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 **26th July 2023** at **8.30 am to 12.10pm** at **Board Room, Trust Headquarters, Dorset County Hospital, Dorchester** and via **MS Teams.**

The agenda is as set out below.

Yours sincerely

David Clayton-Smith
Trust Chair

AGENDA

1.	**Staff Story**	Presentation	Jo Howarth	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: Margaret Blankson, Dawn Dawson Matthew Bryant, Dave Underwood	Verbal	David Clayton-Smith	Note	
	b) Conflicts of Interests	Verbal	David Clayton-Smith	Note	
	c) Minutes of the Meeting dated 31st May 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	Nick Johnson	Note	9.10-9.25
5.	**Balanced Scorecard** • System performance update • Elective Priorities	Enclosure	Executives	Note	9.25-9.40
6.	**Board Sub-Committee Escalation Reports** (June 2023 and July 2023) a) Finance and Performance Committee b) People and Culture Committee c) Quality Committee d) Risk and Audit Committee e) Charitable Funds Committee	Enclosures	Committee Chairs and Executive Leads	Note	9.40-10.05
7.	**Finance Report**	Enclosure	Chris Hearn	Note	10.05-10.15
Coffee Break 10.15-10.30					
8.	**Board Assurance Framework** (June RAC)	Enclosure	Nick Johnson Phil Davis	Note	10.30-10.40
9.	**Corporate Risk Register**	Enclosure	Jo Howarth	Note	10.40-10.50

	(June RAC)		Mandy Ford		
10.	**Committee Priorities**	Enclosure	Committee Chairs	Approve	10.50-11.05
11.	**Complaints Annual Report** (July QC)	Enclosure	Jo Howarth	Note	11.05-11.15
12.	**Maternity Update** (July QC)	Enclosure	Jo Hartley	Note	11.15-11.30
13.	**Safeguarding Children and Adults Annual Report** (June QC)	Enclosure	Jo Howarth Sarah Cake	Note	11.30-11.45
14.	**Infection Prevention and Control Annual Report** (July QC)	Enclosure	Jo Howarth Emma Hoyle	Note	11.45-11.55
15.	**Questions from the Public**	Verbal	David Clayton-Smith	Note	11.55-12.05
	In addition to being able to ask questions about discussion at the meeting, members of the public are also able to submit any other questions they may have about the trust in advance of the meeting to Trevor.hughes@dchft.nhs.uk or Abigail.baker@dchft.nhs.uk.				
	CONSENT SECTION				All items 12.05-12.10
	The following items are to be taken without discussion unless any Board Member requests prior to the meeting that any be removed from the consent section for further discussion.				
16.	**Working Together Committee in Common** • Memorandum of Understanding • Data Sharing Agreement • Terms of Reference	Enclosures	Nick Johnson	Note	-
17.	**Medical Revalidation Report** (June PCC)	Enclosure	Alastair Hutchison Julie Doherty	Note	-
18.	**Digital Services Report** (July PCC)	Enclosure	Nick Johnson	Note	-
19.	**Organ Donation Report** (July QC)	Enclosure	Alastair Hutchison	Note	-
20.	**ICB Board Minutes Part 1** (Standing Item)	Enclosure	Nick Johnson	Note	-
21.	**Any Other Business** Nil notified	Verbal	David Clayton-Smith	Note	-
22.	**Date and Time of Next Meeting**				
	The next part one (public) Board of Directors' meeting of Dorset County Hospital NHS Foundation Trust will take place at **8.30am** on **Wednesday 27th September 2023 in the Board Room, Trust Headquarters, Dorset County Hospital, 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 31st May 2023 at Board Room, Vespasian House and via MS Teams videoconferencing.

Present:		
David Clayton-Smith	DCS	Trust Chair (Chair)
Sue Atkinson	SA	Non-Executive Director
Margaret Blankson	MB	Non-Executive Director (attended via videoconference)
Matthew Bryant	MBr	Chief Executive
Chris Hearn	CH	Chief Finance Officer
Jo Howarth	JH	Chief Nursing Officer
Alastair Hutchison	AH	Chief Medical Officer
Nick Johnson	NJ	Deputy Chief Executive and Director of Strategy, Transformation and Partnership
Eiri Jones	EJ	Non-Executive Director
Stuart Parsons	SP	Non- Executive Director
Anita Thomas	AT	Chief Operating Officer
Stephen Tilton	ST	Non-Executive Director
David Underwood	DU	Non-Executive Director
In Attendance:		
Abi Baker	AB	Deputy Trust Secretary (Minutes)
Jenny Carinan	JC	Rheumatology Nurse (item BoD23/014)
Emma Hallett	EH	Deputy Chief People Officer
Jo Hartley	JHa	Head of Midwifery (attended via videoconference) (item BoD23/026)
Kyle Mitchell	KM	Guardian of Safe Working (item BoD23/023)
Lynn Paterson	LP	Freedom to Speak Up Guardian (attended via videoconference, item BoD23/028)
Ebi Sosseh	ES	Inclusion Lead (attended via videoconference)
Members of the Public (attending via videoconference):		
Kathryn Harrison	KH	Public Governor
Jean-Pierre Lambert	JPL	Appointed Governor, Weldmar Hospicecare
Lynn Taylor	LT	Public Governor
Apologies:		
Dawn Dawson	DD	Chief Nursing Officer, Dorset HealthCare NHS Foundation Trust
Trevor Hughes	TH	Head of Corporate Governance
Nicola Plumb	NP	Chief People Officer

BoD23/014	**Staff Story**	
	JC was welcomed to the meeting. JC was originally from the Philippines and is a rheumatology nurse. JC joined the Trust in 2020 just before the start of the pandemic and prior to this had spent 13 years in Dubai. JC is one of the three co-chairs of the overseas staff network. JC reflected on her experience of joining the Trust at the start of the Covid-19 pandemic, recognising that this was a difficult time for her and her international colleagues. JC was grateful that her team supported her with compassionate leave, following the death of her father. JC noted that she had not been aware of the level of tax or pension she would have to pay in the UK, or the cost of living in Dorset and identified this as a struggle for herself and other international staff. Additionally, the	

	level of accommodation provided for international staff could be improved, particularly in terms of the cost and the number of rooms within a home. JC felt it would be helpful to make candidates aware of this during the recruitment process and suggested it would be helpful for candidates to be able to speak to members of staff from their own country so that they could comfortably ask these sorts of questions. Despite these problems, JC voiced that Dorset was a lovely place to live and was good for families. JC discussed career growth, which had not been available to her in Dubai. JC had researched her career growth options but reflected that these options were not made explicit to her or her international colleagues. JC was now undertaking a nurse prescribers' course as a specialist nurse. Noting the use of agency nurses, JC added that it would be helpful if bank staff could be prioritised first for additional shifts. The Board thanked JC for her openness and honesty. Asked about her induction, JC noted that this had been delayed by the pandemic, but it had been helpful, particularly as she was new to the NHS. The Board recognised there was room to improve the effectiveness of appraisal conversations, as this is where career development conversations should be had. JC was able to dedicate half a day every two weeks to her role as co-chair of the overseas staff network and had administrative support which was shared by all the staff networks. EH noted that approval was being sought to increase the time offered to chairs of staff networks and to increase the funding to the networks. Social events had been particularly beneficial to overseas staff network members. JH outlined that since being in post she had set up the International Recruitment Steering Group, where key individuals including JC and ES, could discuss the issues raised today. JH was already aware of a knowledge-gap regarding tax and pension and recognised this was an area to be strengthened. Moving forward ward leaders would be more involved in the recruitment of international staff and the welcome pack would be updated. JH was also learning best practice of international recruitment from regional colleagues and NHS England. The Board further discussed accommodation for staff. JC noted that the issue was around the availability and cost of accommodation, particularly for families. CH outlined that a number of new staff accommodation sites had come online in recent weeks. These were primarily one-bedroom units, but they would free up capacity from on-site Trust accommodation which could then be turned in to family accommodation, in line with the wider Trust strategy. In terms of affordability CH understood that Dorchester was an expensive place to live and that the Trust was developing a strategy to offer staff support in this regard. CH welcomed further conversation with JC about accommodation outside of the meeting. Another barrier for international staff was the requirement for a deposit for accommodation; this was a cost that staff did not always factor in or have access to.	

	Work was underway to improve the use of bank staff over agency staff and to reduce any barriers for international staff to join the bank. Additionally, JH was working on supporting career progression as this was key to staff retention. MBr thanked JC for her speaking to the Board today, which set the scene for the rest of the meeting and thanked her for her work as a nurse and co-chair. Nearly 200 members of staff participated in the overseas network and the network provided them with a great deal of support. MBr noted that it would be helpful to hear more broadly from the other staff networks, possibly at a Board Development Session.	**AB**
	Resolved that: the Staff Story be heard and noted.	
BoD23/015	**Formalities**	
	The Chair declared the meeting open and quorate and welcomed Governors to the meeting. Apologies for absence were received from Dawn Dawson, Trevor Hughes and Nicola Plumb.	
BoD23/016	**Conflicts of Interest**	
	There were no conflicts of interest declared in the business to be transacted on the agenda.	
BoD23/017	**Minutes of the Meeting held on the 29th March 2023**	
	The Minutes of the meeting dated 29th March 2023 were approved as an accurate reflection of the meeting noting the following clarifications: BoD22/122: third paragraph clarified to reflect that MBr was not expected to attend every board sub-committee of either Dorset County Hospital (DCH) or Dorset HealthCare (DHC). BoD22/124: third paragraph clarified to reflect that the Trust did provide outstanding care in a number of ways, but that there were some gaps that could be improved upon.	
	Resolved: that the minutes of the meeting held on 29th March 2022 were approved.	
BoD23/018	**Matters Arising: Action Log**	
	The action log was considered and updates received in the meeting were recorded within the log with approval given for the removal of completed items. The below updates to actions were noted. BoD22/113: While the requested information was not included in the report shared with this meeting, NJ confirmed that the action was in hand and would be available from the next public Board meeting. BoD22/114.1: MB confirmed that the Equality, Diversity and Inclusion strategy would be returned to People and Culture Committee, as well as a future Board Development Session.	

	BoD22/114.2: Divisions were being reminded on a monthly basis to update on any new or past external reviews. The process is also being picked up within the refreshed governance structure via the Clinical Effectiveness Group. Action to be closed. BoD22/114.4: MBr requested NJ to support with this action. Committees already received the minutes of their counterpart ICB committee, but specific metrics were still under development. Action to be closed. BoD22/124.2: concerns raised previously about letters being sent incorrectly was being managed through the Accessible Information Group. Action to be closed. BoD22/127: DU clarified that this action belonged to Simon Pearson. The charity business plan was recently approved and so the request for it to include greater reference to patients would be picked up in the next iteration of the plan. Action to be closed. The Board noted the importance of updates to the action log being provided ahead of meetings, and of the role of the Corporate Governance team in following up with action owners to receive updates on actions. There were no other matters arising from the minutes.	
	Resolved: that updates to the action log be noted with approval given for the removal of completed items.	
BoD23/019	**Chair's Comments**	
	DCS noted that he had been made to feel welcome by colleagues in this Trust and at DHC. He had now met the Boards and Councils of Governors of both organisations, as well as key colleagues within the system. DCS thanked colleagues for the arrangements that had been made to support his induction to the Trusts.	
	Resolved: that the Chair's Comments be noted.	
BoD23/020	**CEO Update**	
	The report was taken as read and MBr highlighted the following key points. The NHS staff council had voted to accept the agenda for change pay-deal on offer from the government, but two unions remained in dispute. The the Royal College of Nursing (RCN) was currently balloting members for a further mandate to strike. The British Medical Association (BMA) was also balloting consultants for a mandate to strike, and industrial action by junior doctors was planned for 14 to 17 June. MBr thanked colleagues for their work overseeing arrangements to support industrial action and recognised the impact on patients and staff during the action. MBr highlighted the arrangements to mark the 75th anniversary of the NHS in July, which would be a time for celebration and recognition of the progress made. There would be local celebrations and a number of frontline staff had been invited to the national service at Westminster Abbey.	

	Within the Dorset system the operational plan, five-year forward plan and workforce plan had all been submitted. Planning was also advancing for the barge to be hosted in Portland with up to 500 migrants. Health planning for this was being led by the Dorset ICB. Confirmation had been received that funding for the Trust's outlined business case of the New Hospital Programme (NHP) had been confirmed. The next phase of the business case would be submitted in the autumn. MBr further noted that the Trust had been placed in segment two within the quarter three segmentation review, the progress of the Patient Safety Incidence Response Framework (PSIRF), and the development of the Mary Anning Unit. Further discussion about the indicators of excellence in the unit and the frailty strategy would be had at Quality Committee. Asked about the level of potential exposure to further industrial action, EH confirmed that nursing staff were split between the RCN and Unison unions. There were a handful of Unite members within support services. DU noted that it would be beneficial for the NHS 75 celebrations to include a strand on prevention of ill health, as this was one of the original ambitions of the NHS. The Board further discussed PSIRF, reflecting on the importance of communicating to patients and the wider population the changes this framework would make. While there was a deadline to have a PSIRF plan written by September, there would be further work and development in this area after that date. The Board would gain assurance on PSIRF via Quality Committee, although there were workforce elements to the framework as well. A further discussion around PSIRF was scheduled for the June Board Development Session.	**JH/AH**
	Resolved that the CEO Update be noted.	
BoD23/021	**Balanced Scorecard**	
	NJ welcomed feedback on the presentation and content of the report, as it was a work in progress. The scorecard provided valuable data which complemented the deep dive work of committees and allowed the board to triangulate matters. NJ drew the Board's attention to the matrix on page 34 of the papers, which provided an overview of the key metrics, and opened the discussion to questions and comments. The Board commended the paper as helpful, noting that it was developing well and that the commentaries added further detail to the figures. Asked how management teams were adapting to the use of Statistical Process Control (SPC) charts, NJ noted that, broadly, a top-down approach was being taken at this time and it was a work in progress, although some teams were using the tools proficiently. It was helpful for the Board to set a culture of using SPC charts to analyse performance. The development of ward-level dashboards would help embed the tools in to different areas of the Trust.	

	Committee chairs noted that the detail of the report was reflected in the discussions had at their committees. The Board discussed the ward-to-board reporting line and linking this to quality walk-rounds. DCS suggested he use the dashboard on his next quality walk-round. AT noted that there were some inaccuracies on the performance slide. These would be corrected for the next version of the report.	
	Resolved that: the Balanced Scorecard and System Performance Update be received and noted.	
BoD23/022	**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 that some items on the report appeared to be referred to the Board for approval, but this was not entirely accurate. If an item was referred to the Board for governance purposes this should be referred to as "recommended by the committee". If they required Board approval, they would be included on the Board agenda. **People and Culture Committee** MB noted a number of previously deferred items had been presented to the committee in April and May, with a number escalated to the Board for approval. The committee had reviewed the Equality Delivery System and felt that this required further work before it could be escalated to Board so would return in the coming months. MB provided a summary of the Freedom to Speak Up report which would be discussed in further detail later, noting the importance of civility amongst staff and ensuring that staff do not feel a detriment in raising issues. **Quality Committee** SA chaired the April meeting in EJ's absence and noted there had been no specific safety impacts relating to the recent industrial action. The committee had heard about the disruption to the provision of oncology services. MBr noted that the mitigating plan would remain in place for the foreseeable future and the Trust would work with UHD and the ICS to resolve the issue. The committee also heard about the suspension of UKAS accreditation for microbiology; there was limited operational impact on the loss of accreditation and efforts to rectify this were in place. Additionally, an update from the new Clinical Coding Lead had provided a helpful report about the impact on coding on the Trust's Summary Hospital-level Mortality Indicator (SHMI). The committee had recently heard the results of the Patient Led Assessment of the Care Environment (PLACE) annual review which had highlighted poor performance around quality of food and mealtime provision. Work was underway to review and improve the current meal	

	delivery system and was being overseen by the Patient Experience and Engagement Group. EJ noted the key issues reported to the committee in May, as outlined in the escalation report. Positively, the meeting had had a greater focus on reset, with more strategic conversations than were possible during the reactive response throughout the pandemic. EJ outlined the way the committees escalated concerns to one another, and the triangulation this offered. Finance and Performance Committee had recently escalated a number of possible quality impacts to Quality Committee, and these were captured in the minutes of the May meeting. **Charitable Funds Committee** DU noted that the outturn for the charity last year had been £877,000, which was just ahead of target. This was in part due to legacy income at the end of the financial year. There had been a soft launch of the capital appeal in support of the New Hospitals Programme and this would be publicly launched in August. 10% of the £2.2m appeal had already been raised. The March meeting had reviewed the charity's policies, which were presented to the Board for approval today. DU confirmed that these policies would be routinely audited, and that the role of the charity was not to fund the operational requirements of the Trust, but to fund those projects which could not be said to be critical to the functioning of the hospital.	
	Resolved that: Board subcommittee Escalation Reports be received and noted.	
BoD23/023	**Quarterly Guardian of Safe Working Report**	
	The meeting was running slightly overtime and so the Guardian of Safe Working (GOSW) report was brought forward to allow KM to be released to tend to clinical commitments. KM introduced himself for new members of the Board. The report outlined an increase in the junior doctor workforce from 150 to 170 since KM started as the GOSW. The rate of submission of exception reports was static compared to the last data prior to the pandemic. Areas of concern previously reported were Trauma and Orthopaedics and Gastroenterology. These were still vulnerable areas of high clinical pressure, but a great deal of work had been done to address the issues. Reflecting on the conversations earlier in the meeting, KM noted that medical oncology was an area to be aware of due to the impact on a small number of junior doctors. KM drew the Board's attention to national matters impacting junior doctors. The current priority for junior doctors was pay restoration following 20 years of relatively static pay. KM noted this in the context of the current cost of living crisis and the greater impact this was having on junior doctors, particularly in terms of accommodation and travel. KM advised that this was his fourth annual report as GOSW, and he viewed that it should be his penultimate report. After this, KM felt that a new guardian would bring something new to the role.	

	The Board reflected on the difficult time for junior doctors at present and commended KM for his work to keep the junior doctors' forum active and for understanding their concerns. The Board were assured that there were clear arrangements in place to ensure safe working hours for junior doctors. It was also positive to note that junior doctors were not exception reporting in a different than usual way. Referring to the immediate safety concerns detailed in the report, KM noted that the reporting of these concerns had changed significantly, but there was no other evidence to corroborate an increase in immediate safety concerns. KM posited that this mechanism was being used as a way to be heard and, while he did not define how this mechanism should be used, he was mindful that it was helpful to use it only for actual immediate safety concerns so as not to reduce their significance. KM confirmed that all immediate safety concerns detailed in the report had been scrutinised within 24 hours, but some remained outstanding to allow time for actions to be closed. The Chair thanked KM for his report and KM left the meeting.	
	Resolved that: the Quarterly Guardian of Safe Working Report be approved.	
BoD23/024	**Finance Report**	
	CH outlined that the Trust had submitted an ambitious plan for a breakeven position for 2023/24, which included a target saving of £10.9m as well as performance-related targets. Two areas of potential pressure to this plan had been identified; industrial action and unfunded inflationary costs. The Trust was taking action as necessary to alleviate these pressures, such as focusing on the sustainability programme of work and ensuring. Despite these challenges the Trust achieved the cost improvement plan (CIP) target for month one. Approximately half of the year's total CIP had been identified, with two-thirds of the identified CIP being recurrent. The Trust was in the process of implementing a new value-delivery board which would focus on key areas to drive financial savings and longer-term financial sustainability; members of the executive team would be leading on specific workstreams in their fields. The Board commended CH's financial leadership and noted how well the executives were working together in partnership with regards to finances.	
	Resolved that: the Finance Report be noted.	
BoD23/025	**Learning from Deaths Q4 Report**	
	AH drew the Board's attention to the Trust's SHMI, which was showing a positive trajectory and internal predictions indicated that the SHMI would fall within range in the coming months. AH noted that recent HES data had not been 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	

	was aware of the issue which has affected multiple Trusts. If the late data was not accepted by NHS Digital, it could impact the Trust's SHMI for the next 9 to 12 months. AH confirmed that no other data indicated the Trust was experiencing excess deaths and highlighted that the Trust was performing well in the national bowel cancer audit and the national hip fracture audit. The Trust was an outlier in terms of patients discharged home from intensive care, but this related to capacity on the wards, and those patients were medically fit for discharge. The coding team were in the process of recruiting two additional coders which would bring the team to full establishment. There was increased scrutiny from the region on the Trust's SHMI and colleagues from UHD would be reviewing the Trust's processes to ensure there were no areas of concern. AH was also undertaking an audit of 50 consecutive deaths to review whether there was anything of note. Asked about the hospital avoidance data, AH confirmed that the Trust reviewed the data to determine if there were any commonalities to suggest a problem with care. If required a root-cause analysis was undertaken, but PSIRF would show any themes in a more relevant way. The Board thanked AH for his continued focus on ensuring that there was no corroborating evidence to what the SHMI suggested. MBr encouraged the Board to remain focused not just on the SHMI, but on the other aspects of learning from deaths as well. MBr suggested that future iterations of the report could strengthen the organisational learning elements already present, as this would provider greater assurance for Quality Committee and the Board. EJ noted the strong focus Quality Committee had on the SHMI, that AH was supportive of this, and that AH was open about the Trust's position.	**AH**
	Resolved: that the Learning from Deaths Q4 Report be approved.	
BoD23/026	**Maternity Update**	
	JHa took the report as read, highlighting an increase in datix submissions regarding staffing, but an overall reduction in datix submissions; the reason for the reduction was being reviewed. JH noted the continuing risks around Entonox on the ward, the call bell system and the introduction of the BSOTS triage system. The report also included the new national three-year maternity and neonatal delivery plan and the Trust's preliminary benchmarking against this data. Delivery of the plan was being supported by the ICS and the LMNS. With regards to the final point on page 110 of the papers, SA recommended liaising with the Dorset Intelligence and Insight System (DIIS) for population data. JH agreed, noting recent workstreams arising from the Health Inequalities Group. JHa added that she was looking in to how to provide a service to marginalised groups of people who needed extra care and focus and was working with a charity called Black Mothers Matter.	

	Asked about evening handovers, JHa clarified that at present the Trust met the guidance for two face to face handovers every day. However, JHa had been advised that in the near future there would be a requirement to have a face-to-face handover between 8pm and 9pm, which the Trust did not currently have the staffing resource for. JHa was looking in to how to facilitate this and it may require additional consultant sessions. EJ noted that the Quality Committee reviewed the maternity report in detail each month, but that it was a requirement of the Ockenden report that the Board received assurance on the Trust's maternity performance. The maternity report was triangulated with meetings with the Ockenden safety champions and hospital walk-arounds. EJ confirmed the committee received good assurances on maternity matters and if there were any gaps in information JHa was always willing to return an update to the committee.	
	Resolved: that the Maternity Update be received and noted.	
BoD23/027	**WRES and WDES Report**	
	EH presented the Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) report in NP's absence, noting that there were both positive and negative findings. EH highlighted that four of the WRES indicators were based on staff responses, but that there was a low response rate amongst staff from minority ethnic backgrounds. There had recently been a number of mandatory workforce-data returns, and the intention now was to review the strategies in line with the data and to refocus efforts moving forward. MB supported this position, noting that it would offer the opportunity to review action plans and develop specific, measurable outcomes. MBr noted the changes over the past few years in the perception of how the Trust provides equal opportunity for career progression. This should be further investigated, and the Board should hold itself to account for the WRES and WDES and the impact it was making on staff. A more strategic approach and a more comprehensive plan would be vital over the coming months. Discussing the system approach to equality, diversity and inclusion, EH noted one of the year-one priorities of the ICB People Plan was the Leading for Inclusion programme. This was currently being developed and all ICB partners were involved. The programme would have a trainer-approach with approximately five key leaders from each organisation undertaking the programme. These key leaders would be clinical staff. Referring to metric 10 of the WDES SA noted that she had a disability but, as today was her last day, was unclear whether the Board would have disability representation moving forward. It was further noted that the Board was not as representative of its workforce as it could be, in terms of race.	
	Resolved: that the WRES and WDES Report be received and noted.	

BoD23/028	**Freedom to Speak Up and Whistleblowing Bi-annual Report**	
	LP joined the meeting for this item. This was the first report to combine the Freedom to Speak Up information and Whistleblowing arrangements in to one report. LP noted an increase in freedom to speak up cases, primarily attributed to greater visibility of LP as the newly appointed guardian. There had been no formal whistleblowing cases in the reporting period. Freedom to speak up cases primarily revolved around staff wellbeing, incivility, and lack of action. The only anonymous reporting route at present was via datix, but LP was looking to implement a post-box to allow people to speak up anonymously if they wished. Moving forward, LP would be exploring staff's fear of detriment for speaking up and comparing this to data of actual risk of detriment. It was hoped that this exercise would allay any fears staff had. LP continued to be visible to staff on wards and there was now 16 Freedom to Speak Up Champions with whom LP met on a regular basis. JH noted she and LP had an open-door policy for any issues as they emerged. JH further clarified that the allegations of bullying detailed in the report related to two specific teams, rather than being spread across the organisation, and the concerns were being addressed. The Board noted the importance of showing staff that concerns were addressed. The Board further discussed the matter of detriment. LP frequently attended team meetings and spoke about this topic. While she was often able to allay any fears of detriment, there were occasions where the risk of detriment felt more acute. There would be opportunity within the PSIRF model to focus on psychological safety and developing a just and restorative culture. DU suggested that communications from MBr, such as the weekly CEO brief, could reiterate the need for civility, recognising that staff were all feeling pressure, and signposting to the Freedom to Speak Up process. The Board reflected on the Freedom to Speak Up process as a 'safety valve' within the organisation and a mechanism through which the Board could hear about issues it may not otherwise know about. MBr expressed to LP that she had open access to speak to any of the executive team about any issues she was made aware of. MBr reflected that the Board usually heard a balanced view throughout the meeting, but the Freedom to Speak Up report was a more difficult item as it was the voice of staff who had run out of options. The Board needed to remember that each number was an individual who was struggling. MBr encouraged further thought by the Executives over the coming months about the matter of incivility, and thanked LP for her work and report.	
	Resolved: that the Freedom to Speak Up and Whistleblowing Bi-annual Report be received and noted.	
BoD23/029	**Social Value Bi-annual Progress Report**	
	The report was taken as read and the Board were invited to ask questions. SA commended the paper and was pleased to see that the Social Value lead would be attending SLG Working Group meetings now as it was important to apply a social value lens to everything the Trust did.	

	The work was of benefit to the whole community, but particularly to the more deprived areas. MB raised the benefit of supporting staff to understand what social value meant for them in their roles. This would help to bridge the gap of understanding and would mean that all staff could hold the banner of social value. MBr welcomed this point and noted that social value was more prominent at the DCH Board than he had seen at any other Trust he had worked at. MBr noted that SA's legacy was bringing this to the centre of the Board's attention.	
	Resolved: that the Social Value Bi-annual Progress Report be received and noted.	
BoD23/030	**Questions from the Public**	
	LT asked what the Trust's involvement was with the refugees who were being housed on a barge at Portland. MBr advised that the public sector's involvement was being lead by Dorset Council, with the health strand being led by the ICB. There would be up to 500 people on the barge, primarily single men rather than families, but the initial intake would be 50 people. The Trust understood that the individuals had been in the country for three to four months already so had had their health needs identified. The healthcare response would be to provide proactive care for the individuals and that most of their health needs would likely be for primary healthcare. A plan was being developed to offer this support without pulling on the existing primary care resource within Weymouth and Portland. The Trust was a secondary care provider who would be involved when secondary care was required. MBr noted that DHC had a bigger role in this development than the Trust did. KH sought an update on the carparking situation. CH advised that a letter to staff had been drafted and would be sent out in the coming weeks. CH would ensure that KH was advised when the letter had been sent. KH noted how important these matters were to the public and questioned whether they were given enough focus by the Board. MBr assured her that the necessary teams were very focussed on the carparking issue and that it was being progressed as quickly as possible, whilst dealing with technological issues and matters such as staff parking fees. CH concurred, adding that the issues to resolve were more complex than initially thought, so interim measures were being put in place to alleviate issues in the short term. KH added that she, governors and members of the Your Voice patient group were willing to 'buddy' new overseas staff. JH noted this and would get in touch with KH if the request for this arose.	**CH**
	CONSENT SECTION	
	The following items were taken usually without discussion. No questions were previously raised by Board members prior to the meeting.	
BoD23/031	**DCH Charity Policies**	

	Resolved: that the DCH Charity Policies be ratified.	
BoD23/032	**Provider Licence Update**	
	Resolved: that the Provider Licence Update be received and noted.	
BoD23/033	**Subco Quarterly Performance Report**	
	Resolved: that the Subco Quarterly Performance Report be received and noted.	
BoD23/034	**Communications Activity Report**	
	Resolved: that the Communications Activity Report be received and noted.	
BoD23/035	**Bank and Agency Usage and Expenditure Annual Report**	
	Resolved: that the Bank and Agency Usage and Expenditure Annual Report be received and noted.	
BoD23/036	**ICB Board Minutes Part 1**	
	Resolved: that the ICB Board Minutes Part 1 be received and noted.	
BoD23/037	**Any Other Business**	
	DCS highlighted that this was SA's last Board meeting and last day with the Trust. EJ thanked SA for her role, noting that she always goes over and above, was kind and generous, and helped her colleagues focus on population health and the people the Trust serves. SA said that she had enjoyed her time at the Trust and had found positive the way in which the Executive and Non-Executive Teams work together in an open and constructive way. The Board thanked SA for all her work.	
BoD23/038	**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, Trust Headquarters, Dorset County Hospital** and via **MS Teams.**	

Action Log – Board of Directors Part 1

Presented on: 26th July 2023

Minute	Item	Action	Owner	Timescale	Outcome	Remove? Y/N
Meeting Dated: 31st May 2023						
BoD23/014	**Staff Story**	Staff network chairs to be invited to a future Board Development Session.	**AB**	July 2023	Added to the Board Development Session planner.	**Yes**
BoD23/020	**CEO Update**	Quality Committee to consider and discuss the indicators of excellence within the Mary Anning Unit and the frailty strategy.	**JH/AH**	July 2023	Action referred to Quality Committee.	**Yes**
BoD23/025	**Learning from Deaths Q4 Report**	Future iterations of the report to strengthen the operational learning elements of the report.	**AH**	August 2023	To be included in the August Learning from Deaths report.	**No**
BoD23/030	**Questions from the public**	CH to let KH know when the letter to staff re the parking situation had been sent.	**CH**	July 2023	Complete	**Yes**
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**~~ **NJ**	~~May 2023~~ July 2023	In progress, expected in July report.	
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.	

Actions from Committees…(Include Date)						

1. Report Details			
Meeting Title:	Board of Directors		
Date of Meeting:	26th July 2023		
Document Title:	**Chief Executive Report**		
Responsible Director:	Matthew Bryant, Chief Executive	Date of Executive Approval	19.07.23
Author:	Jonquil Williams – Corporate Business Manager to CEO		
Confidentiality:	If Confidential please state rationale:		
Publishable under FOI?	Yes		
Predetermined Report Format?	No		

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

3. Purpose of the Paper	What is the paper about? Why is the paper is being presented and what you are asking the Board / committee to do?							
	Note (✓)	✓	Discuss (✓)		Recommend (✓)		Approve (✓)	

4. Key Issues

National Topics

- On 15 June 2023, the Government published its 2023 mandate to NHS England. In line with the Hewitt review recommendations the Government has set out fewer targets for NHS England
- 13 June 2023 saw the UK COVID-19 Public Inquiry commence the hearing for oral evidence, the inquiry will examine the UK's preparedness for whole-system civil emergencies. The NHS will be responding to requests from the Inquiry as they arise.
- The NHS long term workforce plan was published by the Government on 30 June 2023.

Dorset ICS

- Portland Barge – first residents are due Mid July
- On 22nd June the Dorset Integrated Care System Plan was published
- In line with best practice across England the seven South West Integrated Care Boards have agreed in principle for NHS Dorset to shift from its current role as coordinating commissioner to a lead commissioner model for South Western Ambulance Services Foundation Trust

Dorset County Hospital

- On 28th June CQC visited the Maternity Unit
- On the week commencing 3rd July a Reset week was held
- Dorset County Hospital celebrated NHS75 on 5th July holding a range of activities and had staff representing the hospital attend the Westminster Service.

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

Industrial Action

2.1 On 27 June 2023, The Royal College of Nursing confirmed that following an industrial action ballot, it had failed to reach the turnout threshold needed to continue strike action.

2.2 British Medical Association (BMA) junior doctors continued industrial action in support of pay restoration. Strike action was conducted for a 72 hour period over 14-17 June 2023, and a further five days of strike action took place from 13 to 18 July 2023. Two days of BMA consultant strike action also took place on 20 and 21 July 2023. Dorset system colleagues worked closely together to carefully plan for the upcoming industrial action in order to maintain the safe delivery of health care services for the people of Dorset.

2.3 On 13 July 2023 the government announced a 6% pay rise for doctors in line with the Doctors' and Dentists' Remuneration Review Body (DDRB) recommendations. The BMA has not supported this pay offer, and subsequently announced further consultant strike action to take place on 24 and 25 August. The Trust fully recognises and respects the right of colleagues to participate in industrial action.

NHS 75

2.4 The NHS celebrated its landmark 75th birthday on 5 July 2023. NHS Chief Executive Amanda Pritchard wrote a message to all staff to mark the occasion, and a short video was put together by local NHS organisations featuring 75 one-second clips of staff (including colleagues from our Trust) going about their work.

2.5 We celebrated with staff by delivering cakes around the hospital and sites around Dorset, staff gathered outside the hospital to sing and we had staff represent the hospital at the Westminster service. The service began with a procession of the George Cross, which was presented to the NHS as a whole in 2022 by May Parsons, who administered the first COVID vaccination. With a series of readings and traditional hymns, including contributions from the Prime Minister. There were also spoken addresses by senior NHS England staff and prayers offered by the Health Secretary, Chief Nursing Officer and National Medical Director.

2.6 The CEO of NHS Charities Together spoke about the value of the healthcare staff and they heard from two consultants who helped to bring Ukrainian child refugees who were being treated for cancer share their experience.

Government Response to The Hewitt Review

2.7 On 14 June 2023 the government published its joint response to the recommendations made by the Health and Social Care Committee in its report titled Integrated care systems: autonomy and accountability and The Hewitt Review.

2.8 In its response, the government made clear its commitment and support for the Integrated Care System being the right arrangement to address the shared challenges being faced across the health and care system. Work is underway with the review panel and the NHS Confederation to determine how best to support systems to implement the recommendations.

COVID-19 Inquiry

2.9 The UK Covid-19 Inquiry's public hearings for module 1 commenced on 13 June 2023 and concluded on 21 July 2023. Module 1 is investigating government planning and preparedness and will examine the period between June 2009 (when the World Health Organisation announced that scientific criteria for an influenza pandemic had been met) and 21 January 2020 (when the WHO issued the first situation report on what would become the Covid-19 pandemic). The Trust will continue to respond to information requests from the Inquiry as they arise.

The Government's 2023 Mandate to NHS England

2.10 On 15 June 2023 the government published its 2023 mandate to NHS England. In line with the Hewitt review recommendations, the government has set out fewer targets for NHS England focusing on three key priorities:

1. Cut NHS waiting lists and recover performance.
2. Support the workforce through training, retention and modernising the way staff work.
3. Deliver recovery through the use of data and technology.

2.11 Progress to deliver against the mandate will be monitored by the Secretary of State for Health and Social Care with an annual assessment laid in Parliament and published.

NHS Long Term Workforce Plan

2.12 On 30 June 2023 the NHS Long Term Workforce Plan was published by the government. This is the first comprehensive workforce plan for the NHS, aiming to put staffing on a sustainable footing and improving patient care. It focuses on retaining existing talent and making the best use of new technology alongside the biggest recruitment drive in health service history.

2.13 The plan sets out three key areas of focus:

- **Train:** significantly increasing education and training to record levels, as well as increasing apprenticeships and alternative routes into professional roles;
- **Retain:** ensuring that we keep more of the staff we have within the health service by better supporting people throughout their careers, boosting the flexibilities we offer our staff to work in ways that suit them and work for patients, and continuing to improve the culture and leadership across NHS organisations;

- **Reform:** improving productivity by working and training in different ways, building broader teams with flexible skills, changing education and training to deliver more staff in roles and services where they are needed most, and ensuring staff have the right skills to take advantage of new technology that frees up clinicians' time to care, increases flexibility in deployment, and provides the care patients need more effectively and efficiently.

3. Dorset Integrated Care System

System Operational Performance

3.1 Flow through emergency care pathways has improved in April and May with the introduction of the new discharge pathway and discharge to assess model of care. This has reduced the number of people who do not need to be in hospital. There continues to be no patients wait 2 years for treatment and the those waiting 18 months (78 weeks) has reduced significantly. Cancer treatment times continue to reduce and more people are getting earlier diagnosis.

Portland Asylum Seeker Accommodation

3.2 Following the Home Office confirmation in April 2023 of plans to accommodate up to 500 asylum seekers on an accommodation barge berthed in Portland port, NHS Dorset have worked with Dorset HealthCare, other system partners and the Home Office to ensure safe and effective healthcare provision for the people planned to be accommodated on the barge and help protect local primary care services from impact.

3.3 With the first 50 residents due to arrive in late July 2023, NHS Dorset has undertaken extensive partnership engagement to agree the funding and ensure delivery of the medical facilities on board the barge. These services will be delivered by a healthcare provider with prior experience of the health needs of asylum seekers.

Joint Forward Plan

3.4 On 30 June 2023 NHS Dorset published the Joint Forward Plan: 2023 – 2028 setting out the vision to make Dorset the healthiest place to live.

The plan has five outcomes on which NHS Dorset will work with systems partners and communities to develop and deliver against:

1. We will improve the lives of 100,000 people impacted by poor mental health.
2. We will save 55,000 children from being over-weight (by 2040).
3. We will reduce the gap in healthy life expectancy from 19 years to 15 years by 2043.
4. We will increase percentage of older people living well and independently in Dorset.
5. We will add 100,000 healthy life years to the people of Dorset by 2033.

Dorset Clinical Strategy

3.5 In support of the NHS Dorset Joint Forward Plan and NHS England's approach to major health conditions in its forthcoming strategy, the Dorset system has commenced work to develop its clinical strategy. This strategy is a pivotal area of work that will set out how we will design our clinical services to meet needs of the Dorset population in line with the Integrated Care Partnership strategy and the Joint Forward Plan five strategic outcomes.

3.6 An initial engagement event was held on 23 May 2023 to develop the key principles for the strategy. Over the summer further engagement events are planned with the clinical forums and networks with the final strategic approach to be set out in Autumn 2023.

Dorset Annual Operating Plan 2023/24

3.7 Following submission of the 2023/24 financial breakeven operating plan to NHS England, partners across the system continue to work on the following:

- Developing robust plans to ensure the delivery of all key operational standards.
- Identifying opportunities to reach the agreed break-even financial position, acknowledging the risk of unidentified recurrent savings associated with the plan.

3.8 Increased focus is needed across the system to bring performance back to agreed levels. By the end of quarter two each system is required to develop a medium-term financial plan which will demonstrate how recurrent financial sustainability will be delivered, including how the exit run-rate from 2023/24 will be improved through 2024/25. As a system, Dorset has been taking steps to develop this plan including commencing operational planning earlier than previous years, looking over five years to 2028.

Place Delivery

3.9 Following the publication of national guidance on development of placed based approaches, Dorset has been undertaking place development work to evolve the Dorset approach to implementation of place-based partnerships in each of the two defined places in Dorset: Bournemouth, Christchurch & Poole Place and Dorset Place. The functions of the place-based partnerships have been identified, and the year one agreements for governance, leadership, and work plan proposals has now concluded, subject to further engagement with local authorities and wider system colleagues.

Ambulance Commissioning

3.10 NHS Dorset Integrated Care Board has been the coordinating commissioner for South Western Ambulance Services Foundation Trust since April 2017 and they further took on the commissioning support function responsibility from April 2020. In line with best practice across England, the seven South West Integrated Care Boards have agreed in principle for NHS Dorset to shift from its current role as coordinating commissioner to a lead commissioner model for South Western Ambulance Services Foundation Trust. A lead commissioning agreement has been co-produced by NHS Dorset and partners to set out the roles and responsibilities of the lead commissioner and is with respective South West Integrated Care Boards for approval.

4. Strategy

Working Together Programme (Dorset County and Dorset Healthcare Collaboration)

4.1 A shared change approach, Changing Together, is being developed to support the Working Together Programme. The approach will tailor national guidance and best practice models to guide us in how to make successful change. This common approach will help both trusts make the most of the changes ahead. It will also be a useful guide to support staff in how to make change across the two organisations.

4.2 In addition, the recruitment process is underway for a joint Director of Corporate Affairs. This role will play an important part in simplifying decision-making, increasing integration and improving the quality of care and outcomes for the people we serve across both trusts. It will also help to shape how we work across the two organisations, providing expert and independent advice and guidance on all aspects of statutory regulation, compliance, and corporate governance.

4.3 Further work has continued on the flagship programmes. The Long Term Conditions group are focussing on diabetes and held their first working group on 5 July 2023. The outcome included some quick wins whilst following a consistent approach to transformation.

4.4 A resource plan is under development to identify the workforce and financial requirements for the programme.

4.5 The first sub-committee in common will take place on 7 August 2023. A review of other sub-committees will take place in the second half of 2023/24. A single meeting of the two executive teams will replace the existing separate meetings from mid-August 2023.

4.6 The Clinical Reference Group will meet on 9 August 2023 to consider how to align the clinical strategies for both trusts.

Weymouth Research Hub

4.7 The new Weymouth Research Hub was officially opened on 13 June 2023. Thanks to Investment from the National Institute for Health and Care Research Wessex, colleagues from across Dorset County Hospital and Dorset HealthCare can work together at the hub on vital research, ensuring our COVID-19 vaccines are safe and effective. This is the only vaccine research hub in the UK to be co-located with a vaccination centre.

4.8 The hub is part of a wider network of sites across the Wessex region that are helping to improve our understanding and treatments for viruses. This important work will have a positive impact on the health of our communities and give local people the chance to get involved in vital vaccine research. This project is among the first of many collaborations between Dorset County Hospital and Dorset HealthCare, alongside other partners, and it will deliver real benefits for the people we serve.

NHS Oversight Framework Quarter 4 2022/23 Segmentation Review

4.9 As part of the NHS Oversight Framework process, NHS England and Integrated Care Boards undertake quarterly segmentation reviews. On 30 May 2023 the NHS England Regional Support Group agreed that the Trust's segment 2 rating would remain unchanged for Quarter 4 2022/23.

4.10 The RSG noted that the Trust had demonstrated a good position across several metrics, particularly elective, cancer, primary care, quality (excluding summary hospital-level mortality indicator) and workforce. With regards to the organisation's financial position, although considered individual segment 2 based on the end of year position for 2022/23, the RSG noted some concern with regards to sustainability, as the data suggested a deteriorated run rate into 2023/24. The RSG has indicated that this will be revisited in the Q1 2023/24 review.

4.11 It was noted that there remained some areas of challenge flagged as individual segment 3, which related to:

- UEC - No more than 2% of ED attendances to be waiting more than 12 hours
- Quality – Summary Hospital-level Mortality Indicator

New Hospitals Programme (NHP)

1.1 The helicopter landing site at Dorset County Hospital will temporarily move to allow enabling works and construction of the new Emergency Department and Critical Care Unit. To allow demolition and enabling works to begin, the current helipad - which is at ground level next to the existing Emergency Department, needs to be decommissioned, as it will not be able to be accept flights while construction work is underway. It will move down to the Army Reserve Centre on Poundbury Road, just a short distance from the hospital. The site includes a large field with easy access for crews to transfer patients to an ambulance and be taken to the hospital, less than three minutes away.

5. Dorset County Hospital

Multi-Storey Car Park Update

5.1 On 3rd July the barriers became operational. Payment for patients and visitors has started and payment for staff will start in the coming months.

West Annexe

5.2 Tilbury Douglas has started to work on site. Enabling works to prepare the site for construction of our brand-new Emergency Department and Critical Care Unit are underway. Over the next three months, they will demolish the West Annex building and prepare the site for main construction, including groundworks and preparation for a new access road as part of the scheme. Tilbury Douglas are working closely with our Strategic Estates team and clinicians on the programme, including making sure that our existing clinical services continue to run with minimal disruption while the enabling works are underway.

Recycle, Reset and Refresh week

5.3 During the week of 3 July 2023 we held had a recycle, reset and refresh week. The COVID-19 pandemic led to us working in very different ways within healthcare, with our clinical and support services environments and working practices changing beyond recognition.

We are now returning to a new normal with PPE requirements reduced in most areas and social distancing a thing of the past. However, we haven't really had a chance to recalibrate and refocus on the way we need to go forward.

We'll keep many of the new ways of working that have proved valuable – such as virtual appointments and Microsoft Teams – but it's time for a good clear out of things we don't need anymore, and some head space to refresh our knowledge of practices that make the most difference to our patients.

The 'DCH 3 Rs' Week will offer a chance to 'dump the junk' from departments as well as remind ourselves about best practice in order to provide quality care to our patients.

Areas of focus during the week will include:

- Infection Prevention and Control

- Fall Prevention
- Dementia and Delirium Awareness
- Pain Assessment Tool
- Pressure Ulcer Prevention

CQC – Maternity

5.4 CQC visited our Maternity unit on 28 June 2023. The team are currently working through an action plan and a public report will be available in the coming months.

6. Recommendation

6.1 The Board is asked to note the report.

Matthew Bryant, Chief Executive
July 2023

port Front Sheet

1. Report Details			
Meeting Title:	Board of Directors		
Date of Meeting:	Wednesday 26th July		
Document Title:	Dorset County Hospital Balance Score Card		
Responsible Director:	Nick Johnson, Deputy CEO	Date of Executive Approval	19.07.23
Author:	Jonquil Williams, Corporate Business Manager		
Confidentiality:	If Confidential please state rationale:		
Publishable under FOI?	Yes/No		
Predetermined Report Format?	No		

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

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

4. Key Issues

The Balanced Scorecard can be accessed here:
https://bireports.dchft.nhs.uk/reports/powerbi/DCH%20-%20Trust%20Reports/Executive%20Dashboards/Executive%20Dashboard%20%20-%20July%202023%20Board?rs:embed=true

1. Quality and safety

- Over June 2023, the Trust experiences operational pressures and an increase in use of un-commissioned beds.
-The Trust remains 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.

2. Performance

-Cancer performance is challenged in all areas with the faster to diagnosis standard, two week wait and 62 day standard all performing below trajectory
- Performance of the elective trajectories are all on track or achieving better than plan
- The reporting month of June 2023 for the non-elective standards shows sustained improvements against ambulance handover delays and 4-hour standard.

3. People

-The sickness absence rate reduced to 3.55% in May
-The appraisal rate reduced by 1% in-month, but appraisals are scheduled over the summer months

4. Finance

-Financial position - Impact of inflationary pressures, unfunded beds and over usage of agency
-Delivery against plan covering Corporate, Digital, Covid and Prothesis programmes, however key schemes such as Insight Security reduction and reduction of hight cost

	agency remain away from plan YTD.
5. Action recommended	The Board of Directors are asked to Note this 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			
Strategic Objectives – Place			
Strategic Objectives – 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**	

Dorset County Hospital Balance Scorecard

1. Introduction

July 2023 Executive summary dashboard.

5. Quality and safety

- Annual MUST audit results will be available by July 2023
- Over June 2023, the Trust experiences operational pressures and an increase in use of un-commissioned beds. Whilst mitigations are in place, there are recognised indicators that have been impacted on when demand and associated staffing are under pressure. Full clinical engagement to support junior doctors strike action whilst maintaining safe patient care. Trust remained under trajectory for lapse in care of healthcare – acquired infections.
- The Medicines committee noted - Two Quality Improvement projects were supported by the committee following an audit on administration of medicines: Safer medication rounds and accurate allergy status
- The Trust remains a zero report for Never Events and Number of medication incidents resulting in severe harm or death. Last inicident for both metrics is November 2021
- There has been an increase in awareness, across the wards, with regard to assessing and managing pressure areas, Following retirement of the TVN, there is a current vacancy which will hinder the introduction of thematic analysis of these incidents.

6. Performance

- Cancer performance is challenged in all areas with the faster to diagnosis standard, two week wait and 62 day standard all performing below trajectory. The total waiting list size has increased as has the number of patients in the backlog and backstop.
- Diagnostic performance has improved in month with further reductions in the backlog, however the total waiting list size has increased by over 300 patients
- Performance of the elective trajectories are all on track or achieving better than plan. However, further work is needed at system level to understand activity levels and the impact they have on the systems incomes. DCH is currently under-delivering against the agreed operating plan for activity volumes, with the variance between actual and plan growing in June, as the trust is not achieving the theatre utilisation targets.
- The reporting month of June 2023 for the non-elective standards shows sustained improvements against ambulance handover delays and 4-hour standard. There has been increases in those waiting over 12 hours in the ED department driven by high demand at the front door. Admissions as a proportion of attendances and in terms of volume has significantly increased since May, with volumes still high in June. Some of this increase is a good thing, with patients being admitted to the wards in a timelier way, rather than being held in the ED department. This has been possible due to the reduction in patients with no reason to reside, which while at 19% and is not achieving trajectory is much lower than the highs of 35%

7. People

- Essential skills compliance remains at the Trust target of 90%
- The appraisal rate reduced by 1% in-month, but appraisals are scheduled over the summer months and a return to the upward trajectory is expected.
- The sickness absence rate reduced to 3.55% in May and has reduced each month since January 2023. Both long and short term sickness absence has reduced
- Turnover reduced to 11.52% in-month, which is the lowest rate since June 2022. The overall vacancy rate remained relatively static.

8. Finance

- Adjusted financial position: Impact of inflationary pressures (gas, electric, catering supplies & maintenance contracts, blood products and drugs) above planned levels along with higher than planned agency usage cover during peak industrial action periods, with circa 30 unfunded beds also contributing to the position.
- Agency spend: as adjusted financial position – higher than planned agency usage with June's allocate on arrival usage and HCA cover by RN agency increasing significantly. Cover during peak industrial action periods has impacted the year to date position as has supporting circa 30 unfunded beds.
- Capital expenditure: the position is currently behind plan in month due to timings of capital expenditure purchase made for both internally and externally funded schemes however is expected to recover throughout the years
- Efficiency delivery: Delivery against plan covering Corporate, Digital, Covid and Prothesis programmes, however key schemes such as Insight Security reduction and reduction of hight cost agency remain away from plan YTD.
- Off Framework agency spend: Impact of using RN agency to cover HCA gaps as well as 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.

Executive Dashboard July 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

2023-07-11 09:13:08
data last refreshed:

30 April 2019
metric data from:

30 June 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 | Exception Report | Quality & Safety | Performance | People | Finance | Glossary | Useful Links | Appendix A: SPC Basics | Appendix B: SPC Icon Descriptions | Appendix C: Understanding Assurance | Appendix D: When+Why Recalculate Process Limits

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	12%	12%
Vacancy Rate (substantive)	F	H	9%	5%

QUALITY & SAFETY

Metric Name	Assurance	Variation	Value	Target
Complaints - Total Number Received (Informal & Formal)		H	148	
Friends and Family - Overall - Recommend Rate	?	L	87%	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	71	
Incidents - Pressure Ulcers - Hospital acquired (grade 3) confirmed avoidable			0	
Incidents - Serious Incidents investigated and confirmed avoidable	?		1	0
Infection Control - C-Diff Hospital Onset Healthcare Associated	?		2	3
Infection Control - Gram Negative Blood Stream Infections	?		1	5
Inpatient - % Emergency Re-Admissions (16+ & <30 Days) (1 month arrears)	P		8.69%	13%
Inpatient - Percentage of EDS available within 24 hours of discharge	F	H	79.61%	90%
Inpatient - Percentage of EDS available within 7 days of discharge	F		88.9%	100%
Inpatient - SHMI Value		L	0	

PERFORMANCE

Metric Name	Assurance	Variation	Value	Target
Cancer (ALL) - 104 days from referral to treatment			25	
Cancer (ALL) - 28 day faster diagnosis standard	?		65.28%	75%
Diagnostic - Percentage of Patients waiting less than 6 weeks for a diagnostic test	F	L	77.06%	99%
ED - 12 Hour Waits		H	347	
ED - Ambulance Handover Delays Average Time Lost per Day			12.85	
ED - Overall 4 Hour Performance %	?	H	80.81%	75%
Elective Recovery - Day Case Activity vs 2019/20	?	H	114.92%	104%
Elective Recovery - Elective Inpatients Activity vs 2019/20	F		84.7%	104%
Elective Recovery - Outpatient Activity vs 2019/20	?		101.63%	104%
Elective Recovery - Total Elective Activity vs 2019/20	?		102.66%	104%
Inpatient - Percent Bed Occupied by No RTR	?	L	20%	27%
Outpatient - Virtual Activity %	F	H	22.66%	25%
RTT - 52+ week waits	?	L	1276	1176
RTT - 65+ week waits	F	L	267	335
RTT - 78+ week waits		L	7	
RTT - Waiting List Size	P	H	20388	20402
Theatre - Utilisation	F		71.95%	85%

FINANCE

Metric Name	Assurance	Variation	Value	Target
Adjusted Financial Position	?		-685	-33
Agency Spend (Monthly)			1424	833
Capital Expenditure (Monthly)	?		1666	1822
Efficiency Delivery	P	H	173	500
Off Framework Agency Spend			279	83

Matrix Overview

Dorset County Hospital NHS Foundation Trust

Variance \ Assurance	P	?	F		Total
H		2	3		5
L		2	2	2	6
	1	8	4	4	17
H	3	1	1	3	8
L		1	1		2
				2	2
Total	4	14	11	11	40

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

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

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

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

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

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

Exception Report

This page is limited to metrics that are classed as "Concern" for Variation and/or "Fail" for Assurance.

Balanced Scorecard

QUALITY & SAFETY

Metric Name	Assurance	Variation	Value	Target
Complaints - Total Number Received (Informal & Formal)		H	148	
Friends and Family - Overall - Recommend Rate	?	L	87%	94%
Incidents - Number of Medication Incidents		H	71	
Inpatient - Percentage of EDS available within 24 hours of discharge	F	H	79.61%	90%
Inpatient - Percentage of EDS available within 7 days of discharge	F		88.9%	100%

Commentary

Over June 2023, the Trust experienced operational pressures and an increase in use of un-commissioned beds. Whilst mitigations are in place, there are recognized indicators that have been impacted on when demand and associated staffing are under pressure. Full clinical engagement to support junior doctors strike action whilst maintaining safe patient care. Trust remained under trajectory for lapse in care of healthcare –acquired infections.
The Medicines committee noted Two Quality Improvement projects were supported by the committee following an audit on administration of medicines: Safer medication rounds and Accurate allergy status.

