8 February 2023
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.

Outline plans to develop hospital site approved - 16 January 2023
Outline plans to develop the Dorset County Hospital (DCH) site have been approved by Dorset Council. The Trust's Your Future Hospital programme sets out plans to expand facilities on the site in Dorchester and help meet increasing demand.

Maternity Service achieves best survey results in the country - 13 January 2023
Dorset County Hospital's Maternity Service continues to provide high standards of care, according to the latest national survey results.

Dorset County Hospital is incredibly busy - 3 January 2023
Our Emergency Department is incredibly busy as we enter the New Year. Our focus is making sure our patients are safe and that we keep our critical services running.

Critical incident stood down at Dorset County Hospital – but teams remain under pressure - 30 December
We have stepped down our critical incident status but remain under extreme pressure. We continue to focus on making sure our patients are safe and keeping our critical services running.

Critical incident declared at Dorset County Hospital - 29 December 2022
Dorset County Hospital has declared a critical incident due to the extreme operational pressures following the Christmas bank holidays.

Joint chief executive to take the helm of two Dorset NHS trusts - 15 December 2022
Following a robust recruitment process NHS trusts Dorset County Hospital and Dorset HealthCare have appointed Matthew Bryant to the role of joint Chief Executive Officer.

Hospital marks completion of Emergency Department refurbishment - 14 December 2022
Refurbishment of Dorset County Hospital's existing Emergency Department (ED) is now complete.

Digital systems helping to transform patient care at DCH - 7 December 2022
Clinicians at Dorset County Hospital's (DCH) Emergency Department have been at the heart of developing a new system with the Trust's Digital Team that aims to streamline processes and improve patient experience.

Patients receive highest standards of anaesthetic care at DCH - 29 November 2022
Dorset County Hospital's anaesthetic department has been recognised again for providing the highest standards of patient care.

Orthotics Department win at the HSJ Patient Safety Awards - 8 November 2022
Dorset County Hospital's Orthotics Department has won a national award for its work to treat patients with knee osteoarthritis during the pandemic.

Lung health screening service launched in Dorset - 4 November 2022
A new screening service is being launched in Dorset to identify lung conditions much earlier and improve outcomes for patients.

Local NHS organisations receive funding to expand clinical services at South Walks House - 21 October 2022
Health organisations in Dorset have secured £13m to transform two floors of South Walks House in Dorchester into clinical space.

Staff and volunteers honoured at GEM and Long Service Awards - 4 October 2022
Dorset County Hospital staff and volunteers received well deserved recognition for their hard work and dedication at the 2022 GEM and Long Service Awards.

6. Media Coverage

Each of our news releases generated positive local media coverage. Further coverage was prompted by events, national statistical reports, announcements and public meetings. The charts below show the balance of positive, negative and neutral stories, and the table shows each quarter.

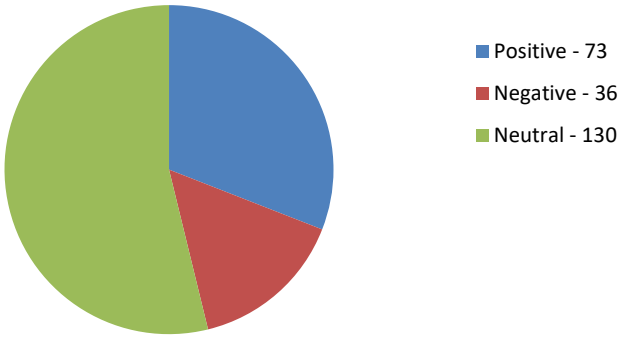
Our positive coverage generally significantly outweighs negative and neutral coverage. During this period, however, we saw an unusual rise in negative coverage which we could do little to mitigate due to the nature of the stories (listed below).

	Q1 April-June 2022	Q2 July-Sept 2022	Q3 Oct-Dec 2022	Q4 Jan-March 2023
Media stories	79	77	100	139
Positive	54	57	37	36
Negative	8	5	13	23
Neutral	17	15	50	80

October 2022 – March 2023 - Coverage to note included:

- More than £13million secured for South Walks House
- Hospital phone lines down
- ED refurbishment completed
- £2million helipad funding
- Outline plans for development approved
- Strike action
- Critical incident
- Tabloid stories about Gary Glitter receiving treatment at DCH
- CQC report on children's services
- Funding for new discharge lounge
- New Chief Executive
- Flooding in ED

Media Coverage - October 2022 to March 2023
239 stories



Report Front Sheet

1. Report Details			
Meeting Title:	Board of Directors, Part 1		
Date of Meeting:	31 May 2023		
Document Title:	**Bank and Agency Usage and Expenditure Report 2022/3**		
Responsible Director:	Nicola Plumb, Chief People Officer Emma Hallett, Deputy Chief People Officer	Date of Executive Approval	15 May 2023 (EH)
Author:	Robert Membury, Temporary Staffing Manager		
Confidentiality:	N/A		
Publishable under FOI?	Yes		
Predetermined Report Format?	No		

2. Prior Discussion		
Job Title or Meeting Title	**Date**	**Recommendations/Comments**
People and Culture Committee	22 May 2023	Noted

3. Purpose of the Paper	This report aims to provide the committee with a deep dive account of agency spend and activity for the period of 2022/23.							
	Note (✓)	✓	*Discuss (✓)*	✓	*Recommend (✓)*		*Approve (✓)*	
4. Executive Summary	Total agency expenditure for the year increased by 14% from the previous financial year to £12.1m. Off-framework expenditure increased by 54% from £2.5m to £4.7m. The high-cost agency project was launched last summer with a focus on nursing as the largest area of expenditure. Actions from the project mitigated expenditure from November 2022 onwards, however operational pressures compounded by annual leave and reduced availability of bank staff caused agency use to increase in Q4. In relation to nursing agency use, reliance on off-framework agencies reduced during 2022/23. A focus on bank recruitment and engagement continued, with 161 bank HCSWs and 34 bank RNs recruited. Regular engagement events have also been introduced for bank staff, recognising that this group often feels isolated due to the peripatetic nature of their work. Unfortunately, whilst there are more bank staff working more hours, the bank shift fill rates have not improved as shift requests (demand) has increased. Medical agency spend totalled £2.55 million in 22/23 with off-framework high cost bookings being used to mitigate long term vacancies in specialties including Acute Medicine, Care of the Elderly and Gastroenterology. The committee is sighted on the ongoing actions to increase the Consultant workforce at DCH, including the use of placement agencies, recruitment initiatives and additional training opportunities. Allied Health Professional agency spend remained predominately stable throughout the year. Spend within Health Science Services was caused by vacancies within the laboratory teams, some of which have since been filled by							