PERFORMANCE

Metric Name	Assurance	Variation	Value	Target
ED - 12 Hour Waits		H	347	
Elective Recovery - Elective Inpatients Activity vs 2019/20	F		84.7%	104%
Outpatient - Virtual Activity %	F	H	22.66%	25%
RTT - Waiting List Size	P	H	20388	20402
Theatre - Utilisation	F		71.95%	85%

Commentary

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.
DCH is currently under-delivering against the agreed operating plan for activity volumes, with the variance between actual and plan growing in June, as the trust is not achieving the theatre utilisation targets.
The reporting month of June 2023 for the non-elective standards shows sustained improvements against ambulance handover delays and the 4-hour standard. There has been increases in those waiting over 12 hours in the ED department driven by high demand at the front door. Admissions as a proportion of attendances and in terms of volume has significantly increased since May, with volumes still high in June. Some of this increase is a good thing, with patients being admitted to the wards in a timelier way, rather than being held in the ED department. This has been possible due to the reduction in

PEOPLE

Metric Name	Assurance	Variation	Value	Target
Appraisal rate	F		76%	90%
Sickness rate (one month in arrears)	?	H	4%	3%
Staff Turnover Rate	P	H	12%	12%
Vacancy Rate (substantive)	F	H	9%	5%

Commentary

The appraisal rate reduced by 1% in-month, but appraisals are scheduled over the summer months and a return to the upward trajectory is expected.
The sickness absence rate reduced to 3.55% in May and has reduced each month since January 2023. Both long and short term sickness absence has reduced.
Turnover reduced to 11.52% in-month, which is the lowest rate since June 2022. The overall vacancy rate remained relatively static.

FINANCE

Metric Name	Assurance	Variation	Value	Target
Efficiency Delivery	P	H	173	500

Commentary

Efficiency Delivery: Delivery against plan covering Corporate, Digital, Covid and Prothesis programmes, however key schemes such as Insight security reduction and reduction of high cost agency remain away from plan YTD.

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

Annual MUST audit results will be available by July 2023.

Over June 2023, the Trust experienced operational pressures and an increase in use of un-commissioned beds. Whilst mitigations are in place, there are recognized indicators that have been impacted on when demand and associated staffing are under pressure. Full clinical engagement to support junior doctors strike action whilst maintaining safe patient care. Trust remained under trajectory for lapse in care of healthcare –acquired infections.

The Medicines committee noted Two Quality Improvement projects were supported by the committee following an audit on administration of medicines: Safer medication rounds and Accurate allergy status.

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.

There has been an increase in awareness, across the wards, with regard to assessing and managing pressure areas. Following retirement of the TVN, there is a current vacancy which will hinder the introduction of thematic analysis of these incidents.

VariationIcon	Pass	Hit or Miss	Fail	Empty	Total
Improvement			2	1	3
Common Cause	1	3	1	2	7
Concern		1		2	3
Neither					
Empty					
Total	**1**	**4**	**3**	**5**	**13**

Metric Group	Metric	Group	Latest Month	Value	Target	Variance to Target	Mean	PY - Month Value	YTD Value	Variation	Assurance
Effectiveness	Inpatient - % Emergency Re-Admissions (16+ & <30 Days) (1 month arrears)	0 - Total	May-23	8.69%	13%	-4.31%	7.91%	6.53%	8.69%		
Effectiveness	Inpatient - Percentage of EDS available within 24 hours of discharge	0 - Total	Jun-23	79.61%	90%	-10.39%	78.18%	83.79%	79.61%		
Effectiveness	Inpatient - Percentage of EDS available within 7 days of discharge	0 - Total	Jun-23	88.9%	100%	-11.10%	88.57%	93.19%	88.9%		
Experience	Complaints - Total Number Received (Informal & Formal)	0 - Total	Jun-23	148			91.96	89	365		
Experience	Friends and Family - Overall - Recommend Rate	0 - Total	Jun-23	87%	94%	-7.00%	91.78%	91%	87%		
Safety	Incidents - Never Events	0 - Total	Jun-23	0	0.02	-0.02	0.06	0	0		
Safety	Incidents - Number of falls resulting in fracture or severe harm or death	0 - Total	Jun-23	0			0.24	1	0		
Safety	Incidents - Number of Medication Incidents	0 - Total	Jun-23	71			55.9	61	204		
Safety	Incidents - Pressure Ulcers - Hospital acquired (grade 3) confirmed avoidable	0 - Total	Jun-23	0			0.61	2	1		
Safety	Incidents - Serious Incidents investigated and confirmed avoidable	0 - Total	Jun-23	1	0	1.00	0.51	1	2		
Safety	Infection Control - C-Diff Hospital Onset Healthcare Associated	0 - Total	Jun-23	2	3	-1.00	2.53	5	7		
Safety	Infection Control - Gram Negative Blood Stream Infections	0 - Total	Jun-23	1	5	-4.00	2.96	1	7		
Safety	Inpatient - SHMI Value	0 - Total	Feb-23	0			1.12	1.11	0		

Performance

Group: 0 - Total

Metric: All

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

Dorset County Hospital NHS Foundation Trust

Commentary
Cancer performance is challenged in all areas, with the faster to diagnosis standard, two week wait and 62 day standard all performing below trajectory. The total waiting list size has increased as has the number of patients in the backlog and backstop.
Diagnostic performance has improved in month with further reductions in the backlog, however the total waiting list size has increased by over 300 patients.
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. DCH is currently under-delivering against the agreed operating plan for activity volumes, with the variance between actual and plan growing in June, as the trust is not achieving the theatre utilisation targets.
The reporting month of June 2023 for the non-elective standards shows sustained improvements against ambulance handover delays and the 4-hour standard. There

VariationIcon	Pass	Hit or Miss	Fail	Empty	Total
Improvement		4	2	1	7
Common Cause		3	2	2	7
Concern	1		1	1	3
Neither					
Empty					
Total	**1**	**7**	**5**	**4**	**17**

Metric Group	Metric	Group	Latest Month	Value	Target	Variance to Target	Mean	PY - Month Value	YTD Value	Variation	Assurance
Cancer	Cancer (ALL) - 104 days from referral to treatment	0 - Total	Jun-23	25			18.26	16	25		
Cancer	Cancer (ALL) - 28 day faster diagnosis standard	0 - Total	Jun-23	65.28%	75%	-9.72%	68.02%	69.09%	65.28%		
Elective	Elective Recovery - Day Case Activity vs 2019/20	0 - Total	Jun-23	114.92%	104%	10.92%	94.23%	100.37%	114.92%		
Elective	Elective Recovery - Elective Inpatients Activity vs 2019/20	0 - Total	Jun-23	84.7%	104%	-19.30%	68.69%	77.24%	84.7%		
Elective	Elective Recovery - Outpatient Activity vs 2019/20	0 - Total	Jun-23	101.63%	104%	-2.37%	91.77%	95.5%	101.63%		
Elective	Elective Recovery - Total Elective Activity vs 2019/20	0 - Total	Jun-23	102.66%	104%	-1.34%	91.86%	95.63%	102.66%		
Elective	Theatre - Utilisation	0 - Total	Jun-23	71.95%	85%	-13.05%	71.26%	75.26%	71.95%		
Outpatient	Diagnostic - Percentage of Patients waiting less than 6 weeks…	0 - Total	Jun-23	77.06%	99%	-21.94%	77.98%	76.66%	77.06%		
Outpatient	Outpatient - Virtual Activity %	0 - Total	Jun-23	22.66%	25%	-2.34%	19.8%	20.91%	22.66%		
Outpatient	RTT - 52+ week waits	0 - Total	Jun-23	1276	1176	100.00	1284.12	1517	1276		
Outpatient	RTT - 65+ week waits	0 - Total	Jun-23	267	335	-68.00	611.73	728	267		
Outpatient	RTT - 78+ week waits	0 - Total	Jun-23	7			289.04	362	7		
Outpatient	RTT - Waiting List Size	0 - Total	Jun-23	20388	20402	-14.00	17142.04	17751	20388		
Urgent and Emergency Care	ED - 12 Hour Waits	0 - Total	Jun-23	347			125.55	173	616		
Urgent and Emergency Care	ED - Ambulance Handover Delays Average Time Lost per Day	0 - Total	Jun-23	12.85			14.35	18.44	12.85		
Urgent and Emergency Care	ED - Overall 4 Hour Performance %	0 - Total	Jun-23	80.81%	75%	5.81%	74.15%	71.07%	80.81%		
Urgent and Emergency Care	Inpatient - Percent Bed Occupied by No RTR	0 - Total	Jun-23	20%	27%	-7.00%	28.19%	37.74%	20%		

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 remains at the Trust target of 90%
The appraisal rate reduced by 1% in-month, but appraisals are scheduled over the summer months and a return to the upward trajectory is expected.
The sickness absence rate reduced to 3.55% in May and has reduced each month since January 2023. Both long and short term sickness absence has reduced.
Turnover reduced to 11.52% in-month, which is the lowest rate since June 2022. The overall vacancy rate remained relatively static.

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	Metric	Group	Latest Month	Value	Target	Variance to Target	Mean	PY - Month Value	YTD Value	Variation	Assurance
Growing For Our Future	Essential Skill Rate	0 - Total	Jun-23	90%	90%	0.00%	88.71%	89%	90%		
Looking After Our People	Appraisal rate	0 - Total	Jun-23	76%	90%	-14.00%	75.59%	63%	76%		
Looking After Our People	Sickness rate (one month in arrears)	0 - Total	May-23	4%	3%	1.00%	3.74%	4%	4%		
Looking After Our People	Staff Turnover Rate	0 - Total	Jun-23	12%	12%	0.00%	9.35%	11%	12%		
Looking After Our People	Vacancy Rate (substantive)	0 - Total	Jun-23	9%	5%	4.00%	7.1%	8%	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

NHS Dorset County Hospital NHS Foundation Trust

Commentary
Adjusted Financial Position: Impact of inflationary pressures (gas, electric, catering supplies & maintenance contracts, blood products & drugs) above planned levels along with higher than planned agency usage providing cover during peak industrial action periods, with circa 30 unfunded beds also contributing to the position.
Agency Spend: As Adjusted Financial Position - higher than planned agency usage with June's allocate on arrival usage and HCA cover by RN agency increasing significantly. Cover during peak industrial action periods has impacted the year to date position as has supporting circa 30 unfunded beds.
Capital Expenditure: The position is currently behind plan in month due to timings of capital expenditure purchases made for both internally and externally funded schemes however is expected to recover throughout the year.
Efficiency Delivery: Delivery against plan covering Corporate, Digital, Covid and Prothesis programmes, however key schemes such as Insight security reduction and reduction of high cost agency remain away from plan YTD.
Off Framework Agency Spend: Impact of using RN agency to cover HCA gaps as well as 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		2			2
Concern	1				1
Neither					
Empty				2	2
Total	**1**	**2**		**2**	**5**

Metric Group	Metric	Group	Latest Month	Value	Target	Variance to Target	Mean	PY - Month Value	YTD Value	Variation	Assurance
Capital	Capital Expenditure (Monthly)	0 - Total	Jun-23	1666	1822	-156.00	1895.78	555	4060		
Revenue	Adjusted Financial Position	0 - Total	Jun-23	-685	-33	-652.00	-249.87	1877	-1647		
Value Board	Agency Spend (Monthly)	0 - Total	Jun-23	1424	833	591.00	1182.33		3547		
Value Board	Efficiency Delivery	0 - Total	Jun-23	173	500	-327.00	158.92	356	977		
Value Board	Off Framework Agency Spend	0 - Total	Jun-23	279	83	196.00	188.67		566		

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 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.
Friends and Family - Overall - Recommend Rate	Percentage of overall Friends and Family recommendation. Sourced from the Patient and Public Experience team.
Incidents - Never Events	Number of occurances of confirmed Never Events based on updated date. Sourced from Datix.
Incidents - Number of falls resulting in fracture or severe harm or death	Number of occurances of falls catagorised as severe or death severity of harm caused, based on updated date. Sourced from Datix.
Incidents - Number of Medication Incidents	Number of occurances of medicine incidents based on reported date. Sourced from Datix.
Incidents - Pressure Ulcers - Hospital acquired (grade 3) confirmed avoidable	Number of occurances of hospital acquired category 3 pressure ulcers confirmed as avoidable by panel date. Sourced from Datix.
Incidents - Serious Incidents investigated and confirmed avoidable	Number of occurances of serious incidents investigated and confirmed avoidable by panel date. Sourced from Datix.
Infection Control - C-Diff Hospital Onset Healthcare Associated	Number of occurances of hospital onset healthcare associated Clostridium difficile (C. diff) incidents by specimen date. Sourced from HCAI data.
Infection Control - Gram Negative Blood Stream Infections	Number of occurances of hospital onset gram negative blood stream infection incidents by specimen date. Sourced from HCAI data.
Inpatient - Percent Bed Occupied by No RTR	Percentage of total adult G&A beds occupied (as per reported in UEC Daily SitRep) by No Reason To Reside (NRTR) patients (as per reported in EPPR Daily Discharge SitRep). Original source PAS / Patient Action Tracker.
Inpatient - Percentage Emergency Re-Admissions (16+ & within 30 days) (1 month in arrears)	Percentage of emergency re-admissions to hospital within 30 days of previous admission. Excludes patients under the age of 16 on original admission. Sourced from Emergency Readmission reporting, original source PAS.
Inpatient - Percentage of EDS available within 24 hours of discharge	Percentage of electronic discharge summaries (EDS) available for GPs to access within 24 hours of discharge from an inpatient spell. Sourced from EDS reporting, original source ICE / PAS.
Inpatient - Percentage of EDS available within 7 days of discharge	Percentage of electronic discharge summaries (EDS) available for GPs to access within 7 days of discharge from an inpatient spell. Sourced from EDS reporting, original source ICE / PAS.
Inpatient - SHMI Value (deaths in-hospital and within 30 days post	Ratio result of Summary Hospital-level Mortality Indicator (SHMI) which reports applicable deaths within hospital, or within 30 days post

Useful Links

Dorset County Hospital NHS Foundation Trust

FutureNHS

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

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

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

Events

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

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

Guides & Cards

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

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

SPC Surgery

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

SPC Basics

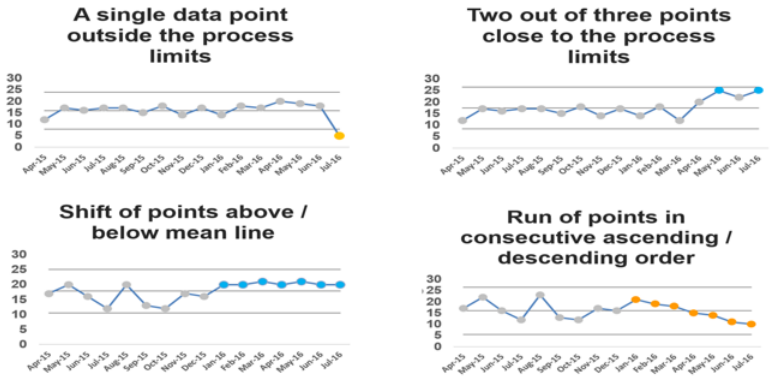
Dorset County Hospital NHS Foundation Trust

Is Performance Changing?

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

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

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



What are Summary Icons showing?

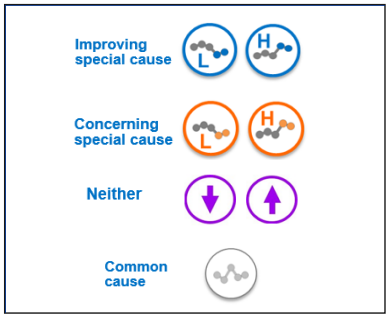
Blue icons indicate significant improvement or low pressure.

Orange icons indicate significant concern or high pressure.

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

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

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



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

What is a Moving Range Chart showing?

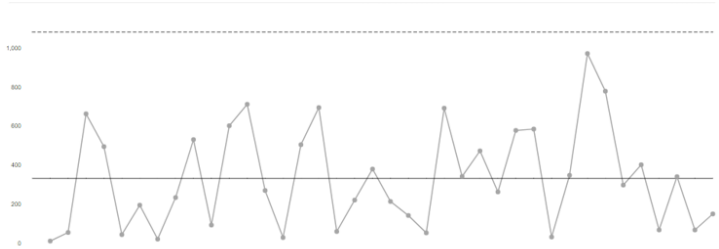
Moving range chart (seen on right) helps to assess the variation in a process by taking the absolute difference between consecutive points.

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

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

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

The moving range chart will display below all SPC visualisations.



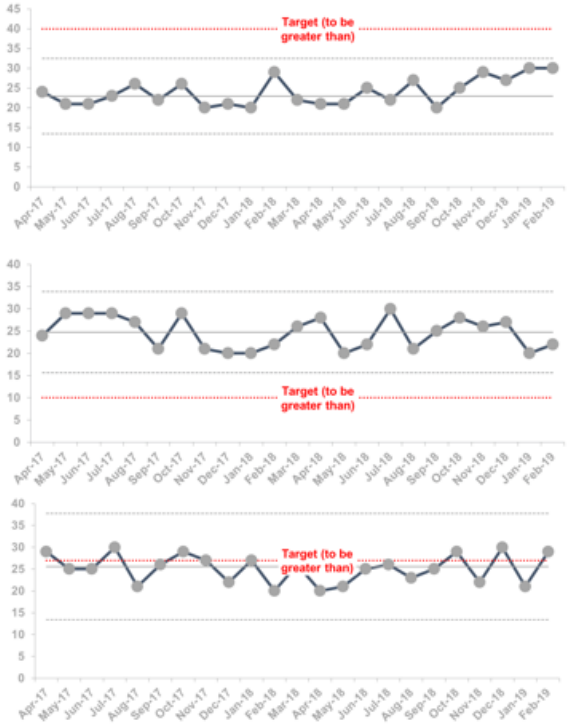
SPC Icon Descriptions

Dorset County Hospital NHS Foundation Trust

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

Assurance icon

Up is good (need to be greater than the target



Failing process

target way above the process limits so it's a failing process, unlikely to ever meet the target without redesign and we use an orange F for FAIL

Capable process

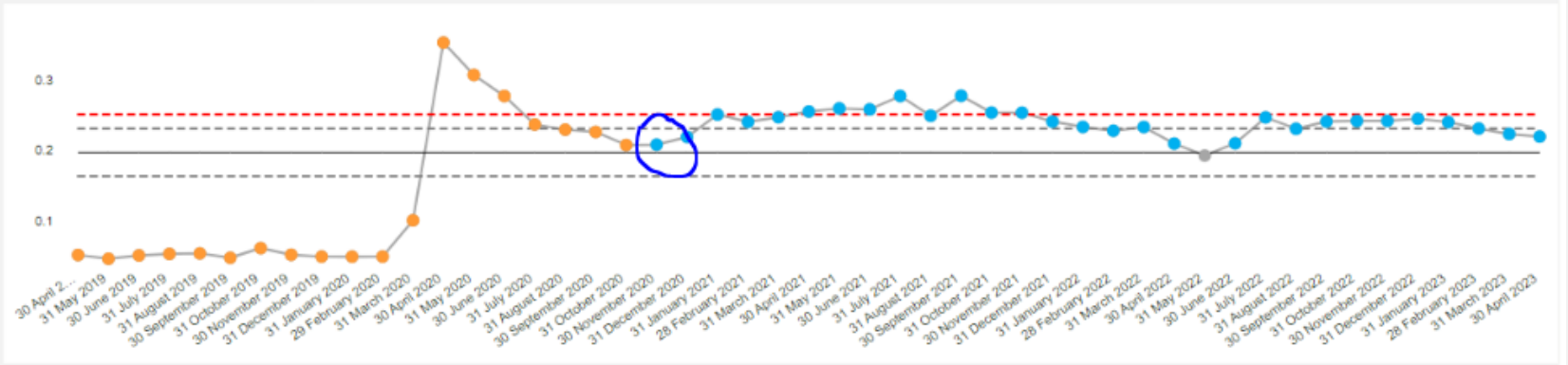
target way below the process limits so it's a capable process and likely to always meet the target and we use a blue P for PASS

Unreliable process (flip flop)

where the target falls in the middle of the process limits and is likely to flip flop and we use a grey ?
This is to show the process may or may not meet target consistently

When+Why Recalculate Process Limits

Dorset County Hospital NHS Foundation Trust



Here we see a brilliant example of the need to recalculate process limits (dashed grey lines).

There is significant change in the data from february-2020 onwards and it stabilises from the first blue dot in november-2020.

Hence to have full benefit of assurance and variation icons as well as SPC rules - we need to recalculate our process limits (dashed grey lines) at the November-2020 point, just after the change and the point it starts to stabilise.

To recalculate there needs to be plenty of points after the recalculation to have a strong SPC with enough points to know whether or not special cause variation occurs.

Report Front Sheet

1. Report Details			
Meeting Title:	Board of Directors		
Date of Meeting:	Wednesday 26th July		
Document Title:	**System Performance Scorecard – extract from ICB Papers**		
Responsible Director:	Matthew Bryant, Chief Executive	Date of Executive Approval	19.07.23
Author:	Jonquil Williams, Corporate Business Manager		
Confidentiality:	If Confidential please state rationale: 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	What is the paper about? Why is the paper is being presented and what you are asking the Board / committee to do?							
	Note (✓)	x	Discuss (✓)		Recommend (✓)		Approve (✓)	
4. Key Issues	Appendix to the Dorset County Hospital Board papers: ICB System Board report – taken to ICB Board on 6th July Extracted Key Issues: Throughout 2022/23, we have seen a sustained increase in demand for health services as the COVID pandemic subsides. This has been seen in the demand for GP services, calls to 111 and 999, response time for urgent care, cancer and elective referrals and timely discharge to the right care setting. As a system, Dorset has responded well in all of these areas during the year. However, there is more work to do to achieve the level of care and response time experienced before the pandemic. Going into 2023/24, flow through the emergency care pathways has improved in April and May with the introduction of the new discharge pathway and discharge to assess model of care. This has reduced the number of people who do not need to be in hospital. There continues to be no patients wait 2 years for treatment and the those waiting 18 months (78 weeks) has reduced significantly. Cancer treatment times continue to reduce and more people are getting earlier diagnosis.							
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**	

Meeting Title	ICB Board
Date of Meeting	6 July 2023
Paper Title	System Performance Report
Responsible Chief Officer	Dean Spencer, Chief Operating Officer
Author	Sarah Charles, Head of Performance and Contracts

Confidentiality	N/A
Publishable Under FOI?	Yes

Prior Discussion and Consultation		
Job Title or Meeting Title	**Date**	**Recommendations/Comments**
N/A	May 2023	The current performance report has contributions from multiple leads within NHS Dorset following liaison with key provider leads.

Purpose of the Paper	The purpose of the paper is to provide members with: • A summary of performance at end of 2022/23 • An overview of current performance against national operational targets for 2023/24 (where available), including exceptions and remedial actions • An update on the developmental work underway for Performance Reporting in 2023/24.							
	Note:	✓	Discuss		Recommend		Approve	

Summary of Key Issues	Throughout 2022/23, we have seen a sustained increase in demand for health services as the COVID pandemic subsides. This has been seen in the demand for GP services, calls to 111 and 999, response time for urgent care, cancer and elective referrals and timely discharge to the right care setting. As a system, Dorset has responded well in all of these areas during the year. However, there is more work to do to achieve the level of care and response time experienced before the pandemic. Going into 2023/24, flow through the emergency care pathways has improved in April and May with the introduction of the new discharge pathway and discharge to assess model of care. This has reduced the number of people who do not need to be in hospital. There continues to be no patients wait 2 years for treatment and the those waiting 18 months (78 weeks) has reduced significantly. Cancer treatment times continue to reduce and more people are getting earlier diagnosis. Exception reports have been prepared for the main areas of challenged performance. The data used in each section is the most up to date reliable data for each indicator.
Action recommended	The Committee is asked to **note** the updates provided within the paper.

Governance and Compliance Obligations		
Legal and Regulatory	**YES**	ICBs (INTEGRATED CARE BOARD) are required to have oversight of the delivery of services to their population. Both providers and the ICB itself are segmented according to their performance across several areas. This report covers many of the areas. Segmentation determines the level of oversight, intervention and mandatory or voluntary support individual providers to the system receive.
Finance and Resource	**YES**	The need to maintain urgent and cancer capacity during significant operational pressures has meant that there has not been any improvement in this forecast. This may impact the ability of the system to deliver a break-even position.
Risk	**YES**	There are clinical risks associated with poor performance especially in respect of long waiting times - and critically in cancer services and ambulance handover delays.

Risk Appetite Statement	
ICB Risk Appetite Statement	The ICB has a low to moderate appetite for risks that impact on the ability of the ICB to meet the required performance indicators.

Impact Assessments		
Equality Impact Assessment (EIA)	**NO**	Not applicable

Quality Impact Assessment (QIA)	**NO**	Not applicable

Fundamental Purposes of Integrated Care Systems	
Improving population health and healthcare	This report indicates areas which need improvement. ICB teams (and relevant stakeholders) have access to insight from population health management tools and specialists to inform any improvement work.
Tackling unequal outcomes and access	In reviewing areas which need improvement ICB teams (and relevant stakeholders) will have access to further developed population health management tools and specialists to inform any improvement work
Enhancing productivity and value for money	Areas of poor performance are likely to provide poor productivity and value for money. ICB teams (and relevant stakeholders) have access to insight from Model health System, Getting It Right First Time (GIRFT) and other reference cost reports which should inform any new models of care.
Helping the NHS to support broader social and economic development	Partners across the system continue to work together to improve performance including the use of mutual aid where possible and sharing of best practice.

System Working	
System Working Opportunities	Not applicable

Dorset Integrated Care Board Performance Report

1. Introduction

1.1 The purpose of the paper is to provide members with an:

- overview of the performance at end of 2022/23;
- overview of current performance against national operational targets for 2023/24, including exceptions and remedial actions, and;
- update on the developmental work underway for Performance Reporting in 2023/24.

2.0 Report

Performance at end 2022/23

2.1 **Appendix 1** sets out a summary of our performance at the end of March 2023. Over the year we have continued to see an increase in demand for urgent and emergency care services, higher acuity of patients and an increase in the number of patients not meeting the clinical criteria to reside. This has impacted on the performance across the system and although we have not delivered against all the national standards, Dorset has responded well. However, there is more work to do to achieve the level of care and response time experienced before

the pandemic. Key highlights from 2022/23 include:

- reduction in the number of people waiting 104 weeks to zero and significant reduction in those waiting 78weeks. Dorset has also seen some of the highest volumes of activity in the region for day case and first outpatient appointment (Dorset County Hospital NHS Foundation Trust) and inpatients (University Hospitals Dorset NHS Foundation Trust).
- improvement in the uptake of Advice and Guidance (14.6% against a standard of 16% for first Outpatient appointments), and Patient Initiated Follow-Up (7.3% against the target of 5%). Increased virtual outpatient activity which had been in decline since the pandemic and is now at 20%;
- improvement in diagnostic waiting times, continuing to be the second-best performing system in the south west, although key challenge in audiology and echocardiography remain;
- improving position in cancer waiting times targets, although not been achieving all targets, this is withing the context of an increase in referrals of 50% between 2019/20 and 2022/23. Both trusts are on an improving trajectory and will continue to be supported into 2023/24;

- delivered the standards for patients accessing psychological therapies within 6 weeks and for the standard for patients who have experienced a first episode of psychosis receiving a care package within 2 weeks. We have seen a slight improvement in the numbers of people being diagnosed with dementia compared to 2021/22 however we did not deliver against the standard of 66.7%. The new model of care for Dementia continues to be embedded and improvements should therefore be realised in the future;
- a reduction in the number of patients meeting the no criteria to reside since the introduction of the new discharge pathways in March 2023; we expect to see improvement in these targets as we move into 2023/24. However, due to the continued demand, we have not delivered the 4 hour A&E target, ambulance handover delays and category 1 response times.

2023/24 Current Performance

2.2 Early indications of system performance for this year is a continuation of the challenges and trends faced in 2022/23. The system recognises the barriers to achieving national targets with system wide plans in place to ensure we reach the targets. The following section of the report sets out the key exceptions, rationale and plans to recover the position.

Elective Performance

Value Weighted Activity - 109%

2.3 NHS England have set commissioners individual targets for the value-weighted elective activity they are expected to deliver during 2023/24, shown as a proportion of the baseline activity delivered in 2019/20. As members will be aware, the 2023/24 contract is based on fixed and variable (payment by results) payment. The variable element is related to the delivery of elective activity measured against an indictive target of 109%. Current performance for last 4 weeks to 21 May 2023 can be seen in the table below:

	Plan @ May 2023	Total	Day case	Inpatient	First Outpatient	Outpatient follow up
Dorset ICB	110%	104.1%	102.7%	136.9%	103.2%	90.1%
UHD		91.7%	94.1%	110.3%	99.1%	85.1%
DCH		93.7%	109.5%	67.5%	97%	89.7%

(Source data: 7th June SW recovery pack)

2.4 Recovery rates are lower than plan at both system and provider levels. We are currently working through the financial impact of this on our providers and ICB allocation and will continue to work with partners in delivery of their recovery plans as set out in the following sections.

Wating Times

2.5 The table below shows position in current validated performance on 7 June 2023 against the **78 weeks** target of zero by 31 March 2023, reflecting the impact of industrial action in April and some patient choice:

	>78 weeks summary		
Trust	**Performance End June 2023**	**Forecast End July**	**Reason**
Dorset County Hospital (DCH)	1	0	• Procedure cancelled in May due to capacity. Patient unable to attend in July booked in for 3 July 2023
University Hospitals Dorset (UHD)	2	2	• Two remaining (for June and July) due to international shortage of nickel-free implants, expected in August 2023.

Please note data is different to slide 13 within the appendix. The frontis reflects most current verified data.

2.6 The Dorset System has planned to deliver **zero 65 weeks** by 31 March 2024, in line with national planning guidance. Current performance can be seen in the table below, showing both the ICB level and University Hospital Dorset currently off plan and Dorset County Hospital performing better than plan. Both Trusts recognise there are risks to achieving the 65 week wait target due to long waiters in the 78 weeks group and cancer patients.

May 2023			
65 weeks	**Plan**	**Actual**	**Variance (% variance)**
Dorset ICB	1524	1870	-346 (23%)
UHD	1149	1533	-384 (33%)
DCH	375	334	41 (11%)
ISPs	0	3	-3

Please note data is different to slide 14 within the appendix as the frontis reflects most current verified data.

2.7 Work continues to focus on the key specialities to support delivery of the waiting list targets. A reduction in >65 week RTT waits has been delivered in May alongside a reduction of 7,622 from the cohort of patients 'at risk' of breaching 65 weeks by March 2024.

The 65 week forecasting at specialty level is currently underway at DCH and has been completed at UHD. UHD forecasting shows 1242 patients are breaching 65 weeks at the end of May 2023. This is 93 above plan, reflecting the impact of industrial action in April 2023 and an additional bank holiday in May 2023. Consistent progress is being made on reducing the 65 week 'at risk' cohort, with this group reducing to below 30,000 this month.

2.8 As set out in previous reports our overall performance continues to be negatively impacted by operational pressures, the planned Junior Doctor Industrial Action in June is likely to further impact our performance. To manage patients during this time, both Trusts are not booking appointments more than a few weeks ahead in some specialties.

2.9 Despite progress made with the 'long waiters', the total waiting list in Dorset continues to grow. An initial analysis of GP referrals has shown a small amount of growth over the last four years, which has increased in recent months, to levels above the position pre-covid. Variation in referrals exists between Trusts, with DCH seeing growth in referrals for Dermatology and Ear, Nose and Throat and UHD seeing a growth in Gynaecology. However, both trusts are seeing growth in Cardiology and a reduction in Ophthalmology referrals (although referrals have increased in ISP particularly for cataract activity). There has been little change for Orthopaedic referrals at DCH, but a reduction has been seen in UHD.

2.10 As with the acute providers actions to improve the status of our waiting include:

- validation of referrals at Primary Care Network (PCN) level, including identification of highest referrers;
- utilising Advice and Guidance to reduce need for referral;
- development of Evidenced Based Interventions (EBIs) which set out clear referral criteria;
- reviewing MSK triage process for all referrals to ensure all EBIs are being followed;
- working with primary care to find the best way of ensuring GPs are only referring patients that meet the criteria.

2.11 Following the publication of the Elective Care Recovery 2023/24 Priorities letter (**Appendix 3**) we have reviewed the current position in Dorset and are developing plans to accelerate Children and Young People (CYP) recovery to reduce the gap between children and young people and adults elective recovery. Work has already been undertaken to support UHD dental surgery waiting lists by running weekend surgical lists for the long waiters through insourcing and UHD have outsourced 50 autism assessments through national funding. Our current elective recovery position for CYP, at the week ending 14 May 2023 was:

- 45.5% inpatients which is lower than the regional average of 111.3%;
- 171.4% day case is significantly higher than regional average (99.5%) reflecting the move to more day case activity where appropriate;
- 123.7% first outpatient attendance, higher than regional average (97.2%);
- 62.6% follow-up outpatient attendance activity is lower than regional average (87.2%), reflecting the target to reduce follow-ups.

2.12 Improvement Plans are in development and by the end of quarter 1 2023/24 we will have:

- developed and agreed approaches and models/ ways of working that can increase elective activity and reduce waiting times';
- agreed trajectories for recovery for each trust and speciality;
- developed and implemented monitoring processes to measure progress and impact;
- identified opportunities for supporting CYP and their families while they are waiting.

Diagnostics

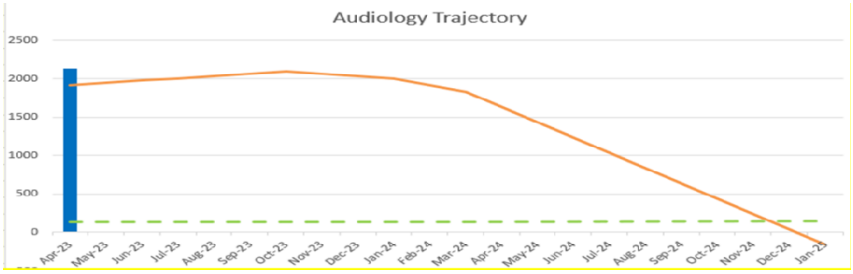
2.13 Overall diagnostic activity is performing to plan, with an overall improvement from 15.9% waiting over 6 weeks in April 2023 to 15.7% at 21 May 2023 (unvalidated position). There was a further reduction in patients waiting over 26 weeks from 206 as of 21 May 2023, compared to 295 at the end of April 2023. There continue to be concerns within the following modalities:

- **Audiology** –we are still not achieving the target of 25% of patients waiting 6+ weeks for a diagnostic test and performance has declined this month from 66% to 68% waiting 6+ weeks (community) and 28% in acutes. The plans for creating one Audiology service have been shared and sets out timetable for additional transfer and recruitment staff (33% vacant post currently) by September 2023 and consolidation of audiology on the Weymouth Community Hospital site, provision of additional capacity from Community

Diagnostic Centre (CDC) from the middle of 2023/24 and phased implementation of new clinical system- east county July 2023, West – Autumn 2023.

The recovery trajectory can be seen below, showing no significant reduction in waits expected until the next financial year. However, Dorset Health Care (DHC) are currently working on a combined recovery trajectory with capacity for both DCH and DHC. The trajectory accounts for recruitment, phased changes in staff skill mix. If recruitment is successful and the service is fully established, then recovery is expected by November 2024.

We are in discussion with DHCFT to challenge the recovery plan as we do not feel the recovery date is appropriate.



- **Echocardiography** – system performance continues to be above plan at 53.8% (no more than 25% of patients should wait over 6weeks). UHD's are performing well at 10.1%, however DCH is still below target at 71.4%. The planned recovery trajectory has been revised and recovery is now expected by October 2023 (previously March 2024).

  This will be achieved through creation of the addition ECHO room at DCH providing additional capacity and further insourcing commencing in June 2023. Recruitment plans are also in place including overseas recruitment, level 4 apprenticeship posts and utilising locum staff.

Cancer

2.14 There has been a continued improvement in delivery of the Faster Diagnosis Standard (FDS) with both Trusts meeting the target of 75% of patients receiving a diagnosis or ruling out of cancer within 28 days for March 2023 (DCH at 80% and UHD 75.7%) following work undertaken to reduce backlogs and reform services to improve efficiency.

2.15 The Cancer Recovery Plan is in place which addresses the pressured tumour sites of Colorectal, Gynaecology, upper GI, and Urology. The new Faecal Immunochemical Test (FIT) lower GI 2 week wait criteria has appropriately reduced referrals enabling the Colorectal services to recover. It is worth noting that there is a risk to the sustained recovery at UHD due to Urology Local Anaesthetic template biopsy capacity due to lead clinician vacancy, however the service is planning to be transitioned to be nurse-led to increase this capacity. It is expected that sustained recovery at DCH is anticipated by December 2023. Performance will be supported through waiting list initiatives funded by the Wessex Cancer Alliance for Q1 whilst the benefits of the high priority actions within the system-wide recovery plan are realised, with particular focus on Gynaecology.

2.16 The 62-day backlog system target of 290 has not been achieved in April with 337 patients in this backlog. DCH achieved their target of 70 with 60 patients waiting, and UHD did not achieve their target of 220 with 279 patients waiting. Industrial action has impacted on capacity and in turn the backlog together with the current issues within the specialities mentioned as the focus of the Recovery Plan for the FDS. In addition, there has been a delay in implementing the Post Menopausal Bleeding clinics due to funding for the Community Diagnostic Centres not being agreed by NHS England yet. This will have a positive impact once agreed and recruitment can take place to run the clinics.

Urgent and Emergency Care

2.17 The target for Emergency Department (ED) Performance is 76% of patients seen within 4 hours and this is currently not being achieved. DCH reports 69.8% in April the unverified data for May is 62.2% and UHD figures show an average of 54.8% for May. High attendance rates and high acuity presentations at ED and with limited flow due to the high numbers of No Criteria to Reside patients means patients are being held in ED longer than desired. Oversight of this is through the Tactical Resilience Group (TRG) and ED performance will be scrutinised at the quarterly performance meetings and actions will be set as required.

2.18 There has been a reduction in the number of 12-hour breaches in EDs across the system in April compared to previous months with DCH only reporting 3. UHD reports a reduction to 169, which remains above average and within levels seen during Winter. The TRG has oversight of 12-hour ED breaches and issues are escalated via resilience alerts. Work continues to transform community and urgent and emergency care to prevent inappropriate attendance at emergency departments and improve timely admission to hospital for ED patients using Virtual wards, Urgent Community Response and Same Day Emergency Care.

2.19 In May the average Category 2 Ambulance response time in Dorset was 30mins meeting the national standard of 30 mins South Western Ambulance Service Foundation Trust (SWAST) 37mins). We are committed to continue to deliver this target by March 2024, and address the actions described in last month's report including the need to reduce handover times to an average of 40 mins each. Please note data is different to slide 25 within the appendix as the frontis reflects most current unverified data.

2.20 The numbers of patients with No Criteria to Reside (NCTR) continue to fluctuate with evidence of some improvements at both UHD sites with a total of 251 patients as on 31 May 2023 (62 DCH, 87 Poole Hospital, 102 Bournemouth Hospital) no longer meeting the criteria to reside. Although there is no statutory target, our system target is to deliver at least a 30% reduction by end June 2023- System 243.6, UHD 168.7, DCH 51.8.

2.21 There has been an improvement seen on actual performance against plan with DCH achieving a daily average of 45 (below target) and UHD achieving a daily average of 179 (above target) with an overall achievement in total delivery in line with the 30% reduction.

Performance Reporting 2023/24

2.22 We have completed the actions set out in the previous report and have developed the draft performance framework and new performance dashboards these are being tested with partners. As part of this work a local training programme for all teams has been developed and will be implemented during June/ July 2023.

3. Conclusion

3.1 The Committee is asked to **note** the updates and next steps set out in the report.

Author's name and title: S. Charles, Head of Performance and Contracts
Date: 9 June 2023

APPENDICES	
Appendix 1	**2022/23 End of Year Performance**
Appendix 2	**Integrated Care Board Performance Report June 2023 FINAL**
Appendix 3	**Elective Recovery Priorities 2023/24**

Appendix 1

2022/23 End of Year Performance

The table below sets out our performance at end of March 2023 against key national operational plan standards.

ICB based indicators	Operational standard	2022/23	2021/22	2020/21
Patients on incomplete non-emergency pathways (yet to start treatment) waiting no more than 18 weeks from referral	92%	54.89%	60.50%	
Patients on incomplete non-emergency pathways (yet to start treatment) waiting no more than 104 weeks from referral - 0 by June 2022	0	0	484	14
Patients on incomplete non-emergency pathways (yet to start treatment) waiting no more than 78 weeks from referral - 0 by March 2023	0	116	1241	
Patients on incomplete non-emergency pathways (yet to start treatment) waiting no more than 52 weeks from referral - 0 by March 2025		5231	4309	8897
Clock stops at 89% or better of 19/20 equivalent	89%	99.70%	88.60%	84.00%
Advice and Guidance rate as per 100 first Outpatients Attendances	16	14.6	7.7	9.9
Patient Intiated Follow Ups as percentage of Total Outpatient Attendances	5%	7.30%	1.40%	1.10%
Outpatient virtual activity	25%	20.80%	22.90%	28.90%
Percentage of patients waiting 6 weeks or more for a diagnostic test (15 key tests)	1% (Regional ambition 25%)	14.80%	16.20%	
Maximum two-week wait for first outpatient appointment for patients referred urgently for suspected cancer by a GP	93%	55.20%	64.30%	81%
Maximum 31-day wait from diagnosis to first definitive treatments for all cancers	96%	96.10%	97.70%	93%
Maximum 62-day wait from urgent GP referral to first definitive treatment for cancer	85%	66.70%	72.90%	60%
60% of people experiencing a first episode of psychosis will commence treatment with a NICE approved care package within two weeks of referral	60%	84.00%	91.30%	100%
75% of people with common mental health conditions referred to the improved access to psychological therapies (IAPT) programme will be treated within six weeks of referral	75%	96.00%	97%	98%

66.7% of dementia diagnosis of the estimated number of people with dementia	66.70%	56.00%	55.70%	56%
A&E waits – percentage of A&E attendances where the patient spent 4 hours or less in A&E from arrival to transfer, admission of discharge: Dorset County Hospital NHS FT	95%	73.90%	65.70%	81.00%
NCTR: Percentage of beds occupied		27.70%		
NHS 111 service: South Western Ambulance Service NHS FT: calls answered in 60 seconds	95%	86.6%	48.20%	88.0%
NHS 999 service: South Western Ambulance Service NHS FT: Category 1 mean response duration	7 mins	8.5 mins	12.3 mins	7.3 mins

NHS Dorset

Integrated Care Board Performance Report

June 2023

Version: 01 Date: 05/04/2023

NHS Dorset

Contents

Service Delivery Performance Scorecards

1.0 Service Delivery Scorecard – Elective Performance

Referral to Treatment

Provider	Dorset ICB					DCH					UHD				
Metric Name	Latest Date	Value	Target	Variation	Assurance	Latest Date	Value	Target	Variation	Assurance	Latest Date	Value	Target	Variation	Assurance
Referral to Treatment: Total Waiting	Apr 23	94910	96725			Apr 23	20353	20371			Apr 23	74557	74886		
Referral to Treatment: 65+ Week Wait	Apr 23	1474	1702			Apr 23	225	409			Apr 23	1249	1268		
Referral to Treatment: 52+ Week Wait	Apr 23	5509	4903			Apr 23	1129	1248			Apr 23	4380	4054		

Diagnostics

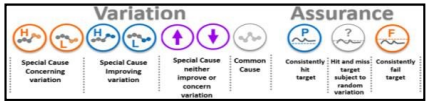
Provider	Dorset ICB					DCH					UHD				
Metric Name	Latest Date	Value	Target	Variation	Assurance	Latest Date	Value	Target	Variation	Assurance	Latest Date	Value	Target	Variation	Assurance
Diagnostic Performance >6 Week Wait	Apr 23	15%	25%			Apr 23	32.9%	25%			Apr 23	8.4%	25%		
Diagnostic Recovery	Mar 23	148%	120%			Mar 23	148%	120%			Mar 23	148%	120%		
Diagnostic Total Waiting List	Mar 23	16988				Mar 23	5093				Mar 23	11895			

Outpatient Transformation

Provider	Dorset ICB					DCH					UHD				
Metric Name	Latest Date	Value	Target	Variation	Assurance	Latest Date	Value	Target	Variation	Assurance	Latest Date	Value	Target	Variation	Assurance
Advice & Guidance Utilisation Rate	Feb 23	13	11												
Outpatient Consultations - Virtual	Mar 23	20.8%	25%			Mar 23	21.1%	25%			Mar 23	20.7%	25%		
Patient Initiated Follow Up - Moved / Discharged Rate	Mar 23	7.36%	4.39%			Mar 23	5.19%	5.00%			Mar 23	8.45%	5.00%		

Cancer

Provider	Dorset ICB					DCH					UHD				
Metric Name	Latest Date	Value	Target	Variation	Assurance	Latest Date	Value	Target	Variation	Assurance	Latest Date	Value	Target	Variation	Assurance
Number of patients waiting <31 days to treatment	Mar 23	96.1%	96%			Mar 23	98.5%	96%			Mar 23	97.1%	96%		
Number of patients waiting <62 days to 1st definitive?treatment	Mar 23	66.7%	85%			Mar 23	73.1%	85%			Mar 23	65.4%	85%		
104 days backstop	Apr 23	77				Apr 23	15				Apr 23	65			
2 ww referrals	Mar 23	3984													
62 day?backlog	Apr 23	337	290			Apr 23	60	290			Apr 23	279	290		
Cancer Faster Diagnosis Standard	Mar 23	76.7%	75%			Mar 23	80%	75%			Mar 23	75.7%	75%		



Elective Recovery – Waiting List >78 Weeks
Elective Recovery – Waiting List >65 Weeks
Elective Recovery –Total Waiting List

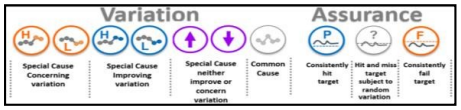
Elective Recovery – Cancer – Faster Diagnostics Standard 28 Days
Elective Recovery – Number of Patients Waiting <62 days to 1st Definitive Treatment
Elective Recovery – Cancer –62 day backlog

NHS Dorset

2.0 Service Delivery Scorecard – Elective Diagnostics

Diagnostics Performance by Modality

Provider	Dorset ICB					DCH					UHD				
Modality	Latest Date	Value	Target	Variation	Assurance	Latest Date	Value	Target	Variation	Assurance	Latest Date	Value	Target	Variation	Assurance
Audiology - Audiology Assessments	Mar 23	27.9%	25%			Mar 23	27.9%	25%			Mar 23	0%	25%		
Cardiology - Echocardiography	Apr 23	53.8%	25%			Apr 23	71.4%	25%			Apr 23	10.1%	25%		
Colonoscopy	Apr 23	27.9%	25%			Apr 23	21%	25%			Apr 23	30.1%	25%		
Computed Tomography	Apr 23	5.29%	25%			Apr 23	6.90%	25%			Apr 23	4.67%	25%		
Cystoscopy	Apr 23	20.7%	25%			Apr 23	3.28%	25%			Apr 23	28.2%	25%		
DEXA Scan	Apr 23	0.122%	25%			Apr 23	0.446%	25%			Apr 23	0%	25%		
Flexi Sigmoidoscopy	Apr 23	30.9%	25%			Apr 23	6.38%	25%			Apr 23	34.8%	25%		
Gastroscopy	Apr 23	22.4%	25%			Apr 23	17.4%	25%			Apr 23	23.9%	25%		
Magnetic Resonance Imaging	Apr 23	3.71%	25%			Apr 23	4.31%	25%			Apr 23	3.63%	25%		
Neurophysiology	Apr 23	5.61%	25%			Apr 23	0.667%	25%			Apr 23	6.93%	25%		
Non-obstetric Ultrasound	Apr 23	3.64%	25%			Apr 23	0%	25%			Apr 23	4.22%	25%		
Respiratory physiology	Apr 23	19.3%	25%			Apr 23	0%	25%			Apr 23	32.2%	25%		
Urodynamics - Pressures & Flows	Apr 23	33.3%	25%			Apr 23	33.3%	25%			Mar 23	0%	25%		

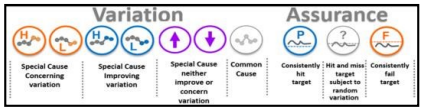


Elective Recovery – Audiology Waiting Times
Elective Recovery – Echocardiography Waiting Times & Activity Performance

3.0 Service Delivery Scorecard – Urgent & Emergency Care

Urgent Care Access

Provider	Dorset ICB					DCH					UHD				
Metric Name	Latest Date	Value	Target	Variation	Assurance	Latest Date	Value	Target	Variation	Assurance	Latest Date	Value	Target	Variation	Assurance
12 hour breaches (Emergency Department)	Apr 23	172				Apr 23	3				Apr 23	169			
Wait to be seen time within 4 hours	Apr 23	69.8%	76%			Apr 23	69.8%	76%							
Adult general and acute type 1 bed occupancy (Daily)	Apr 23	93.5%	96.7%			Apr 23	90.3%	92.1%			Apr 23	94.4%	98.1%		
A&E attendances V 19/20 actual - Month	Apr 23	17018				Apr 23	4397				Apr 23	12621			
No criteria to reside % of beds occupied (Daily)	Apr 23	22.7%				Apr 23	19.9%				Apr 23	23.6%			
No criteria to reside (NCTR) number of patients (Daily)	Apr 23	292				Apr 23	56				Apr 23	235			
Non-Elective (Type 1) Admissions v 19/20 actual - Month	Apr 23	5300				Apr 23	1567				Apr 23	3733			

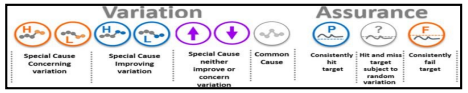


3.1 Urgent & Emergency Care – Exception Report – 12 Hour Breaches
3.2 Urgent & Emergency Care – Exception Report – No Criteria to Reside
3.3 Urgent & Emergency Care – Exception Report – ED Performance

3.0 Service Delivery Scorecard – Urgent & Emergency Care

Urgent Care Compliance

Provider	Dorset ICB					DCH					UHD					SWASFT				
Metric Name	Latest Date	Value	Target	Variation	Assurance	Latest Date	Value	Target	Variation	Assurance	Latest Date	Value	Target	Variation	Assurance	Latest Date	Value	Target	Variation	Assurance
111 Call abandonment (Dorset HealthCare)	Mar 23	0.63%	2%																	
111 Call Answering within 60 secs (%)	Mar 23	86.6%	95%																	
% of 111 calls reaching ED disposition - booked appointment	Mar 23	79.2%	70%																	
% calls where booked GP Practice/Access Hub	Mar 23	53.7%	75%																	
% calls booked into SDEC	Mar 23	0%																		
% calls where caller recommended self-care	Mar 23	4.7%	15%																	
% calls booked into a UTC	Mar 23	88.3%	70%																	
Mean 999 Call answering times (Minutes/Seconds)	Apr 23	2																		
Handovers taking 15 minutes or less (%)	Apr 23	47.5%	65%			Apr 23	80.6%	65%			Apr 23	35.7%	65%							
Handovers taking 1hr or more (%)	Apr 23	13%	0%			Apr 23	0.2%	0%			Apr 23	17.6%	0%							
Handovers taking 30 minutes or less (%)	Apr 23	72.8%	95%			Apr 23	96.5%	95%			Apr 23	64.2%	95%							
Average Hours Lost to ambulance handover delays per handover (Hours)	Apr 23	14:52				Apr 23	04:19				Apr 23	18:43				Apr 23	18:43			
Total Hours lost to ambulance handover delays (month)	Apr 23	2324				Apr 23	39.4				Apr 23	2,285								
% of calls reaching ED disposition that are validated	Mar 23	74.6%	50%																	
Category 1 90th Percentile Response Times	Apr 23	14.7	15																	
Category 1 Ambulance Response Times (Minutes)	Apr 23	7.8	7																	
Category 2 90th Percentile Response Times	Apr 23	55.1	40													Apr 23	71.3	40		
Category 2 Ambulance Response Times (Minutes)	Apr 23	26.6	18													Apr 23	33.4	18		
Category 3 Mean 90th Percentile Response Times	Apr 23	181	120																	
Category 3 Mean Percentile Response Times	Apr 23	74.7	60																	
% of category 3 and 4 calls which are downgraded	Mar 23	71.3%																		
% of category 3 and 4 calls which are upgraded	Mar 23	3%																		
% of category 3 and 4 calls which are validated (in 30 Minutes)	Mar 23	61.4%																		



3.0 Service Delivery Scorecard – Urgent & Emergency Care

3.4 Urgent & Emergency Care – Exception Report – Category 2 Ambulance Response Times

NHS Dorset

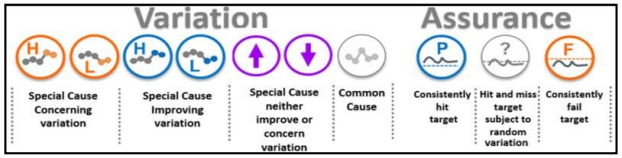
4.0 Service Delivery Scorecard – Mental Health

Mental Health - Access

Provider	Dorset ICB				
Metric Name	Latest Date	Value	Target	Variation	Assurance
CAMHS Gateway < 4 Weeks (28 days)	Apr 23	8%	95%		
Adult CMHT RTA < 28 Days	Apr 23	60%	95%		
OP CMHT RTA < 28 Days	Apr 23	94%	95%		
Children & Young People: Access (1+ Contact)	Apr 23	5625	7813		
Children & Young People: Routine Access to Eating Disorders < 4 weeks	Apr 23	7%	95%		
Children & Young People: Urgent Access to Eating Disorders < 1 week	Apr 23	100%	95%		
Early Intervention in Psychosis Access	Apr 23	78%	60%		
IAPT Waiting Times < 18 weeks	Apr 23	100%	95%		
IAPT Waiting Times < 6 weeks	Apr 23	97%	75%		
IAPT Access	Apr 23	5%			
IAPT Recovery Rate	Apr 23	51%	50%		
Perinatal Access (12 months rolling)	Apr 23	530	714		

Mental Health - Indicators

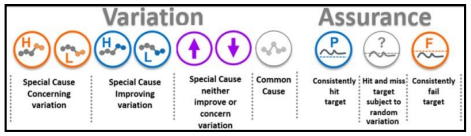
Provider	Dorset ICB				
Metric Name	Latest Date	Value	Target	Variation	Assurance
Adult Acute Bed Occupancy %	Apr 23	95%			
Dementia Diagnosis Rate	Mar 23	56%	66.7%		
Learning disability inpatients: Adult	Apr 23	20	21		
Learning diasability inpatients: Children & Young People	Apr 23	5	1		
Adult Acute Out of Area Placement (occupied bed days)	Apr 23	380			
Adult Acute Out of Area Placement number	Apr 23	7	0		
Perinatal Access (12 months rolling)	Apr 23	530	714		
Mental Health Referrals (MH and LD)	Apr 23	5774			
Serious Mental Illness: Physical Health Checks	Apr 23	59%	60%		



5.0 Primary Care

Primary Care

Provider	Dorset ICB				
Metric Name	Latest Date	Value	Target	Variation	Assurance
Total Primary Care Appointments	Apr 23	370165			
% Urgent appointments	Apr 23	38.4%			
% Face to Face appointments	Apr 23	79.8%			
% Did not attend	Apr 23	3.23%			



Report Front Sheet

1. Report Details			
Meeting Title:	Board of Directors, Part 1		
Date of Meeting:	26 July 2023		
Document Title:	Elective Care Priorities letter- Board checklist		
Responsible Director:	Anita Thomas, Chief Operating Officer	Date of Executive Approval	12/07/2023
Author:	Adam Savin, Director of Operational Planning and Performance		
Confidentiality:	Non-confidential		
Publishable under FOI?	Yes		
Predetermined Report Format?	No		

2. Prior Discussion		
Job Title or Meeting Title	**Date**	**Recommendations/Comments**
Anita Thomas, Chief Operating Officer	12/07/2023	Approved to submit- AS on behalf of AT
Finance and Performance Committee	17/07/2023	Noted

3. Purpose of the Paper	DCH received a letter from NHS England dated the 23rd of May 2023, which reconfirmed the Elective Care Priorities for secondary care, as set out in the 2023/24 Planning Guidance. There was no required for a response to the letter however, there was a checklist that NHSE required Boards to review. This paper and appendices contain the response statements to each of the 24 assurance questions.							
	Note (✓)	✓	*Discuss (✓)*	✓	*Recommend (✓)*		*Approve (✓)*	
4. Executive Summary	The Board checklist posed 24 assurance statements, of which DCH is fully compliant with 11. A further 11 assurance statements have been rag rated amber and are partially complaint. Two assurance statements that have been rag rated as red and require urgent attention.							
5. Action recommended	a) The two assurance statements that are red, and the actions set b) To acknowledge that the checklist has been completed and there is governance in place to monitor compliance against it c) A quarterly report will be produced for FPC to track progress, with the next one due in November 2023							

6. Governance and Compliance Obligations				
Legal / Regulatory Link		**Yes**		*Response to the NHSE Elective care 2023/24 priorities letter, dated 23rd May 2023*
Impact on CQC Standards		**Yes**		*Safe, effective, responsive*
Risk Link		**Yes**		*Quality, patient experience and clinical outcome risks associated with under performance of both elective standards*
Impact on Social Value			**No**	*Standard reporting paper on operational performance*
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	N/A- response to NHSE assurance statements		
	Place	N/A- response to NHSE assurance statements		
	Partnership	N/A- response to NHSE assurance statements		
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**	**No**	N/A- response to NHSE assurance statements
Tackling unequal outcomes and access		**Yes**	**No**	N/A- response to NHSE assurance statements
Enhancing productivity and value for money		**Yes**	**No**	N/A- response to NHSE assurance statements
Helping the NHS to support broader social and economic development		**Yes**	**No**	N/A- response to NHSE assurance statements
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- response to NHSE assurance statements
Quality Impact Assessment (QIA)		**Yes**	**No**	N/A- response to NHSE assurance statements

Title of Meeting	**Finance and Performance Committee (FPC)**
Date of Meeting	**17th July 2023**
Report Title	**Elective Priorities 2023/24- Board check list**
Author	**Adam Savin, Director of Operational Planning and Performance**
Responsible Executive	**Anita Thomas, Chief Operating Officer**

1) Introduction

In May 2023, DCH received a letter from NHS England which reconfirmed the Elective Care Priorities for secondary care, as set out in the 2023/24 Planning Guidance. The letter did not require a response, but did include a Board checklist with the following ask:

The checklist, a response statement and identified actions, can be found in the appendices of this summary paper. Each of the assurance questions/ checklist items has been rag rated in the following way:

Green- Fully compliant, with no action required but continued monitoring
Amber- Partially compliant, with actions identified to move to fully compliant
Red- Not complaint or off track and an area of concern

2) Summary of checklist findings

The Board checklist posed 24 assurance statements, of which DCH is fully compliant with 11. These 11 will continue to be monitored via the Elective Performance Management Group (EPMG) to ensure compliance is maintained throughout the year. A further 11 assurance statements have been rag rated amber and are partially complaint. Some of the actions set are exploratory or require further detailed proposals. All of them have a due date and an owner, who is required to submit the findings of any investigative actions or completed proposals to EMPG. There are two assurance statements that have been rag rated as red, full details of these can be found in section 3.

3) Red raged assurance statements- the detail

Assurance statement 5.1, “Is there agreement between the Trust, ICB and Cancer Alliance on how best to ensure newly opening CDC capacity can support 62-day backlog reductions and FDS performance?” has been rag rated as red.

There is currently no agreement on how the CDC capacity in West Dorset will support the 62-day cancer backlog. With some of the Weymouth activity already online and the trusts 62-day cancer backlog growing and off trajectory, this means without such an agreement, patients will not be accessing the available capacity within clinical priority order. It should be noted that an increase of diagnostic capacity, indirectly supports the cancer agenda, as it releases capacity which can be ringfenced for urgent suspected cancer referrals.

The Dorset Cancer Partnership (DCP) operational group has been discussing this for many months, with it being a standard agenda item on the fortnightly meetings. The Dorset lead for the CDC programme is a member of this group and actively involved in the discussions. That withstanding, an action has been set to escalate the matter to the DCP steering group.

Assurance statement 5.7 “Where is the trust/system against the standards of 85% capped Theatre Utilisation and 85% day case rate?” has been rag rated as red.

As part of the 2023/24 planning round, DCH committed to a trajectory that delivered the 85% theatre utilisation target by June 2023. Improvements have been made, but it continues to fluctuate and remains significantly below the target. This is contributing to the under delivery of elective activity, which while performance trajectories are being achieved, the under delivery of activity will have a financial consequence for the Dorset system. Furthermore, there is a data discrepancy between the nationally reported theatre utilisation at DCH and internal reporting systems.

The Family and Surgical Division have been developing a recovery plan, at specialty level which is due to be presented to EPMG on at the end of July. The recovery plan will have a supporting trajectory and all theatre utilisation data is being converted to SPC charts.

4) Recommendations and to note:

The finance and performance committee are asked to note the following:

a) The two assurance statements that are red, and the actions set
b) To acknowledge that the checklist has been completed and there is governance in place to monitor compliance against it
c) A quarterly report will be produced for FPC to track progress, with the next one due in November 2023

Ref	Assurance question/ checklist	Response statement	Identified action required	Owner of action
1.0	Has any patient waiting over 26 weeks on an RTT pathway (as at 31 March 2023) not been validated in the previous 12 weeks? Has the 'Date of Last PAS validation' been recorded within the Waiting List Minimum Data Set?	Automated report has been created, which shows in real time the patients that require validation. As at the 31st March 2023, all patients over 52 weeks had been validated, but the trust had not achieved the ask getting to week 26. A trajectory to get to week 26 had been set, with delivery by the end of August, however due to team sickness, this has been pushed to September. Performance against this trajectory is monitored via EPMG.	Delivery is off track, recent sickness has resulted in recent gains being lost. Business case needs developing to increase the validation team on a fixed term basis, this is due at the end of July.	Alison Roberts
1.1	Are referrals for any Evidence Based Interventions still being made to the waiting list? Release 3 will be published on 28 May. It focuses on the following specialties: breast surgery, ophthalmology, vascular, upper gastrointestinal surgery, cardiology, urology, and paediatric urology	The Dorset system had a process to monitor and control EBI's pre COVID, however since COVID, Dorset has had a growing volume of EBI procedures being completed, especially in Dermatology and Orthopaedics. A working group, reporting to ECOG has been established with representation from all trusts and the commissioner within Dorset, but in the early stages of developing an action plan. An internal deep dive into the data is underway, as the way procedures are being listed, is suspected to be driving some of the data anomalies.	Internal recovery plan to be developed and working on the system action plan. Urgent review of all cases still on the WL, with an agreed decision matrix to guide decision making to either complete the procedure due to length of wait or remove from the waiting list. A proposal is due Aug.	Alison Roberts
2.0	Are plans in place to virtually eliminate RTT waits of over 104w and 78w (if applicable in your organisation)?	104-week waits have been eliminated. 78-week waits have been eliminated apart from patient choice and where there is a national shortage of orthopaedic kit. The number of patients waiting over 78+ weeks remains below 10.	Monitoring to continue via EPMG.	Alison Roberts
2.1	Do your plans support the national ambition to virtually eliminate RTT waits of over 65 weeks by March 2024?	DCH operating plan delivers zero, 65+ week waiters by March 2024. The trust is tracking ahead of plan at the end of quarter 1.	Monitoring to continue via EPMG.	Alison Roberts
3.0	Are clear system plans in place to achieve 25% OPFU reduction, enabling more outpatient first activity to take place?	Activity reporting and detailed outpatient metrics, such as the new to follow up ratio are all automated and available at speciality level. The Outpatient Transformation group is reviewing all clinic templates to ensure that the reduction in follow up activity, is converted to new OPA's. Year to date, follow ups are 87% of the 2019/20 baseline which is 2% above the target however, DCH is 98.69% against the operating plan for follow ups. A slightly higher activity plan was agreed by NHSE and NHS Dorset, to address our follow up backlog.	Monitoring to continue via EPMG.	Kirsty Owen
3.1	Do you validate and book patients in for their appointments well ahead of time, focussing on completing first outpatient appointments in a timely way, to support with diagnostic flow and treatment pathways?	Regular non admitted PTL meetings are held, with an agenda item covering those patients waiting of diagnostics and how they the DM01 clock has interdependencies with the RTT clock. The trust is also returning all services back to directly bookable, which means patients can book their own appointments, via the national E-Referrals system. This also means booking in all the outpatient waiting list, so new referrals don't jump the queue and are shown dates that are the next available once all other patients have been appointed. The unused slot report has been pushed out to 12 weeks, with anything under this considered short notice booking. PAU is currently a bottle neck though.	Additional capacity required for PAU, to clear the backlog and create a pool of fit patients. Funding ringfenced via the elective recovery pot and weekend clinics have been booked.	Alison Carless
4.0	Where is the trust against full implementation of FIT testing in primary care in line with BSG/ACPGBI guidance, and the stepping down of FIT negative (<10) patients who have a normal examination and full blood count from the urgent colorectal cancer pathway in secondary care?	The FIT <10 pathway has been in operation since Jan-23, there have been issues within primary care, referring before the FIT results are back however these have been escalated to DCP / NHS Dorset. Despite this any patient referred on a 2ww LGI pathway when their FIT result is back if they are <10 then they are transferred over to the safety netting pathway. DCH is fully compliant with this ask.	Monitoring to continue via EPMG.	Nicci Tucker
4.1	Where is the trust against full roll-out of teledermatology?	DCH has now completed a successful test of ingesting pictures from e-RS into the Digital Patient Record. This gives DCH the technical functionality to take advice and guidance requests, with pictures, to complete an initial triage prior to accepting the referral. This allows for roll out of teledermatology in a way that works for the clinicians. No timeframe has been set for this, as the full elective digital transformation programme is going through prioritisation, to ensure the limited resource the Trust has, is focused on the areas of biggest impact.	Project proposal to be developed to implement teledermatology now the technology is in place. Due October.	Kirsty Owen
4.2	Where is the trust against full implementation of sufficient mpMRI and biopsy capacity to meet the best practice timed pathway for prostate pathways?	All patients on the prostate pathway have an mpMRI prior to biopsy - unless there are clinical contraindications regarding suitability for MRI. Where capacity permits, patients do have the biopsy by day 9, having had the MRI however, DCH is not fully compliant with this.	Report to be built to measure time from MRI to biopsy, with actions to address findings. Due Aug.	Nicci Tucker
5.0	Are clear system plans in place to prioritise existing diagnostic capacity for urgent suspected cancer activity?	Diagnostic capacity, for urgent suspect cancer cases is ringfenced within the diagnostic services. Where demand exceeds the ring fenced capacity, routine patients are displaced to accommodate those that are clinically urgent. Escalation processes are in place, where diagnostic activity is booked too far out, risking delivery of the 28 day faster to diagnosis standard.	Monitoring to continue via EPMG.	Julia Morris
5.1	Is there agreement between the Trust, ICB and Cancer Alliance on how best to ensure newly opening CDC capacity can support 62 day backlog reductions and FDS performance?	This is a reoccurring agenda item on the Dorset Cancer Services Coordinating group. It continues to be a topic of discussion but there is no firm commitment that any of the newly created CDC capacity will be used to support cancer patients, in the West of Dorset.	Escalation of concern to DCP steering group, as operational group have not been able to reach an agreement. Due July.	Nicci Tucker
5.2	How does the Trust compare to the benchmark of a 10-day turnaround from referral to test for all urgent suspected cancer diagnostics?	The trust reports against the standard of time between request for tests and the completion of test, for which DCH achieves 85% in 10 days, as most cancer pathways are straight to test. The trust does not currently report on the time between referral received and testing, but this is included within the 28-day standard.	Report to be built to measure time from referral to diagnostic test being completed. Due Aug.	Nicci Tucker

5.3	Are plans in place to implement a system of early screening, risk assessment and health optimisation for anyone waiting for inpatient surgery?	In accordance with the planning guidance ask, the Royal College of Surgeons guidelines and the trusts Patient Access Policy, patients should be reviewed once every 3 months, this can be virtually. The review date is captured on PAS and reported to NHSE as part of the national minimum data set. While the reporting mechanisms are in place, compliance with this is not robust across the trust, which is evidenced in the trusts cancellation data. The Trust has also launched a waiting well campaign, which directs patients to a host of information, including health optimisation videos (hosted by NHS Dorset) that can be viewed from home. The Trust is also partnered with Dorset Live Well, to support patients while waiting for surgery and optimising their health prior to admission.	A review of patients every 3 months on the admitted waiting list, is not robust in all specialities, nor is there a consistent approach to a review. A review of the full validation life cycle is required, due Nov.	Nicci Tucker
5.4	Are patients supported to optimise their health where they are not yet fit for surgery?	Where patients are deemed not fit to proceed with surgery, patients are either referred into services with a secondary care setting, such as Cardiology or diabetes to be supported. In some cases, patients are referred to their GPs if the trust is unable to offer the services required. Patients are booked a follow out outpatient appointment, where they will be re-assessed after a period of time, with a view to readd to the waiting list. Sign posting to other NHS services and life style advice will also be provided, where appropriate.	Monitoring to continue via EPMG.	Alison Carless
5.6	Are the core five requirements for all patients waiting for inpatient surgery by 31 March 2024 being met? 1. Patients should be screened for perioperative risk factors as early as possible in their pathway. 2. Patients identified through screening as having perioperative risk factors should receive proactive, personalised support to optimise their health before surgery. 3. All patients waiting for inpatient procedures should be contacted by their provider at least every three months. 4. Patients waiting for inpatient procedures should only be given a date to come in for surgery after they have had a preliminary perioperative screening assessment and been confirmed as fit or ready for surgery. 5. Patients must be involved in shared decision-making conversations.	1. Yes 2. Any patients who have perioperative risk factors that are highlighted to the admissions team would be sent for pre assessment early to allow for work up. 3. This is not consistently achieved for specialities with longer waiting times. 4. This is met when clinically appropriate. 5. Patients would be offered follow up telephone appointments / consultations where necessary.	See 5.3 action	Nicci Tucker
5.7	Where is the trust/system against the standards of 85% capped Theatre Utilisation and 85% day case rate?	**Latest Model Hospital Data:** Capped Theatre Utilisation - 71.6% (18.06.2023) Daycase Rate - 88.9% (March 2023) There continues to be discrepancies between data sources and thus the performance reported internally, Vs externally via Model Hospital	Recovery action plan to be completed and presented to EPMG by the end of July	Stuart Coalwood
5.8	Is full use being made of protected capacity in Elective Surgical Hubs?	DCH attempted to access capacity at Exeter, but they were unable to accommodate the trust. There are no other surgical hubs that are currently offering capacity that meets the needs of the trust.	No actions set, as no options to exlore this further in the year 2023/24	Stuart Coalwood
5.9	Do diagnostic services meet the national optimal utilisation standards set for CT, MRI, Ultrasound, Echo and Endoscopy?	Meet the standards for CT, MRI and Ultrasound with minimal breachers. Areas known to not meet standards e.g CT Cardiac have undergone action plan and improving monthly.	Monitoring to continue via EPMG, to ensure action plan delivers	Nicci Tucker
5.10	Are any new Community Diagnostic Centres (CDCs) on track to open on agreed dates, reducing DNAs to under 3% and ensuring that they have the workforce in place to provide the expected 12 hours a day, 7 day a week service? Are Elective Surgical Hub patients able to make full use of their nearest CDC for all their pre and post-op tests where this offers the fastest route for those patients??	Weymouth up and running limited 7 days, Workforce out to recruitment, once in post will support full 7 day working. SWH scheduled for Dec 2023. ESH patients able to make use of nearset service/fastest route avalaible.	Monitoring via CDC governance route	Julia Morris
6.0	Are you releasing any Mutual Aid capacity which may ordinarily have been utilised to treat non-urgent patients to treat clinically urgent and long-waiting patients from other providers? Is DMAS being used to offer or request support which cannot be realised within the ICB or region?	The Trust has access to DMAS, but currently we are not in a position to offer mutual aid nationally. Informal requests are still made via the ICB or directly with our partners to share patients waits across the system where possible. Requirement as per the 2023/24 guidance is to be signed up to the site, which DCH are.	Monitoring to continue via EPMG.	Alison Roberts
6.1	Has Independent Sector capacity been secured with longevity of contract? Has this capacity formed a core part of planning for 2023/24?	The Trust has not commissioned directly with any independent sector providers however, Dorset ICB has a £25 million pound ISP programme. The Trust has commissioned ceria £6.5 million of insourcing capacity for 2023/24.	Monitoring to continue via EPMG.	Adam Savin
7.0	Do recovery plans and trajectories ensure specialised commissioned services are enabled to recover at an equitable rate to non-specialised services? Do system plans balance high volume procedures and lower volume, more complex patient care	DCH is not a tertiary centre, so there is very little specialist commissioning activity. All patients and activity are prioritised on clinical need, followed by chronological order, regardless of the commissioning organisation. 2023/24 plans does balance the need for high volume low complexity, with low volume high complexity cases however, the trust is ahead of its day case plan and beyond its elective inpatient plan, with complex inpatient cases, waiting longer than low complex day case procedures.	Recovery plan for theatre utilisation will address some of the imbalance. Theatre staffing review and theatre schedule review also planned for Q3.	Stuart Coalwood

7.1	Have you agreed the health inequality actions put in place and the evidence and impact of the interventions as part of your operational planning return? Was this supported by disaggregated elective recovery data?	Waiting list performance at DCH is reported by ethnicity, deprivation, and learning disabilities, as per national guidance. The operating plan returns did not request this information but rather asked for a yes or no statement, that health inequalities had been considered. The Dorset system has a huge amount of health inequalities data thanks to the DiiS and plans within the trust and the wider system to address the identified health inequalities are still being developed.	Internal Health Inequalities group, led by Jo Howarth has been established and is developing an action plan that supports the delivery of the trust and systems strategy.	Emma Hoyle
7.2	Are children and young people explicitly included in elective recovery plans and actions in place to accelerate progress to tackle CYP elective waiting lists?	Children and young people are included within the elective recovery actions by default, but they are not explicitly a separate programme of work as this was not specified as a requirement in the 2023/24 planning guidance. CYP forms part of the monthly performance monitoring with NHSE and is reflected back into the Trusts elective governance structure.	Using the recently published performance data, asses if a separate recovery plan is needed, as initial report show activity performance is behind plan, but at an equal rate to that of adult activity. Due Sept.	Stuart Coalwood

Escalation Report

Executive / Committee: Finance and Performance Committee

Date of Meeting: Monday 19th June 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:
	• Terms of reference for the following groups reporting to the committee:
	  ○ Capital Planning and Space Utilisation Group
	  ○ New Hospitals Programme
	  ○ Sustainability Working Group
	  ○ Information Governance Group
	  ○ Digital Transformation and Assurance Group
	  ○ Elective Performance Management Group.
	• Committee priorities
	• The SPLUNK risk has been mitigated and a contract is in place.

Key issues / matters discussed at the Committee	The meeting considered the following items:
	• Urgent and Integrated Care Divisional report noting:
	  ○ Continued top performance with ambulance handovers and 4 hour waiting times within the Emergency Department
	  ○ Improved diagnostic pathways
	  ○ Good progress in identifying and delivering cost improvements, although there had been some non-recurrent offsetting.
	  ○ Improvements in Histopathology turnaround times
	  ○ Overseas recruitment to pharmacy vacancies.
	• Family and Surgical Services Divisional Report noting:
	  ○ Improvements in theatre utilisation in May although further work to be undertaken to address early finishes.
	  ○ Sustained reductions in length of stay during building works.
	  ○ Development of a sustainability plan for colorectal and dermatology services.
	• The Performance Report noted:
	  ○ 8.4% increase in urgent and emergency care demand which was inconsistent with partner organisations.
	  ○ Increased referral volumes were under review by the system.
	  ○ Progression of teledermatology to address waiting times.
	  ○ A changing waiting list profile with reducing numbers of people waiting long periods for treatment.
	  ○ Overall elective activity volumes were behind plan but not current impacting Elective Recovery Funding.
	  ○ Concerns regarding cancer waiting time standards – further detail to be presented to the committee and Quality Committee in July.
	• Finance Report noting:
	  ○ A deficit position of £971K due to inflationary pressures and high gas and electricity costs.
	  ○ The use of agency staffing to cover periods of industrial action.
	  ○ £5m of the £10.9m cost improvement target had been identified and work continued to identify further schemes.

	• The Cyber Security Update noting that a contract was now in place for SPLUNK event logging and management tool.
	• There were no contracts for approval.
	• Board Assurance Framework noting planned changes to the risk scoring matrix and further review by the Board at the end of the month.
	• Strategic Estates Masterplan Update noting a potential risk regarding electricity supply.
	• Escalation Reports from the following subgroups were noted:
	  ○ Capital Planning and Space Utilisation Group
	  ○ New Hospitals Programme
	  ○ Sustainability Working Group
	  ○ Digital Transformation and Assurance Group

Decisions made by the Committee	The following items were approved by the committee: • Terms of reference for groups reporting to the committee • Committee priorities.
Implications for the Corporate Risk Register or the Board Assurance Framework (BAF)	• The Board Assurance Framework update was reviewed noting further planned discussion by the Board in light of revised risk appetite statements. • A risk relating to the electricity supply for the New Hospitals Programme was noted.
Items / issues for referral to other Committees	• Nil new

Escalation Report

Executive / Committee: Finance and Performance Committee

Date of Meeting: Monday 17th July 2023

Presented by: Stuart Parsons (Vice Chair)

Significant risks / issues for escalation to Committee / Board for action	• The following reporting group terms of reference were approved:
	  ○ Emergency Planning and Resilience Group
	  ○ Value Delivery Board.
	• There regional contract for the provision of mobile MRI in Dorset was approved and is recommended to the Board for approval:
	• The Waiver and Occupational Health Contract was approved.

Key issues / matters discussed at the Committee	The meeting considered the following items:
	• Urgent and Integrated Care Divisional report noting:
	  ○ Continued best performance in region for ambulance handover times.
	  ○ Best renal centre in the county
	• Family and Surgical Services Divisional Report noting:
	  ○ High numbers of people waiting for treatment over 65 weeks in Family services and risks to delivery of the trajectory due to increased front door demand, suboptimal theatre utilisation and industrial action.
	• Support Services Quarterly Performance Report noting:
	  ○ This was the first performance report from support services.
	• The Performance Report noted:
	  ○ High levels of front door demand above planned activity levels
	  ○ Elective care performance being RAG rated Red.
	  ○ Two tumor site services in 'special measures'.
	• Finance Report noting:
	  ○ £1.7m adverse variance to break even plan in month 3 due to inflationary pressure impact and under delivery of Cost Improvement schemes.
	• Cyber Security Q1 Update noting the successful implementation of a new Fire Wall.
	• Premises Assurance Model noting robust governance arrangements in place.
	• Escalation Reports from the following subgroups were noted:
	  ○ Capital Planning and Space Utilisation Group.
	  ○ Emergency Planning and Resilience Group
	• ICB Finance and Performance Committee Minutes.

Decisions made by the Committee	• The following reporting group terms of reference were approved:
	  ○ Emergency Planning and Resilience Group
	  ○ Value Delivery Board.
	• The Waiver and Occupational Health Contract was approved.
	• The regional contract for the provision of mobile MRI in Dorset was approved and is recommended to the Board for approval.

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

Escalation Report

Executive / Committee: People and Culture Committee

Date of Meeting: Monday 19th June 2023

Presented by: Margaret Blankson (Chair)

Significant risks / issues for escalation to Board for action	• The following are recommended to the Board:
	  ○ Committee priorities
	  ○ Reporting group Terms of Reference:
	  ▪ ED&I Steering Group
	  ▪ Health and Wellbeing Steering Group
	  ○ Health and Wellbeing Review Update.

Key issues / other matters discussed by the Committee	The committee considered the following items:
	
	• People and Performance Report and Dashboard noting:
	  ○ A reduction in sickness absence rates and an increase in appraisal and essential skills training compliance.
	  ○ Successful overseas recruitment to pharmacy
	  ○ An increasing trajectory of bank use.
	• Divisional Report from Estates and Facilities noting:
	  ○ Ongoing inclusion and staff engagement activities.
	  ○ Low appraisal compliance rates due to staff movements.
	  ○ Discussion of pay rates for trades staff and increased competition for staff from the private sector. Discussion with system partners to consistently apply recruitment and retention premia to these posts.
	  ○ Further development and use of apprenticeship schemes to secure future staffing pipelines.
	• Biannual Just and Learning Culture Update and planned alignment with the Patient Safety Incident Response framework (PSIRF)
	• Leavers and Retention Report noting a 10% increase in the number of staff leaving the trust. The immediate focus was on improving retention and providing flexible work options for staff.
	• Apprenticeships and Widening Participation Report reported that the target for new enrolments had been exceeded.
	• Workforce Health and Wellbeing Review noting the positive impact that the trust's offers were starting to have.
	• Medical Revalidation Report
	• Talent Management and Appraisal Report
	• ED&I Steering Group Escalation Report

Decisions made by the Committee	• The following items were approved and are recommended to the Board:
	  ○ Committee Priorities 2023/24
	  ○ Reporting group Terms of Reference:
	  ▪ ED&I Steering Group
	  ▪ Health and Wellbeing Steering Group

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 17th July 2023

Presented by: Margaret Blankson (Chair)

Significant risks / issues for escalation to Board for action	The following reporting group Terms of Reference were approved: • Medical and Dental Local Negotiating Committee (LNC) • Medical Education Group • Partnership Forum • The Digital Report is recommended to the Board.

Key issues / other matters discussed by the Committee	The committee considered the following items:
	• People and Performance Report and Dashboard noting:
	  ○ Downward trends in both long and short-term sickness absence rates.
	  ○ An increase in agency and bank staffing expenditure due to the opening of escalation beds.
	  ○ Appointment to the Respiratory consultant post.
	  ○ Lowest turn over rate in 12 months. Continued industrial action by junior doctors and consultant medical staff.
	• A summary of the NHS workforce plan noting the opportunities for new staffing models and the expansion of entry routes into the NHS.
	• Divisional Reports from
	  ○ **Urgent and Integrated Care Division noting:**
	  ○ Increasing sickness absence rates and targeted wellbeing support offers.
	  ○ Appointment to a number of vacancies.
	  ○ Ongoing support to small teams to improve appraisal compliance rates.
	  ○ **Digital and Informatics Team noting:**
	  ○ The inclusion of sickness absence and turnover rates within the report.
	  ○ Recent approval of five out of seven business cases to support staffing infrastructure.
	  ○ Re-banding of clinical coders to reflect the national average salary. Appointment to the Chief Medical Information role.
	  ○ Plans for greater digital collaboration going forward.
	• Education, Learning and Development report noting:
	  ○ Achievement of mandatory training targets over the previous year.
	  ○ Appointment of the Locally Employed Doctor lead.
	  ○ Ongoing work to identify and accredit educational supervisors.
	  ○ The second Gold Duke of Edinburgh Scheme was being run with 30 participants.
	  ○ Continuing challenges associated in accessing the internationally recruited nursing OSCI examinations – escalated to regional level.
	  ○ Continued expansion of the widening participation and apprenticeship schemes.

	○ A 40% reduction in funding for continuous professional development (CPD). • Escalation Report from ○ Health and Wellbeing Steering Group • ICB People Committee Minutes
Decisions made by the Committee	• The following reporting group Terms of Reference were approved: ○ Medical and Dental Local Negotiating Committee (LNC) ○ Medical Education Group ○ Partnership Forum
Implications for the Corporate Risk Register or the Board Assurance Framework (BAF)	• Nil new
Items / issues for referral to other Committees	• None

INTEGRITY | RESPECT | TEAMWORK | EXCELLENCE

NHS
Dorset County Hospital
NHS Foundation Trust

Escalation Report

Committee: Quality Committee

Date of Meeting: 20th June 2023

Presented by: Eiri Jones

Significant risks / issues for escalation to Board for action	• SHMI within expected range this month. Full quarterly report awaited to confirm if this remains the case. • Loss of microbiology accreditation has created some issues with delays in tests being sent to Bristol. • Evidence of good joint working with DHC in a number of areas, but particularly in relation to safeguarding work. • A strong focus on training in various service areas across the Trust • Impact of digital challenges on the ability to deliver services.

Key issues / matters discussed at the Committee	The committee received, discussed and noted the following reports:
	• Quality and Safety Performance Report noting:
	  ○ Focus on introducing an in-house security team, with a prevention and therapeutic approach.
	  ○ Continued work on nutrition, through MUST and patient experience
	  ○ A future deep dive requested on VTE
	• Divisional Exception Reports from Urgent and Integrated Care Division, and Family Services and Surgical Division, noting that the recent Datix outage caused some issues, but one of the mitigations that has remained in place is weekly safety huddles.
	• Maternity Safety Report and MMBRACE Report noting that the Trust is an outlier in post-partum haemorrhage over 1500ml. Work is ongoing to further understand this. Capacity issues relating to risk of premature birth with steps in place to mitigate and correct this risk.
	• Committee Priorities 2023/24
	• Risk Management: Board Assurance Framework, and Corporate Risk Register – Quality. Alignment work underway with DHC and both documents to be reviewed at the June Board Development Session.
	• Safeguarding Children and Adults Annual Report
	• Quality Review Governance Update
	• CQC Action Plan Update
	• Escalation Reports from the following subgroups:
	  ○ Infection Prevention and Control Committee noting the Trust-wide Recycle, Refresh, Reset week in July.

Decisions made by the Committee	• Committee Priorities 2023/24
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

Escalation Report

Committee: Quality Committee

Date of Meeting: 18th July 2023

Presented by: Eiri Jones

Significant risks / issues for escalation to Board for action	• Delays in various quality improvement workstreams due to requirements and capacity from Estates and Facilities, and Digital teams. • Recent junior doctors industrial action managed with good support and commitment from management and all members of staff.

Key issues / matters discussed at the Committee	The committee received, discussed and noted the following reports:
	• Quality and Safety Performance Report noting:
	  ○ Continued focus on reducing the incidents of pressure ulcers and falls.
	  ○ An update on the action plan arising from the recent Patient Led Assessment of the Care Environment (PLACE) review.
	  ○ Deep dive on VTE requested by the committee.
	• Elective Priorities report
	• Divisional Exception Reports from Urgent and Integrated Care Division, and Family Services and Surgical Division noting:
	  ○ Concerns remain about the challenges with aseptic service.
	  ○ Some assurances received regarding the ophthalmology and cancer services, which is also being overseen by Finance and Performance Committee.
	• Maternity Safety Report and CQC Inspection verbal update. A Trust Action Plan, including recommendations and actions taken in response to initial feedback, was presented. The CQC inspection remains underway, and a draft inspection report is awaited before a full and final action plan can be developed.
	• Current Clinical Plan and Forward View
	• National Patient Survey Results
	• Complaints Annual Report
	• Infection Prevention and Control Annual Report
	• Annual Report on Organ Donation
	• Sub Group Terms of Reference were deferred to August due to time constraints.
	• Escalation Reports from the following subgroups:
	  ○ Medicines Committee
	  ○ End of Life Committee
	• ICB Quality Committee Minutes

Decisions made by the Committee	• Nil
Implications for the Corporate Risk Register or the Board Assurance Framework (BAF)	• Delays in various quality improvement workstreams due to requirements and capacity from Estates and Facilities, and Digital teams. • Alignment with relevant system strategic risks and objectives.

Items / issues for referral to other Committees	• Nil

INTEGRITY | RESPECT | TEAMWORK | EXCELLENCE

NHS
Dorset County Hospital
NHS Foundation Trust

Escalation Report

Committee: Risk and Audit Committee

Date of Meeting: 20th June 2023

Presented by: Stuart Parsons

Significant risks / issues for escalation to Board for action	The following were approved by the committee: • Board Assurance Framework. • Risk Management Policy. • Anticrime Annual Work Plan.
Key issues / other matters discussed by the Committee	The committee considered the following items: • Internal Audit Progress Report ○ Noting the year end position and a small number of outstanding actions which had not been completed due to year end pressures. • Anticrime Annual Work Plan • Anticrime Progress Report noting that all standards had been rated green. • Annual Clinical Audit Assurance Report would be returned to the committee in September. • Board Assurance Framework noting alignment of the risk scoring categorisation with system partners and further discussion by the Board the following week following a revision of the risk appetite statements. • Corporate Risk Register noting the automatic escalation proposal within the Risk Management Policy of all risks rated 15 and above. • Health and Safety Steering Group Escalation Report
Decisions made by the Committee	The following were approved by the committee: • Board Assurance Framework. • Risk Management Policy. • Anticrime Annual Work Plan.
Implications for the Corporate Risk Register or the Board Assurance Framework (BAF)	• Board Assurance Framework and Corporate Risk Register discussion was noted.
Items / issues for referral to other Committees	• Secondary employment staff responsibilities – assurances to be sought by the People and Culture Committee that staff are aware of these responsibilities.

INTEGRITY | RESPECT | TEAMWORK | EXCELLENCE

NHS
Dorset County Hospital
NHS Foundation Trust

Escalation Report

Executive / Committee: Charitable Funds Committee

Date of Meeting: 18 July 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 (18.7.23)** • **DCH Charity Finance/Income 23/24** reports (M3 Jun 2023) received. Total income to date as of end Jun £73,400. Unrestricted funds were £359,905, providing a surplus of £139,905 against the reserves target of £220k. Majority of annual income expected in Q3/4. Financial review (6 month) to be held in October 2023. • **Capital Appeal (ED/CrCU)** report received. £305K income/pledges to date as of Jul 2023. Public launch planned for 30th August 2023. Corporate engagement event held 28.6.23-follow up meetings in progress. Grants funding and donor engagement programme ongoing. • **DCHC Risk Register** – new risk. Draft wording for Economic risk to be circulated to committee for review. To be approved by Charitable Funds Committee (Sept meeting) for inclusion on risk register.
Decisions made by the Committee	• Nil
Implications for the Corporate Risk Register or the Board Assurance Framework (BAF)	• Nil
Items / issues for referral to other Committees	• Nil

Report Front Sheet

1. Report Details			
Meeting Title:	Board of Directors, Part 1		
Date of Meeting:	26th July 2023		
Document Title:	Finance Report		
Responsible Director:	Chris Hearn, Chief Financial Officer	Date of Executive Approval	7th July 2023
Author:	Claire Abraham, Deputy Chief Financial Officer		
Confidentiality:			
Publishable under FOI?	Yes		
Predetermined Report Format?	No		

2. Prior Discussion		
Job Title or Meeting Title	**Date**	**Recommendations/Comments**
Finance and Performance Committee	17th July 2023	Noted

3. Purpose of the Paper	For Information – income & expenditure report on the finance position of the Trust to month three 2023/24 financial year							
	Note (✓)	✓	*Discuss (✓)*		*Recommend (✓)*		*Approve (✓)*	
4. Key Issues	Dorset County Hospital NHS Foundation Trust (DCHFT) has delivered a deficit position in month three of £0.671 million after technical adjustments against a planned surplus of £0.005 million being £0.676 million away from plan. Year to date the Trust has delivered a deficit of £1.652 million against a planned surplus of £0.021 million being £1.663 million away from plan. The month three and year to date performance is largely driven by above plan agency usage contributed to by the impact of industrial action incurred, as well as covering vacancy and sickness gaps, in particular Health Care Assistant gaps. Month three has seen a significant cost increase in agency covering this cohort, as well as increases incurred covering medical rota gaps in Unscheduled Care, Medicine for the Elderly, General Medicine and Urology. Above planned levels of inflation have been incurred with gas 25% higher than planned levels and electricity 40% higher than planned levels, with drugs, catering supplies, blood product contract increases and other contract increases between 8 and 11.5% which contribute to the remaining variance. The Trust is actively reviewing its sustainable energy options including strategy refresh and exploring all contract management opportunities with both cost and volume focus, for ways to mitigate inflationary pressures being incurred. Further initiatives in relation to the high cost agency reduction project must be deployed urgently to ensure the quarter one position is turned around, noting the safe removal of highest cost off framework usage is planned in the coming months, aligned with System collaboration. The Trust's approach to efficiency delivery including a revised governance process has recently been improved with the Value Delivery Board now active. This is designed to reinforce the accountability and deliverables of programmes							

	across the Trust, with focus on flow, bed usage noting improvements to productivity are essential, supported by System partners. The capital spend in month is £1.7 million against a plan of £1.8 million, and year to date £0.8 million behind plan due to timings of expenditure. The cash position is currently 19.1 million as at June, being better than plan in line with the timing delay of capital expenditure payment release.
5. Action recommended	Trust Board is recommended to: 1. **NOTE** the financial position to month three for the financial year 2023/24

6. Governance and Compliance Obligations				
Legal / Regulatory Link		**Yes**		*Failure to deliver the plan position could result in the Trust being put into special measures by NHSE.*
Impact on CQC Standards			**No**	
Risk Link		**Yes**		*The Trust is expected to deliver a break even position as at 31st March 2024, of which 4% (£10.9 million) of efficiencies are required.*
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			
	Place			
	Partnership	BAF references PA 2.1 and 2.2 references to financial sustainability and CIP delivery.		
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**	*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		**Yes**		*Highlights current spend of the Trust.*
Helping the NHS to support broader social and economic development			**No**	*If yes - please state how your report contributes to supporting broader social and economic development*
Assessments		**Have these assessments been completed?** *If yes, please include the assessment in the appendix to the report..* *If no, please state the reason in the comment box below.* *(Please delete as appropriate)*		
Equality Impact Assessment (EIA)			**No**	
Quality Impact Assessment (QIA)			**No**	

INTEGRITY | RESPECT | TEAMWORK | EXCELLENCE

NHS
Dorset County Hospital
NHS Foundation Trust

Financial Position Update 2023/24

June 2023 - Month 3

Chris Hearn
Chief Financial Officer

Outstanding care for our patients in ways which matter to them

Financial Position Update - June 2023

Executive Summary

A summary of progress is presented for the period to June 2023 and is compared with the plan submitted to NHSE on the 30th March 2023.

Dorset County Hospital NHS Foundation Trust (DCHFT) has delivered a deficit position for the month of June 2023 of £0.671 million against a planned surplus of £0.005 million after technical adjustments. The year to date position is £1.663 million away from plan.

The adverse position against plan is predominantly a result of the impact responding to industrial action, as well as ongoing agency costs due to vacancies, sickness and increased pateint acuity. Above planned levels of inflation have been incurred with gas, electricity, catering supplies, blood products, drugs and maintenance contracts significantly above planned levels. Agency expenditure has increased during June due to patient specialling, mental health nurse support required and medical rota gaps across ED, General Medicine and Urology being covered at higher rates than budgeted.

The Trust wide efficiency target for the year stands at £10.9 million and is circa 4% of expenditure budget in line with peers and national planning expectations. Full year efficiency delivery so far stands at £1.3 million with £1.5 million of the total target unidentified at present.

Pay is over plan largely due to increased costs supporting safe cover during industrial action, including agency usage to cover vacancies and to support operational pressures. Patient levels with no criteria to reside did reduce throughout the April, only to increase during May and into June.

Non pay is over plan due to high consumable costs including drugs and activity volumes linked to recovery of elective services ahead of planned levels in conjunction with heightened inflationary pressures.

The Trust is actively reviewing its sustainable energy options including strategy refresh and exploring all contract management opportunities with both a cost and volume focus for ways to mitigate inflationary pressures being incurred.

Further initiatives are also being developed in relation to the high cost agency reduction project to ensure the successful and safe removal of highest cost off framework usage.

Capital expenditure within month three amounted to £1.7 million, which is behind the in month capital plan by £0.2 million due to timings of capital expenditure payments made, and being £0.8 million behind plan year to date.

The cash position to June 2023 amounts to £19.1 million; slighlty better than plan due to the timing of capital payments behind plan.

Financial Position Update - June 2023

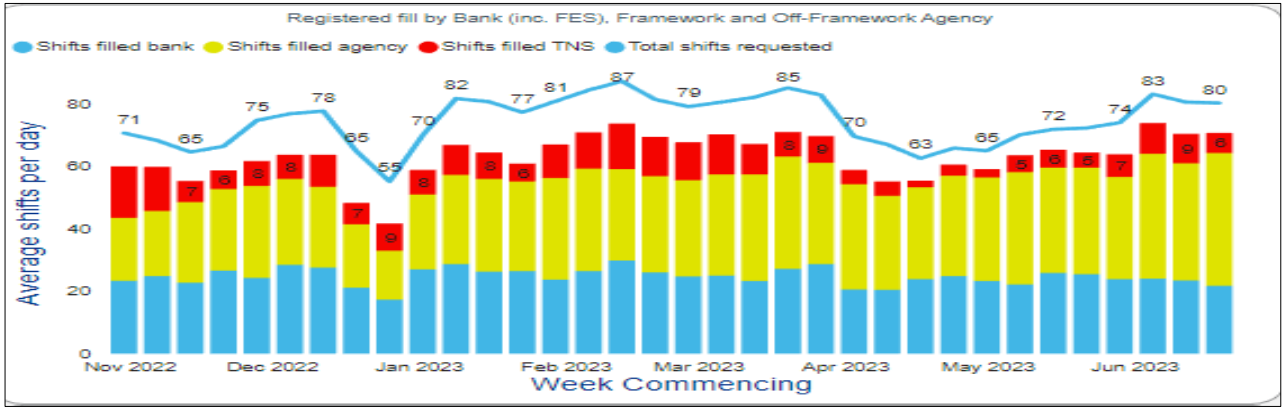
Key Risks

Red Risks:

The Trust has an **efficiency delivery requirement of £10.9 million** in order to reach the planned full year break even position.
Any unidentified efficiency will worsen the Trust deficit position and efficiencies delivered non recurrently where recurrent is expected will negatively impact the Trusts underlying deficit position.

The Trust's approach to efficiency delivery including a revised governance process has recently been improved, led by the now active Value Delivery Board. This is designed to reinforce the accountability and deliverables of programmes across the Trust.

Agency expenditure for Q1 is overspent against plan by £1 million, with £0.554 million spent with highest cost off framework suppliers. Active plans are in place as part of the internal High Cost Agency Reduction group, which is primarily focusing on nursing, must be expediated to help prevent further deterioration of the position against plan. The table below shows registered nursing shift fill by bank, on framework agency and highest cost off framework agency. The Trust must increase bank usage and decrease agency usage whilst maintaining patient and staff safety and quality levels.



Key Risk Status
Red - Significant risk of non-delivery. Additional actions need to be identified urgently.
Amber - Medium risk of non-delivery which requires additional management effort to ensure success
Green -. Low risk of non-delivery – current actions should deliver.

Financial Position Update - June 2023

Key Risks

Amber Risks:

As at the end of June the Trust had 4,855 uncoded episodes for the year. Of these, 1,259 were for Elective activity and 3,596 related to Emergency admissions.

For 2023/24 NHSE have introduced the Elective Services Recovery Fund (ESRF). It is expected that the Trusts elective income could be adjusted where elective financial performance differs to the elective financial baseline set out in the planning process. Uncoded elective activity risks our financial performance being understated against this baseline.

It must however be noted that the coding deadline for completion is mid August with targeted coding underway, therefore mitigating this risk. The table below summarises the monthly episodes:

Coded & Uncoded Activity As At June 2023

	Elective		Emergency	
	Coded	Uncoded	Coded	Uncoded
April	2,278		2,172	57
May	2,598	3	531	1,645
June	1,449	1,256	151	1,894
	6,325	**1,259**	**2,854**	**3,596**

Key Risk Status
Red - Significant risk of non-delivery. Additional actions need to be identified urgently.
Amber - Medium risk of non-delivery which requires additional management effort to ensure success
Green -. Low risk of non-delivery – current actions should deliver.

Financial Position Update - June 2023
Income & Expenditure

Income and Expenditure

The overall revenue position is behind plan by £0.676 million in month largely due to inflationary pressures and agency usage supporting industrial action, with ongoing vacancy and sickness cover requirements.

The Income from patient care activities variance is due to income for Elective Services Recovery Fund, the agenda for change pay award and high cost drugs.

Other Non-Clinical Income is marginally away from plan due to education and training income received below planned levels for the month.

Pay costs are over plan in month largely due to increased costs to cover industrial action, with ongoing bank and agency usage covering vacancies, sickness and supporting operational pressures including increased patient acuity. The agenda for change pay award has also been transacted which is offset by income.

Non pay is over plan due to ongoing above plan inflationary pressures, in particular energy, catering supplies (bread, milk, dairy and oil), blood products, maintenance contracts and laundry.

Above plan expenditure relating to the timing of Insourcing actvity supporting elective recovery contributes to the current position, although is not expected to continue at these levels based on the latest performance modelling.

STATEMENT OF COMPREHENSIVE INCOME	In Month (£'000)			Year to Date (£'000)			Full Year (£'000)
	Plan	Actual	Variance	Plan	Actual	Variance	Plan
Operating income from patient care activities	20,686	21,351	665	60,520	62,334	1,813	242,082
Private Patients	85	81	(3)	312	323	11	1,073
Other clinical revenue	37	33	(4)	111	61	(50)	444
Other non-clinical revenue	2,129	1,942	(186)	6,333	6,141	(191)	26,560
Operating Income	**22,936**	**23,408**	**472**	**67,276**	**68,859**	**1,583**	**270,159**
Charitable income	0	0	0	0	0	0	
Total Income	**22,936**	**23,408**	**472**	**67,276**	**68,859**	**1,583**	**270,159**
Raw materials and consumables used	(3,352)	(3,071)	281	(10,055)	(10,181)	(126)	(38,446)
Employee benefit expenses	(15,524)	(16,351)	(828)	(44,939)	(46,354)	(1,415)	(179,735)
Other operating expenses (excl. depreciation)	(2,731)	(3,393)	(662)	(8,288)	(10,155)	(1,867)	(35,266)
Operating Expenses	**(21,606)**	**(22,815)**	**(1,209)**	**(63,283)**	**(66,691)**	**(3,408)**	**(253,448)**
Profit/(loss) from Operations (EBITDA)	**1,330**	**593**	**(737)**	**3,993**	**2,168**	**(1,825)**	**16,711**
Other Non-Operating income (asset disposals)	(2)	0	2	(7)	0	7	(27)
Other Non-Operating expenses (Impairments)	0	0	0	0	0	0	0
Total Depreciation and Amortisation	(941)	(965)	(24)	(2,822)	(2,895)	(74)	(11,363)
PDC Dividend expense	(373)	(373)	0	(1,119)	(1,119)	0	(4,476)
Total finance income	16	102	86	49	280	232	194
Total interest expense	(63)	(49)	14	(186)	(172)	14	(752)
Total other finance costs	0	(0)	(0)	(£2)	(£0)	2	(2)
SURPLUS/ (DEFICIT)	**(33)**	**(692)**	**(659)**	**(94)**	**(1,739)**	**(1,645)**	**285**
Technical Items Adjusted for:							
DONATIONS - CASH FOR ASSETS	0	(17)	(17)	1	(17)	(18)	(729)
DEPRECIATION - DONATED ASSETS	38	38	(0)	114	114	(0)	450
SURPLUS/ (DEFICIT)	**5**	**(671)**	**(676)**	**21**	**(1,642)**	**(1,663)**	**0**

Financial Position Update - June 2023
Trust Wide Performance: Agency

Pay Analysis - Agency

Agency costs equated to £1.424 million of actual expenditure in month against a plan of £0.833 million.

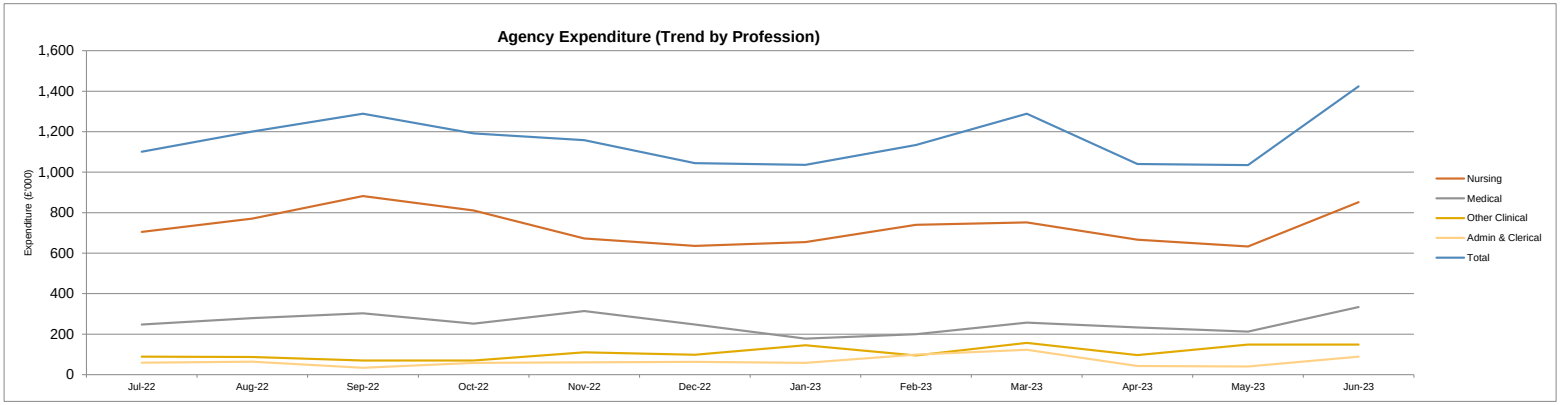
Agency expenditure was 8.7% of total pay and within this highest cost off framework usage was 19.6% equating to £0.279 million in month.

June saw a significant rise in agency expenditure (£0.389m) predominantly due to RN agency covering Healthcare Assistant gaps and increased Allocate on Arrival shifts booked to support safe staffing levels. Abbotsbury ward in particular has seen an increase in patient specialling and trained support for mental health patients in month. Medical agency also increased (£0.121m) primarily within ED, Medicine for the Elderly, General Medcine and Urology covering vacancies, outliers and rota gaps.

Actions from the internal High Cost Agency Reduction project mitigated expenditure from November 2022 onwards, however operational pressures compounded by industrial action, annual leave and acuity including mental health patient challenges have resulted in higher than planned costs.

Agency reduction remains a high priority for the Trust noting NHSE has applied a System spend cap of £42 million for Dorset for 2023/24 financial year, or 3.7% of pay budget.

A number of initiatives are planned that will help reduce and ultimately remove the usage of highest off framework agency expenditure in the coming months, aligned to System collaborative workstreams.
This includes work underway to align and improve the Dorset bank offer with a longer term view to a collaborative bank. Consistency in pay rates and use of agencies is also a key planned area for collaboration.



Agency Spend by Profession (£'000)	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	YTD Actual	YTD Plan	Variance
Nursing	705	771	882	811	673	636	655	740	752	667	633	852	2,152	1,629	523
Medical	248	279	303	252	314	248	178	200	257	233	213	334	780	543	237
Other Clinical	89	87	70	70	110	98	145	95	157	97	149	149	395	210	185
Admin & Clerical	59	64	34	58	61	63	58	99	123	43	40	89	172	117	55
Total	**1,101**	**1,201**	**1,289**	**1,191**	**1,158**	**1,045**	**1,036**	**1,134**	**1,289**	**1,040**	**1,035**	**1,424**	**3,499**	**2,499**	**1,000**

Nursing Agency Category	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23
Off Framework	374	439	537	525	317	240	272	307	285	135	140	279
On Framework - Tier 3b	204	180	189	173	143	151	155	150	209	221	223	271
On Framework - Tier 3	45	50	61	64	58	87	80	97	85	101	83	81
On Framework - Tier 2	28	35	29	28	50	47	59	65	68	80	84	101
On Framework - Tier 1	73	67	66	69	95	93	71	111	77	129	96	126
Orders awaiting allocation	-19	0	0	-49	0	0	0	0	0	0	8	-5
Agency Analysis 2022/23 & 2023/24 YTD	**705**	**771**	**882**	**811**	**663**	**617**	**637**	**731**	**724**	**666**	**633**	**852**

Pay Metrics	In Month Actual	YTD Actual
Agency expenditure as % of total pay	8.7%	7.8%
Off framework expenditure as % of total agency	19.6%	15.8%

Outstanding care for our patients in ways which matter to them

Financial Position Update - June 2023
COVID Expenditure

Covid Narrative
Covid spend decreased in June to £0.086 million from £0.130 million in May. Pay spend saw a decrease in month mainly due to a reduction in costs of backfilling substantive Covid related staff sickness. Non-Pay spend increased slightly mainly due to higher security costs and air filtration equipment. The Trust has reviewed its external security provision and is in the final stages of recruiting to an internal, more cost effective suitable approach for roaming which is anticipated will provide financial as well as improved quality and safety benefits. This roaming usage was expected to cease at the end of May 2023, with associated savings expected from June onwards, however delays in training provision have affected this. Covid funding for 2023/24 has reduced significantly to £2.3 million from £8.1 million last financial year. The Trust is actively reviewing all Covid associated costs to ensure it strives to live within the allocation and mitigate where required.

	Description	Apr-23	May-23	Jun-23	YTD
Plan:		**£191**	**£91**	**£149**	**£430**
Expenditure:					
Pay	Substantive	£40	£22	£13	**£75**
	Bank	£9	£13	£8	**£30**
	Agency	£0	£0	£0	**£0**
Total Pay		**£49**	**£35**	**£21**	**£105**
Non-pay	Clinical Supplies and Services	£27	£26	£7	**£61**
	Other Non-Pay (security)	£50	£56	£43	**£150**
	Premises and Fixed Plant	£11	£14	£14	**£39**
Total Non-pay		**£88**	**£96**	**£64**	**£249**
Total Expenditure		**£137**	**£131**	**£86**	**£354**
Total Surplus/(Deficit)		**£53**	**£131**	**£86**	**£76**

Financial Position Update - June 2023
Sustainability & Efficiency

Efficiency & Sustainability Programme Update

The annual efficiency target for the Trust is circa 4% which equates to £10.9 million for the financial year.

£1.3 million has been delivered full year effect, of which £0.6 million year to date.
A further £2.9 million of schemes are fully developed with £1.4 million plans in progress and £4.4 million of opportunities, leaving £1.5 million unidentified at month three.

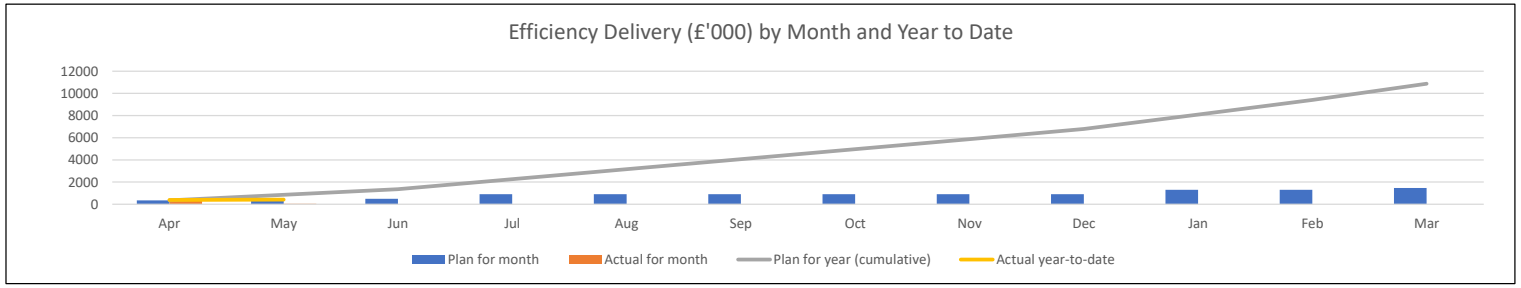
Efficiencies delivered so far include Covid reduction against plan, Corporate savings generated from joint posts, Digital programme delivery and Prothesis programme savings.