	overseas recruitment. Other agency spend occurred in areas such as Clinical Coding and Estates, again due to vacancies within these teams. The challenging position regarding agency use continues into 23/24. The NHSE agency cap for 23/24 for Dorset is £42m. At present Dorset providers have submitted forecasts which include agency spend of £38m, a £10m reduction from that spent in 22/23. At DCH the work underway to reduce spend is overseen by the High-Cost Agency Project, supported by the Transformation Team. Work is also underway to align and improve the Dorset bank offer with a view to a collaborative bank. Consistency in rates and use of agencies is also discussed by providers and there are plans in place to end the use of off-framework providers across Dorset.
5. Action recommended	The Board is asked to note and discuss the report.

6. Governance and Compliance Obligations				
Legal / Regulatory Link		**Yes**		NHSE Agency regulations and compliance
Impact on CQC Standards		**No**		
Risk Link		**Yes**		Agency spend is on the corporate risk register
Impact on Social Value		**No**		Several Areas of the People dashboard feed into the Trust's social value action plan, including the increase of employment opportunities in the local area.
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 use of agency and bank supports the gaps from vacancies and other absences as well as increased pressure from the high acuity and bed occupancy levels. This forms part of the People element of the Trust Strategy and works to support the health and wellbeing of staff by temporarily increasing staff numbers as well as supporting operational demands.		
	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	**22 May 2023**
Report Title	**2022/3 Bank and Agency Usage and Expenditure Report**
Author	**Robert Membury, Temporary Staffing Manager**

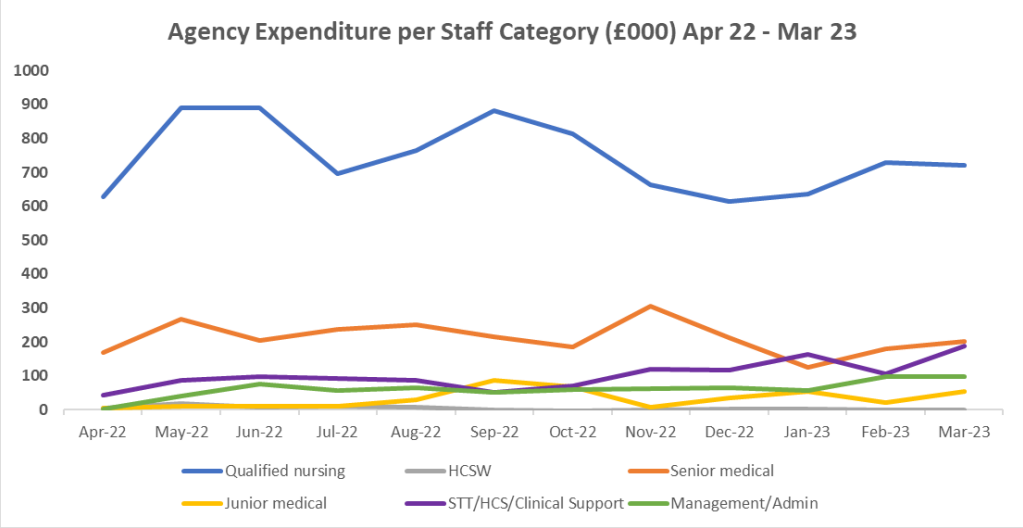
1.0 Executive Summary

1.1 This report summarises the bank and agency usage and expenditure during 2022/23 and mitigating actions and plans to decrease reliance on agency usage moving forward.

1.2 The report covers bank and agency usage across nursing, medical, allied health professional, health science services, non-medical non-clinical, administrative, and remaining Agenda for Change staff groups.

2.0 Current Position

2.1 Agency Spend per Staff Category April 2022 – May 2023



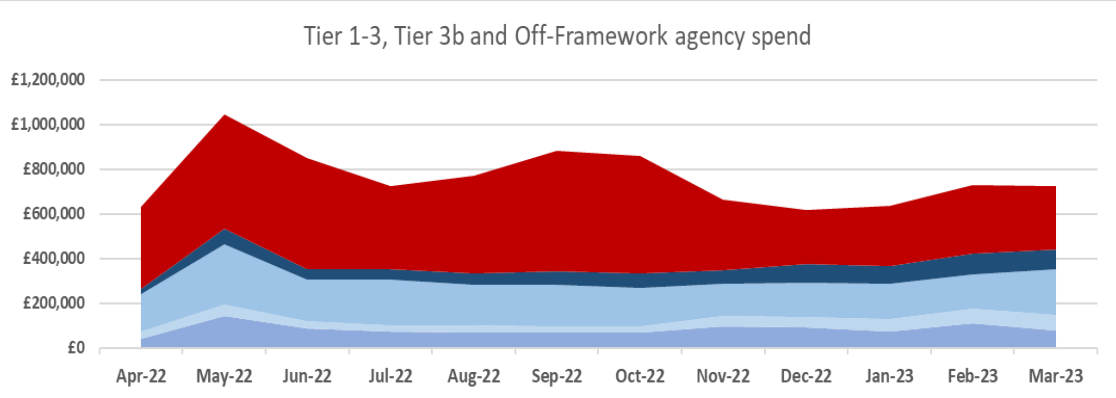
2.2 Context

Total agency expenditure for the year increased by 14% from the previous financial year to £12.1m. Off-framework expenditure increased by 54% from £2.5m to £4.7m. The high-cost agency project was launched last summer with a focus on nursing as the largest area of expenditure. Actions from the project mitigated expenditure from November 2022 onwards, however operational pressures compounded by annual leave and reduced availability of bank staff caused agency use to increase in Q4.

The OPEL Status of the hospital between July until early March remained consistently high, as did vacancies, bed occupancy and the number of NCTR patients, influencing elevated levels of shift requests. In relation to periods of industrial action in Q4, increased surplus agency bookings (known as 'allocate on arrival') were made and retainer schemes were implemented for bank and substantive staff during the action to support the provision of safe care to patients.