The Trusts approach to efficiency delivery including a revised governance process launched in June. This will reinforce the accountability and deliverables of programmes across the Trust.

This programme of work has been shared with the Dorset System with collaborative opportunities being actively assessed and reviewed with focus on on flow, bed usage noting improvements to productivity are essential, supported by System partners.

Area	Year to Date (£'000)			Full Year (£'000)		
	Plan	Actual	Variance	Plan	Full Year Realised @ M3	Variance to be Delivered
Division A	428	257	(171)	3,105	521	(2,584)
Division B	424	111	(313)	3,070	238	(2,832)
	852	**368**	**(484)**	**6,175**	**759**	**(5,416)**
Finance and Resources	97	0	(97)	717	0	(717)
Digital	44	59	15	311	238	(73)
Nursing	44	0	(44)	315	0	(315)
Operations	14	0	(14)	97	0	(97)
Human Resources	15	0	(15)	108	0	(108)
Corporate	21	31	10	149	125	(24)
Sub-total	**235**	**90**	**(145)**	**1,697**	**363**	**(1,334)**
Trust Wide schemes	413	150	(263)	3,000	150	(2,850)
Total CIP	**1,500**	**608**	**(892)**	**10,872**	**1,272**	**(9,600)**
Of which:						
Recurrent	903	242	(661)	6,552	876	(5,676)
Non-recurrent	597	366	(231)	4,320	396	(3,924)
Total	**1,500**	**608**	**(892)**	**10,872**	**1,272**	**(9,600)**

At a glance		
	£ 000	No of schemes
Target	10,872	N/A
Unidentified	1,564	N/A
Delivered	608	26
Fully Developed	2,910	
Plans in progress	1,365	7
Opportunity	4,425	26



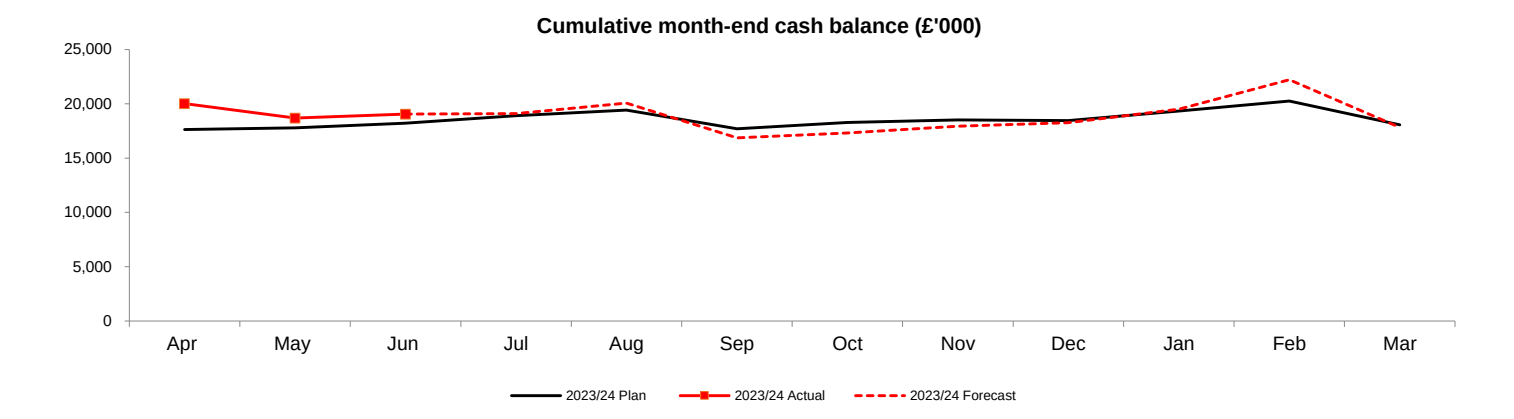
Financial Position Update - June 2023

Cash

Cash Balance incl Forecast

The graph shows the trajectory of the actual and forecast cash balance during year.

The cash position is currently £19.1 million as at June, being better than plan in line with the timing delay of capital expenditure payment release.



Cumulative cash balance	Apr £'000	May £'000	Jun £'000	Jul £'000	Aug £'000	Sep £'000	Oct £'000	Nov £'000	Dec £'000	Jan £'000	Feb £'000	Mar £'000
2023/24 Plan	17,634	17,784	18,219	18,903	19,415	17,711	18,280	18,529	18,456	19,339	20,259	18,081
2023/24 Forecast				19,104	20,072	16,870	17,318	17,948	18,258	19,521	22,223	17,829
2023/24 Actual	20,024	18,694	19,053									

Financial Position Update - June 2023

Capital

Capital Programme Narrative

Capital expenditure at the end of June was £0.809 million behind plan.

Internally Funded schemes are overall above plan by £0.439 million due to:

Estates are marginally behind plan year to date due to timing of purchases to be made.

Digital Schemes are above plan year to date due timing of expenditure incurred from the firewall upgrade.

Medical Equipment is above plan due to timing of purchases of equipment, such as monitors, operating tables and bladder scanners.

IFRS 16 Lease Additions is ahead of plan due to lease remeasurements.

Externally Funded capital is below planned levels of spend by £1.249 million due to timings of New Hospitals Programme, Community Diagnostics Centre expenditure, offset by works on South Walks House that have progressed ahead of plan.

CAPITAL	CURRENT MONTH			YEAR TO DATE			FULL YEAR 2023/24			
	Actual	Plan	Variance	Actual	Plan	Variance	Committed Spend	Forecast	Annual Plan	Variance
Estates	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000
Chemo	0	0	0	0	0	0	0	1,962	1,962	0
Air-Handling Unit	0	0	0	0	0	0	0	750	750	0
Estates Schemes	55	**162**	107	311	**316**	5	1,457	1,819	1,819	0
Digital Services										
Digital Schemes	176	**154**	(22)	505	**310**	(195)	1,400	2,005	2,005	0
Equipment										
Digital Mammogaphy	0	0	0	0	0	0	0	313	313	0
Haemodialysis Machines	0	0	0	0	0	0	0	119	119	0
Other Equipment	197	55	(142)	282	55	(227)	291	498	498	0
Sub-Total Internally Funded Expenditure	**427**	**371**	**(56)**	**1,097**	**681**	**(416)**	**3,148**	**7,466**	**7,466**	**0**
Donated										
Other Donations	10	0	(10)	17	0	(17)	17	17	0	(17)
Chemotherapy Unit Refurbishment	0	0	0	0	0	0	0	716	733	17
Sub-Total Planned DonatedExpenditure	**10**	**0**	**(10)**	**17**	**0**	**(17)**	**17**	**733**	**733**	**0**
IFRS 16 Lease Additions										
Warehouse	0	0	0	0	0	0	0	2,335	2,335	0
Print Management	0	0	0	0	0	0	0	600	600	0
One Dorset Pathology	0	0	0	0	0	0	0	250	250	0
MSCP Lease remeasurement	0	0	0	0	0	0	0	700	700	0
Accommodation & Vehicle Lease Additions	5	0	(5)	6	0	(6)	384	404	404	0
Sub-Total Planned IFRS 16 Expenditure	**5**	**0**	**(5)**	**6**	**0**	**(6)**	**384**	**4,289**	**4,289**	**0**
Total Internal & Leased Capital Expenditure	**442**	**371**	**(71)**	**1,120**	**681**	**(439)**	**3,549**	**12,488**	**12,488**	**0**
Additional funded schemes										
NHP Development	427	520	93	1,127	1,953	826	1,819	10,468	3,868	(6,600)
South Walks House & 24 Bedded Bay	644	573	(71)	1,649	1,219	(430)	2,187	6,877	6,877	0
Mental Health UEC Funding	0	0	0	0	0	0	0	233	233	0
Digital EPR Funding	3	118	115	3	286	283	6	2,093	2,093	0
CDC Funding	150	240	90	150	720	570	150	1,440	1,440	0
Endoscopy	0	0	0	0	0	0	0	2,000	2,000	0
Total Externally Funded Capital Expenditure	**1,224**	**1,451**	**227**	**2,929**	**4,178**	**1,249**	**4,162**	**23,111**	**16,511**	**(6,600)**
Total Capital Expenditure	**1,666**	**1,822**	**156**	**4,050**	**4,859**	**809**	**7,711**	**35,599**	**28,999**	**(6,600)**
Expenditure as a % of Plan			91%			83%				123%

Report Front Sheet

1. Report Details			
Meeting Title:	Board of Directors, Part 1		
Date of Meeting:	26 July 2023		
Document Title:	**Board Assurance Framework (BAF)**		
Responsible Director:	Nick Johnson – Deputy CEO	Date of Executive Approval	04/05/23
Author:	Philip Davis		
Confidentiality:	No		
Publishable under FOI?	Yes		
Predetermined Report Format?	n/a		

2. Prior Discussion		
Job Title or Meeting Title	**Date**	**Recommendations/Comments**
EMT Meeting	04/05/23	Additional feedback from Anita Thomas BAF risks in new FY.
Deputy CIO, CNO and Head of Risk	12/05/23	Discussed and agreed BAF will reference Risk register risks pertinent to each BAF entry. Also, that by Jul-23 BAF and Risk register will adopt new 4x4 risk scoring, in a move to harmonize all Dorset Providers risk reporting.
Risk and Audit Committee	20/06/2023	Noted

3. Purpose of the Paper	To give assurance to Board Committees that the Risks to Delivery of our Trust Strategy (and the benefits therein) are understood, and actions to mitigate them have been put in place.							
	Note	✓	Discuss	✓	Recommend		Approve	
4. Key Issues	**BAF** - BAF Is in 10th iteration and ran bimonthly reviews since publication of the Trust Strategy in Nov-21, changing to quarterly reviews in Mar-23. **Changes to Risk Scores in Jun-23 BAF** PL1.5 Owned by FPC & QC with COO as Accountable Exec. (Changed from score 20 to 16) If our emergency and urgent care pathways do not meet the increase in unplanned attendances then patients will wait too long for appropriate care in emergency situations and therefore the objective of high-quality care that is safe and effective will not be met. Similarly the above concern would mean we are not contributing to a strong, effective Integrated Care System, focussed on meeting the needs of the population Mitigations have been put in place and monitored across FY22/23, including reframed URG and EM Care Boards, Performance Framework Reporting, redesign through ED15, 7 day SDEC offering, Internal Home First Workstreams (as part of Clinical Strategy)							

PL 1.9 owned by FPC and with COO as Accountable Exec. (This risk has been scored at 2 consistently, and has now been removed from the BAF)

If we do not provide as a minimum 35% of our outpatient activity away from the DCH site then we will not be delivering and designing care in a way which matters to patients or building on sustainable infrastructure and digital solutions to better meet the needs of our population.

Risks Scoring 20:

PE1.2 Owned by FPC & QC with COO as Accountable Exec

If we fail to attract and retain the right people with the right skills then more pressure on existing teams

Mitigations are included in the People Plan and include Workforce Business Partner Model, System Attraction Strategy, Career Pathways, CESR Academy, Pilot site for Stay & Thrive initiative, continuing development of Temporary Workforce function, Management Matters and Inclusive Leadership programmes

PL1.1 Owned by QC with CNO as Accountable Exec.

If there is a continuing inability to reliably recruit or retain sufficiently skilled clinical staff to meet patient demand, then we will not be able to meet required care standards, so will not meet the strategic ambitions on quality, personalised care and financial objectives.

Mitigations have been put in place and monitored across FY22/23, including Wellbeing support, international recruitment, Apprenticeships, Training, Retention Programme (as part of People Plan)

Risks Scoring 16:

There are 9 risks that current score Amber (in the range of 15-16), and are classified as High Risk:

PE1.1
PE3.2
PE1.2
PE1.3
PL1.5
PL1.10
PL1.11
PL2.2
PA2.1

Note the Risk scoring will be changing to the new 4x4 matrix from July 2023. This will harmonize all risk scoring, both Risk Register and BAF, across all Dorset Providers.

-

5. Action recommended	The Board is recommended to: 1. **NOTE** the Jun-23 BAF 2. **Review** and **Comment** on the risks and mitigations, especially those risk 20 or scores changed this month. 3. **Recommend** the changes in this iteration (marked in Red).

6. Governance and Compliance Obligations				
Legal / Regulatory Link		**Yes**	**No**	
Impact on CQC Standards		**Yes**	**No**	Clinical Plan is closely focused on improving Patient Outcomes & Patient Experience, and People Plan strongly focused on staff wellbeing
Risk Link		**Yes**	**No**	
Impact on Social Value		**Yes**	**No**	Social Value Action plan sits within Sustainability & Efficiency Workstream, underlying the Trust Strategy
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	BAF directly linked to Trust Strategy Objectives		
	Place	As above		
	Partnership	As above		
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**	
Tackling unequal outcomes and access		**Yes**	**No**	
Enhancing productivity and value for money		**Yes**	**No**	
Helping the NHS to support broader social and economic development		**Yes**	**No**	
Assessments		**Have these assessments been completed?** If yes, please include the assessment in the appendix to the report. If no, please state the reason in the comment box below. (Please delete as appropriate)		
Equality Impact Assessment (EIA)		**Yes**	**No**	
Quality Impact Assessment (QIA)		**Yes**	**No**	

BOARD ASSURANCE FRAMEWORK - SUMMARY
DATE: Jun-23

Summary Narrative

In total, the Board Assurance Framework includes 35 risks, a number of which have remained in the high risk category with scores of over 20. These have been summarised below.

People
Whilst work continues at a system and Trust level to plan and consider new ways of working, a national workforce shortage still exists, therefore the risk of more pressure on teams as a result of failing to attract and recruit the right people with the right skills continues to score 20 (Risk PE 1.2)

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

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

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

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

Risk Heatmap

		LIKELIHOOD SCORE				
		1	2	3	4	5
CONSEQUENCE SCORE		Rare	Unlikely	Possible	Likely	Almost certain
5	Catastrophic	5	10 PL2.1	15	20 PE1.2	25
4	Major	4	8 PA1.1, PA3.1, PA3.2	12 PE2.1, PE3.3, PA2.2 PL2.2	16 PE1.1, PL1.2, PL1.10, PL1.11, PL 2.3, PL1.3	20 PL1.1, PL1.5, PL1.3
3	Moderate	3 PL3.1	6 PE3.4, PL1.4, PA1.3, PA2.3	9 PA1.2, PA4.1, PL2.3	12 PA3.3, PL1.6, PL3.2, PL 3.3, PL4.1, PL4.2, PA1.4	15 PE3.2
2	Minor	2 PL1.9	4	6	8	10
1	Negligible	1	2	3 PL3.1	4	5

Key

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

Risk Ref:	Committee	Accountable Executive	Risk Owner	Risk Register ref. no.	Risk Description/Risk Owner:	Consequence Score	Likelihood Score	Risk Score	Existing Mitigation/ Controls	Assurance/ Evidence	Strength of Control	Strength of Assurance	Target Risk Score	Mitigations - Target Date	# People Risks: 7
People Objective 1															
We will look after and invest in staff, developing our workforce, creating collaborative and multidisciplinary teams to support outstanding care and equity of outcomes															
PE 1.1	PCC QC FPC	CPO	Deputy CPO	1642	**Risk description:** If we fail to create environments that support staff wellbeing then our ability to resource service recovery and ongoing delivery safe care are at risk	4	4	16	• People Plan • People performance dashboard • People Committee reports • People recovery steering group • Targeted wellbeing support • Wellbeing offer • System & national wellbeing offers	• People Plan • People Dashboard - PCC • PCC reports • FPC reports • Divisional performance reviews • Quarterly people pulse survey • National staff survey • FTSUG reports • Staff listening exercises • Exit interviews	Good	Good	12	Nov-22 All mitigations in place.	
									Gaps in Control and Actions: National workforce supply challenges - system workforce planning & new ways of working Impact of pent up demand on the front door and pressures within system impacting workforce stress & anxiety - working across ICS						
PE 1.2	PCC	CPO	CPO	1642	**Risk description:** If we fail to attract and retain the right people with the right skills then more pressure on existing teams	5	4	20	• People Plan • Implementation of workforce business partner model • System attraction strategy • Resourcing function business case • Career pathways • CESR academy proposition • Locally employed doctor appraisal and development • Pilot site for national stay and thrive initiative & international nurse experience deep dive • OD team • Development of flexible & temporary staffing function • Inclusive leadership programme • Management Matters programme (starting Nov 2022) • Transforming people practices programme	• People Plan • People Dashboard - PCC • PCC reports & workplan • Divisional performance reviews • Recruitment control panel • System workforce plan	Good	Good	15	Nov-22 All mitigations in place.	
									Gaps in Control and Actions: National workforce supply challenges - system workforce planning & new ways of working						
People Objective 2															
We will create an environment where everyone feels they belong, they matter and their voice is heard															
PE 2.1	PCC	CPO	Head of OD	1642	**Risk description:** If we fail to create a culture and environment where ALL stay feel valued, heard and that they belong then attraction, availability and retention will be compromised	4	3	12	• People strategy • EDI roadmap – culture transformation programme (inclusive leadership development, management matters programme) • Staff networks x 5 • FTSUG and champions • People performance dashboard as cultural barometer • Exit interviews	• People performance Dashboard - PCC • PCC workplan • PCC deep dives • Divisional performance reviews • EDI steering group • Exec sponsors for staff networks • Quarterly pulse survey • National staff survey • Junior dr survey	Good	Good	8	Nov -22 All mitigations in place.	
									Gaps in Control and Actions:						
People Objective 3															
We will improve safety and quality of care by creating a culture of openness, innovation and learning															
PE 3.1	People & Culture Committee and Quality Committee	CPO / CNO / CMO	CPO / CNO	1643	**Risk description:** If People not feel safe to speak out about safety and care quality then the safety culture is effected and there can be increase in safety risks and harm, with a reduction in teamwork and quality improvement. In addition issues will not be addressed and patients and staff are at risk of harm.	4	2	8	• Trust strategy • Trust values • People Plan • Implementation of just & learning culture principles • Raising concerns policy • Whistleblowing policy • Trust induction • Leadership & management development • FTSUG and champions • Safety walkabouts - In place and ongoing feeding into respective sub-board or group • Ward accreditation framework - Target score: implemented process/ complete first round by April 2023 • Incident reporting -Target score: in pace and reports to Quality Committee and in turn to Board	• People performance Dashboard - PCC • PCC workplan - FTSU report, review of whistleblowing arrangements • Implementation of just & learning culture • Inpatient surveys • Datix	Good	Good	4	Nov -22 All mitigations in place.	
									Gaps in Control and Actions:						
PE 3.2	QC	CEO	Deputy Director of Strategy	1642	**Risk description:** If operational pressures continue then there will be less time for teams and staff to innovate and so the will and capacity for innovation will be stifled.	3	5	15	• Quality Improvement and Innovation Programme overall supports importance and value of innovation and learning and provides resource support • QSIR Training protected and supported by division • Transformation and Improvement team providing support • Research and Innovation strategy and plan • Engagement in Academic Health Science Network • Divisional Performance Meetings with focus on innovation	• S&T SLG reporting on QI programme and progress • Research and Innovation Governance • Divisional Performance Meetings	Good	Good	6		
									Gaps in Control and Actions:						
PE 3.3	PCC	CPO	Head of Education	1642	**Risk description:** If operational pressures reduces capacity for learning then there could be a detrimental impact on placement experience, our ability to attract students, patient safety may be compromised and staff engagement may suffer	4	3	12	• People strategy • Appraisal policy • Medical appraisal • Study leave policy • Mandatory training KPI's • Practice education team • PCC reporting • Quality committee reporting • PCC and QC risk sharing & triangulation	• Mandatory training KPI's • Appraisal KPI's • Monthly performance review • PCC reports • QC reports • Medical and nursing revalidation • System education workstreams	Good	Good	8	Jun -22 All mitigations in place.	
									Gaps in Control and Actions: Demand and capacity challenges - close monitoring and escalation						
PE 3.4	QC	CMO	CMO	1644	**Risk description:** If DCH is not actively encouraging and pursuing research aims in line with the strategy then it will be a less attractive place for staff to work and research income will reduce. So DCH needs to actively encourage and facilitate staff to take part in existing projects and develop new ones.	3	2	6	• Strong clinical research and innovation programme. • Research Strategy in place for 2019-22 with plans to review in 2022. • Now active collaboration with Dorset Healthcare over Linden Unit • Linden Unit being refurbished as joint vaccine research hub opens Jun-23 • Research Hub is a collaboration between DCH, DHC and Southampton	• Reports to Quality Committee through Clinical Effectiveness Committee - with annual reporting to Board.	Good	Good	6	Nov-22	
									Gaps in Control and Actions:						

Risk Ref:	Committee	Accountable Executive	Risk register ref no.	Risk Owner	Risk Description/Risk Owner:	Consequence Score	Likelihood Score	Risk Score	Existing Mitigation/ Controls	Assurance/ Evidence	Strength of Control	Strength of Assurance	Target Risk	Mitigations - Target Date	# Place Risks: 17
Place Objective 1: We will deliver safe, effective and high-quality personalised care for every patient focussing on what matters to every individual															
PL 1.1	QC (triangulation with PCC)	CNO	1642	CPO - Recruitment and retention and People Strategy	Risk description: If there is a continuing inability to reliably recruit or retain sufficiently skilled clinical staff to meet patient demand, then we will not be able to meet required care standards, so will not meet the strategic ambitions on quality, personalised care and financial objectives.	4	5	20	See People objective • Recruitment and retention policies and work streams • International recruitment • Wellbeing support • Maximise use of opportunities through Health Education England and NHSE/I funding streams • Maximise where able apprenticeships • Workforce planning and innovation with redesign of roles to enable clinicians to practice at the top of their licence • Increased opportunities for supported training places • Stay and thrive programme to aid retention Controls non-HR/OD: • Protocols and policies for clinical care • Quality improvement work to streamline care or improve effective patient care • Compliance with national standards to support patient care • Engagement with service users to assist in re-design effective and efficient care to maximise workforce efficiencies • Sub-board oversight of standards delivery and interventions as part of strategic objectives	• Sub board reports: PCC; QC & RAC • Recruitment activity reports • Patient feedback • Staff feedback • Incident data • External assurance monitoring: CQC; CCG; auditors inc GIRFT/Networks • Corporate risk register actions and tolerated/managed risk	Good	Good	12	2024	
									Gaps in Control and Actions: - International shortage of certain clinical professions. Action: part of the stay and thrive programme to improve experience and support of international recruits; workforce planning to grow talent and career pathways into health - Uncertainty over Health Education England funding that impacts upon training, education and funding support for pipeline roles. Action: Close liaison with HEE South West and regional workforce/ people supply work streams - Increase in covid pandemic wave impacting on staffing resource, epidemiology shows a wave with a slight plateau at present. Ongoing waves likely for foreseeable year - Financial pressures hinder options to cover backfill costs of NHSE/HEE opportunities to support workforce bids - Accommodation locally due to the property markets and large numbers of second homes hinder affordable housing options, which impacts upon staff attraction and retention - Cost of living impact on professional roles impacting upon attraction and retention in nursing, AHPs and midwifery - National increase in attribution of students undertaking nursing degree, with a higher issue in the South West of England					
PL 1.2	QC	CNO	1221	CNO - quality and safety CMO - Clinical Strategy and GIRFT CFO - Estates Strategy	**Risk description:** If the population demand is over the ability to create and deliver capacity that meets the constitutional standards and quality standards outline under the CQC regulatory framework then the clinical strategy will not be delivered and therefore the objective of high-quality care that is safe and effective will not be met.	4	4	16	• Capacity planning • Commissioning of capacity • Clinical pathways design and system working for sustained capacity • Estates strategy • Workforce planning including job planning • Quality Improvement to redesign pathways to more efficient or productive with funded capacity • Access policies and processes to ensure effective waiting list management in order of clinical need with consideration for health inequalities • Recovery plan and oversight of the delivery through sub-board committee • ICS partnership working through provider collaboratives • ICS governance framework • Clinical networks to support pathway design and resources based on population need	• Sub-board committee FPC, QC & PC • Estates master plan and associated business cases • Performance scorecard • External performance monitoring (CQC; OFRG; NHSE/I) • Benchmarking data: clinical networks; GIRFT	Good	Strong	8	2025	
									Gaps in Control and Actions: - Gaps in patient pathways out of hospital for those with complex care needs. ACTION: ICS escalation and collaboration workstreams - Mental health capacity to meet growing demand is impacting on potential delivery of longer term care in the right place and therefore clinical outcomes. Escalated to partners and working with partners.						
PL1.3	FPC	COO	1221	Associate Director of Performance	**Risk description:** If we do not achieve the national performance standards for 2022/23* due to long waiting times then we will not provide high quality care in ways that matter for our patients so the clinical strategy will not be delivered and therefore the objective of high-quality care that is safe and effective will not be met. * Eliminate 104 week waiters (exemption for patient choice) Eliminate 78 wk waiters by March 2023 Maintain Waiting List at 2019/20 size Deliver 62 day backlog to the same size as 19/20 Increase cancer 1st treatments (31 day standard) by 20%	4	4	16	• April 22 - Planning Guidance submissions agreed. Guidance acknowledges this is a multi-year improvement plan. Key steps are outlined in the plan for this coming year. DCH has agreed trajectories for achievement which will be tracked through EPMG and reported up through both Divisional governance and EPMG to FPC/Quality cttees. Target date: completed and reporting through to FPC/Board as planned • Quality improvement plans within Divisions and key work streams to support delivery of key KPIs supporting quality improvement. Target date: 6 specialties enrolled in CWT System work (complete), 6 specialties enrolled for System 78wk focus (completed), Theatre program established • Elective Performance Management Group - workstreams aligned to operational planning guidance. Performance Framework - triggers for intervention/support. Target date: completed and reporting through SLG/FPC • Provider assurance framework/Finance and Performance Committee - updated Single Oversight Framework included in FPC/Board reporting (completed)	• Division and work stream action plans. External contracting reporting to ICS. Divisional exceptions at FPC Committee • Performance monitoring via weekly PTL meetings, fortnightly EPMG and monthly Divisional Performance Meetings (through to Sub-Board and Board) Weekly meetings with ICS/Region and postive movement noted	Good	Good	12	All monitoring in place. monthly targets to be reviewed at FPC	
									Gaps in Control and Actions: National Elective Recovery Plan sets out a 3 year plan towards achievement of NHS Constitutional Standards. Trajectories agreed for achievement of in year milestones and will be reported via FPC both in the Performance/EPMG report and the Divisional exception reporting submissions: Mar-23: Trust was predicted to meet the key planning asks in March 2023 however Industrial Action across all key workforce elements within the Qtr have reduced available capacity - potential to miss 78 wk target by <10 patients. W/L size has gown during the period - aligned to CWT referral growth and well understood, also in keeping with other Trusts in SW.						
PL 1.4	FPC	COO	692	Head of EPRR	**Risk Description:** If we don't have Emergency Preparedness and Resilience Plans then we will not have a defined programme to manage safe services and the triggers for altering those services under change services, therefore the objective of high-quality care that is safe and effective will not be met.	3	2	6	• Emergency Preparedness and Resilience Review Group (EPRG), EPRR Framework and associated workplan based on 2022/23 standards System Local Resilience Forum and Partnership	• Reporting from EPRG to Finance and Performance Cttee and via assigned NED to Board. Yearly self assessment against EPRR core standards ratified by Local Health Resilience Partnership. Internal Audit reports against the standards	Good	Good	6		
									Gaps in Control and Actions: The 2023/24 standards have not yet been released - expected in June 2023 with a submission date for evidence in September 2023.						

Risk Ref:	Committee	Accountable Executive	Risk register ref no.	Risk Owner	Risk Description/Risk Owner:	Consequence Score	Likelihood Score	Risk Score	Existing Mitigation/ Controls	Assurance/ Evidence	Strength of Control	Strength of Assurance	Target Risk	Mitigations - Target Date	# Place Risks: 17
PL 1.5	FPC - performance QC - Harm related concerns	COO	1221 and 450	COO	**Risk description:** If our emergency and urgent care pathways do not meet the increase in unplanned attendances then patients will wait too long for appropriate care in emergency situations and therefore the objective of high-quality care that is safe and effective will not be met. Similarly the above concern would mean we are not contributing to a strong, effective Integrated Care System, focussed on meeting the needs of the population	4	4	16	• Urgent and Emergency Care Pathway Redesign agreed by the Urgent and Emergency Care Board for the ICS - in 3 focussed areas - Pre and front Door ED, Internal Flow and Discharge process and capacity (D2A) • Internal DCH UEC Improvement Plan - monitored via Divisional Performance Meetings and escalations to FPC • Increase to 7 day SDEC offer across medicine and surgical action plan part of the above plans specialties. Target date - 7 day service completed - surgical pathways by Sept 23. • Clinical and People Strategies addressing emergency flow. Target Date: New ED build freeing up Em Zone capacity - early pilot in place, feedback on pilot via Divisional Performance Meetings and escalations to FPC D2A is a system led initiative - monitored via Home First presentatons to Inclusive Neightbourhoods and Communities Oversight Group (INCOG) • Internal Patient Flow Improvement work streams - 7 day discharge services, strengthened front door multi-agency response, PAT, ward based discharge processes. Target date: reducing bed use in Summer 2023 Planning submission requires NRTR (Pathway 1-3) to reduce to 45 (or lower) by March 2024. Monitored via System Group Chaired by ICB COO (Quarter Strategic Improvement Group) as delivery is as system not individual organisation.	• Upward reporting and escalation from UECB to SLT and DCH Board. • Ward to Board reporting via FPC Patient Flow Improvement (DCH) governance, tracking and documentation Divisional reporting via Performance Meetings, FPC, Seasonal Surge Plan and reporting IMT Reporting ROI reporting against investment in 7 day services model to UECB/QSIG	Good	Good	12		
									Gaps in Control and Actions: Patient Flow Transformation roles start in June 2023.						
PL 1.6	FPC - performance QC - Harm related concerns	COO	1509 and 461	COO	**Risk description:** If we fail to work with our partners on effective criteria to admit, criteria to reside, and discharge pathways, then patients will have unnecessary and lengthy hospital stays leading to poorer outcomes and therefore the objective of high quality care that is safe and effective will not be met. Similarly the above concern would mean we are not contributing to a strong, effective Integrated Care System, focussed on meeting the needs of the population	3	4	12	• Home First Board membership - As @ Q4 This is now Integrated Neighbourhoods Cttee • Urgent and Emergency Care Board - COO membership • Investments in ED capacity, SDEC 7-day working, 7-day discharge services, increased Acute Hospital at Home capacity. Target date: SDEC and Discharge 7 day services completed. Increased Hospital at Home - Recurrent funding awarded for the 'winter schemes' due to success in reduction of NRTR • Home First (DCH) Steering Group - PAT, redesign of discharge support, CCTR, MDT working, strengthened front door multi-agency response. Completion date: via Patient Flow Program Winter 2022 • VSCE support front door and discharge response. Pilot in place (completed)	Home First Board papers UECB papers Divisional reporting to FPC Performance Report - FPC ROI reporting to UECB on investments into patient flow schemes Home First (DCH) Steering group papers.	Requires Improvement	Requires Improvement	9	Internal mitigations in place for winter 22/23 External mitigations through Home First delivery in 23/24	
									Gaps in Control and Actions: System actions currently in development, low level of confidence actions will meet needs**. Please see action detailed above.** March 2023: Winter Schemes have delivered a consistent drop in NRTR of 10-15 patients by the end of Q4. Further						
~~PL 1.9~~	~~FPC~~	~~COO~~		~~COO~~	~~**Risk description:**~~ ~~If we do not provide as a minimum 35% of our outpatient activity away from the DCH site then we will not be delivering and designing care in a way which matters to patients or building on sustainable infrastructure and digital solutions to better meet the needs of our population.~~	~~2~~	~~1~~	~~2~~	~~• Outpatient Improvements (within Elective Care Board Programme). Target date: Improvement Program established. PAS patch implemented in June 22. Full roll out of virtual offer by March 23~~	~~• Reports to SLG and through to Board via Strategy updates~~	~~Good~~	~~Good~~	~~2~~	~~Internal transformation plan full delivery by March 23~~	
									~~**Gaps in Control and Actions:**~~						
PL 1.10	QC?	CMO	1645	CMO	**Risk description:** If the Trust's SHMI is out of range then it will suggest excess deaths are occurring regardless of the actual cause. So this will cause reputational damage and invite inspections by regulators, which are not necessary if coding is the underlying correctable cause.	4	4	16	• Scrutinising other care quality indicators to assure standards of care • Ensuring accuracy and timeliness of clinical coding by reporting by exception to FPC • The CMO receives a monthly update of number of uncoded SPELLS • Additional staff are being recruiting to coder vacancies	• Regular reports to Hospital Mortality group, Quality Committee and Board. • CMO undertaking audit of 50 consecutive deaths June 2023 • The Dorset ICB is brokering external oversight	Requires Improvement	Good	8	Ongoing	
									Gaps in Control and Actions:						
PL 1.11	RAC	CIO	641	CIO	**Risk description:** If we do not deliver robust, accurate and timely coding then data submitted to NHSE and NHS Digital will not be reflective of the care delivered, so workload will be inaccurate and there will be a negative impact on reputation through KPI's such as the Summary Hospital-level Mortality Index.	4	4	16	The coding department is attempting to recruit a new full-time manager (2 yr FTC now under consideration) and to fill all existing vacancies. The current coding backlog is expected to be recovered before the annual data submission deadline of 19/5/22.	Vacancies versus establishment Coding backlog Improvement in SHMI	Requires Improvement	Requires Improvement	6	?	
									Gaps in Control and Actions:						
Place Objective 2: We will build sustainable infrastructure to meet the changing needs of the population															
PL 2.1	FPC	CFO	1465	Strategic Estates Project Director	**Risk description:** If we do not commit sufficient resources to New Hospital Project and wider strategic estates development then plans and business cases will not be robust so we will not receive funding to deliver	5	2	10	• Full Programme Structure in place with dedicated team • NHP Project Board, Clinical Assurance Group, • Finance and Performance Committee into Trust Board - Lobbying of NHSEI/NHP team re. seed-funding at all levels - SEED funding for 2022/23 now agreed	• NHSEI SOC Approval; - NHSEI NHP Deep Dive re. OBC, OBC submitted June 2022	Good	Good	10	Ongoing	
									Gaps in Control and Actions: - Regular reporting to FPC						
PL 2.2	FPC	CFO	698, 692 , 1172 and 819	Deputy Director of Finance	**Risk description:** If we do not embed appropriate business case approval processes then plans will not be sustainable so we will not be able to meet the needs of patients and populations	4	3	12	• Working group to inform SLG decisions • Business case templates and corporate report front-sheets	• Working Group papers • External approval of business cases e.g. NHP	Good	Good	10	31/03/2023	
									Gaps in Control and Actions: - Lack of adherence to and application of agreed processes - Lack of knowledge of agreed processes - No review/check of business cases against required templates						
PL 2.3	FPC	CFO	1646	CFO	**Risk Description:** If we do not work to improve our sustainability as an organisation then we will increase our environmental impact and so we will not improve the environmental, social and economic well-being of our communities, populations and people.	3	3	9	• Sustainability champions & Sustainability Travel Working Group in place at DCH to encourage long term improvements and sustainability • Sustainability Programme in development in line with the Kings Fund Sustainability Theory bringing together Social, Environmental and Economic factors • Social Value Pledge and Action Plan in place emphasising the commitment to improving the wellbeing of the population • Green plan published and monitored annually • Planned revision of annual report to support triple bottom line reporting	• Regular reporting to Strategy and Transformation SLG • Annual reporting on Green Plan to FPC and Board	Good	Good	9	Ongoing	
									Gaps in Control and Actions:						

Risk Ref:	Committee	Accountable Executive	Risk register ref no.	Risk Owner	Risk Description/Risk Owner:	Consequence Score	Likelihood Score	Risk Score	Existing Mitigation/ Controls	Assurance/ Evidence	Strength of Control	Strength of Assurance	Target Risk	Mitigations - Target Date	# Place Risks: 17
Place Objective 3: We will utilise digital technology to better integrate with our partners and meet the needs of patients															
PL 3.1	FPC	CIO	1287, 1344, 1352, 1300, 1417 and 1337	CIO	**Risk description:** If we do not achieve a Dorset wide integrated electronic shared care record then we run the risk of not making the right information available to care professionals, so we will not be able to make sure the right information is available to the right person in the right place at the right time about the right patient increasing the likelihood of patient harm	1	3	3	Dorset Care Record project lead is the Director of Informatics at UHD. Project resources agreed by the Dorset Senior Leadership Team. Project structure in place overseen by ICS Digital Portfolio Director	• Reports to the Dorset System Leadership Team. Updates provided to Dorset Operation and Finance Reference Group and the Dorset Informatics Group.	Good	Good	3	Achieved - currently at Target Risk	
									Gaps in Control and Actions:						
PL 3.2	FPC/QC/RAC	CIO	1357,1365 and 690	CIO	**Risk description:** If we do not have adequate cyber security defences to protect the Trust's digital assets then we increase the likelihood of impact from a cyber event, so the Trust will suffer partial or complete loss of digital services including access to critical applications, data and/or digitised processes.	3	4	12	Patching of perimeter defences, firewalls, servers, switches, desktop/laptop equipment, penetration tests and regular audits	• Annual Penetration Test Results and associated action plan • Annual DSPT submission • Regular reports to Quality Committee, Risk and Audit Committee, Trust Board • Annual Internal Audits • Annual renewal of ISO27001 accreditation • Tools deployed by the Trust to monitor and report on cyber threats • Use of tools made available by NHSE to monitor alerts/threats i.e. CareCERT • SIRO, Deputy SIRO, Information Security Manager, Data Protection Officer - all posts filled	Good	Good	9	Ongoing task, no fixed delivery date	
									Gaps in Control and Actions:						
PL 3.3	QC/RAC	CIO	690	CIO	**Risk description:** If Trust staff are not trained sufficiently to minimise targeted and social engineering threat attempts then we increase the likelihood of the impact of a cyber event, so the Trust will suffer partial or complete loss of digital services including access to critical applications, data and/or digitised processes.	3	4	12	Part of DSPT annual assurance, digital training team providing training for all new starters and annual refresh training . Regular phishing campaigns.	• Annual DSPT submission • Regular reports to Quality Committee, Risk and Audit Committee, Trust Board • Targeted training resulting from output of internal campaigns • Annual Internal Audits • Annual renewal of ISO27001 accreditation • Tools deployed by the Trust to monitor and report on cyber threats • Use of tools made available by NHSE to monitor alerts/threats i.e. CareCERT	Good	Good	9	Ongoing task, no fixed date	
									Gaps in Control and Actions:						
Place Objective 4: We will listen to our communities, recognise their different needs and help create opportunities for people to improve their own health and wellbeing and co-designing services															
PL 4.1	Quality Committee	CNO	1647	Alison Male - Patient Engagement Jo Hartley: Maternity voices partners	**Risk description:** If we fail to engage and work with partners and stakeholders to effectively maximise the opportunities to engage and co-design with our communities then services will not be meeting the needs of those that use then.	3	4	12	• Your Voice group of service users- Target date: complete process in place and ongoing (reports to PEG and then QC) • Maternity Voices Partners as part of the Local Maternity & Neonatal System - Target date: in place and ongoing (Reports to QC and ICS SQG) • Communication and Engagement lead for estate development to support further engagement with local population: target date: in place and ongoing (reports via project Board) • Learning Disability Advisor linked activity with independent groups of service users- Target date: in place and ongoing (reports to QC) • Engagement roadmap with leadership from Head of patient Experience and Engagement: Target date: in place and ongoing reports to PEFG and QC • Networked links with external engagement partnerships such as Healthwatch Dorset, CCG/ICS team, Dorset Council: Target date in place and ongoing, feeds into QC • Council of Governors links into community coordinated by Trust Secretary • QI methodology includes service user engagement: Target date: In place • Public Health networks into key work streams for population health and wellbeing (such as smoking cessation) • Health Inequalities group and networked activity across ICS to support engagement with diverse population • Communication teamwork across the ICS • ICS strategy work to commence +engagement of population May-Jun 2022 • Patient safety Partners appointed and commenced - patient partner at forefront of patient voice into safety	• PEG actions/ notes • Patient feedback • Healthwatch reports • CQC reports • Maternity Voices reports • Complaints including local MPs related to engagement • Local independent groups reports or complaints • Diis Data and Public Health reports • Health Inequalities data	Good	Good	4	Apr-24	
									Gaps in Control and Actions: - Capacity of internal team to expand co-design and engagement is limited, even with working collaboratively with others in the system through networks. Action: Continue to maximise other resources and support where able and focus upon priorities to mitigate.						
PL 4.2	QC	CNO & CMO	1647	CIO - digital and BI Alison Male - Patient feedback CMO - AHSN CEO/Director of Strategy - ICS	**Risk description:** If we fail to utilise population health data in a meaningful way to inform service development then services will not meet the needs of the population in ways that means an improvement in health and wellbeing	3	4	12	• DiiS dataset • Partnership in ICS with Public health and Local authority at PLACE level • Primary care Networks • Digital data sources with shared records • Business intelligence resources across the system • ICS Health inequalities group • ICS integrated working on pathways • Clinical networks membership with data sharing • Academic Healthcare science networks • ICS governance	• HI group reports and actions • Benchmarking data • Patient feedback • Partners feedback • Data • National published reports or network reports • ICS Clinical reference group notes • National audits on outcomes	Good	Good	4	Apr-24	
									Gaps in Control and Actions: - Gap in analytics of data capacity to support clinical leads: ACTION: part of the One Dorset approach to digital and business intelligence resources aligned to the ICS digital strategy development						

Risk Ref:	Committee	Accountable Executive	Risk Regsiter ref no.	Risk Owner	Risk Description/Risk Owner:	Consequence Score	Likelihood Score	Risk Score	Existing Mitigation/ Controls	Assurance/ Evidence	Strength of Control	Strength of Assurance	Target Risk Score	Mitigations - Target Date	# Partnership risks: 12
Partnership Objective 1: We will contribute to a strong, effective Integrated Care System, focussed on meeting the needs of the population															
PA 1.1	Board	CEO		CEO/Director of Strategy	**Risk description:** If the Trust decision-making processes do not take due account of system elements then the Trust will not be able to engage proactively within the system so the impact of the Trust on the system will be diminished	4	2	8	• SLG and Corporate Governance includes system updates and information • Membership of Provider Collaboratives and system other forums • Board feedback and monitoring of system engagement	• SLG Meetings • Board and Committees • System Oversight Framework	Good	Good	8		
									Gaps in Control and Actions:						
PA 1.2		CIO		CIO	**Risk description:** If the Trust does not embed population health data within decision-making which highlights health inequalities then the Trust will not know if it is delivering services which meet the needs of its populations	3	3	9	• Dorset Insight and Intelligence Service (DIIS) accessible and available to Trust • DIIS/BI dashboards on key trust metrics provided	• Health Inequalities Programme • Digital Portfolio Board	Requires Improvement	Requires Improvement	6	Mar-23	
									Gaps in Control and Actions: Funding being sourced for a Data Scientist to join the DiiS Team Funding being sourced to continue to provide the System PHM team which will benefit efforts at DCH Trust BI team to make more use of inequality data and wider determinants data available in the DiiS in DCH toolsets The resolution requires more staff/more experience , this is pending outcome of planning round, and subsequent recruitment &/or training following						
PA 1.3		CMO		CMO	**Risk description:** If robust departmental, care group and divisional triumvirate leadership does not facilitate genuine MDT working, then services will be less effective, so that poor patient outcomes are more likely	3	2	6	• Divisions supported by the Strategy and Partnerships Team (Estates/place based portfolio). • Development of the clinical strategy - 1st iteration completed 2022	• Reporting through SLG • CMO and DDs attend departmental meetings when available	Good	Good	6	Jul-22	
									Gaps in Control and Actions: • Many Clinical Leads have not had leadership/management training. ACTION: Regular training seminars commenced September 2022 - Deputy CMO; Formalised m**onthly training days for all Clinical Leads in**						
PA 1.4		CMO	1221, 561, 765, 1605 and 1474	CMO	**Risk description:** Recovery of waiting lists plus increasing workload within the hospital may impair our ability to contribute effectively to the objectives of the ICS	3	4	12	• Development of the Clinical and People Strategies, recognising the need for integrated working • Trust Board oversight and assurance of ICS Involvement in Elective Recovery Oversight Group with clinical leads present in key workstreams - MSK, Eyes, Endoscopy, ENT - opportunities noted and acted upon to share resource, space, ideas to maximise recovery as a system	• Monitoring and oversight of Trust Strategy and enabling strategies, reporting to Trust Board evidenced through papers and minutes • ECOG and associated workstream documentation • Achievement of waiting time targets set by NHSE	Requires Improvement/ Good	Good	6	Sep-22	
									Gaps in Control and Actions GAP: Waiting list recovery is hampered by NCTR patients. ACTION: Joint working with DHC and Dorset Council to improve patient flow.						
Partnership Objective 2: We will ensure best value for the population in all that we do and we will create partnerships with commercial, voluntary and social enterprise organisations to address key challenges in innovative and cost-effective ways															
PA 2.1	FPC	CFO	1646	CFO	**Risk description**: If the Trust fails to deliver sustained financial breakeven and to be self sufficient in cash terms then it could be placed into special measures by the regulator and need to borrow externally to ensure it does not run out of cash	4	4	16	• ICS Financial framework and Financial Strategy. • Current operating plan delivers a breakeven and does not require external financing, but are heavily reliant on non recurrent funding and 2.5% CIP.	• ICS Financial framework and Financial Strategy • Reporting to Board, FPC and BVBCB.	Good	Requires Improvement	12	31/03/2023	
									Gaps in Control and Actions: System summit progressing some transformational recovery actions and financial recovery support has been commissioned working across the system to develop a plan to get back into balance.						
PA 2.2	FPC	CFO	1646	CFO	**Risk description**: If the Trust fails to deliver sufficient Cost improvements and continues to be efficient in national financial benchmarking then there will be increased focus from the regulator and a detrimental impact on reputation as well as highlighting financial sustainability concerns.	4	3	12	• Track record, PMO facilitating ideas for savings etc and increasing dedicated workforce resource. • BVBCB, FPC and Board monitoring CIP plans and delivery	• Model hospital, GIRFT reviews, Reference costs index, Corporate services benchmarking.	Good	Good	9	31/03/2023	
									Gaps in Control and Actions: Mitigating schemes to support the Trust delivering a breakeven position have been identified, with work ongoing to deliver these opportunities						
PA 2.3	QC	CEO	1646	CEO	**Risk description:** If the Trust does not engage with commercial and VCSE sector partners then cost effective solutions to complex challenges will be restricted and so the Trust will be limited in the impact it is able to have	3	2	6	• Commercial and Partnerships Strategy and Plan • VCSE engagement via patient and public engagement and charity teams. • SLG reporting	• Commercial strategy delivery reporting • Your Voice Engagement Group • Social Value strategy oversight	Good	Requires Improvement	6		
									Gaps in Control and Actions:						
Partnership Objective 3: We will increase the capacity and resilience of our services by working with our provider collaboratives and networks and developing centres of excellence We will work together to reduce unwarranted clinical variation across Dorset															
PA 3.1	FPC	COO		COO	**Risk description:** If the Trust does not optimally collaborate with provider partners through the ICS Provider Collaboratives and other existing clinical networks then sustainable solutions via collaboration will not be explored or adopted and so vfm, sustainability and variation of services for patients will not decrease sufficiently	4	2	8	• Engagement in current provider collaborative and Clinical Network Group • Working with DHC on UTC developments in the West - Target date for delivery is 23/24 Working with DHC on Flagship initiatives - Target Date: Autumn 2023 South Walks initiative with system partners including Local Authority and community provider. Target date: March 2024 for delivery of whole prgram although elements are already live	• Reporting to Trust Board and FPC • System documentation for INCOG, UECB, Provider Collaborative and CaNDo	Good	Good	8		
									Gaps in Control and Actions: The Provider Collaborative is in theprocess of agreeign the 23/24 focus DCH/DHC collaboration on transfrormation in development						

Risk Ref:	Committee	Accountable Executive	Risk Regsiter ref no.	Risk Owner	Risk Description/Risk Owner:	Consequence Score	Likelihood Score	Risk Score	Existing Mitigation/ Controls	Assurance/ Evidence	Strength of Control	Strength of Assurance	Target Risk Score	Mitigations - Target Date	# Partnership risks: 12
PA 3.2	FPC	CEO		CMO	**Risk description:** If the Trust does not initially support the appropriate delegation of authority to the Provider Collaborative and then does not adequately acknowledge and accept the delegation then effective functioning of the Provider Collaborative will not be possible and appropriate and measured solutions which improve sustainability and reduce variation will not be implemented	4	2	8	• Engagement of Trust Board in ICS discussions and planning • Trust Board review and approval of any delegation. The Trust has a legal obligation to collaborate outlined in the amended provider licence	• Trust Board papers	Good	Good	8		
									Gaps in Control and Actions:						
PA 3.3	QC	CMO		CMO	**Risk description:** If the Trust does not invest and support key services identified as 'centres of excellence' by the clinical strategy then investment into key services integral to the future sustainability of the Trust will not be forthcoming	3	4	12	• The Clinical Strategy will set out the areas for investment and prioritisation. • Investment through business planning will be aligned to clinical strategy to ensure investment in key areas which are integral to the future sustainability if the Trust • Review of investment and impact via divisional performance framework and sub-committee structure.	• Monitoring of clinical strategy via S&T SLG and divisional performance • Business Planning processes	Good	Good	8	?	
									Gaps in Control and Actions GAP: Centres of Excellence need to be identified across all Dorset Trusts and developed jointly. ACTION: Joint working with DHC and within the ICS will support development.						
Partnership Objective 4 Through partnership working we will contribute to helping improve the economic, social and environmental wellbeing of local communities															
PA 4.1	FPC	CEO		Head of Social Value	**Risk description:** If the Trust does not recognise the impact of it's decisions on the wider economic social and environmental well-being of our local communities then our impact will not be as positive as it could be and so the health our populations will be affected	3	3	9	• Social Value Programme. • Social Value Impact Assessments against decision • Reporting of social value programme progress and impact against social value plan to SLG and Trust Board.	• Social Value reporting to SLG and Board • SV Dashboard • SV reporting in annual report	Good	Good	6		
									Gaps in Control and Actions:						

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

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

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

Likelihood score (L)

The Likelihood score identifies the likelihood of the consequence occurring.

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

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

Identifying Risks

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

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

Scoring & Grading

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

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

DOMAIN C1: SAFETY, QUALITY & WELFARE

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

DOMAIN C2: IMPACT ON TRUST REPUTATION & PUBLIC IMAGE

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

DOMAIN C3: PERFORMANCE OF ORGANISATIONAL AIMS & OBJECTIVES

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

DOMAIN C4: COMPLIANCE WITH LEGISLATIVE / REGULATORY FRAMEWORK

	1	2	3	4	5
Domain	**Negligible**	**Minor**	**Moderate**	**Major**	**Catastrophic**
Statutory duty/ inspections	No or minimal impact or breach of guidance/ statutory duty	Breach of statutory legislation Reduced performance rating if unresolved	Single breach in statutory duty Challenging external recommendations/ improvement notice	Enforcement action Multiple breaches in statutory duty Improvement notices Low performance rating Critical report	Multiple breaches in statutory duty Prosecution Complete systems change required Inadequateperformance rating Severely critical report

DOMAIN C5: FINANCIAL IMPACT OF RISK OCCURING

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

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

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

Risks	RAC Dates: Nov-21	11-Jan-22	15-Mar-22	10-May-22	12-Jul-22	20-Sep-22	22-Nov-22	17-Jan-23	20-Mar-23	01-Jun-23	Trend vs Jan-22
PE 1.1	16	16	16	16	16	16	16	16	16	16	Unchanged
PE 1.2	20	20	20	20	20	20	20	20	20	20	Unchanged
PE2.1	12	12	12	12	12	12	12	12	12	12	Unchanged
PE 3.1	8	8	8	8	8	8	8	8	8	8	Unchanged
PE 3.2	12	12	15	15	15	15	15	15	15	15	Worsening
PE 3.3	12	12	12	12	12	12	12	12	12	12	Unchanged
PE 3.4	6	6	6	6	6	6	6	6	6	6	Unchanged
PL 1.1	20	20	20	20	20	20	20	20	20	20	Unchanged
PL 1.2	16	16	16	16	16	16	16	16	16	16	Unchanged
PL1.3	16	20	20	20	20	20	16	16	16	16	Improving
PL 1.4	6	6	6	6	6	6	6	6	6	6	Unchanged
PL 1.5	20	20	20	20	20	20	20	20	20	16	Improving
PL 1.6	12	12	12	12	12	12	12	12	12	12	Unchanged
PL1.7	12										Unchanged
PL1.8	16										Unchanged
PL 1.9	2	2	2	2	2	2	2	2	2		Improving
PL 1.10	16	16	16	16	16	16	16	16	16	16	Unchanged
PL 1.11			16	16	16	16	16	16	16	16	Unchanged
PL 2.1	15	20	15	15	15	10	10	10	10	10	Improving
PL 2.2	16	16	20	16	16	16	16	16	16	16	Unchanged
PL 2.3	9	9	9	9	9	9	9	9	9	9	Unchanged
PL 3.1	6	9	3	3	3	3	3	3	3	3	Improving
PL 3.2		12	12	12	12	12	12	12	12	12	Unchanged
PL 3.3		12	12	12	12	12	12	12	12	12	Unchanged
PL 4.1	12	12	12	12	12	12	12	12	12	12	Unchanged
PL 4.2	12	12	12	12	12	12	12	12	12	12	Unchanged
PA 1.1	8	8	8	8	8	8	8	8	8	8	Unchanged
PA 1.2	9	9	9	9	9	9	9	9	9	9	Unchanged
PA 1.3	6	6	6	6	6	6	6	6	6	6	Unchanged
PA 1.4	12	12	12	12	12	12	12	12	12	12	Unchanged
PA 2.1	20	20	20	16	16	16	16	16	16	16	Improving
PA 2.2	12	12	12	12	12	12	12	12	12	12	Unchanged
PA 2.3	6	6	6	6	6	6	6	6	6	6	Unchanged
PA 3.1	8	8	8	8	8	8	8	8	8	8	Unchanged
PA 3.2	8	8	8	8	8	8	8	8	8	8	Unchanged
PA 3.3	16	16	16	12	12	12	12	12	12	12	Improving
PA 4.1	9	9	9	9	9	9	9	9	9	9	Unchanged

1. Report Details			
Meeting Title:	Board of Directors, Part 1		
Date of Meeting:	26 July 2023		
Document Title:	Corporate Risk Register		
Responsible Director:	Jo Howarth Interim Chief Nursing Officer	Date of Executive Approval	06/06/2023
Author:	Mandy Ford, Head of Risk Management and Quality Assurance		
Confidentiality:	*n/a*		
Publishable under FOI?	*No*		
Predetermined Report Format?	*No*		

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

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

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

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

Audit and Risk Committee
Corporate Risk Register as at 31.05.2023

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

The Committee may be aware that during February the Trust Board held a workshop to look at reframing and reviewing the Trust Risk Appetite statement.

This has been updated within the Risk Management Framework document. However, following a review of our framework, a decision has been made to align it with Dorset Health Care. This will mean a change in the Risk Matrix that we currently use.

Moving forward any risk register items scored 15 or above will be reported to the Risk and Audit Committee and will be escalated to the Corporate Risk register.

A review of all items currently scoring 15 or above is currently being undertaken. Work remains ongoing with the relevant Executives and Teams to review and reframe risks that have been on the Register for a period of 18 months or longer.

1. Introduction

1.1 This report provides an update from the report presented to the March 2023 Trust Board Committee meeting and to highlight any new and emerging risks from within the Trust. It should be noted that this report details the Trust position as at 31.05.2023 unless otherwise stated and is reflective of the operational risks.

1.2 This report is to provide the Committee with assurance of the continued focus on the identification, recording and management of risks across the Trust at all levels. These are managed in line with the current Trust's Risk Management Framework, but will change should the new revised Risk Management Framework be agreed. The Corporate Risk Register is an amalgamation of the operational risks that require Trust level oversight.

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

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

2. New Items to the Corporate Risk register

2.1 1646 – Financial Sustainability 2023/24 (EXTREME (Major (4) x Certain (5))

The final plan for 2023/24 reflects a breakeven position for the Trust. This includes a CIP of £10.9m (4.2%) and unfunded inflationary pressures of c. £3m, which poses a risk to the financial sustainability strategic objective.

There are a number of workstreams in progress across the Dorset system which should partially mitigate the financial challenges, along with the development of a Trust financial transformation programme. Nevertheless, achievement of a breakeven position will pose challenging, with significant risk of delivery.

2.2 1645 – Mortality Indicator (SHMI) (HIGH (Major (4) x Likely (4)) – Replaces 464

An increased Summary Hospital Mortality Indicator (SHMI) may indicate increased in-patient mortality, and/or a failure to code correctly patients admitted to DCH, or a combination of the two.

The current prediction for the next reporting period is that our SHMI will decrease into the expected range, but may rise out of range again in 4 months' time. All deaths are reviewed by the DCH Medical Examiner team, and 20% of all deaths are subject to a Structure Judgment Review (SJR). The national expectation is that 10% of deaths are subject to SJR. The DCH CMO is repeating a 2019 audit of 50 consecutive deaths to look for any lapses of care, with additional outside independent support via the ICS.

The Dorset ICS and SW Region are currently scrutinising mortality data across the Region and offering advice and independent review of the measures currently in place at DCH which the CMO has willingly accepted. Simultaneously, improvements are being made to the DCH Clinical Coding department in the expectation that data quality issues will be resolved over the next 6 – 9 months. However given the retrospective nature of SHMI reporting, this will not influence SHMI until around the time of the publication of SHMI for the 12 months to October 2023 (published in March 2024).

2.3 1561 – Maintaining business as usual during construction phase of NHP (HIGH (Major (4) x Likely (4))

With the demolition of the West Annex starting early June 2023, maintaining business as usual for site services, supply chain and ED access for ambulances and walk in patients is unresolved with current site plan and project phasing.

There are concerns that the design hasn't been developed in suitable detail to understand the maintenance of business as usual during the entire construction/refurbishment phase. Compromised access to site plant rooms (e.g. med gas plant, fuel stores),goods in, decontamination facility and ED. Option appraisals are being worked through with the clinical teams.

2.4 1642 – Failure to attract and retain the right people with the right skills.

2.4.1 The Committee will be aware that, following discussion the following risk register items were moved to managed/tolerated within risk appetite in May 2021.

463 – Workforce planning and capacity for nursing and allied health professionals and health sciences staff (HIGH RISK)

468 – Recruitment and retention of medical staff across all specialities. (EXTREME RISK)

2.4.2 This new risk reframes these two risks, as staffing across the Trust remains challenging. This is being mitigated by the use of agency and bank staff as well as redeploying staff from wards to other services areas to support safe patient care and safer staffing. Work is ongoing to look at

reducing the use of high cost agency, and staff continue to report shortages in staffing across all services. Staffing levels continue to be closely monitored to ensure safe staffing is maintained. No red flag or unsafe shifts have been reported.

2.4.3 Sitting beneath the overarching risk, is a number of service specific risk registers relating to staffing, which are detailed in the appendices.

3. Top Themes:

3.1 1221 - Tackling the backlog of elective care (Extreme (20))

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

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

3.1.3 The Trust continues to work with partners and the ICB where gaps are identified in patient pathways, and for those with complex care needs.

4 UPDATES:

4.1 461- High volume of patients with no reason to reside (Extreme (Major (4) x Certain (5))

4.1.1 We still have a high volume of patients residing in the hospital with no medical need or reason to remain in a hospital bed, which is likely to impact on the patient's well-being and the flow of patients across the hospital. 58 patients were reported across all pathways as NCTR on 30.05.2023. This is lower than reported in the previous two reports. (13 March 2023, the total across all pathways stood at 75 patients. This was reported in January 2023 as 96 patients).

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

4.1.3 Clinical teams continue to report incidents for patients that have no reason to reside due to the impact on their physical and mental well-being, whilst this is difficult to evidence fully, we are aware that delays in discharge are affecting patients. As their condition deteriorates, their care needs increase, which means the assessment and brokerage process has to be recommenced. Asking whether a patient was MFFD at the time of the incident has now been made a mandatory field within the incident reporting form, to better assist in capturing data.

4.2 1251 – Critical Failings in hospital blood bank (MODERATE 12 (previously HIGH 15))

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

4.2.1 The main areas for concerns are:

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

3.3.2 Whilst the risk is being managed, the service have requested that it remains on the Risk Register as a moderate risk until the MHRA feel sufficiently assured of the continued improvements to cease their increased monitoring by the Compliance Management Team.

4.3 472: Community Paediatric Long Waits for ASD Patients (Scored as 4 Major x 5 Certain =20 Extreme)

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

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

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

4.4 1509 – Mental Health patients delays in care pathway and services support (EXTREME (Major (4) x Certain (5))

Linked to this is:
866 – External Multiagency delays resulting in delayed discharges of complex Paediatric patients (EXTREME (Major (4) x Certain (5))
461- High volume of patients with no reason to reside (Extreme (Major (4) x Certain (5))

4.4.1 Mental health capacity to meet growing demand is impacting on potential delivery of longer-term care in the right place and therefore clinical outcomes. This element is detailed separately on the risk register. Issues are regularly escalated to partners and the ICB and we continue to work with partners to try and resolve this issue, recognising that there is a national shortage of mental health beds.

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

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

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

4.5 Emerging Risks from Divisions:

4.5.1 Urgent and Integrated Care

4.5.1.1 Pharmacy service

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

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

  Update (26.05.23):
  - Action plan progressing - 59% of the action plan is between 75-100% complete.
  - Awaiting date for next audit - due August 2023
  - Capacity Plan has been redrafted (awaiting final sign off) but will show the unit as overcapacity. The capacity of the unit will need to be reduced and will drop below demand from Haem/Onc.
  - Exploring Ready-to-administer (RtA) products from commercial providers to bridge the demand/capacity gap. Early signs are promising, but the market is unstable. Indication from NHSE is we can pass through the costs of commercial compounding as long as reasonable.
  - UHD have suspended compassionate use/EAMS schemes to focus on NICE approved treatments. Some clinical teams are trying to get DCH to pick these patients up, but we cannot support non-NICE approved treatments due to our capacity.
  - Unable to support Research activity through the unit.
  - NHS Dorset have reviewed the risk and asked the Provider Collaborative to discuss solutions to the risks across ICS. Chief Pharmacist is producing paper to EMT.
  - 2 failed attempts at recruitment of Lead Pharmacist

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

  Update (26.05.2023):
  - International recruitment of Pharmacist approved by EMT. Process started. Recruited 3 Pharmacists so far, with more to interview.

- Service have appointed UK Band 6 Pharmacists, but already lost 2 due to cost of accommodation/better offer.
- Pharmacy Technician vacancies are starting to rise, with almost 50% in clinical technicians.
- increasing training numbers for Pharmacy Technicians to try and recover that workforce.
- ICS Faculty undertaking promotional campaign.
- Workforce challenges being seen across South West.

4.5.2 Family Services and Surgical Division

4.5.2.1 **1475 Ophthalmology Long wait new patients (scored as 3 Moderate x 4 Likely = 12 MODERATE)** Update provided:03.03.2023
Due to capacity within service we are unable to see patients within the 18 week pathway standard.

Mitigations currently in place:

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

Progress:

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

4.5.2.2 **1474 Ophthalmology FOWL long waiters (scored as 4 Major x 4 Likely = 16 HIGH)**
Update provided:14.04.2023
Due to capacity within service, we are unable to see the follow ups in the appropriate timeframe.

Mitigations currently in place:

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

Progress:

- Still awaiting outcome of business case 1 WTE Orthoptist- advised by divisional manager to submit post onto Trac.
- Weekend insourcing continues. Patients offered injection appointments at the weekend to allow capacity within the week. Failsafe officer for Macula, cross-referencing in-house spreadsheet with FOWL to ensure all patients are accounted for. Action Plan in place and meeting monthly.

4.5.2.3 **1477 Ophthalmology Clinical Space (scored as 4 Major x 4 Likely = 16 HIGH)**
Update provided:14.04.2023
Lack of clinical space means we are unable to meet the needs of the service.

Mitigations currently in place:

- 18 week running activity at weekends for Cataract, Macular & Glaucoma

- Use of Community locations where possible - Increased possibilities due to diagnostic equipment purchased.
- Exploring Procedure room to relocate outside of R.E.I.

Progress:

- New Assistant service manager to assess waiting area options and increase capacity within DCH site.
- Matron, Service Manager and Business Manager to review rooms and clinical space within the dept.

4.5.2.4 561 – Volume of patients on the Orthopaedic Admitted waiting list (EXTREME (Major (4) x Certain (5)).

Inadequate capacity to operate on the volume of patients waiting over the RTT performance standard. This has been compounded by elective cancellations due to Covid-19, bed capacity and a rising demand in Trauma.

Mitigations currently in place:

- Currently outsourcing work of elective surgery to private providers.
- Plans are being drawn up by Theatres Service Manager to outline training plans to increase trained scrub staff numbers.
- LLP weekends have been running to increase capacity lost during the week. However, a significant amount of lists being cancelled due to limited beds & Orthopaedic theatre Staff

5 Digital Technology & Infrastructure (DTI)

5.1 There are a number of risks identified on the DTI registers which are currently being reviewed. A full report on the DTI risk register items will be included in the next report to the Risk and Audit Committee to enable the Chief Information Officer and the Head of Risk Management to undertake a full review of the register.

6. Conclusion

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

7. Recommendation

The Board is recommended to:

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

Name and Title of Author:
Mandy Ford, Head of Risk Management and Quality Assurance
Date: data correct as at 31.05.2023
Appendices

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

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

		Likelihood Score				
score		1	2	3	4	5
		Rare (this will probably never happen 1x year)	Unlikely (Do not expect it to happen but it is possible 2 x year)	Possible (might happen occasionally - monthly)	Likely (will probably happen - weekly)	Certain (will undoubtedly happen – daily)
Impact/Consequence Score	5 Catastrophic	5	10	15	20 (1642)	25
	4 Major	4	8 (1643)	12 (450, 659,690, 1644)	16 (474, 1561, 1645)	20 (461, 472, 1221, 1509,1646)
	3 Moderate	3	6 (1012)	9	12 (919, 1251, 1647)	15 (641)
	2 Minor	2	4	6 (890)	8	10
	1 Negligible	1	2	3	4	5
	KEY	(↓number) (↑number)	Risk score has decreased since previous report Risk score has increased since previous report **Please note that no arrow indicates no change to previous risk score.**			
	Managed/Tolerated risks					
	Closed	464 – Mortality Indicator (reframed in Risk Ref: 1645) 1252 – Financial Sustainability 22/23 (Extreme)				

Corporate Risk Register **Appendix 2**

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

Movement on Risk Register: **NEW**	Risk Statement Added to Risk Register 01/04/2023	CURRENT RISK RATING (Following review and mitigations)	Extreme (20) Consequence: Major Likelihood: Certain Reviewed:19.05.2023
1646	**Financial Sustainability year 2023/24**	Previous Rating	Extreme
Impact on Strategic Objectives		Lead Executive	Chris Hearn
Strategic Objective: People **Strategic Objective: Place** **Strategic Objective: Partnership** The final plan for 2023/24 reflects a breakeven position for the Trust. This includes a CIP of £10.9m (4.2%) and unfunded inflationary pressures of c. £3m, which poses a risk to the financial sustainability strategic objective. There are a number of workstreams in progress across the Dorset system which should partially mitigate the financial challenges, along with the development of a Trust financial transformation programme. Nevertheless achievement of a breakeven position will pose challenging, with significant risk of deliver.		Local Manager	Claire Abraham
Current position As at 19.05.2023 (data correct as at 31.05.2023)		TARGET RATING Target date:	Low (6) Consequence: Moderate Likelihood: Unlikely 31.03.2024
Mitigation: Exploring additional options to mitigate risks against plan not delivering, which will link back to the Trust risk appetite and Board decisions when escalated through FPC **Update:** The Dorset system have submitted a plan to reach breakeven, however, it contains significant risk in delivery and requires a full delivery of cost improvement programmes and financial improvement programmes. The current year to date position is £0.5m worse than plan for the Trust with plans in place to achieve a breakeven position.		Next review date **ACTIONS ONGOING TO MANAGE FINANCES**	30.06.2023

Movement on Risk Register: **Static**	Risk Statement **Added to the Risk Register 03.04.2023**	CURRENT RISK RATING (Following review and mitigations)	Extreme (20) Consequence: Catastrophic Likelihood: Likely Reviewed: 20.04.2024
1642		Previous Rating	Extreme
Impact on Strategic Objectives		Lead Executive	Ruth Gardiner
Strategic Objective: People **Strategic Objective: Place** **How this risk has been scored:** **Consequence: Catastrophic** **Impact on patient safety** - mismanagement of patient care with long term effects **Quality/Complaints/Audit** - Non-compliance with national standards, critical report. Human resources - loss of key staff, low staff morale. **Statutory duty** - multiple breeches in statutory duty, improvement notices, low performance rating, critical report. **Adverse publicity** - National media coverage (being outliers) **Business objectives** - key objectives not met. **Finance including claims** - Non delivery of key objectives loss of >1% of budget, loss of contracts and payment by results		Local Manager	Simon Brown Ian Kilroy
Current position As at 12.05.2023 (data correct as at 12.05.2023)		TARGET RATING Target Date:	Moderate (15) Consequence: Moderate Likelihood: Certain 31.03.2025
Mitigation: • People Plan • Implementation of workforce business partner model • System attraction strategy • Resourcing function business case • Career pathways • CESR academy proposition • Locally employed doctor appraisal and development • Pilot site for national stay and thrive initiative & international nurse experience deep dive • OD team • Development of flexible & temporary staffing function • Inclusive leadership programme • Management Matters programme (starting Nov 2022) • Transforming people practices programme • Values based recruitment -HCA workforce		Next review date **ACTIONS AND MITIGATION AND ONGOING**	31.05.2023

Risk registers sitting under 1642: Mitigations are reported to PCC

ID	Title	Risk Statement	Review date	Care Groups	Service of responsibility	Risk level (current)
1555	Kingfisher staffing levels	Staffing levels on Kingfisher ward are inadequate due to having 14 beds and only three registered Children Nurses working on the ward per shift. As stated within the RCN Mandatory nurse staffing levels that we should have 1:4 that covers 12 beds. Our patient acuity has increased, which is evidenced in the ward acuity audit.	31/07/2023	Family Services (B4)	Paediatrics Service	Extreme
1544	Paediatric CPE	No substantive Paediatric Clinical Practice Educator for Paediatrics to cover Kingfisher, Paediatric Day Surgery and Community/Specialist Nursing.	08/05/2023	Family Services (B4)	Paediatrics Service	High Risk
1552	Shortfall of SPRs	Significant gaps in SPR on call rota and cross cover for wards when impacted by short notice sickness or absence.	12/12/2022	Unscheduled Care (A3)	Across all specialties	High Risk
1606	Facing the Future standards for acute paediatric cover	RCPCH standards recommend consultant paediatric cover during peak times (9am - 9pm) 7 days a week. This is currently not deliverable with the number of consultants and rota pattern.	15/08/2023	Family Services (B4)	Paediatrics Service	High Risk
1556	Staffing Sustainability	High number of staff approaching retirement age within theatres over the next few years. Difficulty in recruiting to skill sets (ODP/Anaesthetic). Funding apprenticeships for ODPs will allow mitigation of staffing shortfalls in the future.	01/06/2023	Anaesthetics, Radiology & Access (B3)	Theatre Service	High Risk
1480	Dermatology CNS Workforce	Insufficient CNS team to manage cancer caseload within Dermatology. Short term sickness has impacted current establishment. Long term the increase in demand is not matched with the establishment	03/04/2023	Head & Neck and Specialist Medicine (B2)	Dermatology Service	High Risk

ID	Title	Risk Statement	Review date	Care Groups	Service of responsibility	Risk level (current)
1483	Orthodontics System wide system capacity/ safety	No Consultant cover in the East, West is providing all Consultant lead service. Long waiting list and 104 week waiters currently being held by UHD and needing Consultant input. Recruitment is national issue and many services have had to close due to this.	30/04/2023	Head & Neck and Specialist Medicine (B2)	Orthodontics Service	High Risk
1495	CRCU Nursing Workforce Education Gap	Nursing workforce establishment has not been re-calculated since mandatory and service specific educational requirements have been implemented. We require 3.48 WTE to cover the education gap. As a result, there is an on-going heavy reliance upon the use of high cost agency staff.	20/04/2023	Anaesthetics, Radiology & Access (B3)	Critical Care Service (CRC)	High Risk
1526	Acute Oncology Staffing Shortage	Acute oncology staffing position is currently challenged. The service is supported by the Lead Oncology Nurse, and one Acute Oncology Nurse, which is a macmillan funded post. Demand for support for acute oncology patients is increasing, putting addtional pressure on teams. There are shortages of both medical staff and nursing staff.	31/03/2023	Integrated and Holistic Care (A2)	Acute Oncology	High Risk
1529	Neurodevelopment Nursing	Neurodevelopment Nursing Team have seen a significant increase within their patient referrals over the past few months. The current nursing service is 1.0WTE band 7 Nurse who covers West Dorset with CYP with a diagnosis of a Neurodevelopment condition or is going through diagnostics. The service is supported by the Community Paediatricians who refer into the service. The Neurodevelopment Nurses have stopped taking direct referral as they have a caseload of over 120 CYP under their service which has now reached capacity to support all of the CYP. The role has developed significantly over the past few years with the service also supporting EHCPs and Schools.	08/05/2023	Family Services (B4)	Paediatrics Service	High Risk
1540	No substantive nursing establishment funding for South Walks Assessment OPD Centre	No substantive nursing establishment including a department nurse lead, funding for newly opened assessment outpatient centre.	30/06/2023	Anaesthetics, Radiology & Access (B3)	Outpatients Services	High Risk
530	Ilchester -- Staffing and Capacity	Ongoing use of Ilchester Escalation Capacity (planned and unplanned), leading to insufficient nursing cover particularly if opened at short notice, contributing to increased risks and having an impact on staff wellbeing.	04/05/2023	Unscheduled Care (A3)	Across all specialties	High Risk

ID	Title	Risk Statement	Review date	Care Groups	Service of responsibility	Risk level (current)
662	Pharmacy Workforce - vacancy rate	Pharmacy is in a period of instability due to vacancy rates, primarily in pharmacists. The Clinical Pharmacists will shortly be running approximately 70% vacancy rate. This also impacts the provision of aseptic services, and the subsidiary Fortuneswell Pharmacy, as the Clinical Service provides cover for these services.	30/04/2023	Pharmacy, Pathology and Medical Physics (A4)	Pharmacy Service	High Risk
714	Estates and Facilities Staff shortages	Staffing levels are critically low for key services at certain times, i.e., evenings and weekends. Risk to food safety, allergens and infection control	07/06/2021	Chief Finance Officer	Facilities Department	High Risk
721	Shortfall in Cardiac Physiology Staffing for Remote Monitoring Service	Not enough Cardiac Physiologists to perform monitoring of Implantable Loop Recorders (Reveals) and ICD home monitoring systems and ambulatory ECG analysis. Staff diverted to cover ECHOs. Current level of activity/service demands is not sustainable. 4 June 2021 - Task and Finish group considering physiology capacity encompassing role of the Principal Physiologist 26 Oct 2022 - 3 band 6 physiologists employed from overseas due to start in next three months. Investigating physiology support worker roles to complement trained staff.	31/03/2023	Vascular and Metabolic (A1)	Cardiology Service	High Risk
729	Pharmacy Support in CRCU	Current level of pharmacy staffing in Critical Care does not meet standard of service specification: The wider context is that the pharmacy department, specifically pharmacists is in a critical state owing to unfilled vacancies (over 1 year- requires separate risk register entry). The impact of this is that the CrCU pharmacist cannot provide the required level of service to CRCU owing to having to provide cover for multiple areas. This will result in delays in specialist intervention and expertise being available to CrCU, which could directly impact patient care and safety.	20/06/2023	Anaesthetics, Radiology & Access (B3)	Critical Care Service (CRC)	High Risk
769	Inadequate HEN staffing	Inadequate HEN staffing to meet the increased demand (quantity and complexity of patients).	17/02/2023	Integrated and Holistic Care (A2)	Dietetics and Nutrition Service	High Risk

ID	Title	Risk Statement	Review date	Care Groups	Service of responsibility	Risk level (current)
775	Care of the Elderly Nursing staffing levels	Elderly care floor have a vacancy factor of 8.31 WTE with potentially 4 preceptees commencing in sept. Stroke 1.81 B5 vacancy, Barnes 3.0 B5 vacancy, DLW 3.5 B5 vacancy. This leaves the floor compromised over the summer period. M 22/01/20- Care of the older persons unit (Barnes & DLW) and stroke have improved their vacancy factor with DLW now having the most Vacancies of Band 5. We are continuing to work closely with recruitment and Bank to decrease this gap and we are also recruiting overseas nurses, accepting new preceptees and participating in the alternative pathways Ie: Nursing assistants and RNDA. This in itself means a constant review of skill mix and appropriate available support in all areas	31/03/2023	Integrated and Holistic Care (A2)	Medicine for Older People Service	High Risk
776	Inpatient Occupational Therapy Staffing	Patient care at risk; speed of response, quality of discharges, delivery of rehabilitation limited. Staff wellbeing is a concern, with high sickness rates (especially mental health) as well as capacity to sufficiently supervise and support junior staff. High demand on services could risk inefficient working, particularly in areas/wards with no dedicated ward presence from therapies (low referring areas) Affecting the rotas (unable to sustain current rotas) and being able to do seven day working including supporting the Yeatman project	20/02/2023	Integrated and Holistic Care (A2)	Adult Occupational Therapy Service	High Risk
735	In patient SACT/Chemotherapy capacity within the Trust	Lack of consistent clinical staff to deliver safe SACT/Chemotherapy treatment capacity within Fortuneswell Ward. Risk of: Error due to staffing levels and pressure Cancellation of cycles due to capacity issues Potential disease progression in patients who have had delays in receiving treatments. Staff attrition due to pressure Wait time to access SACT treatment at 3-4 weeks (Dec-22).	31/03/2023	Integrated and Holistic Care (A2)	Clinical Haematolgy	High Risk
748	Orthopaedic Junior Doctor Vacancies	Significant gaps in the Orthopaedic Junior Doctor rota due to vacancies. New F3 posts (2) have been included in 23/24 business planning awaiting sign off to mitigate risk. Been informed that incoming F2 in Ortho from April has been removed due to unknown reasons & GP trainee from Feb 23 has been removed.	03/04/2023	Surgery & Gastroenterology (B1)	Orthopaedics Service	High Risk

ID	Title	Risk Statement	Review date	Care Groups	Service of responsibility	Risk level (current)
836	Children's Community Nursing Staffing	RCPCH recommendations for CCN staffing not met. Staffing levels cannot cater for current case load complexities, not meeting national standards for core CCN team offer. There is no robust governance for clinical procedures in the community. Limited resilience for sustainability of service as individual team members have their own specific skill set and this is not generalized across the teams offer. CCN Team Lead is working with a high acuity/complex caseload and is studying 0.5wte at present until August 2021. Due to these constraints this can currently not be explored or remodelled. CCNT are commissioned to train staff in school, but not in nursery or PHB. There is currently a gap in service for children in these settings, however CCN Team are not commissioned to provide this service and have no capacity to deliver this in current staffing model.	26/06/2023	Family Services (B4)	Paediatric Community Nurses	High Risk
839	Specialist Epilepsy Paediatric Service	Funded 1.0wte within the Children's Community Nurse to cover Epilepsy for children and young people, this includes about 180 mainstream and complex epilepsy patients.	08/05/2023	Family Services (B4)	Paediatrics Service	High Risk
876	Maternity Staffing	Very few shifts are fully staffed in all areas of the maternity service. This a combination of vacancies, long term sickness (poor mental health prevalent) STS and covid-related absence. This is patient safety issue and has been highlighted in the recent Ockenden Report.	01/05/2023	Family Services (B4)	Maternity Service	High Risk
884	Urology Consultant Workforce	Significant medical staffing issues, unable to recruit at Consultant level, reliance on agency locums.	13/02/2023	Surgery & Gastroenterology (B1)	Urology Service	High Risk

ID	Title	Risk Statement	Review date	Care Groups	Service of responsibility	Risk level (current)
1152	Current Digital Staffing levels present risk to both operational and strategic activities	Current levels of staffing across the different Digital Services Teams are unable to keep pace with the demands of the operational services and strategic developments for the Trust. The increase in demand for digital services to support both response to the covid pandemic and the Trust's recovery programme has exposed the insufficient level of investment in people and technology over the last years. Core technology is now operating beyond its expected and supported life. Single points of expertise in our staffing are now suffering under increasing volume and pressure of work. This is coupled with several major conflicting strategic projects at ICS and DCH levels are putting additional pressure on the same staff and resources. As a result key system maintenance is falling behind creating risk of system and technology failure and failure to meet project timelines which result in financial risk for the Trust. As of the beginning of September some significant strategic areas of work have had to be deferred until January due to loss of short-term project staff so a key strategic project for ED can be delivered and operational services are be maintained.	30/09/2023	Chief Information Officer	Digital Portfolio team	High Risk
1154	Regular movement of Ortho nursing staff to other wards to support their staffing levels	Both trained and untrained staff from both ortho wards being moved to other wards, across both divisions to cover their shortfall of staff leaving the ortho wards short staffed on a regular basis. This then leaves both wards with a staffing shortfall.	30/06/2023	Surgery & Gastroenterology (B1)	Orthopaedics Service	High Risk
1165	Radiology capacity to support implementation of AI and risks if not implemented	limited / lack of capacity due to workload for radiology to support the implementation of Rapid AI for the stroke service. This would impact on patient care regarding thrombectomy. If AI is not implemented this will result in delayed urgent treatment for Stroke patients and can prolong their recovery or reduce their ability to recover from a Stroke.	31/03/2023	Integrated and Holistic Care (A2)	Stroke Service	High Risk
1194	Day Surgery Staff Resignations due to Use as Inpatient Ward	Staffing levels in the Day Surgery Unit as falling below establishment requirements affecting the running of the department. Staff have resigned citing the reason as the use as a 24/7 inpatient unit.	27/01/2023	Anaesthetics, Radiology & Access (B3)	Theatre Service	High Risk

ID	Title	Risk Statement	Review date	Care Groups	Service of responsibility	Risk level (current)
1196	Backlog of Paediatric & Ocular Motility Appointments	Paediatric/ocular motility consultant left the trust in August 2020. We recruited a permanent consultant in April 2021. In between this time clinics were few and far between and we were left backlogged. We have 1 clinic every week but due to staff absences a lot have been cancelled and so we are falling further behind. It is getting to the point where patient safety is likely to be impacted from delayed wait times for appointments.	21/04/2023	Head & Neck and Specialist Medicine (B2)	Orthoptist Service	High Risk
1210	CRCU Clinical Psychologist	Clinical psychologist required to facilitate follow up clinic as part of GPICS standards, and for patient journey through CRCU. Support staff in recognising patients at risk suffering with PTSD, and support them with training. Research ongoing to improving overall care of CRCU patient and psychotic burden.	20/06/2023	Anaesthetics, Radiology & Access (B3)	Critical Care Service (CRC)	High Risk
1225	Consultant staffing in Elderly Care and Stroke services	Currently have 1 wte vacancy in Elderly Care and will have an additional 0.64 wte vacancy from 1st June 2022. We also have an aging workforce that are approaching retirement (3 Consultants)	31/03/2023	Integrated and Holistic Care (A2)	Medicine for Older People Service	High Risk
1235	OT vacancies	staff have left to reduce commute, private practice, improve work-life balance ASD OT post in particular has been out to advert 4 times with no interest (post adj to include training/development and relocation package)- this impacts the CDT pathway Also have B6 and B7 vacancies	23/05/2023	Family Services (B4)	Children's therapy service	High Risk
1247	ANP - system competition	Increasing competition for skilled ACPs across Dorset is resulting in advertisements offering higher Bands than DCH offer for similar roles. The risk is that current staff will be enticed to leave DCH and DCH will be disadvantaged in recruiting to these roles. The ACP (previously ANP) workforce is most dominant in ED & SDEC and could severely compromise these services.	27/09/2023	Unscheduled Care (A3)	ED - Majors Service	High Risk
1272	Trust integration specialist	Loss of key skills and knowledge of Trust Integration Engine (TIE) to manage over 40 system interfaces between corporate clinical systems. The TIE is supported by 0.5 WTE supporting over 40 interfaces across patient based systems. Failure of interfaces or incorrect management can and has resulted in major corporate wide clinical systems failure. Currently there is a single individual with advanced skills in systems integration and whereas more junior staff are being skilled up to deal with routine integration tasks, we are still reliant on a single point of expertise. The Trust would not have the skills required to provide support and development of critical interfaces across core patient systems. This would require additional support at cost from the TIE supplier and given the limitations of the supplier service capacity this may not be at a time required by the Trust.	30/09/2023	Chief Information Officer		High Risk

ID	Title	Risk Statement	Review date	Care Groups	Service of responsibility	Risk level (current)
1293	Personnel - clinical system administrators	Loss of key skills and knowledge of core clinical systems administrators For ICE, VitalPAC, Pathology, Radiology and some smaller clinical systems there are single individuals who have the skills and knowledge to provide support, critical maintenance and development for systems. This creates difficulties in providing cover for leave but will be a critical risk if these skills are lost due to staff turnover	30/10/2023	Chief Information Officer	Digital Portfolio team	High Risk
1466	Inability to support and finance 'growing our own' skilled staff	Inability to support and finance 'growing our own' skilled staff in sufficient numbers to run new services and deliver workforce transformation	29/03/2023	Chief Finance Officer	Strategic Estates	High Risk

Movement on Risk Register: 	Risk Statement Added to Risk Register 29.09.2021	CURRENT RISK RATING (Following review and mitigations)	Extreme (20) Consequence: Major Likelihood: Certain Reviewed:19.05.2023
461	High volume of patients with no reason to reside	Previous Rating	Extreme
Impact on Strategic Objectives		Lead Executive	Anita Thomas
Strategic Objective: People **Strategic Objective: Place** **Strategic Objective: Partnership** Patients stay too long in hospital due to (a) internal delays or (b) lack of external care capacity/inefficient process e.g. home with care or community hospital bed. Patients who remain in hospital for longer than they should are at risk of harm.		Local Manager	Andrew Miller Stuart Coalwood
Current position As at 19.05.2023 (data correct as at 31.05.2023)		TARGET RATING Target date:	Moderate (10) Consequence: Minor Likelihood: Certain 31.03.2024
Mitigation: • Patient tracker • Complex discharge huddles to allocate funding streams. • Discharge summits aimed at reducing care packages. • Social admission avoidance pathways being explored. • Flow cell review of P0 and criteria led discharge. • Pathway for step-down patients from ED to COHOs in place. • Escalated complex huddles to allocate section 256 funds to fund out of hospital if responsible commissioner cannot be agreed. • Rapid home to die pathway expanded for placements as well as home. **Update:** We still have a high volume of patients residing in the hospital with no medical need or reason to remain in a hospital bed, which is likely to impact on the patient's well-being and the flow of patients across the hospital. 58 patients were reported across all pathways as NCTR on 30.05.2023. This is lower than reported in the previous two reports. (13 March 2023, the total across all pathways stood at 75 patients. This was reported in January 2023 as 96 patients).		Next review date **ACTIONS ONGOING TO MANAGE FINANCES**	30.06.2023

Movement on Risk Register: 	Risk Statement Community Paediatric Long Waits for ASD Patients **Date added to Corporate Risk Register 09.06.2021** **Opened by Service 10.09.2018 – reviewed monthly** **Escalated to Division 08.06.2021 request to escalate to Corporate**	CURRENT RISK RATING (Following review and current mitigations)	Extreme (20) Consequence: Major Likelihood: Certain Reviewed: 18.04.2023
472	There has been a significant increase in referrals to the ASD (Autism Spectrum Disorder) service, alongside ongoing commissioning issues for the service.	Previous Rating	High (15)
Impact on Strategic Objectives		Lead Executive	Anita Thomas
Strategic Objective: People **Strategic Objective: Place** **Strategic Objective: Partnership** **How the risk has been scored:** **Consequence: Major** **Impact on patient safety** - major injury leading to long term incapacity/ disability, mismanagement of patient care with long term effects **Quality/complaints/audit** - non-compliance with national standards with significant risk to patients if unresolved, multiple complaints, low performance rating **Statutory duty** - multiple breeches in statutory duty, low performance rating **Adverse publicity** - National media coverage <3-day service well below reasonable public expectation **Finance including claims** - Claims between £100k and £1m **Likelihood:** Certain		Local Manager	James Male (service Manager)
Current position As at 18.04.2023 (data correct as at 31.05.2023)		TARGET RATING Target date	Very Low Risk (4) Consequence: Minor Likelihood: Unlikely 31.03.2024
Mitigation: • Interviews for specialist grade took place 08.10.21. Post was appointed to start date 01.02.2022. Target date amended to reflect the start date. Staff member appointed and in post • Validation needed for ASD pathway and current waiting list • All Age Autism Review led by CCG underway • Specialist Grade, Community Paediatrics now in post • ASD funding awarded from the CCG to be spent in 21/22, to support patients awaiting ADOS assessment • Meeting to discuss ASD database arranged – 11/2 **Update:** • Current wait times are 18 months. • No vacancies within the team but a backlog of referrals remains, under 5 years prioritised. • Referrals being graded and added to PAS by Central Admissions. Referrals being rejected and returned if all required information not included. • Meetings with NHS Dorset to look at potential changes to pathway. Looking into the possibility of rejecting referrals when parents have not accessed first line interventions. • Funding of £76k to be used to potentially outsource assessments via Psicon.		Next review date **OTHER ACTIONS ONGOING TO MANAGE WAITING LIST.**	30.06.2023

Movement on Risk Register: 	Risk Statement **Date added to Risk Register 22.02.2022**	CURRENT RISK RATING (Following review and mitigations)	Extreme (20) Consequence: Major Likelihood: Certain Reviewed: 15.05.2023
1221	Tackling the backlog of elective care	Previous Rating	Extreme (20)
Impact on Strategic Objectives		Lead Executive	Anita Thomas
Strategic Objective: People **Strategic Objective: Place** **Strategic Objective: Partnership** **How this risk has been scored:** **Consequence: Major** **Patient safety** - major injury leading to long term incapacity/ disability. **Quality/complaints/audit** - multiple complaints, low performance rating, non-compliance with national standards with significant risk to patients if unresolved. **Adverse publicity** - national media coverage with <3 days service below reasonable public expectation (no access for RESUS teams) **Likelihood:** Certain		Local Manager	Adam Savin All speciality leads
Current position As at 15.05.2023 (data correct as at 31.05.2023)		POST MITIGATION RATING (TARGET) Target date	Low (8) Consequence: Minor Likelihood: Likely 31.03.2025
Mitigation: • Capacity Planning and Commissioning of capacity • Clinical pathways design and system working for sustained capacity. • Estates strategy • Workforce planning including job planning. • Quality Improvement to redesign pathways to more efficient or productive with funded capacity • Access policies and processes to ensure effective waiting list management in order of clinical need with consideration for health inequalities. • Recovery plan and oversight of the delivery through sub-board committee • ICS partnership working through provider collaboratives and the ICS governance framework • Clinical networks to support pathway design and resources based on population need. **Update:** • Gaps in patient pathways out of hospital for those with complex care needs. ACTION: ICS escalation and collaboration workstreams • Mental health capacity to meet growing demand is impacting on potential delivery of longer-term care in the right place and therefore clinical outcomes. Escalated to partners and working with partners.		Next review date	30.06.2023

Movement on Risk Register: 	Risk Statement **Date added to Risk Register 22.02.2022**	CURRENT RISK RATING (Following review and mitigations)	Extreme (20) Consequence: Major Likelihood: Certain Reviewed: 15.05.2023
1509	Mental Health patients delays in care pathway and services support	Previous Rating	Extreme (20)
Impact on Strategic Objectives		Lead Executive	Anita Thomas
Strategic Objective: People **Strategic Objective: Place** **Strategic Objective: Partnership** **How this risk has been scored:** **Consequence: Major** **Patient safety** - major injury leading to long term incapacity/ disability. **Quality/complaints/audit** - multiple complaints, low performance rating, non-compliance with national standards with significant risk to patients if unresolved. **Adverse publicity** - national media coverage with <3 days service below reasonable public expectation (no access for RESUS teams) **Likelihood:** Certain		Local Manager	All speciality leads
Current position As at 15.05.2023 (data correct as at 31.05.2023)		POST MITIGATION RATING (TARGET) Target date	Low (8) Consequence: Minor Likelihood: Likely 31.03.2025
Mitigation: • LAEP meetings • Review of SLA with DHUFT re psychiatric liaison service • Independent system reviews of individual cases • Working with provider collaborative • Escalation to executive level to enable exec to exec conversations within the system. • Legal action when appropriate and agreed. **Update:** • Mental health capacity to meet growing demand is impacting on potential delivery of longer-term care in the right place and therefore clinical outcomes. Escalated to partners and working with partners.		Next review date	30.06.2023

Movement on Risk Register: 	Risk Statement **Date added to Risk Register 12.09.2018**	CURRENT RISK RATING (Following review and mitigations)	High (16) Consequence: Major Likelihood: Likely Reviewed: 17.03.2023
474	Review of Co-Tag system and management of issuing/retrieving tags to staff	Previous Rating	Extreme (20)
Impact on Strategic Objectives		Lead Executive	Chris Hearn
Strategic Objective: Place **How this risk has been scored:** **Consequence: Major** **Patient safety** - major injury leading to long term incapacity/ disability. **Quality/complaints/audit** - multiple complaints, low performance rating, non-compliance with national standards with significant risk to patients if unresolved. **Adverse publicity** - national media coverage with <3 days service below reasonable public expectation (no access for RESUS teams) **Service/business interruption** - major impact on environment **Likelihood:** Certain		Local Manager	Don Taylor
Current position As at 17.03.2023 (data correct as at 31.05.2023)		TARGET RATING Target date	Very Low (2) Consequence: Negligible Likelihood: Unlikely 31.07.2023
Mitigation: • Estates managing ad-hoc issues as the arise; Communications on management of site security; Site security in place Update: • Delayed delivery due to issue with DCH supporting resource, expected completion April / May 23 • we currently have 78 doors out of 220 yet to be enabled - 40 of those doors are in ED. • Support has been requested from DTI re the connectivity issues.		Next review date	30.06.2023

Movement on Risk Register: 	Risk Statement **Date added to Risk Register 12.07.2019**	CURRENT RISK RATING (Following review and mitigations)	High (15) Consequence: Moderate Likelihood: Certain Reviewed: 16.02.2023
641	Clinical Coding	Previous Rating	Extreme
Impact on Strategic Objectives		Lead Executive	Ruth Gardiner
Strategic Objective: Place **Strategic Objective: Partnership** **How this risk has been scored:** **Consequence: Moderate** **Impact on patient safety** - mismanagement of patient care with long term effects **Quality/Complaints/Audit** - Non-compliance with national standards, critical report. Human resources - loss of key staff, low staff morale. **Statutory duty** - multiple breeches in statutory duty, improvement notices, low performance rating, critical report. **Adverse publicity** - National media coverage (being outliers) **Business objectives** - key objectives not met. **Finance including claims** - Non delivery of key objectives loss of >1% of budget, loss of contracts and payment by results **Likelihood:** Certain		Local Manager	Victoria Stevens (commenced in post Nov 2022)
Current position As at 16.02.2023 (data correct as at 13.03.2023)		TARGET RATING Target Date:	Low (6) Consequence: Minor Likelihood: Possible 31.05.2023
Mitigation: • Monitor other data for assurance on mortality, Escalation of any variance from plan for consideration of resources and prioritisation where possible. **Update:** • Both the Mortality and Clinical Coding risks had been open on the Risk Register for some time. These now need to be reviewed and reframed as the reporting requirements and positions had changed. This is anticipated to have been completed for the start of the new financial year. • CMO will discuss coding on risk register with the Interim Chief Information Officer with a view to moving this risk to that portfolio. • New clinical coding manager commenced in post and is having an impact. • The SHMI remains high as quite a few cases are still being sent in uncoded. However, the depth of coding has improved significantly over time. The new Coding Manager has plans to remove backlog altogether.		Next review date: **ACTIONS ONGOING AND CURRENTLY ON TARGET**	30.04.2023 FOLLOWING JANUARY HMG MEETING – RISK TO BE REVIEWED AND ALLOCATED TO INTERIM CIO **MEETING ARRANGED TO DISCUSS JUNE 23**

Movement on Risk Register: **NEW**	Risk Statement **Date added to Risk Register 21.04.2023**	CURRENT RISK RATING (Following review and mitigations)	High (16) Consequence: Major Likelihood: Likely Reviewed:21.04.2023
1645 (replaces 464)	Mortality Indicator (SHMI)	Previous Rating	Moderate
Impact on Strategic Objectives		Lead Executive	Alastair Hutchison
Strategic objective: Place **How the risk has been scored:** **Consequence: Moderate** **Impact on patient safety -** major injury leading to long term incapacity/ disability, mismanagement of patient care with long term effects **Quality/complaints/audit - non**-compliance with national standards with significant risk to patients if unresolved, multiple complaints, low performance rating **Human resources -** Uncertain delivery of key objectives/ service due to lack of staff, loss of key staff, very low staff morale **Statutory duty -** multiple breeches in statutory duty, low performance rating **Adverse publicity - National** media coverage <3 day service well below reasonable public expectation **Business objectives -** Key objectives not met. Likelihood: Possible		Local Manager	Alastair Hutchison
Current position As at 21.04.2023 (data correct as at 31.05.2023)		TARGET RATING Target date:	Low (9) Consequence: Moderate Likelihood: Possible 31.03.2024
Mitigation: Triangulation of other data for assurance on mortality; SJR process; Medical Examiners escalation process; Learning from deaths Mortality report reviewing situation and learning. **Update:** • The Trust continues to investigate reasons behind the higher than expected SHMI on a regular basis. Processes are overseen by the Learning from Deaths Hospital Mortality Group, which reports to the Quality Committee. • Medical Examiners scrutinise all deaths of in-patients at DCH and recommend which cases require further investigation by RCA, SJR or review at an M&M meeting. The Group also reviews audit data gathered both locally and nationally to search for any evidence of unnecessary deaths. • Monthly information on deaths, care quality and safety is provided by the Dr Foster team.		Next review date **SHOULD BE READ IN CONJUCTION WITH RISK 641**	UPDATE FOLLOWING JANUARY HMG MEETING – Risk to be reviewed and reframed for next report.

Movement on Risk Register: **NEW**	Risk Statement **Date added to Risk Register**	CURRENT RISK RATING (Following review and mitigations)	High (16) Consequence: Major Likelihood: Likely Reviewed:02.03.2023
1561	Maintaining Business As Usual During Construction Phase of NHP	Previous Rating	Moderate
Impact on Strategic Objectives		Lead Executive	Chris Hearn
Strategic objective: Place **Strategic objective: People** **Strategic objective: Partnership** **How the risk has been scored:** **Consequence: Major** **Impact on patient safety -** major injury leading to long term incapacity/ disability, mismanagement of patient care with long term effects **Quality/complaints/audit - non**-compliance with national standards with significant risk to patients if unresolved, multiple complaints, low performance rating **Human resources -** Uncertain delivery of key objectives/ service due to lack of staff, loss of key staff, very low staff morale **Statutory duty -** multiple breeches in statutory duty, low performance rating **Adverse publicity - National** media coverage <3 day service well below reasonable public expectation **Business objectives -** Key objectives not met. **Likelihood: Likely**		Local Manager	Tristan Chapman
Current position As at 02.03.2023 (data correct as at 31.05.2023)		TARGET RATING Target date:	Low (9) Consequence: Moderate Likelihood: Possible 31.03.2026
Mitigation: • ED service have SOPs in place to mitigate some of the issues • Plans to be reviewed and discussed with clinical teams • No changes to be made until ED staff are happy with proposals and that they have a workable solution. **Update:** • TD working through options strategy and Clinicians have asked for a more detailed work up of option 4 which uses entrance to northside of existing ED entrance for all ambulance/drop off and walk in patients. Options for building the link corridor still under investigation. Will be approved via CAG governance. • Options appraisal development scheduled for 7/14th March. • Options appraisal 21/23/28th March. Concern that option 4 isn't workable given the requirement to turn in FM yard. • Concern that option 5 isn't workable given distance from South 1 to Majors/Resus and the increase of 'big sick' patients arriving independently at ED		Next review date	30.06.2023

INTEGRITY | RESPECT | TEAMWORK | EXCELLENCE

NHS
set County Hospital
NHS Foundation Trust

Report Front Sheet

1. Report Details			
Meeting Title:	Board of Directors, Part 1		
Date of Meeting:	26 July 2023		
Document Title:	**Review of Committee Priorities 2023/24**		
Responsible Director:	Chris Hearn, Chief Financial Officer Anita Thomas, Chief Operating Officer Nicola Plumb, Chief People Officer Jo Howarth, Chief Nursing Officer Alastair Hutchison, Chief Medical Officer	Date of Executive Approval	Approved at June committees
Author:	Directors listed above Stephen Tilton, Non-Executive Director Margaret Blankson, Non-Executive Director Eiri Jones, Non-Executive Director		
Confidentiality:	No		
Publishable under FOI?	Yes		
Predetermined Report Format?	No		

2. Prior Discussion		
Job Title or Meeting Title	**Date**	**Recommendations/Comments**
Finance and Performance Committee	19/06/2023	Finance and Performance Committee priorities approved
People and Culture Committee	19/06/2023	People and Culture Committee priorities approved
Quality Committee	20/06/2023	Quality Committee priorities approved

3. Purpose of the Paper	The purpose of the report is to present the outcome of the annual review committee priorities and to seek approval of the committee priorities.							
	Note (✓)		*Discuss (✓)*		*Recommend (✓)*		*Approve (✓)*	✓

4. Key Issues

The key priorities identified for the committee for the coming year (2023/24) are detailed below. The priorities have been mapped to key regulatory references, such as those within the Board Assurance Framework and the Corporate Risk Register, or CQC domains.

<u>Finance and Performance Committee:</u>

1. Planning framework including:

2023/24 Operational Plan submission which includes;

- Elective recovery against 2019/20 baseline of Day case 111.9%, Inpatient 97%, Outpatient 1st OPA 106.9%, Outpatient procedures 86.6%, Outpatient follow ups 94.3%
- ED 4 hour performance of 76% by March 2024
- Zero elective patients over 65+ weeks by March 2024
- Elective waiting list size trajectory
- Cancer backlog trajectory
- 52+ weeks elective waits reduction on previous year
- Reduction of NRTR to 45
- DM01 to 95% by March 2024

- Maintain PIFU at 5%

2. **Seasonal Surge Plan:**
   - Surge demand and capacity plan
   - Associated workforce models for escalation areas and increased emergency activity
3. **Financial recovery of underlying deficit:**
   - Delivery of the Trust's planned breakeven position.
   - Delivery of the 2023/24 CIP target (£10.9m)
4. **Capital Programme**
   - Delivery of the Trust's planned capital programme.
   - Delivery of objectives relating to the key strategic NHP project.
5. **In year performance monitoring:**
   - Operational standards; and
   - Performance against the 2023/24 Financial Plans
   - Theatre productivity, to include theatre utilisation, late starts, early finishes, touch time and returning list volume to 2019/20 levels

People and Culture Committee:

Five overarching draft PCC priorities have been identified. These are:

- Workforce Planning
- Recruitment
- Retention
- Inclusion
- Culture and Collaboration

Each priority has a set of planned activities to be completed in-year.

These priorities align to the CQC 'well-led' requirements, the People elements of the Board Assurance Framework (BAF), specifically PE 1.1, 1.2, 2.1, and 3.1, the ongoing collaboration work with Dorset Healthcare (DHC) and the year two DCH People Plan priorities.

Next steps will be to share the priorities with the other Committees and Executive Leads. The Senior People Team will devise a clear set of deliverables for each priority, specifying the intended impact. The PCC work plan will be reviewed to ensure that the PCC is provided with sufficient reassurance of progress.

Quality Committee:

The key priorities identified for the committee for the coming year (2023/24) are detailed below. The priorities have been mapped to key regulatory references, such as those within the Board Assurance Framework and the Corporate Risk Register, or CQC domains.

1. Develop a revised dashboard for Ward to Board quality performance reporting. Start to use DiiS to gain data in relation to health inequalities.
2. Strengthen assurance in relation to clinical audits and the data they provide in relation to quality of care. Gain assurance in relation to the benefits of the partnership working programme with DHC.
3. Gain good assurance in relation to patient experience, especially in relation to areas where improvements in care are demonstrated as required, e.g nutrition, falls.

	Shared priorities with other sub-Board committees: 1. With Finance and Performance Committee: Review and gain assurance in relation to any areas of performance which identify a quality issue or risk 2. With People and Culture Committee: Review staffing levels twice a year with specific reference to NHS England, Developing Workforce Safeguards guidance, in relation to safe levels of care. With Risk and Audit Committee: Review the BAF and Corporate Quality Risks on a quarterly basis, identifying and gaining assurance in relation to key areas of risk
5. Action recommended	The Board is recommended to: 1. **APPROVE** the committee priorities.

6. Governance and Compliance Obligations				
Legal / Regulatory Link		**Yes**		Committees of the Board are required to undertake an annual review of their effectiveness
Impact on CQC Standards		**Yes**		All of the priorities support the Trust's compliance with the effective and well-led CQC domains.
Risk Link		**Yes**		The priorities align to a number of Board Assurance Framework and Corporate Risk Register references. Full references detailed in the report.
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 Place Partnership	The committee priorities and work plan reflects the Trust's strategic objectives 'People', 'Place' and 'Partnerships'.		
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)			**No**	
Quality Impact Assessment (QIA)			**No**	

Finance and Performance Committee Work Plan: Proposed Work plan overarching priorities 2023/24

The Finance and Performance Committee (FPC) work plan reflects the Board Assurance Framework (BAF) strategic objectives 'People', 'Place' and 'Partnerships'.

This work plan has been updated to reflect any current learning from the Covid-19 pandemic, with ongoing review to optimise integrated care provision across the local health and social care system as the country emerges from the pandemic and as in line with the national direction to promote collaboration between system partners in support of Integrated Care Board (ICB) development. The work plan will consider the Trust's risk appetite, including financial implications of the emerging agenda.

FPC has an administration and reporting plan that underpins its agenda planning on core business of the committee, such as activity and financial performance reports, annual sub-groups reporting etc. The administration plan supports the effective organisation and management of financial and partnership governance and associated standards, including:

- Risks management relating to finance and activity,
- Assurance and identification of any gaps in control in improvement to deliver the strategic objectives
- Lessons learnt that aid improvement and learning to improve efficiency in performance and financial sustainability
- Adherence to national guidelines and contractual standards
- Service transformation, estates and infrastructure development and the wider partnering agenda
- Policies that apply to financial management.

To support this work FPC propose these overarching work plan priorities (below) which align to the corporate risk register (CRR), Board Assurance Framework (BAF) and assist in the triangulation for continuous service improvement and efficiency. They reflect the learning over the last year and the recovery priorities for the NHS and Trust in the forthcoming year.

FPC will undertake quarterly deep dives on key risk areas in order to gain a higher level of assurance and challenge.

Underpinning these priorities are key themes and enabling strategies that will support delivery of the overall objectives. These include: Digital Strategy; Clinical strategy collaborative system working; capacity and demand as outlined in the business planning assumptions; Estates Strategy; and the Peoples' Strategy. In addition, there may be other emerging strategies or guidelines that result in the priorities changing or being expanded.

Work plan priorities	Regulatory Reference	Outcome
1. Planning framework including: 2023/24 Operational Plan submission which includes; • Elective recovery against 2019/20 baseline of Day case 111.9%, Inpatient 97%, Outpatient 1st OPA 106.9%,	BAF Risk Objective PL 1.3, PL 1.9 CRR 919, 1221, 641, 461, 690	

Work plan priorities	Regulatory Reference	Outcome
Outpatient procedures 86.6%, Outpatient follow ups 94.3% • ED 4 hour performance of 76% by March 2024 • Zero elective patients over 65+ weeks by March 2024 • Elective waiting list size trajectory • Cancer backlog trajectory • 52+ weeks elective waits reduction on previous year • Reduction of NRTR to 45 • DM01 to 95% by March 2024 • Maintain PIFU at 5%	CQC Domain: Effective, Well Led	
2. Seasonal Surge Plan: ▪ Surge demand and capacity plan ▪ Associated workforce models for escalation areas and increased emergency activity	BAF Risk Objective PL1.5, PL 1.6 CRR 919, 450, 461, 690, 463, 468 CQC Domain: Effective, Well Led	
3. Financial recovery of underlying deficit: ▪ Delivery of the Trust's planned breakeven position. ▪ Delivery of the 2023/24 CIP target (£10.9m)	BAF Risk Objective PL 2.2, PL 2.3, PA 2.1, PA 2.2, PA 2.3 CRR 919, 1252 CQC Domain: Effective, Well Led	
4. **Capital Programme** • Delivery of the Trust's planned capital programme. • Delivery of objectives relating to the key strategic NHP project.	BAF Risk Objective Pl 2.1 CRR 919, 1252 CQC Domain: Effective, Well Led	
5. In year performance monitoring: ▪ Operational standards; and ▪ Performance against the 2023/24 Financial Plans ▪ Theatre productivity, to include theatre utilisation, late starts, early finishes, touch time and returning list volume to 2019/20	BAF Risk Objective PL 1.3, 1.5, 1.6, 1.9, 2.1, 2.2, 2.3 PA 2.1, 2.2, 2.3 CRR 919, 1221, 461, 450, 472	

Work plan priorities	Regulatory Reference	Outcome
levels	CQC Domain: Effective, Well Led	

To support the above, ongoing communication and triangulation will be required with other Board committees. The assurance responsibilities and key priorities / work streams of other sub-board committees that link to the work of FPC are outlined below:

DRAFT People and Culture Committee priorities 2023/24

The People and Culture Committee (PCC) priorities reflect the overarching Trust strategy and the enabling People Plan. The four People elements of the Trust strategy are:

- We will look after and invest in our staff, developing our workforce to support outstanding care and equity of access and outcomes.
- We will create an environment where everyone feels they belong, they matter, and their voice is heard.
- We will improve safety and quality of care by creating a culture of openness, innovation and learning where staff feel safe themselves.
- We continue to create collaborative and multidisciplinary professional team working to maximise skills, knowledge, and respect.

The priorities and those shared with other Board Sub-Committees reflect the need to attract and retain a workforce aligned with our commitment to financial and social sustainability. As an organisation our commitment to fulfilling our role as an anchor institution has been set out within our Social Value Pledge. The People Plan aligns in supporting DCH in being a model employer, contributing to the local economy through employment opportunities and principles of good work.