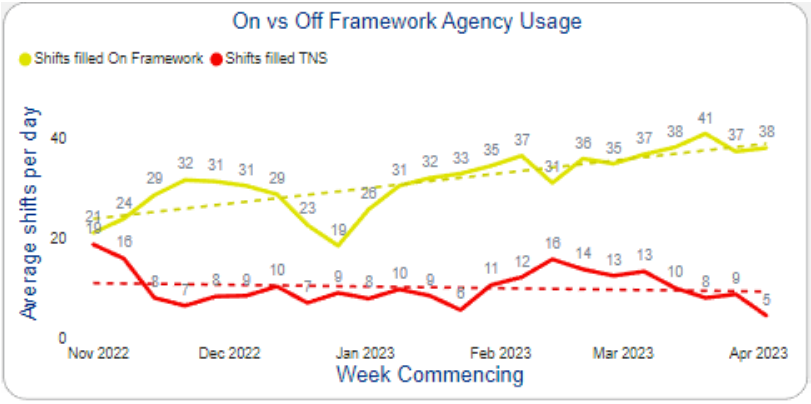
3.0 Nursing Agency Spend

3.1 Reliance on off-framework agencies reduced during 2022/23. Framework rates were increased in October 2022 via the Dorset-wide Agency Project and framework providers were aligned on the highest rate card and longest booking periods. Tier 3b remained separate as an escalation alternative.



	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Totals
Off	£366,436	£508,888	£498,977	£374,497	£439,143	£536,613	£525,480	£317,280	£239,893	£272,039	£307,168	£284,752	£4,671,16
Tier 3b	£27,143	£70,719	£44,604	£45,396	£49,757	£60,595	£63,601	£57,950	£86,769	£79,841	£97,473	£85,185	£769,034
Tier 3	£166,242	£270,885	£188,277	£203,541	£180,489	£188,960	£173,355	£142,620	£151,193	£155,188	£150,073	£209,176	£2,180,00
Tier 2	£30,042	£52,905	£31,514	£27,883	£34,838	£28,953	£27,916	£49,554	£46,878	£58,618	£65,072	£68,307	£522,481
Tier 1	£42,175	£140,529	£87,405	£73,419	£67,229	£66,419	£69,350	£95,385	£92,725	£71,334	£111,431	£76,890	£994,290

By mid-November increased framework bookings contributed towards a reduction in off-framework agency expenditure, and an increasing framework supply resulted in a net saving between November and March.



4.0 Growth of Bank

4.1 Recruitment to Bank

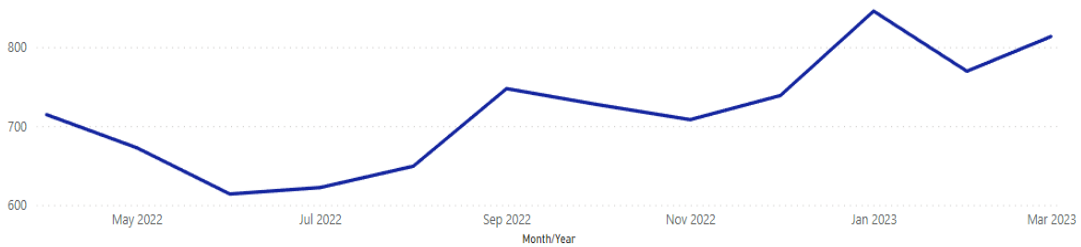
Rolling Bank adverts started in April 2022 following the recruitment of a Clinical Engagement Lead. Using NHSE funding four fixed term additional roles were added to the Workforce Resourcing Team to increase bank recruitment and engagement. Targets were agreed with the Finance and Performance Committee to recruit between 26-65 HCSWs and 12-36 RNs within the year. Stretch targets were added during the High-Cost Agency Project, increasing the HCSW target to 142 and the RN target to 61.

The stretch target for bank HCSWs has been exceeded, 161 HCSWs have been offered a bank contract and 100 of those have now commenced work. Unfortunately, the Trust did not generate sufficient applications to meet the bank RN stretch target, but 34 RNs have been offered a bank contract and 20 have commenced work.

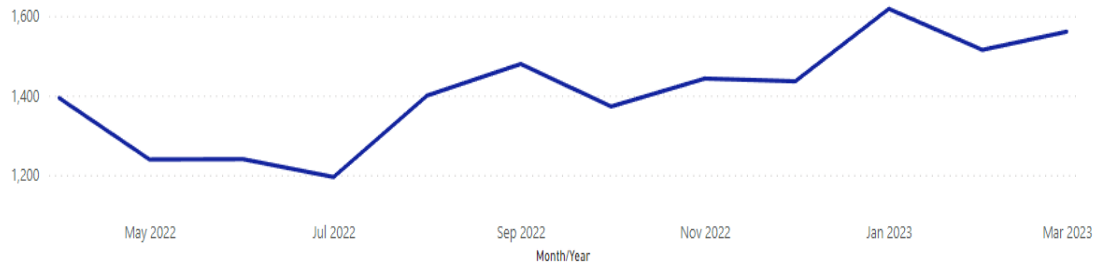
4.2 Bank fill rates

The successful recruitment to the bank translated into more bank hours worked.

Registered Nurses – Bank hours Worked



HCSWs – Bank hours Worked



Alongside recruitment, Flexible times for 'Allocate on Arrival' shifts have been introduced with support from Matrons. These include shorter shifts that fit within school hours. This has been a success both for supporting family friendly work patterns but also in providing cover on the ward at peak times.

DCH aligned with University Hospitals Dorset and Dorset Healthcare to introduce a Winter Loyalty Payment to increase uptake of bank shifts. The scheme began on 5th December 2022, with bank staff receiving a payment if they met the qualifying hours within two 4-week periods. Whilst it is positive that a Dorset-wide initiative was agreed and implemented, unfortunately there is little evidence that it increased bank fill rates during this time. At DCH localised extremis incentives have proved more successful over the past few months and have helped to both fill shifts and avoid escalation to high-cost agency.

Unfortunately, whilst there are more bank staff working more hours, the bank shift fill rates have not improved as shift requests (demand) has increased.