The PCC receives regular divisional performance updates and regular deep dives on key areas of People activity to gain a higher level of assurance and challenge. Local and national workforce key performance indicators are also used for monitoring and assurance e.g., the monthly people performance dashboard, national staff survey and people pulse data, WRES and WDES data.

The PCC has shared priorities with Quality Committee relating to **safe staffing and quality** and with Finance and Performance Committee relating to the **reduction of agency spend**.

PCC propose these overarching priorities (overleaf) which align to the CQC ‘well-led’ requirements, the People elements of the Board Assurance Framework (BAF), specifically PE 1.1, 1.2, 2.1, and 3.1, the ongoing collaboration work with Dorset Healthcare (DHC) and the year two People Plan priorities.

Work plan priorities	Planned Activities (in-year)	How will we know we are having impact?
1.Workforce Planning	The creation of five-year workforce plans for all staff groups Enabling work for New Hospital Programme and DHC clinical collaboration programmes Continuation of work on new workforce models – including CESR, Physicians Associates and Advanced Clinical Practice Implementation of Dorset-wide Medical Staffing System Programme for medical job planning and rostering	Sustainable workforce plans will be in place at staff group level based on demand and capacity planning Reliance on agency spend will reduce Service KPIs (such as time to hire etc) will improve There will be positive improvements in the monthly People Performance Dashboard in: • Turnover • Vacancy rate • Mandatory training • Appraisal compliance • Appraisal quality data • Exit interview thematic analysis • Shortlist to hire equalities data • Increased diversity in roles 8a & above • Apprenticeship and widening participation growth • National staff survey • Quarterly pulse check • WRES, WDES and EDS data • FTSUG data and
2. Recruitment	Implementation of Recruitment and Retention Strategy with particular focus on • Inclusive recruitment practices • Automation and Process Improvement • Marketing Continuation of widening access and participation work, including continued increase in apprenticeships and T-levels and the relaunch of the work experience programme	
3. Retention	Implementation of Recruitment and Retention Strategy with particular focus on • Better onboarding and support for new recruits • Embedding the Health and Wellbeing offer for staff, working in collaboration with DHC • Increasing flexible working opportunities and modern working practices Continuation of just and learning culture work, with a focus on moving from HR operations to HR relations Further development of appraisal, talent	

Work plan priorities	Planned Activities (in-year)	How will we know we are having impact?
	management and succession planning processes Continuation of bank engagement work to retain and develop bank staff at DCH	thematic analysis • Shift from formal to informal resolution of ER issues A culture of collaboration and improvement will develop Efficiencies within People Services will be delivered
4. Inclusion	Revise EDI Strategy and Action Plan to include the Trust-wide activities related to both staff and patients, exploring a joint strategic approach with DHC Provide next stage of inclusive leadership programme in collaboration with DHC, incorporating the ICS Leading for Inclusion programme	
5. Culture and Collaboration	Refresh Trust values through the lens of civility and kindness Develop and deliver a programme for senior leaders from DHC and DCH to help nurture a collaborative culture Identify and develop opportunities for shared People services starting with Occupational Health, Payroll, International recruitment and a collaborative bank	

Quality Committee Work Plan: Proposed Work plan overarching priorities 2023/24

The Quality committee (QC) work plan reflects the Board Assurance Framework (BAF) strategic objectives People, Place and Partnership, aligned to national priorities for safe, well-led, quality care. This is aligned to the CQC standards and any updated actions for continuous quality improvement.

This work plan has been updated to reflect any current learning from the Covid-19 pandemic, with ongoing review to fully integrate as part of our quality and safety priorities. This will be considered in line of the Trust risk appetite, including financial implications of Covid-19.

Quality Committee has an administration reporting plan that underpins its agenda planning on core business of the committee, such as quality performance report, annual sub-groups reporting etc. The administration plan supports the effective organisation management of clinical governance and associated CQC standards, including:

- Risks relating to quality of care – Patient Safety, Patient Experience and Clinical Effectiveness.
- Assurance and identification of any gaps in control in improvement to deliver the strategic objective
- Lessons learnt that aid improvement and learning to benefit quality, safe care and best practice including clinical audit.
- Clinical adherence to national guidelines or standards such as NICE
- Patient and public feedback including complaints, plaudits, surveys and patient involvement in services (such as volunteers experience and carers' experience).
- Policies that apply to quality and safety principles.

To support this work Quality Committee propose these overarching work plan priorities (below) which align to the corporate risk register (CRR), Board Assurance Framework (BAF) and assist in the triangulation for continuous quality improvement. They reflect the learning over the last year and the restart, recover priorities for the NHS and Trust in the forthcoming year.

Quality Committee will undertake quarterly deep dives on key risk areas of safety to gain a higher level of assurance and challenge.

Underpinning all of these priorities are key themes that run as a golden thread, these are: Clinical Plan; People Plan; and Digital Plan. In addition, there may be other emerging strategies or guidelines that result in the priorities changing or being expanded as the ICS develops and embeds.

Work plan priorities	Regulatory reference
1. Develop a revised dashboard for Ward to Board quality performance reporting. Start to use DiiS to gain data in relation to health inequalities.	
2. Strengthen assurance in relation to clinical audits and the data they provide in relation to quality of care. Gain assurance in relation to the benefits of the partnership working programme with DHC.	

Work plan priorities	Regulatory reference
3. Gain good assurance in relation to patient experience, especially in relation to areas where improvements in care are demonstrated as required, e.g nutrition, falls.	
Underpinning fundamental CQC standards (Regulation8)	
Underpinning performance reporting on quality account quality priorities; contracted quality surveillance targets; and CQUINs	

To support the above the ongoing triangulation across committees will be required. Below outlines key priorities/ work streams the other sub-board committees have assurance responsibility for that link

Shared Priorities with other Sub-Board Committees	
Work plan priorities	**Sub-Board committee/ CQC/BAF reference (as of April 2022)**
1. With Finance and Performance Committee: Review and gain assurance in relation to any areas of performance which identify a quality issue or risk	
2. With People and Culture Committee: Review staffing levels twice a year with specific reference to NHS England, Developing Workforce Safeguards guidance, in relation to safe levels of care.	
3. With Risk and Audit Committee: Review the BAF and Corporate Quality Risks on a quarterly basis, identifying and gaining assurance in relation to key areas of risk	

Report Front Sheet

1. Report Details			
Meeting Title:	Board of Directors, Part 1		
Date of Meeting:	26 July 2023		
Document Title:	**Annual Complaints Report**		
Responsible Director:	Jo Howarth, Interim Chief Nursing Officer	Date of Executive Approval	13/07/2023
Author:	Ali Male – Head of Patient Experience and Public Engagement		
Confidentiality:	No		
Publishable under FOI?	Yes		
Predetermined Report Format?	No		

2. Prior Discussion		
Job Title or Meeting Title	**Date**	**Recommendations/Comments**
Patient Experience and Public Engagement Committee		Noted and for onwards reporting to Quality Committee
Quality Committee	18/07/2023	Noted

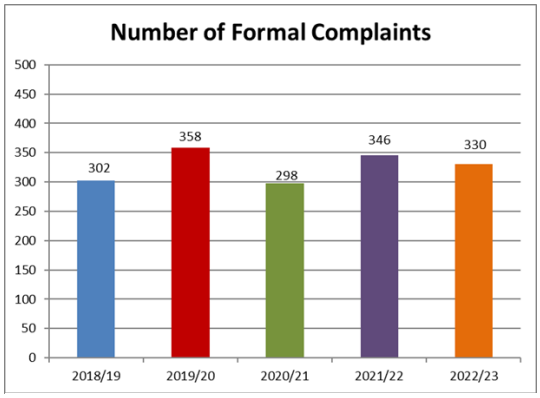
Purpose of the Paper	*Note (✓)*	✓	*Discuss (✓)*	✓	*Recommend (✓)*		*Approve (✓)*	

3. Executive Summary

The paper covers the reporting period 1st April 2022 – 31st March 2023

- The total number of formal complaints received by the Trust for this year was 330 which have decreased by 5% from the previous year. There were also 933 recorded contacts for PALS informal issues resolved, also an increase of 28% on the previous year.

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



- During this year 41 complaints (12%) have been reopened. Complaints are normally reopened for the following reasons:

Complainants contact us to seek further clarification about the complaint raised indicating that the complaint has not been fully addressed or they disagree with aspects of the response from their perspective.

Additional questions have been asked following receipt of their response.

Complainants take up the offer of a meeting with staff to discuss their complaint in more detail.

- Of the 41 reopened complaints 36 of those reopened were due to additional questions being asked, or ongoing concerns; 4 requested a meeting or

	telephone call with staff and 1 complainant provided a patient story. The opportunity to learn from complaints should not be missed by the Trust and most complainants make complaints for the organisation to learn from what has happened to them. We will continue to ensure that we learn and take action when our patients tell us they have not had a good experience with us. Learning from complaints assures our patients that the Trust has taken their complaints seriously and taken the opportunity to learn from their feedback. Examples of the learning points included in the complaint responses. We have continued with a 40 working day response timeframe which was agreed by both Divisions. As the hospital has continued to experience high demand, this enabled the Trust to respond to complaints in a realistic timeframe due to the demands on the clinical staff during the past year. Due to the continued demand on the hospital and clinical teams, this has occasionally not been met and this will continue to be monitored via the Patient Experience Group. We recognise the requirement to implement the revised Complaints Standards over 2023.
4. Action recommended	The Board is recommended to: 1. **NOTE** the report. 2. **RECEIVE** assurance on actions to address any performance issues.

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

Title of Meeting	**Board of Directors, Part 1**
Date of Meeting	**26 July 2023**
Report Title	**Annual Complaints Report 2022/23**
Author	Alison Male, Head of Patient Experience and Public Engagement Emma Hoyle, Deputy Chief Nursing Officer

1.0 INTRODUCTION

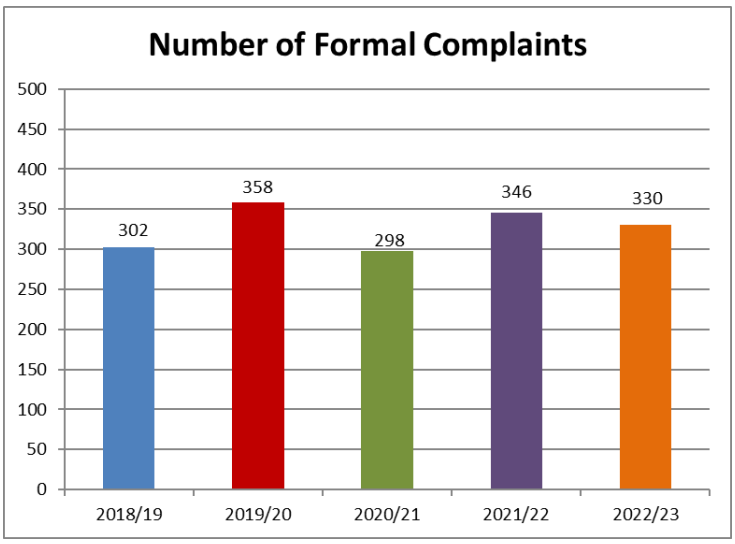
1.1 The annual complaints report complies with The Local Authority Social Services and National Health Service Complaints (England) Regulations 2009, which requires each NHS Trust to produce regular reports about complaints received, including an annual report.

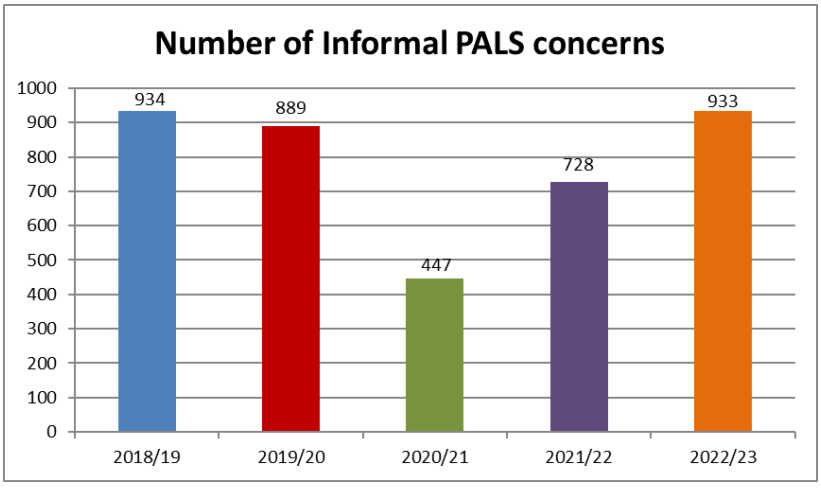
1.2 This annual report includes an overview of the number and nature of complaints received and how complaints are handled.

2.0 NUMBER OF COMPLAINTS RECEIVED

2.1 The total number of formal complaints received by the Trust for this year was 330 which have decreased by 5% from the previous year. There were also 933 recorded contacts for PALS informal issues resolved, also an increase of 28% on the previous year.

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





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

2.4 During this year 41 complaints (12%) have been reopened. Complaints are normally reopened for the following reasons:

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

Of the 41 reopened complaints 36 of those reopened were due to additional questions being asked, or ongoing concerns; 4 requested a meeting or telephone call with staff and 1 complainant provided a patient story.

3.0 PROCESS FOR COMPLAINTS HANDLING

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

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

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

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

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

4.0 RESPONSE TO COMPLAINTS

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

We have continued with a 40 working day response timeframe which was agreed by both Divisions. As the hospital has continued to experience high demand and the impact of Industrial Action, this enabled the Trust to respond to complaints in a realistic timeframe due to the demands on the clinical staff during the past year.

Although some complaints were not responded to within the 40 working day timescale, the complainant has been contacted to renegotiate the response date and the new agreed timescale has been met where possible.

Complaint timescales will be monitored via the Patient Experience & Public Engagement Committee and Quality Committee.

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

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

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

4.2.3 Send out a weekly report of the number of holding letters sent to complainants, and where relevant escalate those complaints that have received 3 holding letters for review and action by the Divisions.

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

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

5.0 LEARNING FROM COMPLAINTS

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

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

5.3 Staff from across the Trust regularly reflect on complaints at divisional and departmental meetings and support is provided by the Patient Experience Team which enables them to understand the emotional experience from the complainant and staff perspective and reflect upon improvements in relation to aspects of care.

5.4 Learning and actions from complaints are monitored through the Divisions and Care Groups and where appropriate learning is shared across the organisation. Examples of learning from complaints are included in the quarterly Patient Experience report and reviewed by the Quality Committee.

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

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

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

Concern raised:	**Learning/Actions taken:**
Patient with a feeding tube was not kept nourished and medication was not given.	• The Emergency Department's Clinical Practice Educator arranged teaching sessions to include tube feeds by the diabetic/nutritional team for all staff in the department.

	• For patients whose routine has been changed from what is normal for them regarding medication and nutrition, staff should discuss this with the nurse in charge for any additional support required.
Patient unhappy with their clinical care around the management of their Tresiba insulin and was asking for a referral to another hospital	• It is important to deliver written documentation to the patient about the advice that has been given and information that has been offered – this includes information as to what should be done and what should be stopped. • Comprehension of the action and usage of the different types of insulin is vital when patients are empowered to make changes for themselves. • It is important to ensure that documentation includes features in software/devices, even if only to refer to the instructions available. • Consistence of information and education processes between the hospital and community diabetes services. • Regular review of the DVLA rules for driving with diabetes are important.
Issues raised from the premature birth of a baby and the impact on the mother.	• 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. • Recruiting of more staff to provide further expertise and continuity for postnatal care.
Missed diagnosis - Patient with a respiratory condition became unwell and came to hospital. An x-	• Current guidance explained that steroids should only be given if the patient required oxygen.

ray was taken, which the patient was told was crystal clear and to go home and use their inhalers. A call from the GP confirmed that the x-ray was not clear and the hospital doctor had missed Covid pneumonia.	• Staff to inform patients that their x-rays are reviewed by specialists and if further investigations are required, they may be contacted. • It was highlighted to the doctors the importance of considering more individualised treatment plans in the cases of people with underlying respiratory conditions and ensure that when treatment is not indicated, the reasons why are thoroughly explained.
Family provided with incorrect medication for their 8-week old baby.	• Reduction in interruptions and distractions within the dispensary. • Extending safe storage of medicines audits within the Pharmacy Dispensary. • Clearer segregation of stock in the unlicensed storage section.

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

5.9 The Patient Experience Team will be working with the Patient Safety team and be part of the new Patient Safety Incident Response Framework (PSIRF) process which will involve patients and families in serious incident investigations.

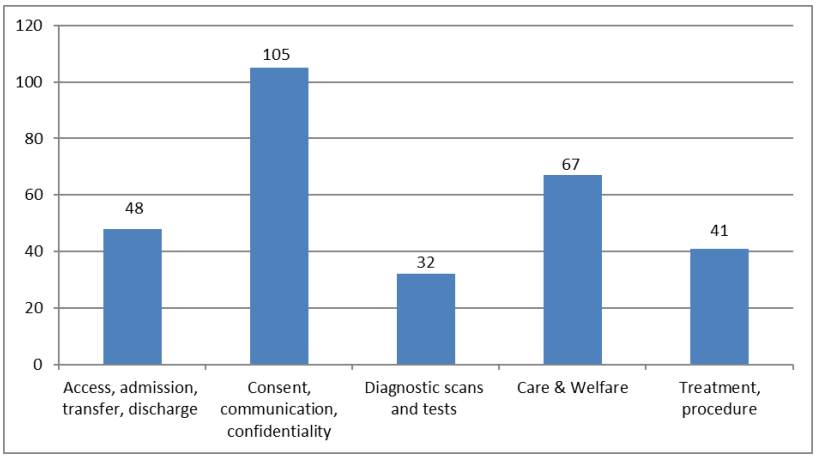
6.0 REPORTING & MONITORING

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

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

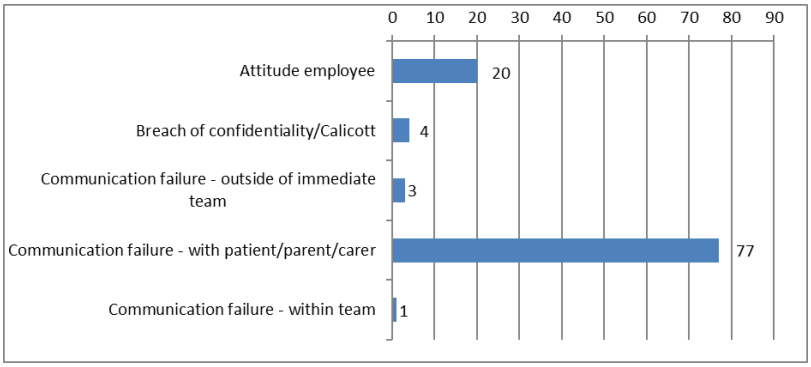
6.3 Complaints related to Consultants are shared with the Medical Director for professional conversations as required.

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

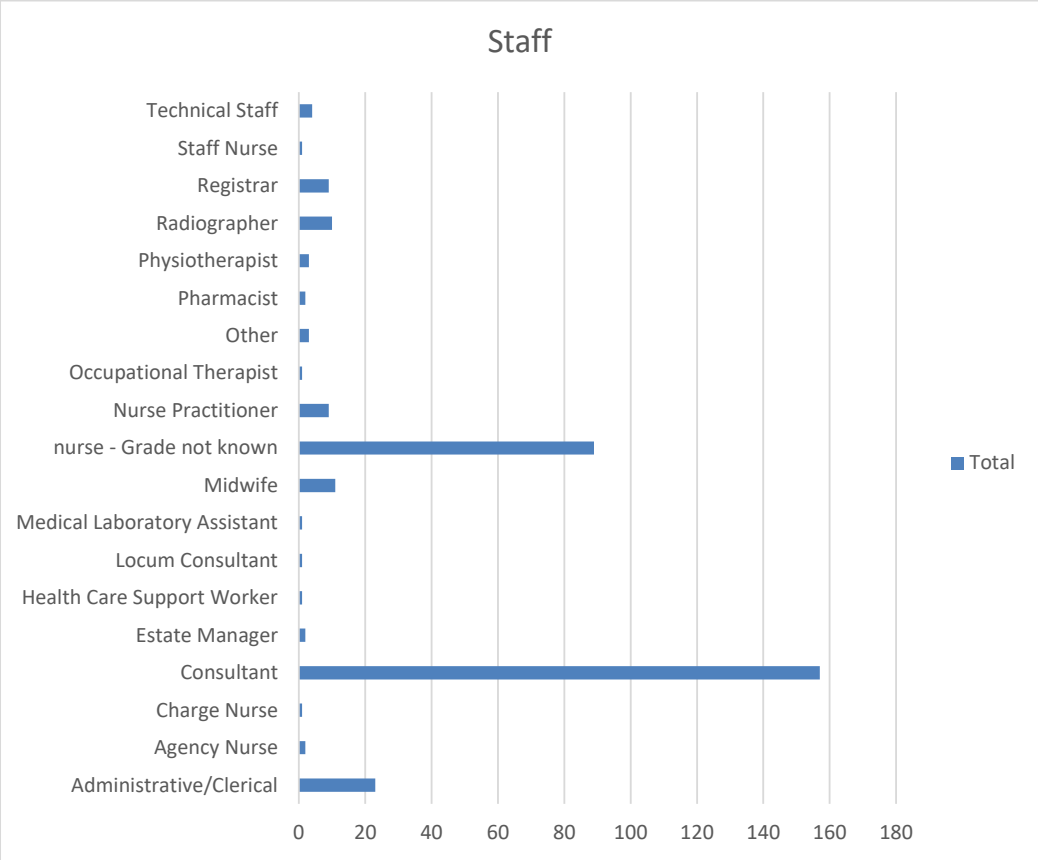


NOTE: SOME COMPLAINTS ARE LOGGED TO MORE THAN ONE SUBJECT

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



7.0 COMPLAINTS BY STAFF GROUPS



8.0 PARLIAMENTARY AND HEALTH SERVICE OMBUDSMAN

8.1 Contact information for the Parliamentary and Health Service Ombudsman (PHSO) is provided to all complainants should they remain unhappy with the outcome of the Trust's investigation and response. During the last year we have been contacted by the PHSO on 5 occasions. One contact related to a patient who felt that their colonoscopy had caused mobility issues. The PHSO reviewed the documents and did not uphold the complaint. One contact relates to the discharge of a terminally ill patient and their spouse was not fully informed of their entitlements for end of life care. The PHSO are currently reviewing the complaint file and medical records. One complaint related to an initial complaint submitted in 2019, regarding a deceased patient with dementia, which became a Root Cause Analysis (RCA). The complainant subsequently approached the PHSO at the beginning of Covid to review their concerns and as they were only investigating urgent cases, they have only now reviewed the case. Actions taken at the time of the complaint and RCA were able to be evidenced and further supporting information was provided to the PHSO to show that actions identified at the time were still in place and had been developed. The complainant is also considering a patient story. There were two other complaints relating to deceased

patients. One related to a joint complaint with another Trust. The PHSO identified the outstanding issues for the complainant, who has since declined a joint Trust meeting and has requested a further response, which is currently being prepared. The other complaint relating to a deceased patient, resulted in a mediation meeting with the PHSO, the Trust, the spouse and a friend. This was the first mediation meeting the Trust has been involved in with the PHSO, and this resulted in a successful outcome.

9.0 NEW NHS COMPLAINTS STANDARDS

9.1 Led by the Parliamentary Health Service Ombudsman (PHSO) these standards were tested in pilot sites in 2021 and have been updated and will be introduced across the NHS later in 2023.

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

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

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

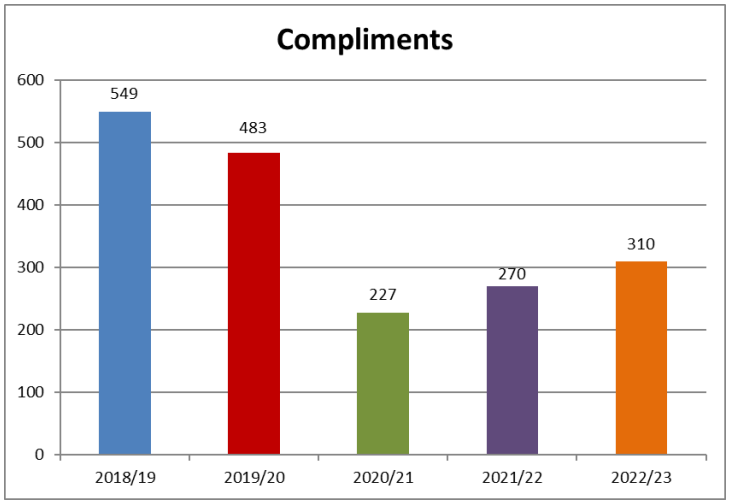
Earlier resolution of complaints will also reduce the possibility of complaints becoming legal claims or being referred to the Ombudsman. This can save financial and emotional costs for everyone.

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

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

10.0 COMPLIMENTS

10.1 The graph below shows the number of compliments collected by the Patient Experience team in recent years, with the number of compliments received this year being 310. The Hospital Hero award ceremony is part of the monthly Team Brief virtual meeting and those staff who are nominated received their certificate in the post and a voucher for tea/coffee & cake from Damers Restaurant. The 'Celebrating Success' weekly email is circulated to the organisation which highlights those staff who have been complimented about their work during the past week.



11.0 CONCLUSION

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

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

	ACTION:	Timescale/Update
1	Monitor the number of extensions granted and the reasons for needing the extension.	Process in place - completed

2	Meet with Divisions (as per Division capacity /resource) on a weekly basis to highlight complaints response times, and complaints in need or urgent response.	Process in place - completed
3	Send out a weekly report highlighting which complaints and concerns are outstanding and complaint timeframes to Divisions and senior management team and Deputy Director of Nursing & Quality	Process in place - completed
4	On-going monthly monitoring of response timeliness. A monthly report is provided to reflect progress and numbers received. To be continually monitored to maintain target of 95%.	Process in place - completed
5	Review the complaint journey from receipt of complaints for further development of the Complaints web-based module on Datix in light of the new Patient Safety Incident Response Framework (PSIRF).	With Risk Management & Patient Safety Team – December 2023
6	Review the complaints training & complaint process information offered to staff in response to the new Complaint Standards in 2023.	December 2023
7	Provide adhoc training and support to clinicians and managers around complaint responses.	Process in place
8	Plan quarterly meetings with Patient Experience & Engagement Lead and Divisional Managers to review progress and track improvement made.	Process in place - completed
9	Send out the complaint process survey regularly throughout the next year to gain feedback on the complaint process and monitor the impact of improvements made.	December 2023
10	Theme the learning from complaints identified in complaint response letters - to be included in the Patient Experience Quarterly report.	Process in place - completed
11	Identify and record if complaints are upheld, partially upheld or not upheld. Information to be recorded on Datix	Process in place – completed.
12	Review the process of collating and recording compliments	September 2020 - completed

12.0 RECOMMENDATIONS

12.1 The Board is requested:

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

Report Front Sheet

1. Report Details			
Meeting Title:	Board Meeting		
Date of Meeting:	26th July 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	18th July 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 June 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.

- Significant increase in datix submissions, notably staffing and delayed inductions
- 3 incidents relating to missed Clexane during pregnancy – relating to risk assessment
- Data from Power BI provided
- All open SIs
- One new risk added to the risk register – the management of a second theatre for an obstetric emergency
- Safety and quality enhancement projects outlined
- One new complaint concerning overall experience during labour and birth
- Training figures provided in greater detail
- Risk register reviewed with updates
- The action tracker from the Safety Champion Meetings updated
- Updated Insight Visit actions
- Summary of the Maternity Voices Survey – key themes identified

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

July 2023 (June activity)

Submitted by Jo Hartley, Director of Midwifery & Neonatal Services

Executive sponsor: Jo Howarth CNO

.

Executive Summary

This report sets out to the Trust Quality Committee the quality and safety activity covering the month of June 2023 and the first quarter, if relevant. This is to provide assurances of maternity quality and safety and effectiveness of patient care with evidence of quality improvements to the Trust Board.

- Significant increase in datix submissions, notably staffing and delayed inductions
- 3 incidents relating to missed Clexane during pregnancy – relating to risk assessment
- Data from Power BI provided
- All SIs with updates including recommendations as appropriate
- One new risk added to the risk register – the management of a second theatre for an obstetric emergency
- Safety and quality enhancement projects outlined
- One new complaint concerning overall experience during labour and birth
- Training figures provided in greater detail
- Risk register reviewed with updates
- The action tracker from the Safety Champion Meetings updated
- Updated Insight Visit actions
- Summary of the Maternity Voices Survey – key themes identified

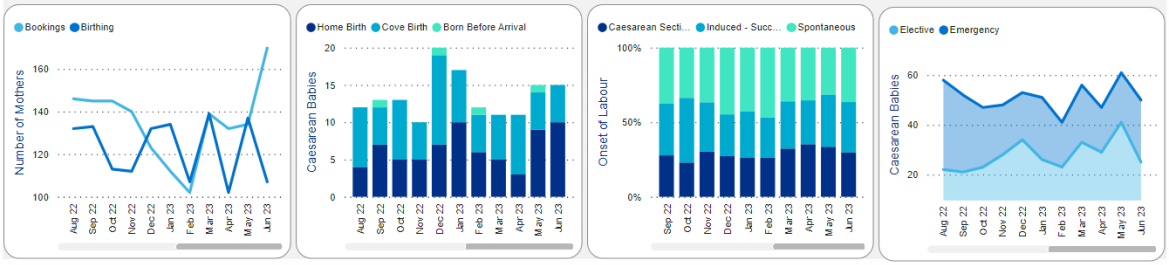
Activity

MAT006 Maternity Report - Key Metrics

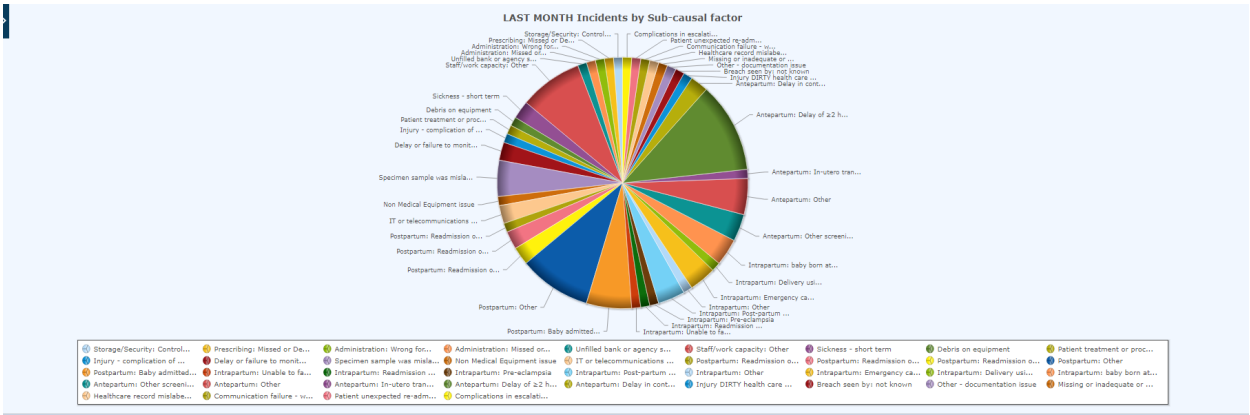
Click HERE to see integer values.

Dorset County Hospital
NHS Foundation Trust

	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 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	May 23	Jun 23	Total
Bookings	156	153	157	165	140	152	140	123	144	126	146	145	145	140	123	112	102	139	132	134	170	3218
Mothers Delivered (Registerable Births)	138	130	122	108	113	114	117	140	130	146	129	133	112	110	132	134	106	136	102	137	106	2875
Babies (Registrable Births)	139	132	123	108	114	114	119	144	131	148	132	136	114	111	135	135	109	136	102	140	107	2914
% Babies Born at Home	5.0%	6.0%	6.5%	7.4%	6.0%	7.8%	7.6%	2.7%	6.1%	4.0%	3.0%	5.1%	4.3%	4.4%	5.2%	7.4%	5.5%	3.6%	2.9%	6.4%	9.3%	5.4%
% Babies Born at The Cove	2.9%	0.0%	3.2%	3.7%	5.2%	6.1%	6.7%	9.6%	7.6%	4.7%	5.9%	3.7%	7.0%	4.4%	8.9%	5.2%	4.5%	4.3%	7.8%	3.5%	4.6%	5.1%
% Caesarean Babies	42.1%	37.3%	43.5%	42.6%	42.2%	37.4%	36.1%	45.9%	38.9%	38.9%	43.0%	38.2%	40.9%	42.5%	39.3%	37.8%	37.3%	40.3%	46.1%	43.3%	46.3%	40.3%
% Elective Caesarean Babies	19.3%	21.6%	19.4%	19.4%	20.7%	17.4%	21.0%	15.1%	17.6%	16.8%	16.3%	15.4%	20.0%	24.8%	25.2%	19.3%	20.9%	23.7%	28.4%	29.1%	23.1%	20.1%
% Emergency Caesarean Babies	22.9%	15.7%	24.2%	23.1%	21.6%	20.0%	15.1%	30.8%	21.4%	22.1%	26.7%	22.8%	20.9%	17.7%	14.1%	18.5%	16.4%	16.5%	17.6%	14.2%	23.1%	20.1%
% Mothers Induced Successfully	28.8%	28.8%	33.3%	27.8%	31.3%	37.4%	25.6%	31.7%	27.7%	29.9%	33.3%	34.6%	43.4%	33.0%	28.0%	31.3%	27.1%	30.9%	29.4%	29.9%	30.8%	30.5%
% 3rd/4th Degree Tears	0.7%	0.8%	1.6%	0.9%	0.9%	1.7%	0.9%	0.0%	2.3%	1.4%	1.5%	1.5%	0.0%	0.9%	0.8%	2.2%	2.8%	0.7%	1.0%	0.7%	0.0%	1.1%
% PPH more than 1000ml	8.6%	13.6%	13.8%	13.0%	13.9%	5.2%	6.8%	14.8%	8.5%	14.3%	13.6%	10.5%	9.7%	11.6%	9.1%	11.2%	10.3%	7.9%	11.8%	8.0%	9.3%	11.2%
% First Feed Maternal	74.3%	64.2%	73.4%	66.7%	67.2%	66.1%	67.2%	65.1%	64.9%	77.9%	65.2%	76.5%	73.0%	73.5%	72.6%	68.9%	70.0%	67.6%	83.3%	75.9%	72.2%	70.3%



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 July 2022 to June 2023

July	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	June
76	70	63	74	62	60	34	44	38	37	77	101
Number of incidents overdue: 10						Relates to incidents requiring input from other specialties and/or agencies					

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

Added RF4 and RF11 to better reflect concerns pertinent to DCH's service

Red flag	Descriptor	Incidents for June
RF1	Escalation to divert of maternity services & poor staffing numbers, including medical staffing and SCBU	10 for maternity, 3 for SCBU,
RF2	Missed medication	3
RF3	Delay in providing or reviewing an epidural in labour	0
RF4	Lack of clinic space for women at risk of premature birth	2
RF5	Full examination not carried out when presenting in labour	0
RF6	Delay of ≥2 hours between admission for induction of labour & starting process	10
RF7	Delay in continuing the process of induction of labour	
RF8	Unable to provide 1 to 1 care in labour	0
RF9	Unable to facilitate homebirth	0
RF10	Delay of time critical activity	0
RF11	PPHs over 1500mls	2

RF2	Missed medication	3 cases relating to missed clexane during pregnancy. This will be addressed via the monthly newsletter

Specific risks of interest

Reference date	Incident	comments
DCH83601	patient was brought to theatre for category 3 c-section. Spinal anaesthetic completed. 40 minute wait for surgery to start.. Concurrent maternal collapse on maternity unit but this was not communicated with theatre team. Emergency bell was not heard in theatre. No decision was made to stop or postpone spinal anaesthetic following obstetric collapse as this was not communicated. Obstetric surgeon started at 45 minutes post-spinal. C-section completed, baby born and	**Review by consultant anaesthetist** Mild hypotension and bradycardia are expected side effects of a spinal anaesthetic and were treated appropriately. I am not surprised that this happened, especially with the delay. The labour ward consultant had gone to perform a gynae operation and therefore wasn't available when the reg

	required transfer to SCBU for ventilatory support. No other complications for mother.	was tied up with a labour ward emergency. A different obstetric consultant was sought to perform the caesarean. **Review by fetal monitoring lead midwife** Notes reviewed, concerns around FH post spinal, alongside cat of C/S. I have discussed the case with the midwife and the coordinator around the human factors of the shift, limited staff and skill mix for the complex situations demanded a change of allocation, limit time for SBAR handover to the midwife now going to theatre with the woman, she was informed that a CTG had been completed prior to C/S but this was a few hour previously. No communication around drop in BP post spinal and delay, the midwife understands that it is her responsibility to listen to the FH post spinal and escalate any concerns to the obstetric team, in a timely manner, use of 2222 from theatre would alert the team to concerns and action, the midwife could also have asked for a CTG to enable to continuous monitor FH. Discussion with coordinator around emergency on the ward and the delay for the case in theatre. Highlighted that although the team were present on the ward for the emergency, if the 2222 for the emergency then theatre would also have been aware of the ongoing emergency and the potential delay for the theatre case. They would then of been able to delay the spinal or plan ongoing management. Improved communication in theatre around changes to maternal BP and from coordinator to theatre would of improved the situation and reduced delay. Baby did have some resuscitation post a difficult delivery, with normal gases, with additional risk factors, baby later admitted to SBCU for ongoing support as increased respiratory effort. both midwife and coordinator understand their role and how small changes could made differences in this situation. good staff debrief held post event

DCH835329	08:49 Due to an EMCS ongoing in maternity theatre, 2nd theatre in main theatre being opened to aid another EMCS. Theatre team assembled quickly to theatre 2 with all staff being informed. Resuscitaire taken up and neonatal trolley taken up. Arrived in theatre 2 at 09:18.	Preterm baby born in 2nd theatre in a timely manner (reviewed by fetal monitoring lead MW). Baby transferred to tertiary centre (expected as below 32 weeks) for ongoing care. Fetal monitoring lead had identified good practice and sent feedback to involved staff. The case will be further reviewed via the exception report meeting.
DCH83411	Transferred to theatre for trial of forceps due to rising baseline, maternal pulse and decelerations on ctg trace. Successful forceps in theatre, episiotomy performed at time of delivery. Postpartum Haemorrage following delivery. Immediate Action Taken21.48 Transferred to theatre, 21.55 Paediatrician contacted to attend due to instramental trial. 22.10 Baby delivered by forceps, episiotomy at delivery. 22.11 10iu oxytocin given for third stage 22.12 Placenta delivered. Cord gases taken and sent 22.13 steady blood loss noted, appears to be from the episiotomy, fundus firm, sutering commenced. 22.15 txa given trickling continues 22.18 placenta full check healthy and complete. 22.20 swabs weighed currently at 180mls, appears alot more in the bag, awaiting to measure. 22.24 second cannula inserted bloods taken and sent for fbc, coagulation, blood cultures, crp. due to increased heartrate ? sepsis. 22.30 Blood bank have been contacted for 2 units of blood, blood loss settling with sutering, fundus remains firm. 22.45 blood loss has settled, mr s. contacted and informed of events. 22.50 lactate and hb results. hb 125, lactate 3.5 total measured blood loss 2240mls	**Review by consultant obstetrician** The decision to deliver this patient by a trial of instrumental in theatre at 21:29 on 11th June 2023 was correct because the patient had been fully dilated with an ROP position for two and half hours and had an abnormal CTG. The PPH was managed appropriately, as has been documented by the anaesthetist and the midwives. The registrar documented debriefing the patient at 8:30 the following morning which was good practice. **The learning in this case is the requirement for appropriate documentation by the registrar about the cause and management of the PPH.** **Review by consultant anaesthetist** She was looked after by one of our senior specialty doctors with extensive obstetric experience and this is clear from the exemplary management. Atony and PPH were addressed with medical management including TXA and 2 litres of stat warmed fluid, also calcium given. Consideration and preparation for blood transfusion, but the tachycardia (which is expected with such an acute loss especially with epidural top up on board) resolved with fluid and above management and it appears she managed to avoid transfusion with Hb 94. Open mind re ?sepsis good to see with plan to cover. Clear notes and escalation plan. Plan to remove epidural catheter once happy with repeat postop bloods - I can't see the note to document the removal but the bloods were not concerning.

DCH83135 01/06/2023	As is normal practice at DCH, one doctor working in the maternity dept on a night shift. Consultant helpful throughout and would have attended if requested. 3 emergencies at same time……I updated the maternity co-ordinator in case any emergencies, bleep me. The ward is about 10-15 minutes walking away. in the middle of my gynae patient assessment I was bleeped by the co-ordinator about the poor ctg and a bradycardia which had recovered - terbutaline advised to be given stat whilst I would come down to review, ctg now recovered so I continued with gynae assessment for the time being unless bleeped again, I have advised if ctg deteriorates again to bleep consultant and myself, who will both come and review if needed. it took me about 15 minutes to complete the assessment then I planned for blood transfusion and CT scan, booked urgently, I left the anaesthetic reg on call to manage iv fluids and pain relief of the gynae patient. Consultant made aware of the situation and will help if needed. I came back to labour ward and reviewed the ctg, a second bradycardia - longer than 4 minutes so I made the decision for cat 1 cs, consultant aware of plan. after the cs I reviewed the 2nd woman who had a trail of instrumental then unfortunately proceeded to cat 2 cs. CT scan result of gynae patient came through immediately before the 1st cs - large amounts of fluid in the abdomen and pelvis - no time to review the patient as I was in maternity reviewing emergencies. I called the day surgery to find out how the patient was doing clinically before immediately updating the consultant and making a plan. patient was stable and anaesthetic team set up a PCA for good analgesia I called consultant and updated them - plan for conservative management. I also updated the consultant regarding the obstetric patients,	**Comments from Obstetric Consultant**: I don't dispute any of the detail below. I can confirm that no harm came to the patients. I can confirm that the Middle Grade doctor, the coordinator, and I worked together. I would commend the doctor's sensible MDT working (he asked the anaesthetist for help with the gynae patient) and that I offered to come in if needed. I note that after this Risk Event we have had the CQC visit and there is now a plan in place to have an SHO-level doctor resident for nights. In such a scenario as detailed below this will be helpful.

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

Babyloss statistics for quarter one until early June		
Intrauterine death	Neonatal death	Late neonatal death
1 loss Pregnancy loss at <20 weeks gestation. Consented for Post-mortem and will have a follow up appointment with Obstetric Consultant in October with results.	nil	nil

Serious incidents and HSIB
DCH66382
Intra uterine death. **June update**: the DoM has suggested to the Risk Dept this incident/RCA is now closed as national and regional action is required and resolution will be a lengthy process **July update:** agreed closure at LMNS Safety meeting
DCH76500
Baby born with birth injury. **Update:** this has now been presented at the Learning from Incident Panel in March. Actions reviewed in relation to complaint from family **July update:** report with covering letter sent to family
DCH77894
Patient transferred to ITU following massive obstetric haemorrhage 2.6litres **Update:** this has now been presented at the Learning from Incident Panel **July update:** patient has met with consultant obstetrician. Now awaiting confirmation from ICB to close **Recommendations from RCA** • Midwives and doctors to be reminded they must adhere to the Management of Anaemia in Pregnancy Guideline. This message is to be reinforced at the mandatory PROMPT training as well as through the newsletter, at staff meetings and at the monthly Governance Meeting – **completed and ongoing** • The use of IV Iron therapy in instances when there is a short timeframe between identification of anaemia and birth to be reflected in the guideline and staff to be reminded (as above) - **completed** • Risk factors must e reviewed and if required, updated at each contact with the pregnant woman. This must be recorded in her digital maternity record • The Management of APH guidance requires review to mirror the RCOG green top guidance for APH • The Anaesthetic Consultant must attend all PPH which are over 1.5L and on-going – **disseminated amongst anaesthetic team** • The blood gas analyzer on the maternity unit does not analyze lactate – this needs to be considered in relation to usage and cost – **currently, this is cost prohibative and lactates are processed on a co-located machine**
DCH79162
Surfactant required for a baby admitted to the neonatal unit. Equipment failure **Immediate actions** Parents informed and reassured All same LOT number removed from circulation DATIX submitted MHRA incident form completed

June update: parents have met with the Lead Consultant for Neonatal Services and the Lead Nurse.. The RCA will be shared with them as well, once completed
DCH79901
Antenatal (prior to labour) caesarean for abnormal CTG. Baby profoundly anaemic. Baby cooled. **Update:** SI investigation ongoing
DCH79898
Attended Day Assessment Unit with a history of reduced fetal movementsand sadly, confirmed intra-uterine death. **Update:** 72 hour report completed and submitted. Joint PMRT review meeting with UHD on 30/03/23. **July update:** scheduled for LIP 21/07
DCH79954
Baby born by caesarean. Baby deteriorated after birth and requied neonatal admission **July update:** DoM and Paediatric Consultant met with parents recently (and baby) to discuss what happened and ensure their questions are included in the RCA.
DCH80360 10/2/23
Baby born in poor condition following appropriate artifical rupture of membranes. Baby born in poor condition but has made a good recovery. Referred to HSIB (14/2/23) waiting for their triage process to see if case will be investigated by them. Trust 72 hour report did not identify any initial concerns **July update:** awaiting HSIB report

Safety and quality enhancements projects

Project	Category	Assigned To	Project Lead(s)	progress
Team of the shift	Team Culture	Safety Team	Lindsey Burningham	No progress currently
BFI UNICEF accreditation	Clinical Outcomes	BFI	Emma Barrett	Ongoing with funding from LMNS
Feeding SCBU Parents	User Experience	SCBU	Jo Hartley & Patsy Bonnett	Completed successfully
Hegenberger Retractor Trial	Clinical Outcomes	Individual	Laura Cannon	Staff training prior to roll-out
BSOTS &triage	Clinical Outcomes	ANDAU	Louise Pride	Ongoing and on risk register. Project to identify suitable triage system for DCH
Second Stage C/S	User Experience	Individual	Khalid Ali	
Entonox exposure	Safety	Corporate	Jane Hall	Awaiting work on rooms
Neonatal Hypoglycaemia	Clinical Outcomes	Postnatal Team	E Barrett & G Westaway	New policy agreed based on national and regional guidance
Parentcraft	User Experience	Management	Tara Pointer-Putt	
Transitional Care	Clinical Outcomes	SCBU	Dom Sheehy	Linked to the Maternity Incentive Scheme. 12 month project to embed TC and provide required

				audits
Elective caesarean	User Experience	Labour Ward	Shelley Cassidy	Preliminary meeting being arranged with clinicians to review the elective pathway and how to improve the experience for women and the efficiency on the ward
Birth after caesaean	User Experience	Individual	Jen Green & Pawla Weekes	Review of women's experience of using this service
Call Bell System	Safety	Management	Tara Pointer-Putt	Ongoing and on risk register
Obstetric Handover	Safety	Management	Jo Hartley, James Male	Ongoing and on the risk register. Ninth consultant to be appointed
Pelvic Health	Clinical Outcomes	Postnatal Team	Chris Leadley	LMNS funded project. Excellent engagement from DCH. Recently presented at a national conference about APPEAL
Enhanced bereavement cover	User Experience	Bereavement Team	Sophie Wilson	New recurrent funding from NHSE to improve bereavement cover
ANDAU Electronic Diary	Safety	Digital Team	Fran Dubey	Completed successfully
Restorative clinical supervision (RCS)	Health & Wellbeing	PMA Team	Pawla Weekes	Ongoing with RCS being offered to newly qualified midwives and to student midwives. Also available to all staff on a 1:1 with PMA
Anaemia in pregnancy	Clinical Outcomes	Safety Team	Elizabeth Passells	Ongoing
PPH >1500mls	Clinical Outcomes	Safety Team	Linda Deadman	Ongoing

Risk Register

ID	Title	Risk Statement	Open	Risk	Risk Level
1689	Opening a second theatre in an emergency	Maternity has access to one dedicated theatre 24/7, located on the maternity unit. If theatre is in use and an emergency procedure is required - for example a category 1 caesarean, instrumental birth, obstetric haemorrhage, a second theatre is made available as a priority. This is a rare event (9 times in the last 30 months) that is always reported via datix and reviewed by the Safety Team, including if relevant, the fetal monitoring lead. Despite the challenges of this situation, knife to skin remains within the time frame for category 1 & 2 caesarean and there has not been an incident where a theatre was not made available immediately. We also do simulation training for opening a second theatre. Whilst this is rated as a moderate risk, there have been no poor outcomes related to this risk and there is no prospect of a second theatre being built for maternity in the current estates work plan.	29/06/2023 Quarterly review	moderate	division
1666	delays in screening booking bloods for pregnant women	following the UKAS inspection of the Microbiology Service u in March against the ISO 15189 standards, the decision was that Microbiology's UKAS Accreditation should be suspended for six months due to a number of areas not evidencing that the department could satisfy the standards. Currently antenatal infectious diseases samples are being sent to a laboratory in Bristol. However, reporting of some of the samples has fallen outside of the IDPS standard of 8 working days. This appears to relate to delays in the Bristol lab processing the samples and is currently being reviewed by the Microbiologist consultants **July update:** awaiting advice from the National Screening Committee	06/06/2023 Monthly review	moderate	Care group

1665	lack of capacity to provide consultant led care to women at risk of premature birth	the provision of consultant led care for women at risk of premature birth is nationally mandated in the Saving Babies Lives Care Bundle and the Maternity Incentive Scheme. Funding has been received from NHSE via the LMNS to fund an increase in consultant led antenatal care. Currently we are unable to expand the ANC offer due to consultant availability/clinic and USS space. This means high risk women are not being seen early in pregnancy, as per NICE guidance, MIS and SBLCB to ensure a care plan is in place to reduce the risk of a premature birth. **July 2023:** the appointment of a ninth consultant will alleviate pressure and provide time to increase antenatal clinics for women at risk of premature birth	06/06/2023 Quarterly review	moderate	Care group
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** This risk has now grown to include the requirement of the attendance of the consultant at an 8pm handover, To facilitate this an extra session will be required which will necessitate an extra consultant being employed. Business care currently being written **June 2023** Currently, the service continues with MDT handovers at 0830, 1330 and 1700/1730 with a handover at 2100 between the two registrars and a telephone conversation between the night registrar and the consultant oncall. At the weekends and BH, the consultant attends for two handover/ward rounds. One in the morning and one in the afternoon. Discussions continue about the possibility of being able to fund a new consultant post. This would facilitate the evening handover as well as other issues on the Risk Register **July 2023** The appointment of a ninth consultant will enable face-to-face handover in the morning, lunchtime and evening (9pm)	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 **July 2023** CQC inspection confirmed requirement for robust triage system. Not necessarily BSOTS required. Currently considering most effective system for DCH	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 **July 2023** Room still not in use as further structural concerns identified	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.* **June 2023** Floor plan reviewed and the placement of call bell panels etc. agreed. Awaiting a start date following a ward in the hospital being completed. A datix was submitted recently relating to an emergency bell in Day Assessment not being heard in the office but instead heard on Labour Ward. It was responded to promptly but should have been audible in the Day Assessment office as well as LW **July 2023** Call bells tested every day 11am – recorded on daily checks checklist. Awaiting improvement work from Estates		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 **July 2023** This remains on the risk register but no new incidents	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 offered a first point of contact appointment face to face which includes BMI, bloods and CO reading. This will significantly improve the compliance. **June 2023** Funding from the MIS has been confirmed (less than was requested but that was expected) – some of which must be used to improve compliance with this standard **July 2023** – significant improvement in CO monitoring noted	17/03/2022 Quarterly review	moderate	Care group

871	Levels of Entonox Exposure on the maternity unit	**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 • **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. • **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 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. • **Annual testing** – all reports from 2015 until present day. We use Cairn Technology Ltd who provide us with 10 sorbent tubes for personnel testing • **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	24/12/2019	High	Division

1127	Maternity Staffing	**Update:** staffing remains challenging. Recruitment continues with interviews soon for band 5 &6 posts. but there is a high number of midwives retiring. However, sickness rates have improved considerably (see end of paper). The mitigation remains the same - reallocating staff, asking staff to work extra shifts, utilising bank staff. **June 2023** Awaiting conclusion of maternity staffing business case. Narrative around posts externally funded has been provided by the DoM to the DM. Significant increase in datix submission around staffing and there have been some very challenging shifts where inductions have been delayed, staff haven't had breaks and the postnatal ward is staffed by only one midwife and one MSW. **July 2023** Recent meeting with Finance and Division – further information required about business case. Continued increase in datix relating to staffing and to delayed inductions of labour	20/07/2021 Quarterly review	moderate	division

Complaints

Total informal and formal

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

C23089	Patient raised concerns about multiple issues related to their labour and birth. Currently being reviewed by the MDT for a response
C22918	Patient raised concerns regarding the anaesthetic given to them at the time of a Caesarean, the care afterwards on the ward, their ongoing difficulties following the anaesthetic, and the impact this has had on their life. **July update**: Response sent to complainant. Overall, care was good. Action: • Reconfirming that sterilisation is not a procedure that can be reversed
C22459 This complaint relates to the provision of postnatal care to a woman with a baby <37 weeks gestation	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 Presented at M&M. Far reaching discussion about the impact of the care on patients mental health and the importance of properly assessing the baby and where responsibility for care should reside
C21589 This complaint relates to an intrauterine death during the covid pandemic.	**Update** DoM and consultant to meet with patient

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 **July update:** MNVP not required to be involved in actual response to patient but involved in learning and service improvement in relation to complaints. RAG green as confirmed very god working relationship with MNVP
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 (consultant, registrar and SHO) handovers during the shift every day (0830, 1330 and 1730) with a handover at 2100 registrar to registrar) However, the standard will soon be that the consultant will be required to be present for the night-time handover. For DCH to provide this, a further consultant post will be required. This is currently being discussed in relation to funding

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)

Guidelines

Safety Champions Action Tracker

Area	Arising from	Action	Owner	Timescale	Outcome	Remove ? Y/N
Meeting Dated: 19 April 2023						
	Exec Safety Champion & Chair	**Safety Champion meeting format** Create standing agenda Create action tracker Oversight via Quality Committee	LB	End May	Standing agenda and action tracker template created – to be agreed at next Safety Champion meeting	
		Organisational Risk Policy Update Update LMNS regarding review of risk scoring matrix and	LB	End April	LMNS partnership meeting updated regarding review and possible revision	

		language to align with region and aid collaboration with DHC				
Maternity Anaesthetics	Datix Strike action	**ELSCS QI Project** Increasing LSCS rate identified, 1 operating theatre impacting capacity and flow. RCOA stipulates ELSCS should be Cons Anaesthetist led – recent strikes all elective work cancelled further highlighting and impacting known issues; Delay, cancellation, rescheduling and flow -consider separate staffing -consider second theatre	KB		QI project being led by a senior midwife to improve pathway for elective LSCS Elective activity continuing during strike action	
		Learning around escalation/Hot debrief -Submit Datix for collation -include clinicians in Hot Debriefs as well as Divisional Managers	JH			
	Ockenden MIS	**PROMPT Compliance** Currently unknown mandate on obstetric anaesthetist requirement for PROMPT compliance -Discuss with OAA -Discuss with NHSR	KB LB		Ongoing KB has contacted OAA – Chris Elton committee member has clarified they are querying it with NHSR also who are about to go out for stakeholder review. KB considering PROMPT sims afternoons for all obs anaesthetists	

		-Compile a paper for Trust Board with SBAR format – National recommendation , GAP analysis, Mitigation, Risks and a plan			in the interim	
Neonatal	BAPM	**Neonatal Hypoglycaemia** Local guideline currently not aligned with BAPM guidance resulting in neonates undergoing unnecessary invasive blood testing procedures -Revised guideline to align with BAPM	CH	End May	New guideline ratified in line with BAPM and regional guidance	
Meeting Dated: 2 March 2023						
Neonatal	Neonatal Network Wessex MatNeoSip	Implement daily updates to Peridash – new dashboard to identify regional cot availability	CH		Ongoing	N
Neonatal	Wessex MatNeoSip	**Pre-Optimisation:** - Delayed Cord Clamping (DCC) guideline (drafted) - Education & training (posters displayed)	CH		Ongoing	N
Neonatal		**Post ductal O2 Sats screening** Improvement in completion required -Education & training -Documentation	CH		To be presented at Governance meeting	N
Maternity Neonatal	User feedback	**Informed Consent**	JoH		Ongoing Service user voice	N

	Datix Investigations	Improve clinicians understanding around informed consent – what it means and how to empower service users -Birthrights Charity Training sessions -Trust wide introduction of e-consent			represented at departmental safety & quality meetings Funding established via LMNS for training – session dates to be agreed – move to PD team action tracker No update	
Maternity	Ockenden	**Doctors evening handover** Align Consultant and other grade Doctors handover times (currently 30-minute differential) to a unified 17:30	James Male/ JoH		Ninth consultant soon to be recruited allowing for the introduction of face-to-face handover at 9pm	N
Maternity	MSW Safety Champion RCM NHSE	**Job roles & responsibilities B2 & B3** - Practice Development team & Line Managers to design robust induction programme for new MSWs -MSW line managers to review JDs -Maternity team reminder of difference between B2 & B3 role and responsibilities at staff meeting & via newsletter	JoH	End April	Induction package in development – action moved to PDM team action tracker Action completed Action completed JH provided update on National drive for B2 entry point, working towards B3 by achieving competencies then automatic uplift. This will generate local workstream – Trust group to be established to address funding, training, and uniform issues etc.	Y

					local programme management with Trustwide oversight and department actions	

Audit

Maternity Staffing

Sickness absence over last 12 months	June 2023
midwives	4.6%

Sickness absence	June 2023
MSW	4%

Maternity Voices questionnaire

The response to the MVP survey in 2022 was excellent. With 242 service users across Dorset responding. The key themes are below

Antenatal	intrapartum	Postnatal
Continuity of care	**Covid restrictions impacted substantially on labour and birth experiences**	**Women need to be better informed about the options for a birth debrief**
More time to discuss birth options	**More respect needs to be shown to women's birth choices**	**More face-to-face postnatal care**
More information needed on birth, infant feeding and healthy lifestyle	**staffing levels were a concern**	**More attention paid to women's emotional wellbeing**
Long waits to be seen in Clinic	**More information needed to make informed decisions during labour**	**Feeding support could be improved, including those having subsequent babies**
Staff need to be more informed about previous traumatic pregnancy	**Delayed inductions**	**Women with babies in the neonatal unit needed more support to visit and feed their babies**
Women need to feel listened to in clinic		**Staffing impacted on the quality of postnatal care**
Key areas to focus on in the next 12 months	**Informed choice and consent Infant feeding and support Labourline Mental health and emotional wellbeing Continuity of care (seeing the same midwife)**	
How could Dorset services be improved?	**Better staffing on postnatal wards More mental health support**	

	More information available **Continuity of care (seeing the same midwife)**

Training compliance

TRAINING	STAFF GRADE	PERCENTAGE OF ATTENDANCE	NUMBER OF NON COMPLIANCE	**RAG**
PROMPT – Practical Obstetric Emergency Procedure Training a PROMPT TIMETABLE.doc	Obstetric Anaesthetist (Covering Obstetrics)	92%	2	
	Consultant Obstetrician	87.5%	1	Booked 14/07/23
	Registrars	100%	0	
	ST1/F2	67%	1	Booked 14/07/2023
	GP Trainees	100%	0	
	Midwives	91.5%	11	1 mw attended comm sim 13.03.23
	MSW	87%	4	1 booked 14/7/23
BASIC LIFE SUPPORT Maternity Training Programme 2023.doc	Obstetric Anaesthetist	85%	5	
	Consultant Obstetrician	75%	2	1 booked
	Registrars	87.5%	1	
	ST1/F2	100%	0	
	GP trainee	75%	1	
	Midwives	96%	6	
	MSW	94%	2	
NLS Yearly	Midwives	95%	6	
NLS 4 Yearly	Senior Midwives and Homebirth Midwives	96.5%	1	1 currently not able to book as no courses available
Saving Babies Lives study day SBL update day	Midwives	93% 2021 91% (rolling 12 months 22/23)		

K2 CTG	Consultants	100%		
	Registrars	100%		
	Midwives	93%	16	Reminders sent

PROMPT - Two midwives taken off PROMPT to cover ward in June – (1.5%).
New Anaesthetists and F2 SHO allocated in July – unable to attend previous dates.
One Consultant just out of date June 15th. Requested to attend July.
BASIC LIFE SUPPORT – All m/w's have training within mandatory study day and MSWs supported to attend this. All doctors need to attend BLS via Trust Education 0815-1045.

ADDITIONAL TRAINING DATA (lfe = learning from events)

Pool Evacuation Training	In PROMPT programme for all attendees Jan 2022-Dec 2022	93% midwives and 93% MSWs compliant Prompt 2022 Year
Perinatal Mental Health	45-minute update within Day 2 Mandatory Education Day for midwives 2022 programme	
Community/SWAST Training 4 hours (min 4 scenarios) Homebirth emergencies	Shoulder Dystocia In/Out of pool (includes lfe) PPH, Eclampsia in PN woman, Secondary PPH, NLS, Breech.	38 attendances in last 12 months June 22-June 23 (mostly cygnet team, always 1-2 SWAST per session)

Report Front Sheet

1. Report Details			
Meeting Title:	Board of Directors, Part 1		
Date of Meeting:	26 July 2023		
Document Title:	Safeguarding Annual Report		
Responsible Director:	Jo Howarth, Chief Nursing Officer	Date of Executive Approval	31/05/2023
Author:	Sarah Cake		
Confidentiality:	No		
Publishable under FOI?	Yes		
Predetermined Report Format?	No		

2. Prior Discussion		
Job Title or Meeting Title	**Date**	**Recommendations/Comments**
Safeguarding Group Quarterly Committee Meetings	2022-2023	Assurance and governance requirements Annual report / activity to be sent through Quality Committee.
Quality Committee	20 June 2023	Approved

3. Purpose of the Paper	Offer assurance of the process for Safeguarding at Dorset County Hospital NHS Foundation Trust							
	Note (✓)	x	Discuss (✓)		Recommend (✓)		Approve (✓)	
4. Key Issues	A review of the activity for the Safeguarding team through 2022-2023 , to include activity in relation to adults , children, maternity , learning disabilities and the Mental Capacity Act .							
5. Action recommended	The Board is recommended to: **NOTE** the report prior to sharing with NHS DORSET as part of the safeguarding assurance framework							

6. Governance and Compliance Obligations			
Legal / Regulatory Link	**Yes**		All providers have a legal responsibility to safeguard the welfare of adults under Care Act 2014, Mental Capacity Act 2005, and Deprivation of Liberty Safeguards (DOLS) 2009. All providers that deliver services to children have a legal requirement to meet Section 11 of the Children Act (1989, 2004).
Impact on CQC Standards	**Yes**		Provide assurance of compliance with the Care Quality Commission Registration Standards: Regulation 13 (safeguarding service users from abuse and improper treatment), fundamental standard 5 (safeguarding from abuse) and Safe Domain (safeguarding arrangements).
Risk Link		**No**	

Impact on Social Value		**Yes**		Safeguarding encompasses all the social values , as it is fundamentally linked to the Human Rights act 1998.
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	Investing in staff to ensure delivery of high-quality care , prevention of harm , recognition of a neglect or abuse of risk of harm , promote workforce to remember that safeguarding is everyone's responsibility .		
	Place	Consideration of the communities that we serve and improve health and social outcomes , through a strength-based Safeguarding approach .		
	Partnership	Contribution to effective Integrated care system as part of the Pan Dorset Children's Partnership and Adult safeguarding board . Collaborative work in progressing partnership learning from serious case reviews		
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**		Effective work in recognition & management of those using our service and the Health Inequalities they may experience due to their physical health , neurodiversity or psychosocial needs for example : domestic abuse , social deprivation , people with a learning disability and or autism .
Tackling unequal outcomes and access		**Yes**		As above
Enhancing productivity and value for money		**Yes**		As above
Helping the NHS to support broader social and economic development		**Yes**		As above
Assessments		**Have these assessments been completed?** *If yes, please include the assessment in the appendix to the report.* *If no, please state the reason in the comment box below.* *(Please delete as appropriate)*		
Equality Impact Assessment (EIA)			**No**	
Quality Impact Assessment (QIA)			**No**	

Title of Meeting	**Board of Directors, Part 1**
Date of Meeting	**26 July 2023**
Report Title	**Annual Safeguarding Report**
Author	Sarah Cake, Head of Safeguarding Joanne Findlay, Learning Disability and Mental Capacity Act Lead; Hanna Wellman, Specialist Nurse for Safeguarding Children; Sarah True, Safeguarding Lead Special Care Baby Unit.
Responsible Executive	Jo Howarth, Interim Chief Nursing Officer

Purpose of Report

The purpose of this annual report is to inform and assure members of the Quality Assurance Committee the Safeguarding activities within Dorset County Hospital during 1st April 2022 – 31st March 2023

Foreword

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

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

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

The Annual Safeguarding Report aims to:

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

and improper treatment), fundamental standard 5 (safeguarding from abuse) and Safe Domain (safeguarding arrangements).

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

Paper Previously Reviewed By

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

Strategic Impact

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

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

Domestic Abuse and Violence Against Women final statutory guidance published July 2023 Domestic Abuse Bill https://www.gov.uk/government/publications/domestic-abuse-act-2021/domestic-abuse-statutory-guidance-accessible-version

Serious Violence Duty Statutory Guidance Dec 2022

https://www.gov.uk/government/publications/serious-violence-duty

Safeguarding Children is still on the political agenda with increased focus on Modern Slavery, Child Sexual Exploitation, Criminal Exploitation, County Lines sexual abuse within education and increasing knife crime by teenagers.
National Review into the murders of ALJ and SH
https://www.gov.uk/government/publications/national-review-into-the-murders-of-arthur-labinjo-hughes-and-star-hobson

Increase in children and young people with mental health issues requiring specialised treatment.

Liberty Protection Safeguards now postponed, no date for commencement.

Risk Evaluation

Key Risks for the Service

1. **Activity and Demand – I**ncreasing safeguarding activity Trust wide.
2. **Training –** Training compliance, specifically for Level 3 children's compliance.

3. **Information Sharing –** To ensure information shared with community services in a timely and robust manner following the attendance of a child at DCHFT. Patient information systems integration. Digitalised systems to improve the ability to streamline the review of records. 4. **Talent Management –** Ensuring that the DCH Safeguarding Team has the correct people with the capabilities to deliver outstanding care, now and going forward. 5. **Mental Health –** Increasing need for mental health provision in an acute physical environment, specifically for children and young people.
Impact on Care Quality Commission Registration and/or Clinical Quality Safeguarding Children, Young People & Adults, Mental Capacity Act compliance and Deprivation of Liberty assessments are key quality indicators and are subject to external inspection. All Deprivation of Liberty outcomes are forwarded to CQC for notification.
Governance Implications (legal, clinical, equality and diversity or other): The Trust has legal responsibilities as detailed within the strategic impact section. The reassurance of a robust service is measured through audit or assurance tools comparing practice against policy. Electronic flagging of patients with learning disabilities and/or Autism is a recognized national system, however, this does categorise individuals and, therefore, has an acknowledged implication for equality and diversity. This is in line with our equality duty and supporting published papers on Equality in Health. This ensures pathways of care are reasonably adjusted and patients with disability are not disadvantaged by the service provided. National Flagging through CPIS (Child Protection Information Sharing) for children who are subject to a Child Protection Plan; or a cared for child; or an unborn infant, who will be subject to a Child Protection at birth, is maintained by Social Care partners and is shared to Health Providers.
Financial Implications: Failure to adhere to the standards can result in penalties and/or legal claims. Cost and resource implications for the introduction of the Liberty Protection Safeguards.

Freedom of Information Implications – can the report be published?	Yes

Recommendations	The Board is asked to: a) Receive and review the report, recommending any areas for further improvement at Safeguarding Group. b) Receive assurance of Safeguarding activity.

	c) Support delegated responsibility to the Safeguarding Group for the development of the 2022–2024 work-plan, which the Lead for Safeguarding will focus on, in conjunction with the Safeguarding Team. d) Recommend the annual report Trust Board.

Safeguarding Annual Report Quality Committee

2022- 2023

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

1.0 PURPOSE OF REPORT

1.1 This report provides a summary of the Safeguarding activity from 1st April 2022 – 31st March 2023. The purpose of this annual report is to provide assurance and inform members of the Committee of how Dorset County Hospital meets its duties to safeguard adults by preventing and responding to concerns of abuse, harm or neglect.

2.0 INTRODUCTION

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

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

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

The Safeguarding Annual Report 2022- 2023 provides a summary of the activities of the Adult, Children and Midwifery Safeguarding Teams across the Trust to demonstrate to the Trust Board, external agencies and the wider community how the Trust discharges its statutory duties in relation to current safeguarding expected national standards and best practice guidelines challenges and future priority.

Definitions

Safeguarding:

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

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

- Live independently
- Are a parent themselves
- Are in Custody
- Are a member of the Armed Forces

This does not change their entitlement to protection or safeguarding.

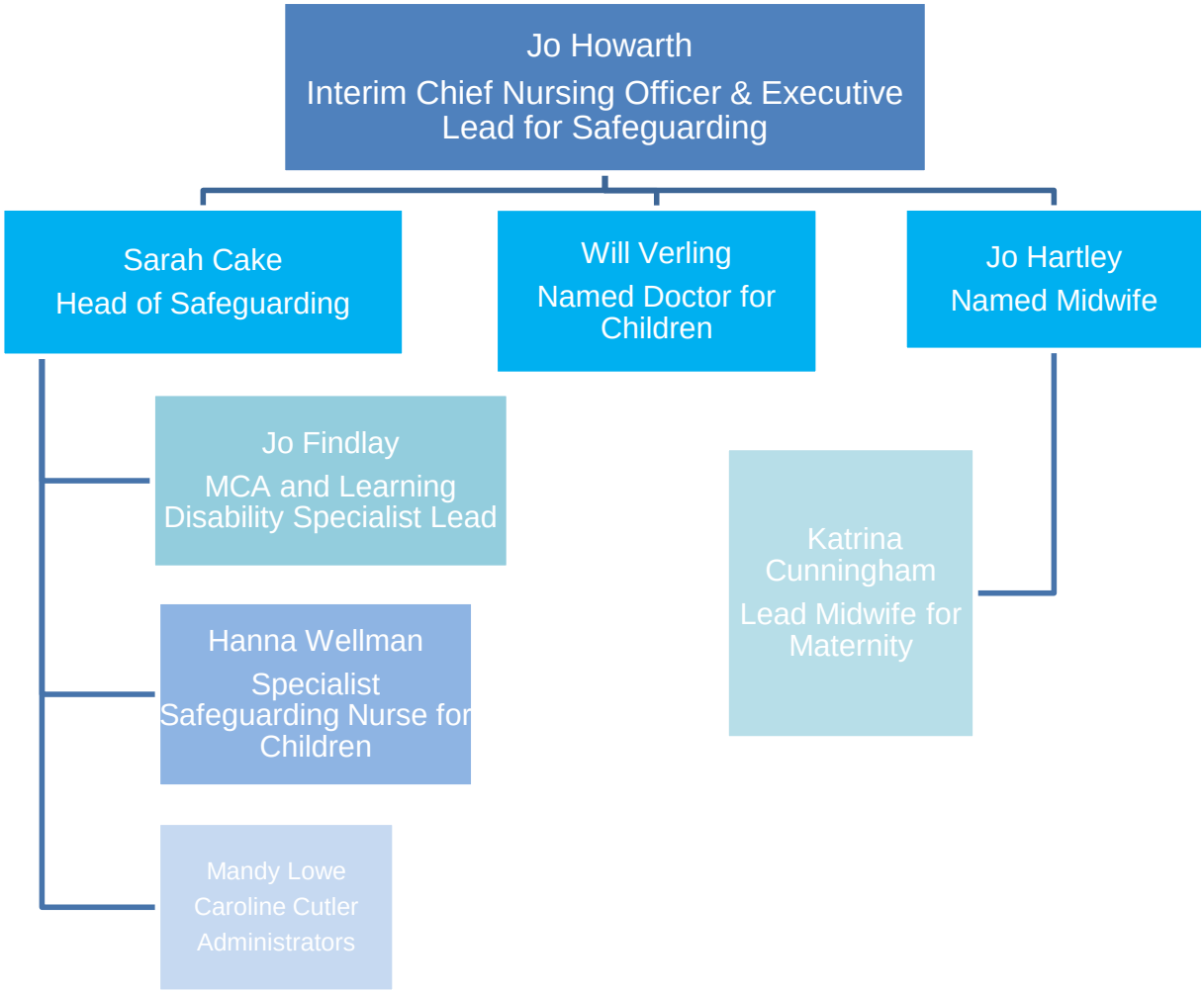
Safeguarding Adults: An adult is an individual aged 18 years or over. The Care Act 2014 defines an 'adult at risk' as:

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

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

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

The Safeguarding Team at Dorset County Hospital Foundation Trust



3.0 ADULT SAFEGUARDING ACTIVITY

3.1 During the past 12 months staff have formally submitted concerns for 109 people using our service. The majority of these were not investigated through a Safeguarding investigation but were signposted to other services. The `other` activity in relation to contact with the Safeguarding Team has also intensified, common themes have been regarding discharge planning/safety netting/advice on mental capacity. Many contacts are made for advice rather than through the formal route of referral through the cause for concern process.

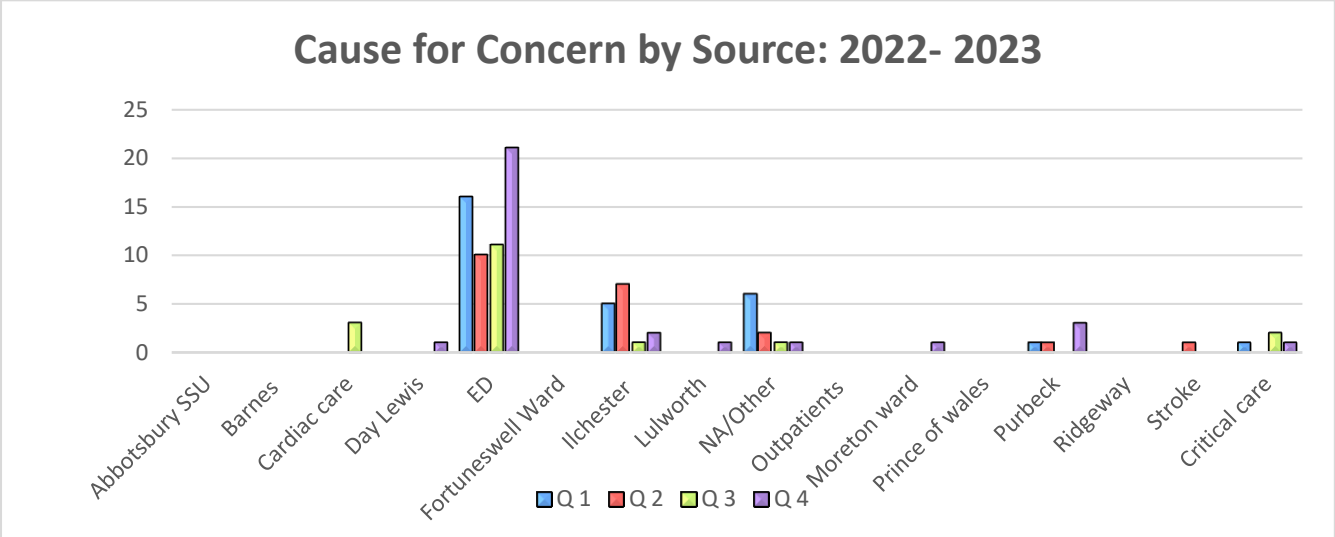
In 2022- 2023 there were 6 concerns raised in relation to Dorset County Hospital Foundation Trust by external agencies. All of these were investigated through a nominated enquiry process and did not proceed on through to a full safeguarding investigation. The main issues related to discharge planning, communication with partner agencies at point of discharge and safe transfer into the community. The findings of the investigation are communicated to the department where the incident occurred for learning, they are informed that the issue is not being pursued through Safeguarding, but any changes to practice will need to be adopted through their quality-of-care agenda.

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

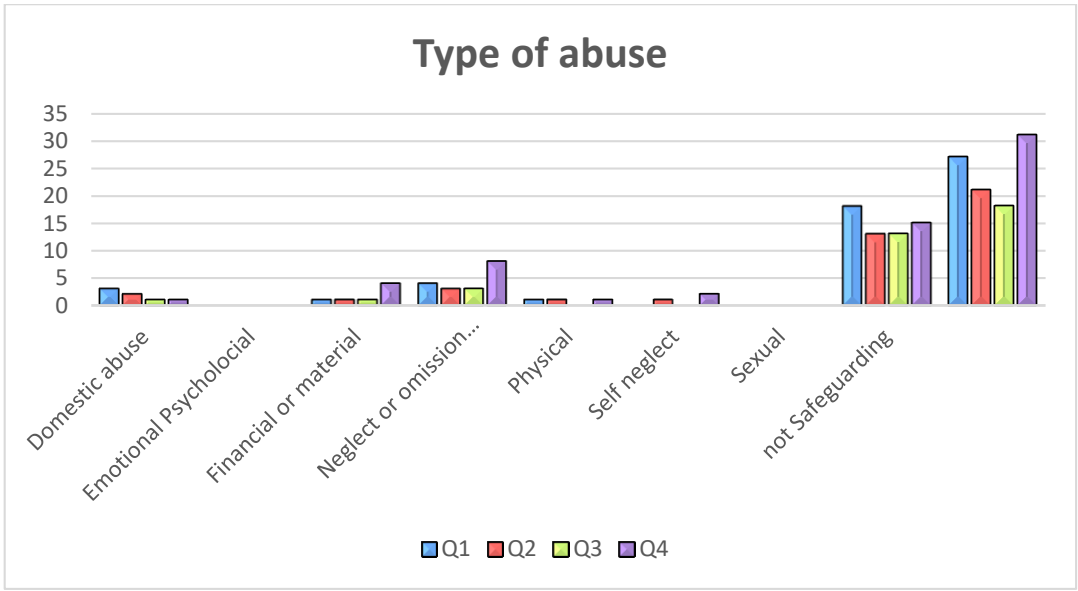
Ultimately the decision is decided by the Dorset Council Safeguarding Triage Team Manager.

3.3 There were **no** external investigations by Dorset County Council under Adult Safeguarding Procedures during 2022-2023.

3.4 The below graph indicates the majority of concerns are raised by the Emergency Department at initial presentation.



3.5 The highest category of abuse reported was `not safeguarding` - the majority of these were supported through a review of care and support needs/discharge to assess process. Cases that don't meet the criteria under the Care Act eligibility framework are safeguarded/safety netted through other processes, for example Domestic Abuse Advocate, Housing, Citizens Advice.



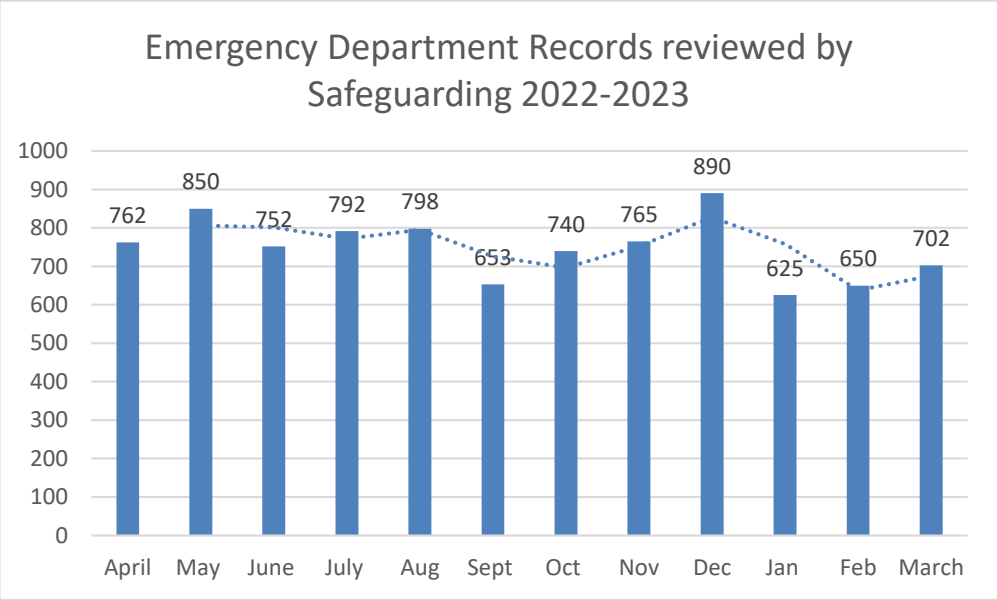
There have been no Modern Slavery cases that have required referral through the National Referral Mechanism.

There have been no Radicalisation referrals through the Prevent Programme in 2022-2023. Data has been submitted quarterly through the National NHS data collections portal. NHS Dorset chair the Health PAN Dorset Prevent meetings on a quarterly basis.

4.0 CHILDREN'S SAFEGUARDING ACTIVITY

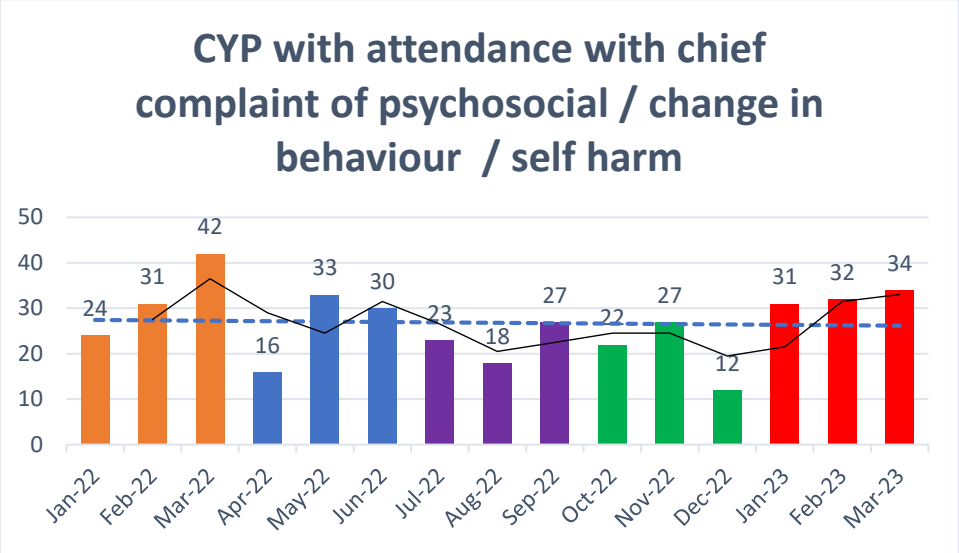
4.1 The Safeguarding Team at Dorset County Hospital align with the Dorset Council approach to safeguarding with a strength-based approach to managing concerns. This methodology formulates part of the training and supervision offered to staff who are more used to a more protection or paternalistic approach.

4.2 The Safeguarding Team continue to review the Emergency Department records for all 0-17 year olds. The Team have been fully involved in the creation of the safeguarding module for the new digital system (AGYLE) in the Emergency Department. The live access has improved the documentation for the Safeguarding Team, although the Team still cannot review CPIS (National flagging information sharing service through AGYLE or DPR). This means that all CYP that are not Dorset Council area residents hospital number details are manually put through PAS by the safeguarding practitioners reviewing the ED records.



4.3 The Safeguarding Team in conjunction with Kingfisher Ward/Liaison Psychiatry/ED and Paediatricians review on a weekly basis any children that have a mental health diagnosis, presented with self-harm and/or a safeguarding concern or a frequent attender to ensure all documentation and processes have been completed. Themes are reviewed and escalated as applicable, learning shared in the departments, which has seen an improvement in initiation of risks and the correct use of Dorset Council`s agreed health tool for identification of exploitation (CERAT).

4.4 The figures for children and young people with a presentation to DCHFT with self-harming behaviour and/or mental health crisis/intoxication. All children should have an assessment by Psychiatric Liaison/CAMHS (Child & Adolescent Mental Health Services) provided by Dorset Healthcare with self-harming behaviour, however, some due to the delay in accessing the services after 8.00 pm and are deemed to have capacity don't receive this service. Others are known to the core CAMHS and decide to directly contact their own worker rather than being seen by the Acute Team.



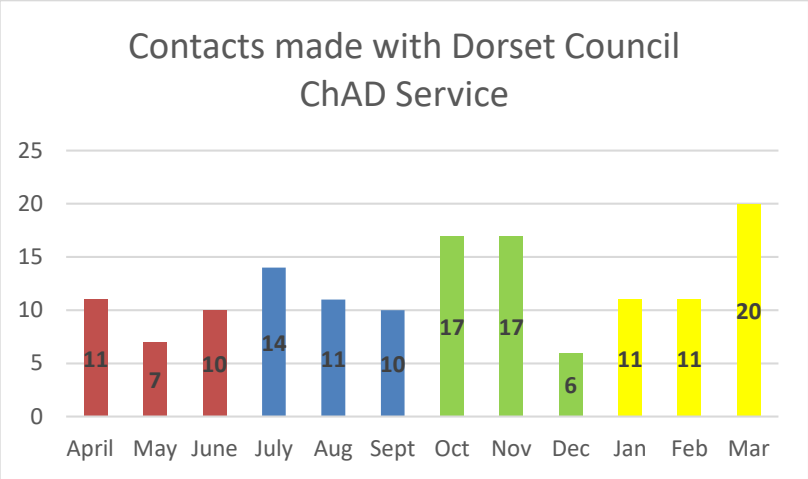
Most attendees with a psychosocial issue are aged between 11–17 yrs. Only 6 attendances were under the age of 11.

There has been an increase in attendance to ED due to assault affecting both girls and boys through 2022-2023, which aligns with partner agencies concerns in the rise in weapon-carrying in young people. Sharing of community information such as increase in assault activity is through the monthly PAN Dorset Children`s Partnership (Dorset place based) Child Exploitation Tactical Group. Dorset County Hospital NHS Foundation Trust Safeguarding form part of the membership.

CQC undertook an unrated inspection in 2022 of children to Dorset County Hospital NHS Foundation Trust admitted with a mental health issue after an Index case, an Action Plan was formulated post this inspection with work undertaken across a variety of specialities, including safeguarding.

4.5 Children's and Advice Duty Service

ChAD is the Children's and Advice Duty Service, which is a 24-hour service/ priority line in Dorset, which offers advice to professionals requiring immediate responses for safeguarding children/young people and families. ChAD is a single point for contacts regarding safeguarding and promoting the well-being of children in Dorset. It does not always result in a referral through to Children's Social Care, it may be that the Early Help Service is more applicable, or no action required. ChAD is not a referral; it is a contact/ conversation to determine the appropriate action for any safeguarding or social concern relating to a child/young person or concerns relating to the adult who cares for a child/young person. ChAD offers professionals the chance to speak to the most relevant person/or team for the child/family in question, discuss the actions that need to be taken and helps to ensure the child receives the right support at the right time.

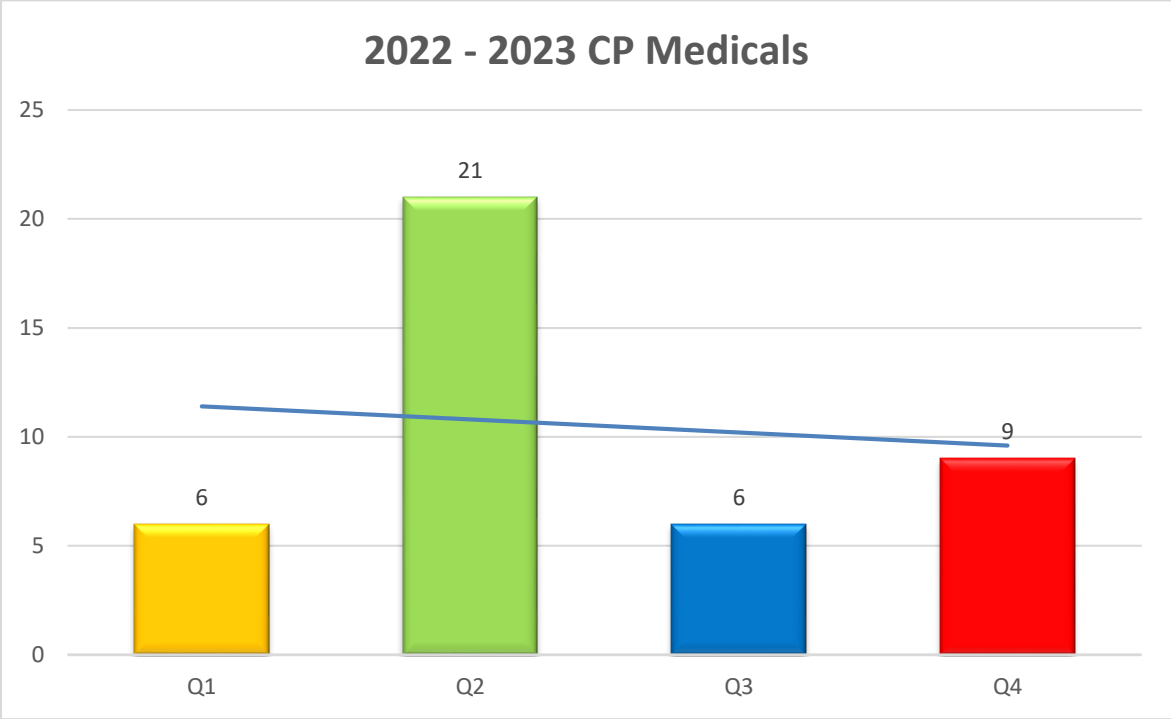


4.6 The above details only indicates those contacts that we as a Safeguarding Team have been made aware of, for example a contact made for advice on whether a child is known to services would not usually be shared with the Team. There has been over the past 12 months a significant increase in referrals due to a concern for the parent's attendance rather than the child. This has been predominantly due to mental health crisis or self-harming behaviours that raise worries about the safety of the child or children within the home environment. This increase emphasises that the 'think family approach` is having an impact on the way staff working within the Trust consider the needs of the whole family.

4.7 Contacts are also recorded for out of area Social Work Teams and contacts made directly to Social Workers to share information regarding a child that may attend that is on a Child Protection Plan or known to one of the specialist teams, for example the Children with a Disability Team, if they present with a concerning attendance, such as aggression/psychosocial issues.

4.8 The Safeguarding Administrators' roles include co-ordinating the Child Protection medicals; share the request for information in relation to adoption medical that are performed at University Hospital Dorset; forward all requests for information and/or attendance at Child Protection Conferences and Review meetings. They also are the administration support for the Child Death Review process.

Child Protection Medicals undertaken by Dorset County Hospital Paediatricians



4.9 For children and young people who may have experienced physical abuse or neglect, Paediatricians undertake a medical assessment of the child to identify any injuries or health needs related to the abuse. DCHFT does not undertake sexual abuse medical assessments; these are referred to either University Hospitals Dorset (Poole Hospital site or the Sexual Assault Referral Centre). The Paediatricians, clinical staff and a representative from Social Care review all these cases monthly as part of their governance, supervision and learning process.

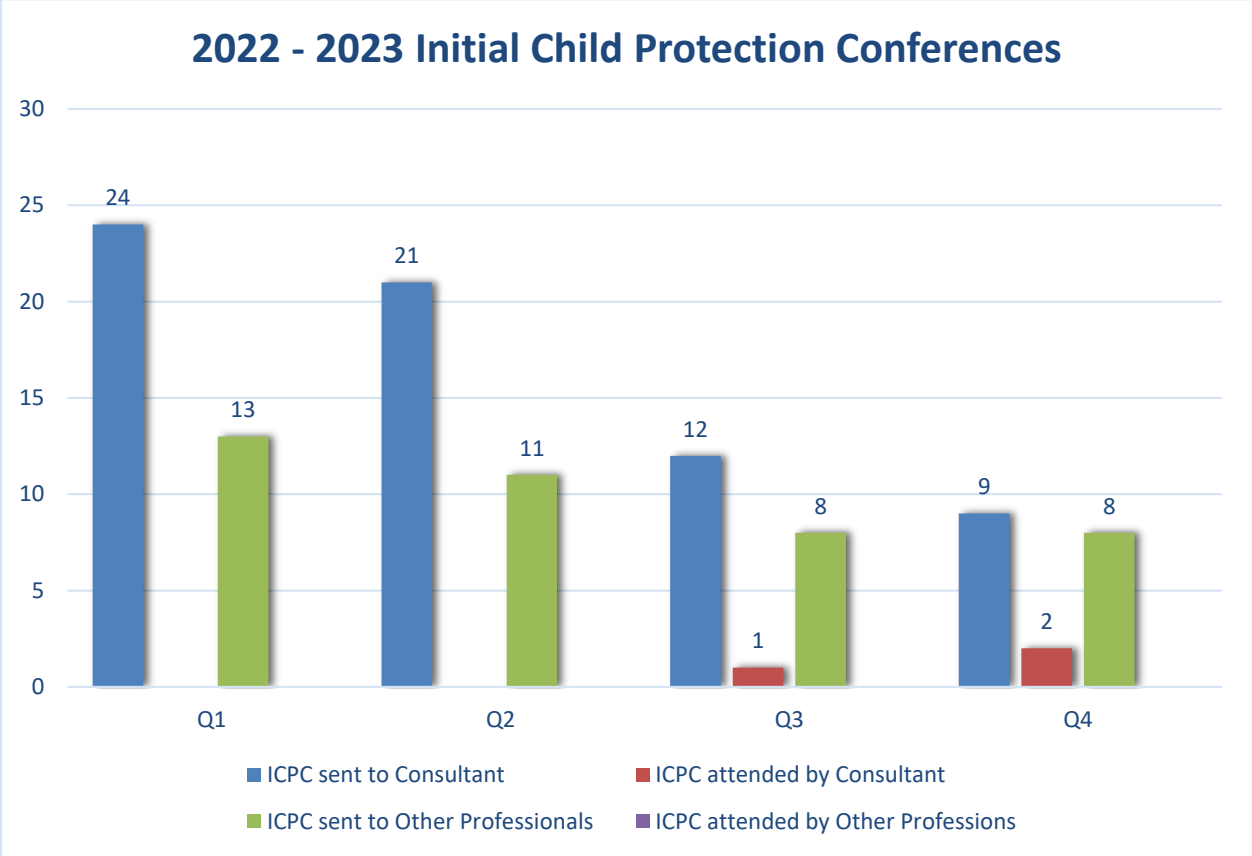
4.10 An Initial Child Protection Conference must be convened when it is believed that a child may continue to suffer, or to be at risk of suffering, significant harm.

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

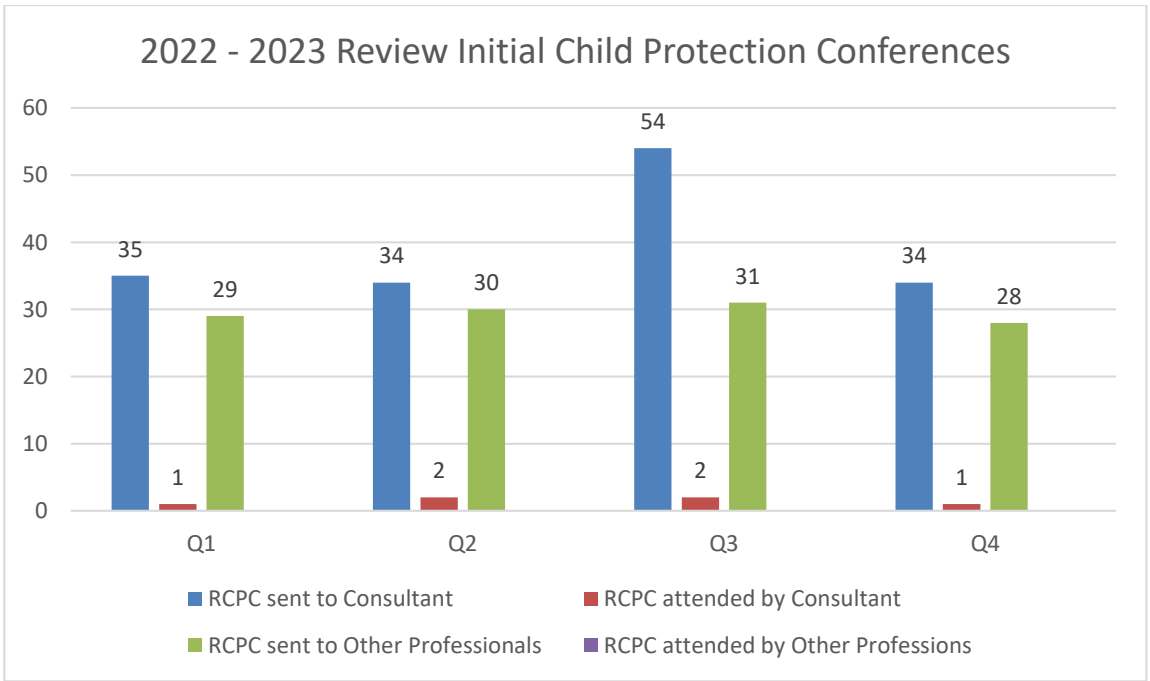
The Children's Social Care Manager is responsible for authorising the decision to convene an Initial Child Protection Conference, and the reasons for calling the Conference must be recorded.

Practitioners and Paediatricians that have either been involved with the Child Protection process for that child, or they are already on their case load, will be asked to contribute either in person or by written report. The Local Authority`s Children's Social Care Service may well send through requests where the child

is not on a current caseload, or the Trust has not been directly involved in the Child Protection process, therefore attendance is not required.



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



5.0 MATERNITY

6.0 SERIOUS CASE REVIEWS

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

During the 2022- 2023 period:

Independent NHS Dorset Commissioned Review/Action Plan devised for Dorset County Hospital NHS Foundation Trust.

X3 Rapid Reviews - one will progress to a full Local Child Safeguarding Practice Review.

Submission by Dorset County Hospital NHS Foundation Trust for consideration of CSPR, this was not agreed, however was accepted for a learning event/ learning cycle.

No request for information for Domestic Homicide Review.

No requests made for information for Safeguarding Adults Review.

Maternity completed an out of area Child Safeguarding Practice Review yet unpublished.

7.0 TRAINING

7.1 Adults

All staff are required to undertake training in Safeguarding Adults, either Level 1 or Level 2, this is aligned with the competency framework and dependent on job role.

The Safeguarding Team have delivered face to face training on the preceptorship programme for newly qualified Allied Health Professionals and Nurses, the International Nurses' programme and Junior Doctor programme and recommenced face to face training for Level 3 Safeguarding Children. Level 3 adults are currently not mandated but can be accessed via the e-learning for health platform if staff wish to access.

7.2 Children

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

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

Clinical staff working with children, young people and/or their parents/carers and who could potentially contribute to assessing, planning, intervening and

evaluating the needs of a child or young person are offered internal training at Level 3.

All training has been appraised and updated during 2022-2023 to ensure emerging themes, learning from case reviews is included.

The overall training figures when considering the intense pressure staff have been under in the past 12 months is satisfactory, however, Level 3 Safeguarding for Children training figures have remained stagnant, even with extensive work being undertaken by both Divisions, the Safeguarding Team and Education. There are now available three methods of gaining compliance of the requirements for Level 3 Safeguarding Children, all have been widely shared through Education bulletins, direct e-mailing of non-compliant staff and safeguarding meetings.

Trust Wide Results.	Quarter 1 (average) scores includes all staff and volunteers	Quarter 2 (average) scores include all staff and volunteers	Quarter 3 (average) scores include all staff and volunteers	Quarter 4 (average) scores include all staff and volunteers
Adults				
SGA Level 1 >90%	90	90	90	91
SGA Level 2 >90%	92	90	90	90
MCA/ DOLs Level 1 >90%	89	90	90	91
MCA/ DOLs Level 2 >90%	89	90	90	89
BPAT	92	92	93	90
WRAP	97	96	97	92
Children				
Level 1 >90%	88	90	90	90
Level 2 >90%	92	91	91	90
Level 3 >90%	75	74	72	73
Level 4/5 Adults and CYP	100%	100	100	100

8.0 SUPERVISION

Supervision sessions have been undertaken throughout 2022-2023. There is adequate provision across all specialities to offer and deliver supervision. Supervision sessions are recorded/actions documented, although daily ad-hoc supervision is not, unless action is required.

9.0 MENTAL CAPACITY ACT

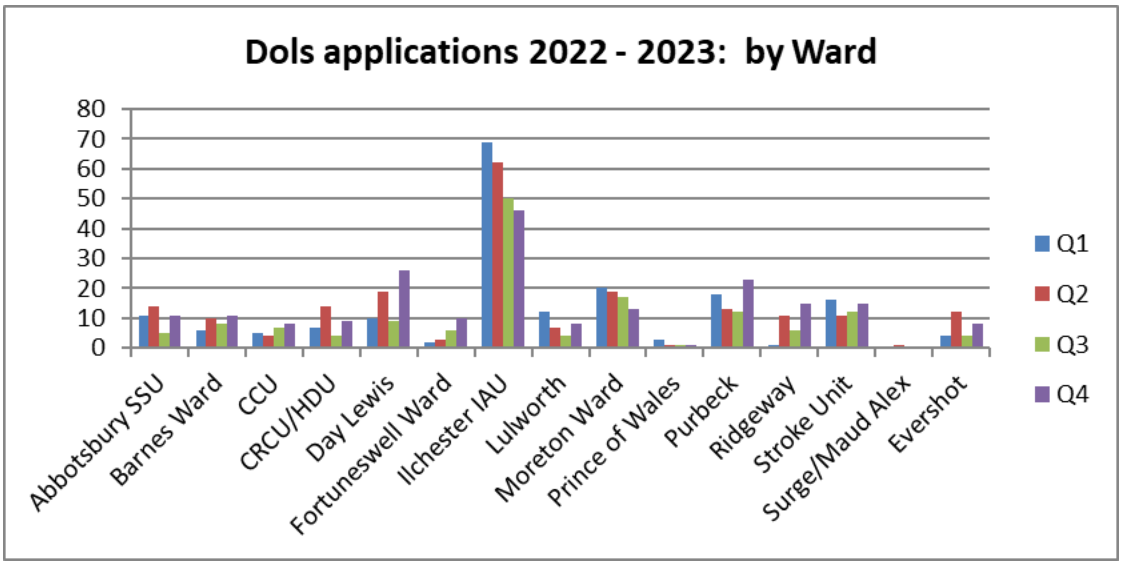
9.1 The LD and MCA Lead and wider Safeguarding Team have continued to provide advice and support to staff around the application of the MCA in practice. The MCA and DoLs pages on the intranet have been maintained and updated as changes occur. There has been a drive to raise awareness of the MCA for 16 and 17 year olds within Paediatric Services.

10.0 DEPRIVATION OF LIBERTY SAFEGUARDS

10.1 The Deprivation of Liberty Safeguards continue to be the prescribed process by law for the authorisation of any deprivation of liberty within a hospital setting. For those under 16 and those 16 and 17 year olds where a deprivation has been identified, legal advice was sought to ensure any deprivation was lawful.

10.2 The Liberty Protection Safeguards have now been officially placed on hold until the end of this Parliament. Throughout 2022-2023 the LD and MCA Lead worked with colleagues across the Dorset system and SW region to plan for the implementation. Some of the work will not be lost as this will feed into ongoing work around MCA and DoLs.

10.3 There have been a total of 812 Deprivation of Liberty Safeguards (DoLs) applications in the reporting period; this is a significant increase from 741 in 2021- 2022.



11.0 DOMESTIC ABUSE

11.1 Domestic Abuse and Violence against Women final statutory guidance published July 2023 Domestic Abuse Bill. Throughout 2022-2023 Dorset County Hospital NHS Foundation Trust has had in post a Health Domestic Abuse Advocate, this partner agency commissioned post is due to end August 2023. NHS Dorset are reviewing the posts across Dorset. and a request for submission for a National review has been submitted by Dorset County Hospital NHS Foundation Trust.

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

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

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

11.2 Domestic Abuse is significant to the Health Care agenda due to:

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

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

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

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

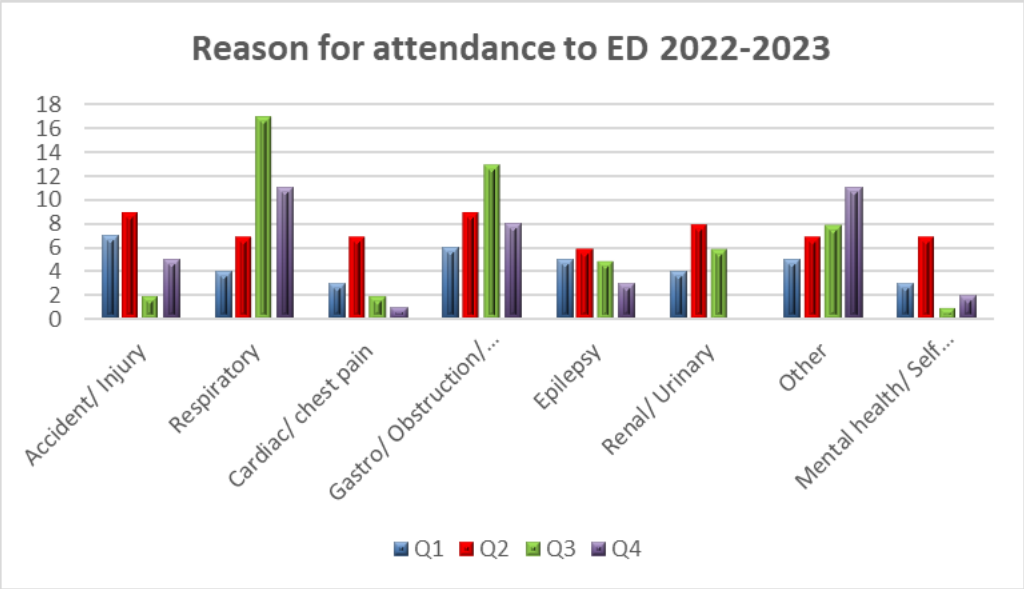
11.3 All staff receive domestic abuse awareness as part of their mandatory training. Bespoke domestic abuse training sessions aligned with Level 2 and Level 3 safeguarding training have been well attended and have received positive feedback.

11.4 In the past 12 months contacts and referrals through for support have increased each quarter, over 120 staff have received enhanced training through 2022- 2023 .

12.0 LEARNING DISABILITY

12.1 Attendances at ED for people with a learning disability 2022 -2023.

This data is based on those with a Learning Disability flag on the PAS system.



12.2 DCH submitted data to the NHS I E Learning Disability Benchmarking exercise 2022-23. The report for the previous year (2021-22) has only recently been provided to the benchmarking platform.
The report details the findings of the third NHS England NHS Improvement learning disability improvements standards collection. The standards focus on 5 areas:

1. Trust overview
2. Respecting and protecting rights
3. Inclusion and engagement
4. Workforce
5. Specialist Learning Disability Service

There is a 3-pronged approach of organisational level, staff level and service user level data collection.
A benchmarking Action Plan from the previous year's benchmarking has been developed and continues to be 'live'. This was shared within the Health Inequalities Group as well as Safeguarding Committee. Going forward this will likely sit within the Mental Health and Learning Disability Steering Group.

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

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

12.5 The LD and MCA Lead has worked with the Business Intelligence Team to look at Primary Care Data and PAS data for those with a learning disability and Autism. The Business Intelligence Team now provide daily updates on inpatients with a learning disability, as well as those due to come in for Outpatients and other interventions. This piece of work will continue to be refined over the coming year. The aim is to enable easy identification of those requiring reasonable adjustments, ensuring services are flexible and adaptable to meet users' needs.

12.6 Oliver McGowan Mandatory Training for learning disabilities and Autism.
The Health and Care Act 2022 made it a statutory requirement from 1 July 2022 for all health and care staff to receive training on learning disability and Autism appropriate to their role. The Oliver McGowan Mandatory Training on Learning Disability and Autism is the Government's only preferred and recommended training. It is not just a statutory requirement for staff working in learning disability and Autism services, it is for all staff working in CQC regulated services in Health and Care.
Within the Dorset system there is a Steering Group responsible for the implementation of the training. There are several elements to the training which require significant planning and resourcing. Since the end of March 2023, Tier 1, Part 1 (which is e-learning) is available for staff to access. The work on the roll out of the other elements of the training is ongoing and in partners across the Dorset Health and Social Care system.

13.0 PREVENT

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

13.2 NHS Trusts are required to: -

- train their staff to have knowledge of Prevent and radicalisation and to spot the vulnerabilities that may lead to a person becoming radicalised, and how to raise a concern;
- train Workshop to Raise Awareness of Prevent Training (WRAP) facilitators to cascade more detailed Prevent training to staff;
- report concerns of people becoming radicalised to the Prevent hotline;
- attend the Local Authority Channel Panel. This multi-agency Panel discusses the risk posed by vulnerable people who are referred for multi-agency support;
- report the training figures and number of people referred to Channel on a quarterly basis to NHS England.

13.3 The training is completely e-learning and is a requirement for all staff.

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

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

13.6 There have been no Prevent referrals or Channel referrals in the past 12 months.

14.0 SAFEGUARDING INCIDENTS INVOLVING STAFF

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

15.0 AUDIT

15.1 Overarching MCA/Safeguarding Assurance audit is completed 6 monthly. The format for this aligned with the CQC KLOES, however, due to the inspection process changing it will need to reference the new key line of enquiry.
Two 'deep dives' were completed in Q2 and Q4 looking at the completion of the restrictive interventions and DoLs care plan.
One 'deep dive' was completed in Q4 looking at the completion of the reasonable adjustment and risk assessment care planning for people with a learning disability and/or Autism.

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

15.3 Section 11 audit completed in June 2022, Action Plan devised and completed. This included a quality visit undertaken by NHS Dorset**.**

16.0 OTHER ACTIVITIES / Compliments and Complaints

Development of a bespoke training package for Level 3 Safeguarding Children.

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

Six monthly Safeguarding Newsletters shared with all employees at DCH.

Improvements to recording Safeguarding within the DPR system.

Assistance with AGYLE system development.

17.0 SAFEGUARDING DORSET COUNTY HOSPITAL WORK PLAN 2023-2024 Quality Improvement Plan (addendum)

References

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

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

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

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

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

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

Dorset County Hospital
NHS Foundation Trust

Safeguarding Quality Improvement Programme

April 2023 to March 2024

Sarah Cake, Head of Safeguarding

Joanne Findlay, Lead for Mental Capacity and Learning Disabilities

Dorset County Hospital NHS Foundation Trust serves a wide geographical area which includes rural and socially deprived communities. Having an awareness of the demography of our service users ensures future planning for our staff to deliver excellent care, that is safe and effective to meet the needs of the patients.

Dorset County Hospital NHS Foundation Trust is committed to safeguarding all who access services across the Trust.

The Trust in its Strategic objectives reflects the principle that all people coming into our care require safe, effective personalised high quality care and will fulfil its duties in regards to Safeguarding requirements. These are outlined in Working Together to Safeguard Children (2018), The Children's Act (2004), The Care Act (2014) and are set out in the Care Quality Commission fundamental standards. This enables us to provide assurance that the safeguarding provision at DCH is robust, fit for purpose and it can be demonstrated that Safeguarding is `Everybody's Business `.