4.3 Retention of bank staff

It is as important to retain bank staff as to recruit them. The Temporary Staffing Team build upon the initial engagement with new starters by making contact prior to induction, attending induction to meet the new starters in person and again during the care certificate to support and answer any questions. All new bank staff are offered between 2-8 supernumerary bookings, depending on their experience. It is anticipated that wards supporting these bookings will achieve a higher fill rate as bank staff will be familiar with the area and happy to return.

Ongoing engagement events are held for bank staff, recognising that this group often feels isolated due to the peripatetic nature of their work. More recently the team secured £6k of charity funding for bank engagement and have used it to purchase DCH branded clothing to help bank staff feel like part of a team.

4.4 Substantive staff

Many of the staff at DCH have bank contracts and undertake additional work. Substantive staff without a bank contract were reviewed in November 2022 and, with support from the TIGER team, 400 staff members were contacted to encourage them to join the bank. This generated 39 additional HCSW and 45 RN bank contracts. A digital enrollment portal was introduced in

January 2023, speeding up the process further.

The Temporary Staffing Team continue to promote the bank to substantive staff. A temporary

staffing bulletin is issued to all staff on a fortnightly basis, containing a link to the enrollment portal. The team also attend Trust inductions to promote the opportunities and benefits of bank work.

4.5 Next Steps

The internal High-Cost Agency Project continues, supported by the Transformation Team, and is at present refreshing its focus, given the challenging financial position faced in-year. The NHSE agency cap for 23/24 for Dorset is £42m. At present Dorset providers have submitted forecasts which include agency spend of £38m, a £10m reduction from that spent in 22/23.

Analysis of working patterns at DCH shows that the average bank worker works one long shift per week and substantive staff who hold bank contracts work on average less than one shift per week. Using these figures, it is estimated that 125-150 additional bank HCSWs and between 20-40 additional bank RNs will need to be recruited to further reduce reliance on agency. Bank recruitment and engagement continues to be a key focus, but it is clear this will not solve the problem alone.

DCH remains an active participant of the Dorset agency reduction collaboration project and proposals at this level include aligning and improving the bank offer with a view to a collaborative bank. Consistency in rates and use of agencies is also discussed by providers at this forum and there are plans in place to end the use of off-framework providers across Dorset.

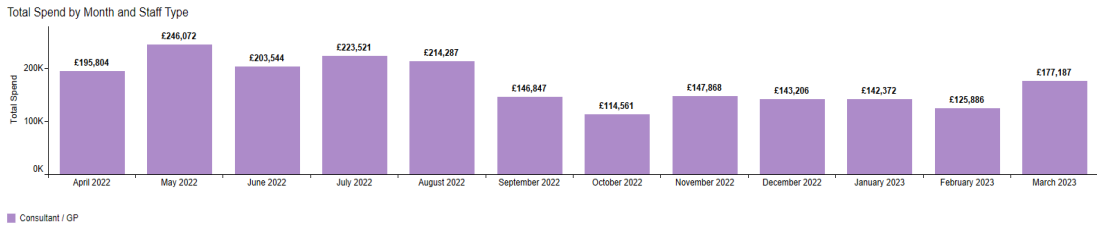
The committee is sighted on the ongoing actions to increase the nursing workforce at DCH, through continued overseas recruitment and preceptorship and the 'grow our own' routes of RNDA, TNA and scholarships. Nursing establishments are regularly reviewed to ensure they are appropriate for clinical need and the last review initiated an uplift in headroom (which is used to cover training, sickness and leave etc.) from 20.5% to 22% in inpatient areas which will also have a positive impact on agency reliance once filled.

The CNO implemented daily staffing review meetings in November 2022, and these have had a positive impact on agency reliance. These meetings continue and a new role of Safer Staffing Matron is being introduced to seek further improvements in rostering and staff allocation.

5.0 Medical Bank & Agency Usage

5.1 Consultant Agency Expenditure

The total agency spend on Consultants during 2022/23 was £2.55 million. Expenditure peaked in May 2022.

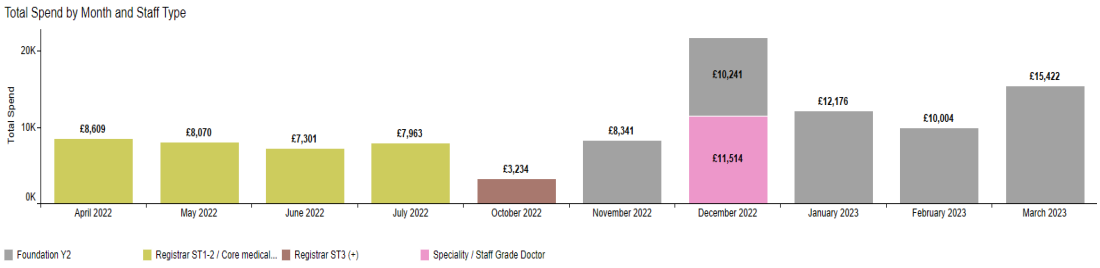


Off-framework bookings increased from July onwards, with bookings in Acute Medicine, Care of the Elderly and Gastroenterology, all due to vacant posts. Off-Framework bookings are only made if there are no framework options, as rates are marginally higher, and the Trust pays VAT as Direct Engagement bookings can only be completed with Framework suppliers. Additionally, off-framework bookings can pose a variety of other risks such as finder's fees and IR35 liabilities.

Vacant posts remain the predominant reason for Consultant agency cover, with some requests relating to sickness in Q1. The committee is sighted on the ongoing actions to increase the Consultant workforce at DCH, through overseas recruitment, the use of placement agencies, an increase in training roles and the introduction of recruitment initiatives such as warm welcome and refer a friend payments. Several Consultant appointments have been made in the last quarter, including in Anaesthetics, Orthopaedics and Microbiology and plans are underway to extend CESR opportunities at DCH, supporting middle grade doctors to become Consultants.

5.2 Other Medical Agency Expenditure

The total agency spend on other medical grades during 2022/23 £392k. Bookings during the first half of the year were at Registrar level, due in the main to vacant posts. In the second half of the year this changed to bookings at F2 level which were additional staff to provide support during the winter period. Additional F3 posts were approved via Business Planning for 23/24 which will reduce reliance on agency F2 cover moving forward.



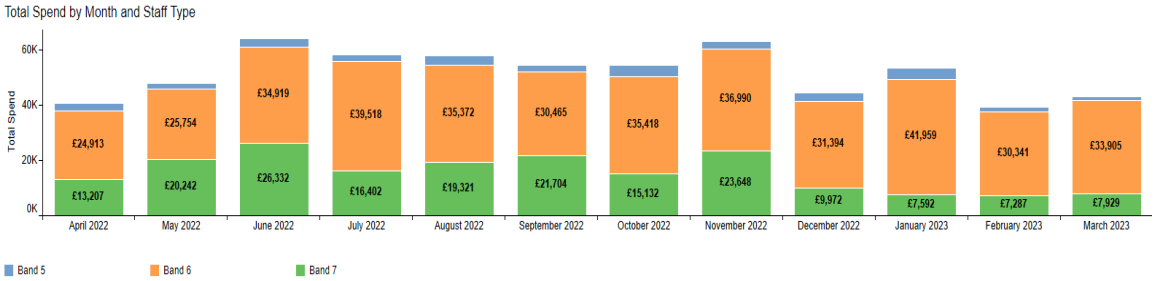
5.3 Medical Bank

The Trust accesses junior and middle grade medical bank staff (employed at DCH and other NHS providers) via a portal called Locums Nest. A Task and Finish Group has been created to maximise use of Locums Nest so as to minimise and hopefully avoid agency use in this category. The key element to the success of Locums Nest is for all new recruits to enroll, so that they have access to the shifts that need covering. The Temporary Staffing Team simplified and relaunched the enrollment process in February 2023 and since then the DCH element of

Locums Nest has increased from 251 to over 280 medical bank staff.

6.0 Allied Health Professional Agency Usage

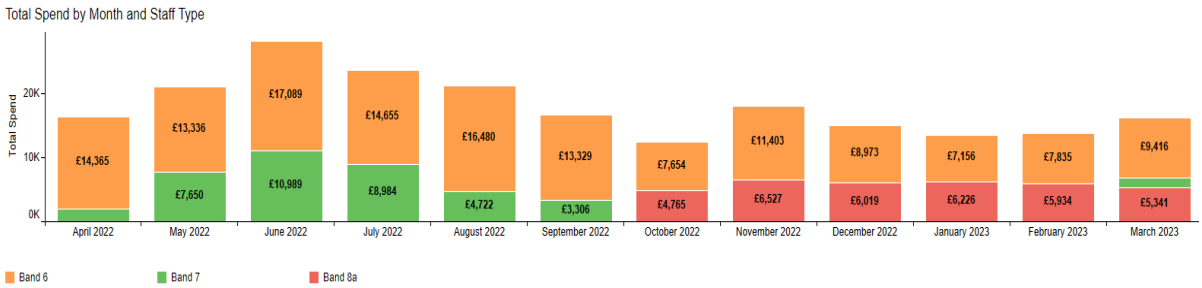
6.1 The total spend on AHP agency staff during 2022/23 was £624k. Bookings remained predominantly on-framework and relatively stable through the year with the main reason being long term unfilled vacancies.



6.2 The committee is sighted on the work underway to increase recruitment in this staff group as qualified applicants are scarce and hard to attract. In line with our People Plan, a rolling apprenticeship programme for Radiography, Occupational Therapy and Physiotherapy is underway. International recruitment is being used to recruit Operating Department Practitioners who will arrive in the Trust in 2023.

7.0 Health Science Service Agency Usage

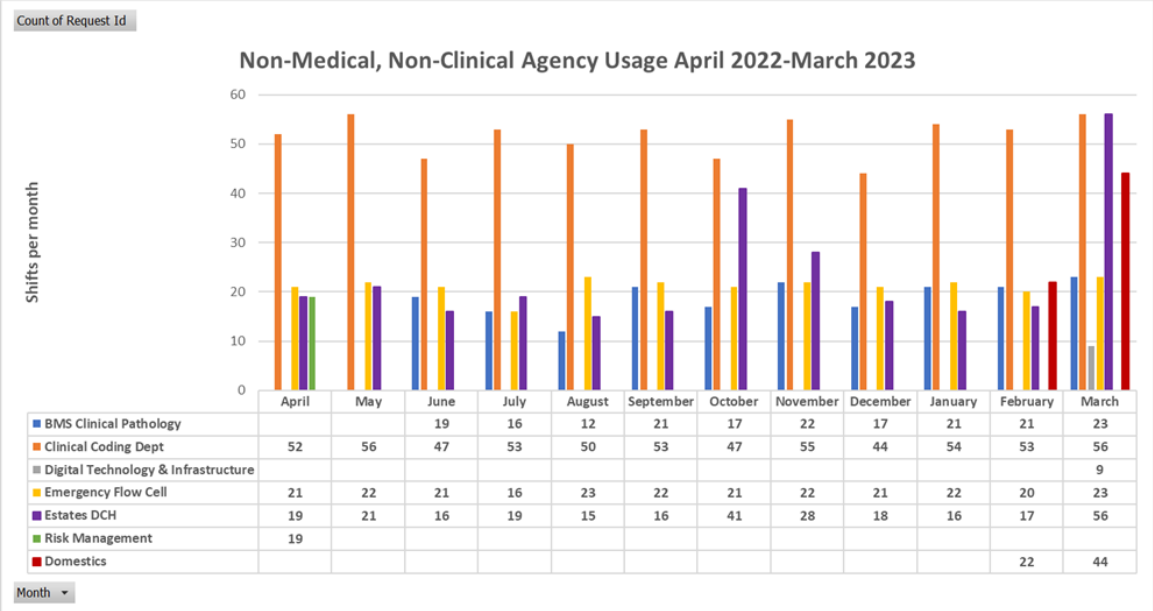
7.1 The total spend on HSS agency staff during 22/23 was £215k. These are bookings to support the laboratory teams due again to long term vacancies. Use was initially on-framework, but off-framework use was necessary from October 2022 onwards to support the blood bank team through re-accreditation.



7.2 Whilst recruitment remains challenging in this staff group also, the Trust has proactively and successfully recruited Biomedical Scientists from overseas. DCH is also a participant of the One Dorset Pathology initiative which seeks to maximise the efficiency of the existing pathology workforce in Dorset.