What is Safeguarding?

Everybody has the right to be safe from abuse and protected from harm, no matter who they are, where they live or their social circumstances. Safeguarding children, young people and adults is a collective responsibility; this strategy considers the steps taken to ensure safeguarding issues are appropriately escalated and how we endeavour to protect children, young people and adults in our care. It is about people and organisations working together to prevent and stop both the risks and experience of abuse or neglect while at the same time making sure that the wellbeing, views, wishes and beliefs of adults and children are promoted within the safeguarding arrangements.

Learning and development is a crucial component of safeguarding that enables all staff to be alert to the potential indicators of abuse or neglect of people at risk and know how to act on those concerns. Another critical element of safeguarding is the legislative frameworks that provide guidance for all partner agencies regarding the requirements for safeguarding adults and children at risk.

As society changes and this is reflected in our community, so does the need to respond to safeguarding concerns. This Improvement Plan needs to reflect the changes to the communities that we serve and the contextual safeguarding issues that affect its residents.

Core Legislation and Legal Frameworks Underpinning Safeguarding

Children Act (1989, 2004 and 2017)/ Children's and Families Act 2014	Domestic Abuse Act (2021)
The Care Act (2014)	Homelessness Act (2002)
The Mental Capacity Act (2005) Mental Capacity (Amendment) Act 2019 Deprivation of Liberty Safeguards (2009)	Modern Slavery Act (2015)
The Human Rights Act (1998)	Equality Act (2010)
Mental Health Act 1983	Children's and Families Act 2014

Introduction

The programme will be monitored quarterly through the Safeguarding Committee with an annual progress report presented to the Quality Committee. Each work stream / action is RAG rated as follows:

- **G** Fully completed.
- **A** Partially completed with actions still to be completed, but due for completion with timescale
- **R** Not completed, unlikely to be completed within timescale or significant risks to compliance

Key Objectives

Objective 1 – Safeguarding patients that we care for:

We will do this by:

- Provide services that protect individual human right and effectively safeguard against abuse, neglect, discrimination, or poor treatment.
- Demonstrate that appropriate systems and processes are in place to discharge statutory duties in terms of safeguarding children and adults.
- Ensuring that we meet the organisation, legal and strategic responsibility under the Children Act and CQC fundamental standards.
- Ensuring we meet the organisation legal and strategic responsibility under the Care Act, Human Rights Act, Mental Capacity Act and CQC fundamental standards.
- We will support all our team members recognising the emotional impact of our work.
- Ensure that staff at all levels are provide with evidence based safeguarding training commensurate with their role.
- We will provide guidelines and policies for staff to fulfil their safeguarding responsibilities.
- We will share learning from reviews and incidents, to improve future outcomes, through changes to practice.
- Ensure that the voice of the child, young person or adult is captured wherever appropriated to improve and better measure outcome and benefits as perceived by individuals.

Objective 2 –
"To ensure compliance with relevant legislation, regulatory requirements and the Trust's safeguarding, mental capacity, learning disabilities policies".

We will do this by:

- Maintaining compliance with CQC regulations for the essential standards for quality and safety.
- Review and monitor the application of the Mental Capacity Act/ Review and monitor the applications for Deprivation of Liberty safeguards.
- Review and monitor the reasonable adjustment and care plans devised for people using our service who have a learning disability and/or autism.
- Review and monitor the documentation of safeguarding through the variety of patient systems to ensure clear concise patient focused documentation.
- Publishing an annual report and annual work plan for Safeguarding.
- Participation in Section 11 audit.
- Adhere to the NHS England accountability and assurance framework.
  https://www.england.nhs.uk/wp-content/uploads/2015/07/B0818_Safeguarding-children-young-people-and-adults-at-risk-in-the-NHS-Safeguarding-accountability-and-assuran.pdf
- Safeguarding supervision for staff groups.
- Improve engagement with people using our services and hear their voices.

Issue	Desired Outcome	Actions	Evidence/ Assurance	Lead/ responsibility	Target Date	Update	Rag
***Inadequate documentation of mental capacity, under-utilisation of care plans (DoLs care plan/ reasonable adjustments care plan*)**	Improved patient centred care planning. Clear evidence of consideration the service user's ability to consent to their care and treatment. Evidence of review process for care plans and assessment of capacity /applications of deprivations of liberty/ considerations of reasonable adjustments.	Forward teams to implement care plans for those people using our service that require them as per the Learning Disability Policy and MCA and DoLs guidance. Relaunch of sessions for ward teams by LD/MCA Lead to explain the implementation of the care plans.	Audit	Ward Leads/ Matrons LD/MCA Lead and Acute Health Facilitator	Sept 2023		

Competency template used for Children and Young People / documentation of consent and capacity	Accurate record keeping, clear evidence of consent.	Changes made to AIRS document sticker in place. Staff training, specific session undertaken and included with Level 3 face to face training.	Clinical Audit registered awaiting confirmation	Safeguarding Team/Paediatric Matron	Dec 2023		
Improve the voice of child / adult those using our service	That the voice of the child, young person or adult is captured where appropriate to improve and better measure outcomes and befits as perceived by the individuals	Conversation cafés for people with a learning disability. Support with capturing the voice through already established tools: for example, HEADSS assessment / This is me etc. Making safeguarding personal, capture the wishes and	Feedback from service users. Dip checks of notes quarterly and results shared through the Safeguarding Committee. To be part of the ward accreditation.	PALs, LD and MCA Lead/ Acute Health Facilitator/ Quality Manager Ward Teams/ Leaders	Dec 2023		

		concerns of the individual.					
Improve the experience and quality of care for those people using our service with a learning disability and/or autism	The experience is improved for those that use our services, reduction in complaints about the DCH care provision for people with a learning disability and or autism	Operational practitioner in place to review service user experience. Conversation café. Refresh the LD champion role. Use of DIIS information to update PAS system to facilitate greater awareness for clinical teams. Breast imaging focus group. Creation of 4 'Virtual tours' Coming in for an operation Coming into ED Coming to Outpatients		LD/MCA Lead and Acute Health Facilitator for people with a learning disability/LD champions/ PALS/Quality Manager Digital Development Team/Business Intelligence LD and MCA Lead/Acute Health Facilitator/Mary Godden LD and MCA Lead/Acute Health Facilitator/Reps from each area/ Transition Nurse/ Film Producer	Oct 2023 March 2024 Sept 2023 March 2024	To trial BI TCI reports for Day Surgery and Endoscopy as interim Awaiting storyboards for ED and Theatres from Film Producer	

		Coming to hospital					
Improve the recognition of potential contextual risk for CYP	All CYP that attend with criteria for CE risk review have completed a CERAT, exploration of how life looks for them, their worries and concerns documented and escalated as required.	CE risk assessment checked through ED records, through Integrated Liaison Meeting. Risks identified by partners shared with departments. Serious Violence Duty work to be progressed with digital process for capturing this metric.	Integrated Liaison Meeting Dip check of Emergency Department and Paediatric notes for HEADSS assessment/ Child exploitation risk assessment. Evidence of professional curiosity. Clear documentation within clinical notes/digital records of the voice of the child, their worries and concerns. Process in ED for review of assaults already progressing senior review CE checks and referrals to CSC /Safeguarding /Police.	ED/Paeds Matron Safeguarding Team			

Improve the IT systems to ensure they accurately record family/ carers details. Alerts for CPIS.	That all CPIS alerts can be viewed through DPR That staff can add key contacts to individual's digital care records to reduce non-attendance/ was not brought	Nil progress for CPIS PAS system waiting to be switched to allow more than one contact, however, this is still not viewable		IT SYSTEMS Digital transformation team			
Improve supervision provision for Emergency care team	Ensure all staff that require supervision in ED receive this in a timely way	SR in ED to commence sessions for Band 5 and above. Progress when Safeguarding Team fully staffed to initiate safeguarding			Jan 2024		

		huddle with Emergency Department Head of Safeguarding to attend Senior Team meeting 3 monthly. Ad hoc session to be available for specific cases. Integrated Liaison Meeting to include more input from a variety of the ED team.					

INTEGRITY | RESPECT | TEAMWORK | EXCELLENCE

NHS
Dorset County Hospital
NHS Foundation Trust

Report Front Sheet

1. Report Details			
Meeting Title:	Trust Board of Directors		
Date of Meeting:	18th July 2023		
Document Title:	**Infection Prevention & Control Annual Report 2022-2023**		
Responsible Director:	Jo Howarth, Chief Nursing Officer, Director Infection Prevention & Control	Date of Executive Approval	
Author:	Emma Karamadoukis, Infection Prevention & Control Lead Specialist nurse.		
Confidentiality:	No		
Publishable under FOI?	Yes		
Predetermined Report Format?	No		

2. Prior Discussion		
Job Title or Meeting Title	**Date**	**Recommendations/Comments**
Quality Committee	18/07/2023	Noted

3. Purpose of the Paper	**Infection Prevention & Control Annual Report 2022-2023**							
	Note (✓)	✓	*Discuss (✓)*	✓	*Recommend (✓)*		*Approve (✓)*	
4. Key Issues	As part of the assurance required for Trust Board an annual Infection Prevention and Control report is required. This meets the national requirements set via NICE, NHSE/I The Board of Directors is asked to accept the report from Quality Committee (18 July 2023). For noting: • The Trust met the trajectories set for MRSA bacteraemia, Gram Negative Organisms, and following Root cause Analysis of *Clostridium difficile* infections for 2022-2023. • The Trust continued to develop and adjust in the global pandemic of COVID-19 in response to the local and national requirements as we moved from pandemic to endemic guidance 'living with COVID-19' plan set out by the government. • Hand hygiene compliance has remained high and sustained at 98.7%. • The trust continued to meet mandatory requirements for Surgical site surveillance for hip and breast categories. • The Sterile Supplies department continues to maintain a full Quality Management System in line with BSO standards.							

	• Face to face education and training continued following the postponed teaching due to COVID-19, combined with an updated e-learning programme, we have maintained good compliance with IPC training. • Mitigation and enhanced monitoring continued to mitigate risk of pseudomonas and legionella in tap water in high-risk areas.
5. Action recommended	The Board of Directors is recommended to: 1. **NOTE** the report. 2. **RECEIVE** assurance on actions to address any performance issues.

6. Governance and Compliance Obligations				
Legal / Regulatory Link		**Yes**		Inability to achieve progress or sustain set standards could lead to a negative reputational impact and inability to improve patient safety, effectiveness, and experience.
Impact on CQC Standards		**Yes**		As this report incorporates standards outlined by the CQC it is important to note progress or exceptions to these standards.
Risk Link		**Yes**		Links to Board assurance Framework
Impact on Social Value			**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	Credibility of the trust and linked to Board Assurance Framework.		
	Place	Serving the population of Dorset.		
	Partnership	Collaborative system working to achieve high standards of care.		
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**		Collaborative working with the ICS IPC team and post infection monthly review process to identify learning.
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**	

2022/2023 Infection Prevention & Control Annual Report

Contents

Abbreviations

Abbreviations	Full Description
AMR	Anti-Microbial Resistance
ASG	Antimicrobial Stewardship Group
CCG	Clinical commissioning groups
C difficile	Clostridioides difficile
CDI	Clostridioides difficile infection
COHA	Community onset Hospital Acquired
COVID-19	Coronavirus disease 2019
CQC	Care Quality Commission
CQUIN	Commissioning for Quality and Innovation Payment Framework
DCHFT	Dorset County Hospital Foundation Trust
DH	Department of Health
DIPC	Director of Infection Prevention & Control
DON	Director of Nursing
E.coli	Escherichia coli
ESBL	Extended Spectrum Beta Lactamase
GDH	Glutamate dehydrogenase antigen of C. difficile
GRE	Glycopeptide Resistant Enterococcus
GP	General Practitioner
HCAI	Health Care Associated Infection
HOHA	Hospital Onset Hospital Acquired
IM&T	Information & Technology
ICS	Integrated Care System
IPC	Infection Prevention & Control
IPCC	Infection Prevention & Control Committee
IPCN	Infection Prevention & Control Nurse
IPCT	Infection Prevention & Control Team
MGNB	Multi resistant gram-negative bacilli
MHRA	Medicines and Healthcare Products Regulatory Agency
MRSA	Methicillin Resistant staphylococcus aureus
MSSA	Methicillin Susceptible staphylococcus aureus
PCR	Polymerase Chain Reaction
PFI	Private Fund Initiative
PHE	Public Health England
PLACE	Patient-led assessments of the Care environment
PPE	Personal Protective Equipment
RAG	Red, amber, green
RCA	Root Cause Analysis
SSI	Surgical Site Infection
UKHSA	UK Health Security Agency

EXECTIVE SUMMARY

The annual report provides a summary of the infection prevention and control activity over the last year and status of the healthcare associated infections (HCAIs) for Dorset County Hospital NHS Foundation Trust (DCHFT). Infection Prevention and control is the responsibility of everyone in healthcare and this is successful with strong leadership and collaborative working.

The Chief Nursing Officer is the accountable board member responsible for infection prevention and control and undertakes the role of the Director of Infection Prevention and Control. This year DCHFT has welcomed a new Chief Nursing Officer/Director of Infection Prevention and Control, Jo Howarth, who has a wealth in experience and knowledge within the field of IPC.

The Infection Prevention and Control Group has a function to fulfil the requirements of the statutory Infection Prevention and Control committee. It formally reports to the sub-board Quality Committee, providing assurance and progress exception reports. All Trusts have a legal obligation to comply with the Health and Social Care Act (2008) – Code of Practice on the Prevention and Control of infections and related guidance, which was last updated in December 2022.

The work plan, led and supported by the Infection Prevention and Control Team (IPCT), sets clear objectives for the organisation to achieve with clear strategies in place to meet the overall Trust strategic mission: “Outstanding care for people in ways which matter to them”.

Overall, 2022- 2023 was another challenging but successful year, meeting key standards and regulatory requirements for infection prevention and control. Below is the highlight of those: -

- The Trust met the trajectories set for MRSA bacteraemia, Gram Negative Organisms, and following Root Cause Analysis reviews of *Clostridium difficile* infections for 2022-2023.
- The Trust continued to develop and adjust in the global pandemic of COVID-19 in response to the local and national requirements as we moved from pandemic to endemic guidance ‘living with COVID-19’ plan set out by the government.
- Hand hygiene compliance has remained high and sustained at 98.7%.
- The trust continued to meet mandatory requirements for Surgical site surveillance for hip and breast categories.
- The Sterile Supplies department continues to maintain a full Quality Management System in line with BSO standards.
- Face to face education and training continued following the postponed teaching due to COVID-19, combined with an updated e-learning programme, we have maintained good compliance with IPC training.
- Enhanced monitoring continued to mitigate risk of pseudomonas and legionella in tap water in high-risk areas.

Trust remains key national benchmark for use of data management system in infection prevention & control (ICNET).

INTRODUCTION

The Director for Infection Prevention and Control (DIPC) annual report summarises the work undertaken in the Trust for the period 1st April 2022– 31st March 2023. The Annual Report provides information on the Trust's progress on the strategic arrangements in place to reduce the incidence of Healthcare Associated Infections (HCAI's). The purpose of the report is to provide assurance that the trust remains compliant with the Health and Social Care Act (2008) – Code of Practice on the Prevention and Control of infections and related guidance Department of Health, 2015). The code sets out 10 criterion which are listed in the contents and the report uses these criterions as a guide to provide evidence and assurance.

The pandemic has continued to remain challenging for the Trust and Infection Prevention and Control over the reporting year as the governments COVID-19 response guidance shifted focus from pandemic to endemic and 'Living with COVID-19'. The Infection Prevention and Control team have been vital in developing and supporting the Trust with this response. They have continued to provide expert counsel to others across the system and southwest region, sharing best practice and challenge to ensure a COVID-19 secure environment for patients and staff.

The Trust met the target for zero cases of preventable MRSA bacteraemia. The Trust reported 17 trajectory cases of *Clostridium difficile* against a target of 46 cases (59 total cases) and was under trajectory for gram negative organisms. The Infection Prevention and Control Team have seen their system and partnership working as key to supporting the health and safety of the population, sharing good practice, offering support where able and championing the benefits of digital support in the management of infection prevention and control.

These lower rates of infection have been achieved by the continuous engagement of the Trust Board and most importantly the efforts of all levels of staff. The commitment to deliver safe, quality care for patients remains pivotal in the goal to reduce HCAI's to an absolute minimum of non-preventable cases.

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

The Health and social care Act 2008: code of practice on the practice on the prevention and control of infections compliance ten criterion follow below individually demonstrating the trust compliance and evidenced assurance in meeting the ten criterions.

CRITERION ONE:
Systems to manage and monitor the prevention and control of infections. These systems use risk assessments and consider the susceptibility of service users and any risks their environment and other users may pose to them.

INFECTION PREVENTION & CONTROL GROUP (IPCG)

The IPCG met 6 times during 2022- 2023. It is a requirement of *The Health and Social Care Act 2008 Code of Practice on the prevention and control of infections,* that all registered providers: "*have in place an agreement within the organisation that outlines its collective responsibility for keeping to a minimum the risks of infection and the general means by which it will prevent and control such risks".*

The IPCG was chaired by the Interim Chief Executive Officer, Nick Johnson, Chief Nursing Officer, Nicola Lucey, who also is the Director of Infection Prevention and Control (DIPC), and following change in appointment Chief Nursing Officer Jo Howarth, is in attendance and acts as Chair, with the responsibility for reporting to the sub-board Quality Committee for assurance.

DIPC REPORTS TO QUALITY COMMITTEE

The DIPC has presented to the following items during 2022-2023:

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

INFECTION PREVENTION & CONTROL TEAM

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

- Jo Howarth, Chief Nursing Officer / Director of Infection Prevention and Control
- Emma Hoyle, Associate Director Infection Prevention and Control/Deputy Chief Nursing Officer
- Dr Cathy Jeppesen, Infection Control Doctor and Consultant Microbiologist
- Dr Lucy Cottle and Dr Amy Bond, Consultant Microbiologists
- Emma Karamadoukis, IPC Lead Specialist Nurse
- Julie Park, IPC Specialist Nurse
- Christopher Gover, IPC Specialist Nurse
- Abigail Warne, IPC Specialist Nurse, currently on career break
- Helen Hindley, IPC Nurse
- Sophie Lloyd, IPC Nurse (Secondment - Joined October 2021)
- Cheryl Heard, Senior Administrator & Fit Mask Co-ordinator
- Rhian Pearce, Antimicrobial Pharmacist 2 days a week

The IPCT work within the structure of the newly developed IPC work plan, which has been developed alongside the ten criterions. Appendix A

HEALTHCARE ASSOCIATED INFECTIONS

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

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

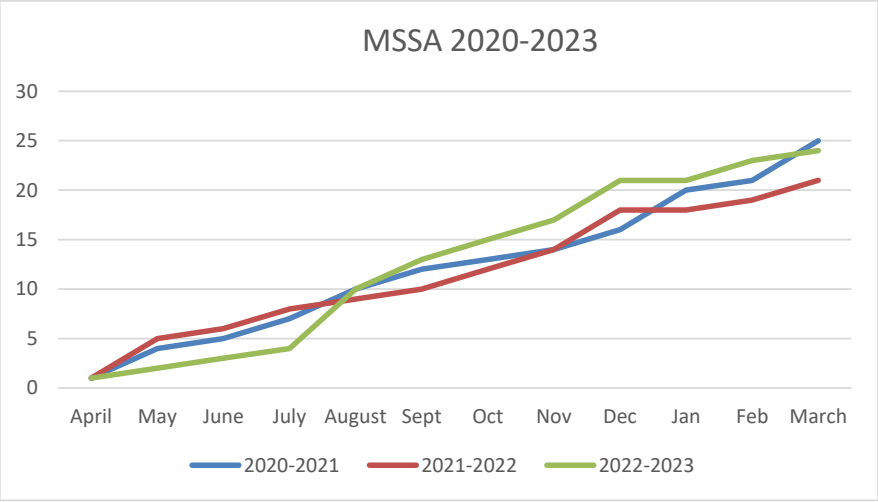
For the purposes of agreed trajectories HOHA and COHA are now combined in reporting.

METICILLIN RESISTANT *STAPHYLOCOCCUS AUREUS* (MRSA)BACTERAEMIA

There were no preventable cases of MRSA bacteraemia in 2022-2023 assigned to the Trust. The last case of preventable MRSA bacteraemia assigned to the Trust was July 2013. This provides confidence that the IPC practices in place have been sustained. Our performance is in keeping with national data whereby Trust apportioned cases of MRSA (blood samples taken ≥48hours post admission) have significantly reduced. In 2022-2023 the trust had 2 MRSA Bacteraemia cases in total.

***STAPHYLOCOCCUS AUREUS* BACTERAEMIA (MSSA)**

In 2022-2023 there were a total of 24 cases of MSSA bacteraemia, identified >48 hours after admission. No national trajectories have been set for these organisms. At DCHFT this demonstrates stability in cases over the last three year.



To manage MSSA blood stream infections we have implemented control measures that include, screening for certain high-risk patient groups, decolonisation of high-risk

patients prior to procedures and close monitoring of indwelling devices via audit. All Hospital onset Healthcare associated MSSA infections have a full Root Cause analysis review, with the results and learning feedback to IPCG and senior leaders within the trust.
The IPCT have led on a deep dive review within the renal service of MSSA bacteraemia's with the aim to align policy with practices and ensure high standards of evidenced based practice.

GRAM NEGATIVE BLOOD STREAM INFECTIONS

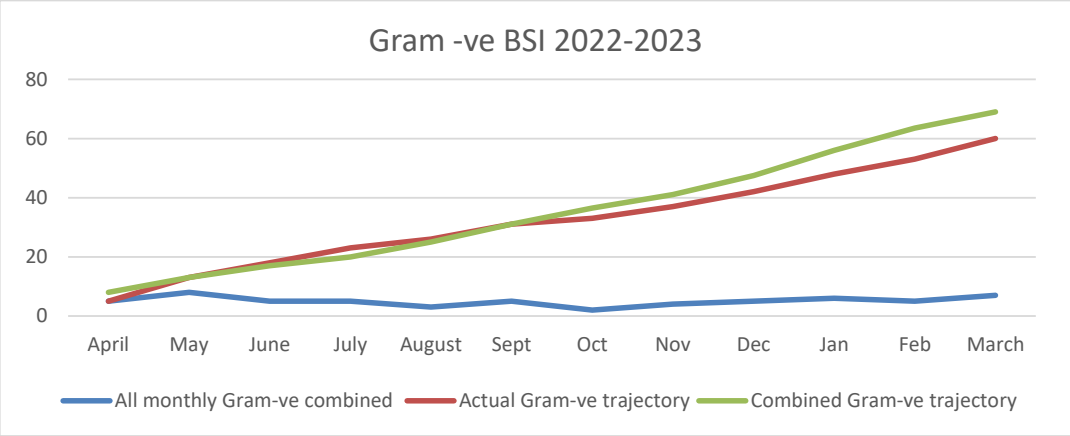
Gram-negative blood stream infections (BSIs) are a healthcare safety issue. From April 2017 there has been NHS ambition to halve the numbers of healthcare associated Gram –negative BSIs by 25% March 2021 (PHE 2017) and 50% March 2024 (PHE 2019). February 2019 it was announced that the date for achieving this reduction has been changed to 2024/2025. The Gram-negative organisms are *Escherichia coli (E. coli), Pseudomonas aeruginosa (P. aeruginosa)* and *Klebsiella* species (*Klebsiella spp.).*

Mandatory data collection has been in place for several years for E. coli. In addition, from April 2017 additional mandatory data collection and surveillance has been in place for Klebsiella app. and Pseudomonas *aeruginosa.* 2022-2023 formal trajectories for gram-negative blood stream infections were set by NHSE/I at 69 cases (43 *Escherichia coli* 9 Pseudomonas *aeruginosa* and 17 Klebsiella sps). Noted this trajectory was HOHA and COHA combined.

In 2022-2023 there were a total of 42 positive BSI samples for E. coli which were attributed to the Trust – HOHA & COHA. All cases of E. coli that occur >48hrs after admission are reviewed by the Infection Prevention & Control Team. A full data collection process is carried out in accordance with UKHSA guidance; this includes all mandatory and optional data.

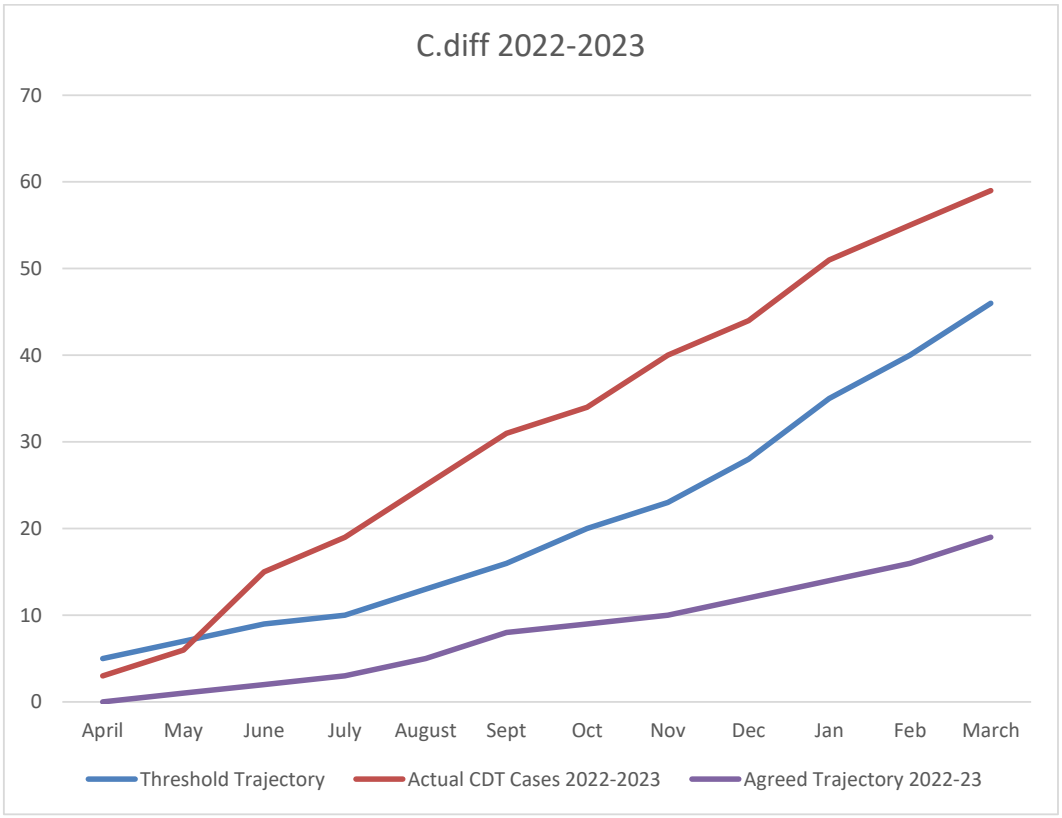
In 2022-2023 there were a total of 11 positive BSI samples for Klebsiella, which were attributed to the Trust – HOHA & COHA. All cases of Klebsiella sps. that occur >48hrs after admission are reviewed by the Infection Prevention & Control Team. A full data collection process is carried out in accordance with UKHSA guidance; this includes all mandatory and optional data.

In 2022-2023 there were a total of 7 positive BSI samples for Pseudomonas *aeruginosa*, which were attributed to the Trust – HOHA & COHA. All cases of Klebsiella sps. that occur >48hrs after admission are reviewed by the Infection Prevention & Control Team. A full data collection process is carried out in accordance with UKHSA guidance; this includes all mandatory and optional data.



CLOSTRIDIUM DIFFICILE INFECTION (CDI)

In 2022-2023 Clostridium Difficile formal trajectories for were set by NHSE/I at 46. In total the Trust reported 59 cases detected HOHA/COHA; of these cases 18 were identified as preventable with lapses in care; and learning implemented trust wide.



All cases of hospital acquired CDI require a Root Cause Analysis investigation. The results are presented to Nicola Lucey and now Jo Howarth (Chief Nursing Officer/Director of Infection Prevention and Control) and Emma Hoyle (Deputy Chief Nursing Officer/Associate Director of Infection Prevention and control) and scrutinised to identify any relevant learning from the cases. The learning actions when completed are then presented and signed off by the Divisional Matron at the IPCG. The IPCT and consultant microbiologists have continued a CDI Deep dive review of all the CDI

cases, looking for trends, areas of improvement and emerging themes. The IPCT have also completed an extensive collaborative data collection on all Potential CDI and CDI cases. NHS England are reviewing this data, which also includes all Dorset anonymised case information.

OUTBREAKS OF INFECTION

NOROVIRUS

There have been two outbreaks of Norovirus in the reporting year 2022-2023. This is against the backdrop of high winter incidence of norovirus within the community.

INFLUENZA/RESPIRATORY SYNCYTIAL VIRUS (RSV)

There has been a national increase in cases of Influenza A, B & RSV during the Winter of 2022-2023 in comparison to the previous years. The identification of these cases at point of admission into DCHFT has been greatly assisted by point of care testing which has enabled prompt isolation of patients attending for emergency care and subsequent admission and therefore reducing transmission in hospital and the occurrence of outbreaks.
In preparation for 'seasonal flu' all Trust staff were offered the annual flu vaccine and 42% of all staff have been vaccinated within the trust but the percentage of staff vaccinated will be higher due to staff receiving the vaccine buy another means.

CLINICAL AUDIT

SURGICAL SITE SURVEILLANCE

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

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

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

During 2022-2023 the IPC team have supported 3 modules for surveillance. The IPCT can facilitate a less time-consuming model of data collection utilising the IPC data tool ICNet. The system facilitates readmission alerts, and data upload from PAS, theatre and microbiology systems and the ability to directly upload the data to PHE SSI site.

Three audits were completed for 2022/2023. Oct-Dec 2022 Hips found only one infection where the orthopaedic and microbiology teams reviewed and managed the case. Elective Colorectal surgery and Breast surgery for Jan- March 2022 are yet to be submitted.

PERIPHERAL VENOUS CANNULA (PVC) AUDIT

PVCs are devices commonly used in acute hospitals, for the administration of intravenous fluids and medication. Failure to monitor these devices correctly can result in early signs of infection being missed with the potential for serious infections to develop. The evidence presented in the national guidance suggests a move away from routine PVC replacement to regular review and early removal if signs of infection are evident or when the PVC is no longer required. Regular monthly auditing to check that all PVC's are having visual infusion phlebitis (VIP) score checks completed has continued this year and remains ongoing. The annual average compliance for this year's audits has been 91% up from 79% last year.

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

COMPLIANCE WITH URINARY CATHETER POLICY

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

- Indwelling Urinary Catheter Recording on Vital Pac

Compliance with the requirement to accurately document indwelling urinary catheter insertion on Vital Pac has been good with an overall trust compliance of 93% of all catheters being recorded. When split between the Divisions, Family and Surgery returned 91% compliance and Urgent and Integrated Care 95% compliance. These percentages are an average. Urinary tract infections are one of the largest single group of healthcare associated infections in the UK. Insertion of a urinary catheter is known to be a significant risk factor in the development of urinary tract infections and the risk increases with the duration of catheter insertion. It is therefore important to ensure there is a comprehensive process in place to ensure that the risk of urinary tract infection is considered prior to insertion of the urinary catheter and there is a continuous process for review.

CARBAPENEMASE PRODUCING ENTEROBACTERIACEAE AUDIT (CPE)

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

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

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

DCHFT carried out a CPE quarterly audit, between April 2022 and March 2023, which aims to determine the level of compliance across the trust with the screening assessment being conducted on admission and the correct actions taken if screening is required.

Results show that the overall compliance with undertaking the admission screening risk assessment was 81%. This has increased by 5% on the previous year's 76.3% result. To demonstrate continued adherence to CPE guidance and Trust policy this audit will be repeated quarterly or 2023-24. In conjunction with the role out of a new CPE policy back in 2021 and ward/unit leads have had the opportunity to discuss changes in guidance with the IPC Team, it has demonstrated a positive impact on these audit results.

COVID-19

The global pandemic of Covid-19 and changes in NHS England and UKHSA guidance remains ongoing and at the forefront of providing healthcare services that are safe for both patients and staff. The trust response continues to be led by the Incident Management Team, see table 5 total number of covid cases for DCHFT per month.

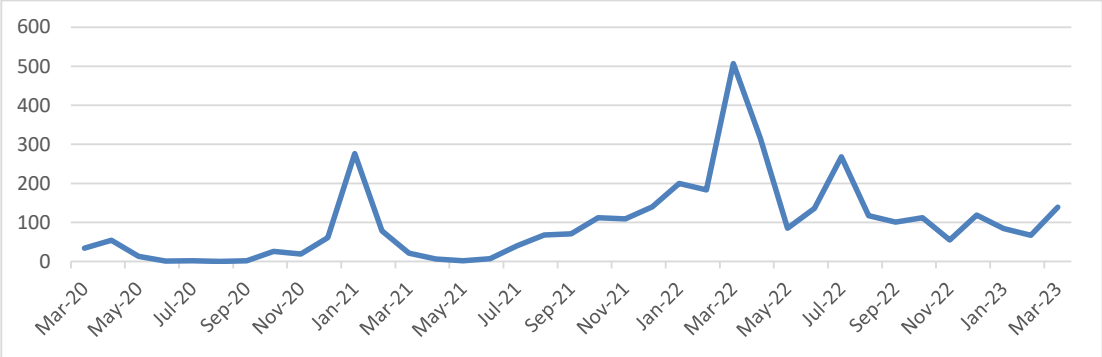
The hospital environment has been adapted to suit the needs for this new ongoing virus and the complexities that it creates. Over the past 3 years the IPCT have continued to support the trust throughout the pandemic with updates to guidance in line with Public Health England/UKHSA and expert response to emerging situations. The IPCT have also worked closely with the Dorset wide ICS to share best practice and learn from other trusts in the Southwest region and beyond.

However, due to the extremely transmissible nature of Covid-19 and increased prevalence in the community we did have 3 wards with identified outbreaks between April 2022 and March 2023. This was a low number of outbreaks for an inpatient setting in the Southwest region.

The Trust followed national IPC guidance throughout the pandemic, and this is supported by the Infection Prevention and Control Board Assurance Framework Winter 2022 (Appendix B). On investigation due to the nature of the virus and its transmissibility it was hard to identify the root cause of outbreaks. However, the outbreaks were during a period when visiting was not completely restricted and community rates were rising.

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

Table 5: Total number of covid cases over each month for DCHFT



INFECTION PREVENTION & CONTROL WEEK - OCTOBER 2022

To celebrate 'International Infection Prevention week' on the 16th – 21st October 2021. The IPCT requested wards to produce a poster presentation with an IPC theme (in View of the current workloads, Covid-19 pandemic, and ongoing staffing issues) on Clostridium Difficile and / or Antimicrobial Stewardship.

The poster presentation could encompass any area of Clostridium Difficile and / or Antimicrobial Stewardship. The overall aim is to improve staff knowledge on CDI. Many wards within the trust produced beautiful poster displays encompassing many different topic areas and the judging was carried out by the IPCT and N Johnson (Interim Chief Executive). Prizes were awarded to all the wards that entered, as the posters were all too good to pick a clear winner. During the week the IPCT also carried out a quiz in Damers restaurant and a lucky dip quiz on all our ward rounds.

CRITERION TWO:
Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections.

Add Estates, Water & Ventilation report.

Add Decontamination report.

HOTEL SERVICES REPORT- CLEANING SERVICES- Sarah Jenkins

Throughout the past year the Housekeeping Team have continued to work hard to maintain the cleanliness of the hospital, coping, as all services, with the fast-changing nature of the service due to the exceptional pressures we have experienced through the past months in terms of the number of patients we have had within the Trust. There have also been new areas to clean, many of these outside the main area of the hospital and there continue to be more to come.

This work has not been done in isolation but with the support of our colleagues across many disciplines. The importance of a clean environment, which has been supported by all teams helps to ensure our continued focus on providing and maintaining a hygienically clean and appropriate environment for our patients, visitors, and colleagues.

CLEANLINESS

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

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

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

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

DEEP CLEANING

The continued pressures on the hospital have meant that the annual deep clean programme has once again been delayed. As per usual we have taken every opportunity to carry out these cleans as and when spaces have been available and when such a clean is indicated due to the type of infection the patient has presented with.

The deep clean process is supported by fogging with a hydrogen peroxide vapour. Following the acquisition of two new machines last year, we have purchased a third machine which enable us to support more cleans and a times effective flow from the emergency department. Training has been rolled out to several staff across all shifts so that we are able to carry out deep cleans at all times. The new machines provide far greater assurance in terms of reporting of itself and in ease of checking that an area has been cleaned and are safer for the operatives in that the machines are turned on remotely once the operator has sealed the room, the vents and fire alarm sensors are covered without the operator having to use a ladder and reports are generated to confirm successful operation.

With the introduction of the space which has become available following the purchase of the new modular discharge lounge it is hoped that there will be a more robust plan of deep cleaning the wards and bays in particular, with the space being available to decant patients whilst the deep clean and some remediable estates works are being carried out.

INTERNAL MONITORING

The housekeeping team monitor the cleaning standards through audits. The frequency of these audits is dependent on the new functional risk categories to which the area is

assigned, and these vary between weekly and annually. The timescale for rectification of failures is also dictated by this categorisation.

Star ratings are being assigned for display instead of the percentage of cleanliness achieved, rated from 5 to 1 star. The percentage needed to achieve the five-star status is also linked to the functional risk category. Should an area receive 3 stars or less than a list of remedial actions is followed to ensure that the area is brought back up to and remains at standard. In the past 12 months.

The housekeeping supervisors have, despite a few technical issues, been using the new auditing software with increasing confidence. We have recently been able to add the email address of those who wish to receive the reports and so going forward the outcome of the audit and the areas of failure will be available on the wards immediately following completion of the audit.

We have also started to undertake efficacy audits on many areas as advised in the National Standards of Healthcare Cleanliness. These audits focus on the process of cleaning rather than its outcome to ensure that standards are maintained in the process and not just the outcome.

PATIENT LED ASSESSMENT OF THE CARE ENVIRONMENT (PLACE)

Following a pause since 2019, we were able to carry out the first Patient Led Assessment of the Care Environment in the autumn of 2022.

PLACE assessments are an annual appraisal of the non-clinical aspects of NHS and independent/private healthcare settings, undertaken by teams made up of staff and members of the public (known as patient assessors). The questions are focussed around 6 domains, the relevant ones for this report being the cleanliness and condition of the buildings. The percentage scored for cleanliness was 98.37% with 2408 marks out of a possible 2448 being achieved. That for condition was 94.8% with 1058 out of a possible 1116 being scored.

Whilst we should not be complacent and always strive for perfection, it should be observed that the PLACE findings represent a snapshot of the areas as they were found on the day, and the good scores in these domain areas are a testament to the hard work of the housekeeping and wider estates teams as they strive to maintain the environment with stretched resources.

We have also introduced PLACE lite audits at other times during the year. These act as a mini-PLACE audit and allow us to see areas in which we have improved and those areas where there is still room for action. We are joined on these by our patient assessors, to give the patient's perspective on the environment, and whilst we do not report on these nationally, they give us an indication of how we are doing.

CRITERION THREE: Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance.

ADD AMS REPORT from Rhian.

CRITERION FOUR: Provide suitable accurate information to patients/service users, visitors/carers and any person concerned with providing further support or nursing/medical care in a timely fashion.

The IPC Team works closely with the clinical site managers, ward leads, ward staff and facilities services and attends all bed meetings throughout the day to support patient placement and cleaning requirements. Infection control Patient Activity summary (PAS) flags are added as applicable to all newly identified infections.

The IPC team visit in person all newly diagnosed patients with MRSA and C Diff infections, providing the patient with an information leaflet, discuss the diagnosis and answer any questions.

The IPC Team work closely with the communications team and updates the trust staff via email when new guidance is implemented. We also have a dedicated IPC section on the trust intranet site, which is updated regularly and when any guidance changes are implemented. We also review the IPC information leaflets regularly. We have a dedicated covid-19 section on the trust intranet with many Covid Action cards, which are kept up to date as and when guidance is updated. These Action cards provided up to date information on staff, patient testing, PPE and visiting guidance.

The IPC team monitor all C Diff and Potential C Diff infections daily and include an in-depth weekly review of patients. Escalating concerns to medical teams, wards, and consultant microbiologists. Our consultant microbiologists contact GP's directly when patients are diagnosed with CDI. We also send out GP letters, in a timely manner alerting them of any new CDI, Potential CDI, MSSA, MRSA and Gram-negative Blood stream infections.

INFECTION PREVENTION AND CONTROL SURVEILLANCE SYSTEM (ICNET)

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

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

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

b. The IPC Programme is divided into three phases:

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

There have been several delays due to the pandemic which consisted of staff availability in testing, pathology lab issues and new pathology systems due to be installed. By the end of this current year the system has be running smoothly across all the Dorset system trusts.

CRITERION FIVE: Ensure early identification of individuals who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infections to others.

The use of ICNET allows the IPC team and clinical site managers out of hours to be alerted to any new alert organisms or existing alert organisms. The IPC team are constantly reviewing these patients. The microbiology consultants also use the ICNET system for note documentation to enable seamless sharing of information between teams. This information is also shared across NHS Dorset following the rollout of ICNET across Dorset Trusts.

As a team we link closely with GP's, ensuring they are promptly informed via letter or verbal contact via the consultant microbiologists of any new organisms, such as C Diff, Potential C Diff infection, MSSA and MRSA BSI's and Gram-Negative organisms.

The Trust is able to demonstrate that responsibility for infection prevention and control is effectively devolved to all professional groups by means of inclusion in all job descriptions and mandatory inclusion in appraisal documentation including for medical staff.

The IPC Team are involved in the management of outbreaks and periods of increased incidence. The IPC team monitors all alert organisms to identify trends and potential links between cases based on their location. If links are identified, a Period of Increased Incidence (PII) investigation is commenced and a weekly meeting to discuss potential cases is held as soon as possible. This task is greatly aided using ICNET.

In 2022/23 4 Periods of increase incidents of C Diff, 2 Norovirus outbreaks and 3 COVID-19 outbreaks were declared during this time frame. All outbreaks are discussed for the purpose of shared learning and service development through divisional governance meetings. Recurring themes from these investigations are disseminated through the IPC governance meetings. Action plans that are put in place by the ward manager and/or matron are monitored by the IPC team for compliance.

CRITERION SIX: Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection.

EDUCATION

The Infection Prevention & Control Team continued to provide formal and informal face to face education training sessions for both clinical and non-clinical staff. IPCT have also been incorporated into the following teaching programmes and all the nursing team were involved in delivering the sessions:

- Care Certificate for Health Care Support Workers
- Preceptorship Training
- Medical Tutorial Teaching programme
- Overseas Recruitment Training

Mandatory Training for clinical and non-clinical staff has been also offered via an online workbook.
Overall compliance with mandatory IPC training over the year was 90% for clinical staff and 84% for non-clinical staff. The Divisions are responsible to release staff to access their training.

IPCT recognised that additional support and training was required and also provides face to face mandatory training in addition to the online package. The E-learning IPC Mandatory training programme has recently been updated and includes all the relevant IPC Core Skills Training Framework.

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

The IPC team carryout daily ward rounds, during these ward rounds we support staff, monitor practice, and provide continued IPC education.

FACE MASK FIT TESTING

Fit testing has declined in numbers this past year. After many clinics being added and offered to staff, the uptake has been minimal. During 2022/2023 only 380 staff were fit tested using the porta count machine. These staff are mainly new starters. Sessions are advertised on the intranet along with separate sessions for the Education Department. It is a growing concern now that the pandemic has eased that staff are not making the effort to be fit tested even though it is a legal requirement. This has been escalated via the IPC governance meeting and has been supported by divisional leads and will be a focus as we move into 2023-2024.

CRITERION SEVEN: Provide or secure isolation facilities.

ISOLATION

DCHFT has 11% isolation cubicle against the standard bed base. There is no recent statistics to compare this figure to the national average within acute trusts. This percentage can impact the ability to isolate patients according to national guidance, DCHFT follow the National Infection Prevention and Control Manual for England 2023. Using the concept of cohort nursing patients during high prevalence of certain infections such as Flu A, Covid-19 or RSV.

The IPCT carryout daily ward rounds to review the use of side rooms, providing a daily spreadsheet to housekeeping and clinical site managers. The IPC Team risk assesses as necessary and the IPC Team support ward staff and clinical site managers to ensure the most effective use of side rooms according to risk, throughout the day.

ISOLATION AUDIT

This year's side room isolation audit took place in February and looked at all inpatient areas (excluding Kingfisher Ward and ITU) with results as follows; Out of 39 rooms in use for infection control purposes 77% had correct signage, 33% incorrect signage and a total of 100% overall side rooms in use across the trust. At the time of audit being carried out staff were educated on the importance of using correct signage to protect not only the patient but also themselves and visitors and thus reducing the transmission of infection. We have developed new trust isolation posters with the aim to implement these posters early May 2023.

CRITERION EIGHT: Secure adequate access to laboratory support as appropriate.

The laboratory services are located on site, there is a provision of seven-day laboratory working and 24 hour access to microbiology and virology advice, including a 24 hour Point-Of-Care Testing in ED and the Paediatric ward for PCR testing when required (e.g. COVID-19, Influenza, RSV) The IPC team are based within the Laboratory department and have a close working relationship with the Microbiology Consultants, we also have a weekly meeting between the IPCT, microbiology consultants and lead biomedical scientist.

Microbiology – underwent an audit by UKAS in April which resulted in the suspension of the labs accreditation status. It is anticipated that the suspension will be for between 3 – 6 months. Service users have been notified and a recovery plan is in development. A new Head of Microbiology has been successfully recruited and commenced in post early in April.

DCHFT are still one WTE consultant microbiologist short. Attempts to appoint to this post have so far been unsuccessful. This reflects a shortage of consultant microbiologists UK wide. We are hopeful to appoint into this post in the near future. The microbiology consultants are extremely busy but still find to assist the IPC team and we link closely together. (Since this report has been written the trust has appointed one 0.85 WTE consultant microbiologist).

CRITERION NINE: Have and adhere to policies designed for the individuals care and provider organisations that will help prevent and control infections.

POLICY DEVELOPMENT/REVIEW

There is a comprehensive list of infection Prevention and control policies, prod cures and guidance on the trust intranet. These polices are reviewed by the IPCT and relevant specialities on a three or five yearly review date, these documents are evidenced based and reflect national guidance. Compliance is audited with key polices as detailed in Criterion one.

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

Aseptic and Aseptic Non-touch Technique (Clean) Protocol
Portable Fans in the Healthcare Environment - Guidelines for the Use of
Decontamination Policy
Ward Closure Policy Due to an Outbreak of Healthcare Associated Infections
MRSA Policy
Isolation Policy
Isolation Requirements for Listed and Infecting Agents
Seasonal Influenza Policy
Pets for Therapy Policy
Ward Outbreak Pack
Standard Operating plan (SOP) for the cleaning of toys, games and play equipment
Guidance for staff on the management of Accidental injury and exposure (including needlestick injuries)

CRITERION TEN: Have a system in place to manage the Occupational health needs and obligations of staff in relation to infection.

DCHFT Occupational health service is provided by Optima health, and they proved bimonthly sharps injury report for IPC governance meeting, and this is cross referenced to the sharps injury DATIX's. Optima health supported the update of the policy for the 'Guidance for staff on the management of accidental injury and exposure (including needlestick injuries) in February 2022.

CONCLUSION

Last year has continued to be a challenging year for IPC, Covid-19 as well as other respiratory viruses have dominated our IPC workload, particularly over the winter. Eliminating avoidable healthcare associated infection has remained a priority for the trust to ensure our patients, staff and the public are kept safe. The work of the IPC team remains unpredictable and although I am new in post, I would like to thank all the team for their hard work, dedication, and positive attitude throughout the year.

2022-2023 has been a successful year, trajectories for Gram negative blood stream infections were achieved and very low incidence of MRSA blood stream infections, we have worked hard to keep our Clostridium difficile rates as low as possible and our continued deep dive review, ensuring our CDI management meets national guidance, close working with the IPC integrated care system and NHS England data collection will continue to reduce CDI.

This report demonstrates the continued commitment of the trust and demonstrates the success and service improvement through the leadership of a dedicated and committed IPC team. Infection Prevention and Control is the responsibility of all the Trust employees and the IPC team do not work in isolation. The successes over the last year have also only been possible due to the commitment for infection prevention and control of all DCHFT staff ensuring IPC is high on everyone's agenda.

The annual work plan for 2022-2023 reflects a continuation of support and promotion of IPC. Looking forward to 2023-2024 high standards of IPC and developing strong Antimicrobial Stewardship, ensuring our staff maintain a high level of compliance with IPC and a robust governance approach across the whole organisation will remain crucial in the prevention of all healthcare associated infections.

Throughout 2022-2023 the IPC team will continue to strength and support close working relationships with the IPC Integrated care system. Dorset-wide use of ICNET will support this work.

The trust remains committed to preventing and reducing the incidence and risks associated with HCAI's and recognises that we can do even more by continually working collaboratively together with colleagues, patients, service users and careers to develops and implement a wide range of IPC strategies and initiatives to deliver clean, safe care in our ambition to have no avoidable infections.

Emma Karamadoukis
IPC lead Specialist Nurse

REFERENCE

Department of Health (2015) Health and Social care Act 2008, Code of practice on the prevention and control of infections and related guidance, Available at: Health and Social Care Act 2008: code of practice on the prevention and control of infections , Accessed 15.04.2023

National Infection Prevention and Control manual for England (2022), NHS England » National infection prevention and control

APPENDIX A

INFECTION PREVENTION & CONTROL WORK PLAN 2022-2023 V4

	Health & Safety Act Criterion	Objective	Action	Measure of Success	Responsibility/ Operational Lead	Date of Completion	Evidence
1	Systems to manage and monitor the prevention and control of infection	Assurance to Trust Board that Infection Prevention & Control standards are maintained throughout the Trust	Bi- monthly Infection Prevention Group to meet and ensure provision of exception and assurance report to the Quality Committee	Further reduction in Healthcare Acquired Infections (HCAIs)	Director of Infection Prevention & Control (DIPC)	Bi-Monthly	Bi-monthly IPCG meetings in place.
		Business continuity and provision of 'live' data for quality of IPC care to remain at a high standard	IPCT to maintain current contract with ICNet. Support of the Dorset wide project to be clinically lead by DCHFT	Contract renewal	Associate Director Infection Prevention & Control (ADIPC)	October 2022	May 2022 Dorset wide ICNet roll-out in progress. Sept 2022 – System now live across the ICS
		The Trust will maintain a high standard of Infection Prevention & Control	Heads of Nursing to report on a monthly basis to Divisional Quality & Governance meetings. IPC performance standard dashboard to be achieved. Learning from performance data to be disseminated and evidenced via Divisional performance reports	Evidence that IPC performance dashboard is discussed and actioned at Divisional Governance meetings	Divisional Heads of Nursing / Quality	March 2023	Via dashboards

	Health & Safety Act Criterion	Objective	Action	Measure of Success	Responsibility/ Operational Lead	Date of Completion	Evidence
2	Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections	DCHFT will maintain a clean and safe environment for patient care	Dorset County Hospital to support PLACE assessment	The environment is safe and clean. Cross infection rates low	Facilities Manager	Sept 2023	Sept 2022 – Planned 30/09/2022
			Maintain current annual deep clean programme with Facilities/Heads of Nursing/ Estates. Execute agreed deep cleaning programme	Deep clean programme is undertaken.	Facilities Manager	March 2023	Sept 2022 – Update expected at IPCT meeting. Dec 2022 – Confirmed to formally commence April 2023 – areas deep cleaned in accordance with IPC recommendations
			Participation in weekly environmental technical audits	Review of weekly audits identifies deficits and monitors remedial actions have been taken	Facilities Manager (Lead) Estates Manager Patient representatives Pharmacy IPC Team	March 2023	
		All clinical equipment is clean and ready for use at point of care	Daily/Weekly Nursing Cleaning regimes in place in all clinical areas	Evidence via weekly audits – report compliance to IPCG	Divisional Heads of Nursing / Quality	Bi-Monthly	Sept 2022 – Divisions to feedback at Sept 2022 IPCG
		DCHFT will maintain a clean and safe water system	Policy in place and implemented Trust wide. Regular audits will be carried out to confirm the effectiveness of the policy.	DCHFT will deliver the Water Safety Policy. Water Safety is a standing item at IPCG. Additional meetings to be	Head of Estates	March 2023	May 2023 – Post COVID recovery meetings in place

	Health & Safety Act Criterion	Objective	Action	Measure of Success	Responsibility/ Operational Lead	Date of Completion	Evidence
				arranged and reported on for individual locations.			
		DCHFT will maintain a clean, safe and effective ventilation system	Establish ventilation safety group the reports to IPCG on a bi-monthly basis. Develop Ventilation Policy to measure compliance with HTM-03 and reduce risk of airborne infections in the healthcare settings	Compliance with refurbishment with HTM – 03 a/b	Head of Estates	March 2023	
		DCHFT will adhere to NHS Cleaning Standards 2021	Facilities and Housekeeping to ensure standards are maintained and audited vi monthly audit process	DCHFT will maintain high standards for cleaning within new framework – Bimonthly feedback to IPCG	Head of Facilities	March 2023	
3	Provide suitable accurate information on infections to service users and their visitors	Patients will be fully informed about their presenting infections. All new cases of *Cdifficile,* MRSA and ESBL will be counselled by an IPCN	IPCT to visit newly identified infectious patients and their carers. Provide verbal and written information and contact details	Positive patient feedback	IPCT	March 2023	May 2022 – IPCT continue to visit patients with newly acquired infections and established infections to provide information and reassurance.
		The Trust will have up to date patient	Review of all IPC patient information. Check meets	Positive patient feedback	IPCT	March 2023	Sept 2022 – Full review completed

	Health & Safety Act Criterion	Objective	Action	Measure of Success	Responsibility/ Operational Lead	Date of Completion	Evidence
		information relating to infection control	standards and revise accordingly. Apply Equality and Diversity policy to all IPC information leaflets				
4	Provide suitable accurate information on infections to any person concerned with providing further information support nursing/ medical care in a timely information	The Trust will have a reliable and available Infection Prevention & Control Team. Providing support to all patients and staff	IPCT to continue to carry out a daily ward round to all acute areas including Kingfisher, Maternity & Emergency Department, providing clinical support to staff and patients. Offsite support available e.g., South Walks House, Redwood House, Weymouth OPD	Minimum cross infection, reduced prolonged outbreaks of infection, reduced HCAIs	IPCT	March 2023	May 2022 - Daily IPCT ward rounds in place.
5	Ensure that people who have or develop an infection are identified promptly and receive the appropriate treatment and care to reduce the risk of passing on	Achieve trajectory for *Clostridium difficile* infection (CDI) TBC cases 2022-2023 (does not include cases whereby no lapses of care were identified)	Divisions to undertake Root Cause Analysis of all hospital acquired cases of CDI under the revised definitions – Hospital Onset-Healthcare Acquired and Community Onset Healthcare Acquired. IPCT to support. Antimicrobial Pharmacist and IPC	All cases of CDI will have RCA investigation and relevant action plan if deficits identified. RCA's will be discussed by IPCT, and any trends reported to Infection	Divisional Heads of Nursing / Quality / Matrons	March 2023	See dashboards

	Health & Safety Act Criterion	Objective	Action	Measure of Success	Responsibility/ Operational Lead	Date of Completion	Evidence
	the infection to other people		Doctor to support pharmacy and medical element. This must be completed within 14