8.0 Other Agency Usage

8.1 During 22/23 a total of £728k was spent on other agency usage. Again, most of this use has been driven by vacant posts.



	April	May	June	July	August	September	October	November	December	January	February	March
BMS Clinical Pathology			19	16	12	21	17	22	17	21	21	23
Clinical Coding Dept	52	56	47	53	50	53	47	55	44	54	53	56
Digital Technology & Infrastructure												9
Emergency Flow Cell	21	22	21	16	23	22	21	22	21	22	20	23
Estates DCH	19	21	16	19	15	16	41	28	18	16	17	56
Risk Management	19											
Domestics											22	44

8.2 A plan is in place to remove agency use in Clinical Coding. Roles within the team have been re-banded to align with other Trusts and assist with recruitment and digital capabilities are being expanded to allow coding to be undertaken remotely. The Emergency Flow Cell Project Manager has been recruited to the Trust on a permanent basis and commences in June. Estates bookings cover a range of vacancies for positions such as Electricians and Mechanical Supervisors. This is already an area of significant challenge from a recruitment perspective and is also an area where the age profile of the workforce indicates that retirements are imminent. Apprenticeships are being developed to provide a longer-term workforce supply and a recruitment and retention premia (RRP) is also being explored.

9.0 Recommendation

9.1 The Committee is asked to note the contents of this report and the work that continues to reduce reliance on agency spend.

Minutes of the meeting of the ICB Board – Part 1 - Public
of NHS Dorset
Thursday 2 March 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
	Philip Broadhead (PB)	Bournemouth, Christchurch and Poole Council and ICB Local Authority Partner Member (East) (nominated deputy for Drew Mellor)
	Cecilia Bufton (CB)	ICB Non-Executive Member
	Jonathon Carr-Brown (JCB) (virtual)	ICB Non-Executive Member
	Dawn Dawson (DD)	Acting Chief Executive Dorset Healthcare NHS Foundation Trust and ICB NHS Provider Trust Partner Member
	Spencer Flower (SF)	Leader Dorset Council and ICB Local Authority Partner Member (West)
	Paul Johnson (PJ)	ICB Chief Medical Officer
	Patricia Miller (PM)	ICB Chief Executive
	Rob Morgan (RM)	ICB Chief Finance Officer
	Debbie Simmons (DSi)	ICB Chief Nursing Officer
	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
	Graham Farrant (GF)	Chief Executive, Bournemouth, Christchurch and Poole Council
	David Freeman (DF)	ICB Chief Commissioning Officer
	Dawn Harvey (DH)	ICB Chief People Officer
	Leesa Harwood (LH)	ICB Associate Non-Executive Member
	Nick Johnson (NJ) (virtual)	Interim Chief Executive Officer, Dorset County Hospital NHS Foundation Trust
	Karen Loftus (KL) (virtual)	Chief Executive, Community Action Need
	Matt Prosser (MP)	Chief Executive, Dorset Council
	Ben Sharland (BS) (virtual)	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:		
	Lucy Compiani (LC) (for ICBB23/046)	Practice Educator
	Liz Beardsall (LBe) (minutes)	ICB Company Secretary
	Cara Southgate (CS) (for item ICBB23/053)	Acting Chief Nursing Officer, Dorset Healthcare NHS Foundation Trust

	Sarah Tilbury (ST) (for item ICBB23/046)	Head of Workforce Expansion and Professional Development
	Natalie Violet (NV)	Business Manager to the ICB Chief Executive
Observing:		
	Jane Ellis	Programme and Project Specialist, NHS Dorset
Public:		
	2 members of the public in attendance Plus members of the public via Livestream	
Apologies:		
	Sam Crowe (SC)	Director of Public Health Dorset (participant)
	Siobhan Harrington (SH)	Chief Executive University Hospitals Dorset NHS Foundation Trust and ICB NHS Provider Trust Partner Member
	Manish Tayal (MT)	Interim Non-Executive Member

ICBB23/042 Welcome, apologies and quorum

The Chair declared the meeting open and quorate. There were apologies from Sam Crowe, Siobhan Harrington and Manish Tayal. The Chair welcomed Cllr Phil Broadhead, the new Leader of Bournemouth, Christchurch and Poole Council (BCP), to the meeting.

ICBB23/043 Conflicts of Interest

There were no conflicts of interest declared in the business to be transacted on the agenda.

ICBB23/044 Minutes of the Part One Meeting held on 5 January 2023

The minutes of the Part One meeting held on 5 January 2023 were agreed as a true and accurate record.

Resolved: the minutes of the meeting held on 5 January 2023 were approved.

ICBB23/045 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.

Resolved: the action log was received, updates noted and approval was given for the removal of completed actions.

ICBB23/046 Staff Story: Lucy Compiani – Nursing Times Practice Educator of the Year

The ICB Chief People Officer introduced the Staff Story, and welcomed Lucy Compiani and Sarah Tilbury to the meeting. Lucy was recently awarded Practice Educator of the Year by the Nursing Times for her work in clinical placement expansion for nursing in primary care.

The Board watched a video regarding Lucy's work, including how expanding clinical placement work in primary and social care enhances an individual's skills and understanding of services, provides an entry route into primary and

social care nursing, and improves workforce retention. The video included positive feedback from a practice manager and a student who had benefitted from Lucy's work as a practice educator.

The Board thanked Lucy for her interesting presentation and congratulated Lucy on her award.

The Board noted the challenges to supporting learners including culture, physical aspects including estate and support for learners due to limited GP capacity. Areas of greatest need, promotion of health and care careers, on-boarding of staff and retention by providing a positive learner experience, and supporting individuals during transition and in the early years were discussed.

There was a need to continue to build on the existing collaborative working in this area, but it was important that expansion was not to the detriment of quality of the student experience. There was a real opportunity to promote placements, such as creating videos with apprentices to showcase the programme to young people.

The Board thanked Lucy and Sarah for their work and their presentation.

ICBB23/047 Chief Executive Officer's Report

The ICB Chief Executive Officer (ICB-CEO) introduced the previously circulated CEO's Report, which was taken as read. Key items were:

- £150 million of increased funding for mental health services
- Increasing concerns about an escalation of industrial action, noting the good work by NHS organisations in manging strike days to date
- NHS England (NHSE) had published the delivery plan for recovering urgent and emergency care services
- PWC working with the system on Place development with a view to running a shadow format from October
- The Hewitt Review was coming to its conclusion with the aim of publishing the report on 15 March
- From July NHS Dorset will take on the role of lead commissioner for the region for ambulance commissioning. There had been good improvements in performance over the last few weeks and SWAST were being supported to make further improvements.

The Board discussed the need to consider the cumulative effect of industrial action, and the challenges this would present to performance and the transformation agenda. Delivery of the NHS planning guidance and the ICP strategy, and the ongoing work around transformation plans were also discussed.

The Board welcomed the move to use the Executives and Deputies Meeting as the main operational decision-making forum for the ICB.

The Chair thanked the ICB-CEO for her report.

PM left the meeting.

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

<u>Items for Decision</u>

ICBB23/048 There were no items for decision.

Items for Noting/Assurance/Discussion

ICBB23/049 Quality Report

The ICB Chief Nursing Officer (ICB-CNO) introduced the previously circulated Quality Report, which had been discussed in detail at the February Quality and Safety Committee (QSC). The main issues included:

- Challenges around the Urgent and Emergency Care (UEC) Pathway and patient flow. Support was being provided to the wider system and, following visits to the providers, a new streamlined discharge pathway was planned for implementation on 1 April
- Work was still ongoing on Initial Health Assessment (IHA) performance
- An update was provided on Oliver McGowan Learning Disability and Autism Training
- Good progress was being made in meeting the NHS patient safety strategy
- The ICB was compliant with the Chief Nursing Information Officer (CNIO) requirements, and a Dorset network of CNIO's had been established
- Feedback from Dorset System Quality Group to QSC included the UEC pathway, workforce, system beds, and refugee hotels
- Dorset County Hospital were the only Trust nationally to be ranked 'Much Better Than Expected' in the 2022 national maternity survey recently published by the Care Quality Commission.

The Board discussed the markers for measuring the success of the revised UEC pathway, and workforce and bed capacity in the system. The robust serious incident framework was noted.

Jonathon Carr-Brown joined the meeting

It was highlighted that the VTE Risk Assessment data in the Quality Report was dated 2022. The ICB-CNO offered to check if this date was correct and if so, why was the reporting a year in arrears.

ACTION: DSi

The Board discussed the revised UEC pathway, noting the importance of not inadvertently increasing pressure on primary care. The revised pathway should reduce the complexity of the discharge process and enable the system to better understand the issues within the pathway. The process can then be re-evaluated over time. It was noted that there were similar issues that needed addressing in mental health services and similar visits to those undertaken to Dorset County Hospital (DCH) and University Hospitals Dorset (UDH) would be carried out at Dorset HealthCare (DHC).

Louise Bate left the meeting

Resolved: the Board noted the Quality Report.

ICBB23/050 Performance Report

The ICB Chief Operating Officer (ICB-COO) introduced the previously circulated Performance Report. The main issues included:

- There were zero 104 week waiters predicted for the end of March, and the Board thanked the providers for their hard work on achieving this
- The number of patients waiting more than 78 weeks at University Hospitals Dorset (UHD) was forecast to be 123 across four specialties at 31 March 2023. These were due to capacity issues and the Trust was working towards reducing this figure. Dorset County Hospital (DCH) were reporting zero patients waiting at the end of March 2023
- In diagnostics, activity recovery was generally good but challenges remained in endoscopy, echo cardiography and audiology
- No Criteria To Reside patients, which had been as low as 300 and as high as 360, were now at 340. Focused work from October had managed to stem the increase but there was not yet a sustained reduction
- Category 2 mean ambulance response times had not been compliant with the target of 18 minutes since May 2021.

The Board discussed the changes which were required to current information technology systems to support Patient Initiated Follow Ups, the issues underlying ambulance response times and how these could be addressed, and the potential impact of planned industrial action on performance.

The Chair thanked the ICB-COO for his report.

Resolved: the Board noted the Performance Report.

ICBB23/051 Finance Report

The ICB Chief Finance Officer (ICB-CFO) introduced the previously circulated Finance Report regarding the financial position of both the ICB and ICS NHS providers as at December 2022 (Month 9), and provided a verbal update on the current financial position in month 12.

The Board had previously reconfirmed the plan to deliver a breakeven position for year end, and the ICB and NHS providers remained confident that this would be achieved. However it had required £60 million of non-recurrent money for Dorset's breakeven position to be reached. It was noted that 14 of 42 ICBS would not reach a breakeven position this year. The plan for the coming financial year would be discussed in the Part Two Board meeting.

The Chair thanked the finance team and the provider CFOs for their hard work in reaching a breakeven position for the financial year.

The Board questioned the pressure of agency spend, noting that Dorset County Hospital and Dorset HealthCare were holding a relatively flat position. It was noted that the system was in a good position to meet the planning guidance on agency spend, however the system continued to work on reducing agency costs.

The Board discussed the impact of industrial action on activity and finance. It was noted that the costs relating to the junior doctors' strike was not yet quantifiable but the priority remained safe coverage. The need to understand the triangulated impact of industrial action, in relation to activity, quality and

finances was discussed. The Board requested an update on the financial impact of the industrial action at the next meeting.

ACTION: RM

Resolved: the Board noted the Finance Report.

ICBB23/052 NHS Dorset ICB Operating Model

The ICB Chief Operating Officer introduced the NHS Dorset ICB Operating Model. The model had been co-designed with the ICB workforce. The model set out 'how we work'. The model was built on the system values, relevant legislation, the four ICB aims, and the national context set by the NHS operating model. The model set out the role of the ICB in the system context, what the ICB planned to achieve and how it planned to achieve this, and the governance and decision-making mechanisms. The model would evolve over time and would be underpinned by an implementation pack for the teams. The next step was to design an operating model for the system.

The Board welcomed the Operating Model, noting that it was concise and clear. The Board raised the following in relation to the model:

- Transformation and how this fits into the model
- Consideration of what services could be outsourced or shared
- Supporting decision making in the short term which serves the long term, mechanisms for working and decision making across units, and the importance of reserving matters for decision where appropriate
- The need for better integration of the slide regarding those groups sitting under the System Executive Group, but noting that this would segway into the System Operating Model and that this structure would be refined once the Operating Plan and priorities were in place
- The need to bring the Provider Collaboratives and Place into the decision-making structure, noting that the ICB Board would need to work through where these sit after the development phase
- The importance of Quality Impact Assessments and Equality Impact Assessments in decision-making.

PM rejoined the meeting

Resolved: the Board endorsed the Operating Model.

ICBB23/053 Quality and Safety of Mental Health Inpatient Services

Cara Southgate Acting Chief Nursing Officer, Dorset Healthcare NHS Foundation Trust (DHC) joined the meeting to introduce the previously circulated report on the Quality and Safety of Mental Health Inpatient Services. At the Board's request, the report provided an update on the previous report which detailed DHC's response to the letter from Claire Murdoch, National Director Mental Health.

The paper outlined the key actions in relation to all workstreams, including safeguarding of care, Freedom to Speak Up arrangements, Advocacy provision, workforce, culture and leadership, hearing and acting on the patient voice, including lived experience peers and restrictive interventions.

The next steps were completing the actions identified within timeframes set out in the action plan and providing evidence and assurance that actions had been embedded into practice.

The Board thanked the Acting Chief Nursing Officer DHC for the report which provided the Board with assurance regarding the actions. The Acting Chief Executive Officer DHC confirmed that progress would be monitored through DHC's governance processes.

The ICB Chief Nursing Officer noted that the report offered assurance on those patients in NHS facilities. She offered to liaise with the ICB Chief Commissioning Officer to consider how similar assurance could be provided to the Quality and Safety Committee regarding adults and young people in external placements.

ACTION: DSi and DF

The Chair thanked the Acting Chief Nursing Officer DHC and Acting Chief Executive Officer DHC for the report.

Resolved: the Board noted the report on the Quality and Safety of Mental Health Inpatient Services.

ICBB23/054 Eating Disorder Service Update

The Acting Chief Executive DHC introduced the Eating Disorder Service Update which was requested by the Board following the Quality Report at the January meeting. The report provided background for the current waiting times for patients to access the Dorset All Age Eating Disorder Service (DAEDS), with a particular focus on Children and Young People (CYP) and the recovery plan being implemented to resolve the current issues and achieve national and local referral to treatment (RTT) targets.

The COVID pandemic had a significant impact on mental health, especially for young people, as evidence in the recently published National Audit Office report. There was a surge in demand for the service following the pandemic (para 2.4). There was a recovery trajectory in place. Recovery was being managed by active management of the waiting list, partnership working with the voluntary sector, and two-year non-recurrent funding from NHS Dorset to support the recruitment of a number of fixed term posts to recover the service position, clear the waiting list and achieve the RTT metrics. A new purpose-built inpatient and day patient unit for Adult Eating Disorders was due for completion in February 2023.

Dean Spencer left the meeting

The Board discussed the use of transformation work in getting 'upstream' of the current issues and the need to accelerate the speed of change, the need to consider the role of prevention in relation to eating disorders, the issues underpinning retention challenges, the proposed new children's psychiatric unit, the role of voluntary sector in providing a first line of response, the need for consideration to the given to the support and signposting available for those whose referrals were rejected by the service. It was noted that this linked into the work that would be reported on in the next paper on children and young People mental health services.

Nick Johnson and John Beswick left the meeting

Resolved: the Board noted the Eating Disorder Service Update.

ICBB23/055 Children and Young People (CYP) Mental Health Services Update

The ICB Chief Commissioning Officer introduced the update on Children and Young People (CYP) Mental Health Services.

Louise Bate rejoined the meeting

Mark Harris joined the meeting and spoke to the previously circulated presentation which covered the current challenges across the local Child and Adolescent Mental Health Services (CAMHS) offer, the immediate actions to address challenges and an overview of the joint health and social care transformation programme for children and young people's mental health. The transformation project would be led jointly across both Places, using the Thrive framework and focused on 'no wrong door' and co-production. The implementation date for the project was March 2024, but the presentation outlined the other initiatives and projects which were underway or would be put in place prior to this date.

The Board welcomed the direction of travel, noting the Clinical Commissioning Committee's endorsement of the plan and the ICB Chief Commissioning Officer's confidence that the programme would deliver change. The Board discussed:

- the pace of change and whether this could be increased
- the need for a focus on prevention and resilience, noting the work that was already underway with schools, and the links to work in the adult sector on family support and expansion of perinatal mental health services.
- the need for cultural development work to wrap around the programme, the impact this would have on the successful delivery of the programme and the important of taking the time to embed this cultural change
- the importance of noting the range of conditions encompassed by mental health and the need to consider the impact of wider determinants and not to over-medicalise
- the challenges being created by ADHD/ASD assessments of children undertaken by private providers, noting that there was a separate workstream underway regarding assessment and treatment, with a focus on access to support without a diagnosis.

Ben Sharland and Paul Johnson left the meeting

Resolved: the Board noted the Children and Young People (CYP) Mental Health Services Update.

Items for Consent

There were no items for consent.

ICBB23/056 Questions from the Public

No questions were received in advance of the meeting from members of the public.

ICBB23/057 Any Other Business

Cllr Phil Broadhead, Leader BCP Council, raised the issue of collective use of assets and the possibility of using government grants available to local authorities to support investment for partners. It was noted that the ICB Chief Finance Officer (CFO) would lead on the next stage of the estates and capital plan. Use of capital across the system was not a current workstream but the ICB-CFO would work with local authority colleagues to develop this.

The Board welcomed Matt Prosser's, CEO Dorset Council, report that the first housing round-table had taken place and he would bring updates back to the ICB Board as appropriate.

ICBB23/058 Key Messages from the Meeting

The Chair summarised the key messages from the meeting as:

- The value that clinical placements add, and the importance of continuing to support these, using mechanisms such as long-arm supervision.
- The need for information to underpin important discussions e.g. No Criteria To Reside, and the workforce enablers for each report
- The Board noted the impact of COVID on mental health, welcomed the assurance provided on local services and welcomed the programme of work on Children and Young People's services. The Board expressed a commitment to deliver on these services and to deliver thriving communities.

ICBB23/059 Date and Time of Next Meeting

The next meeting of the ICB Board would be held on Thursday 4 May 2023 at 10am, in the Boardroom, Vespasian House, Barrack Road, Dorchester, Dorset DT1 1TG

ICBB23/060 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: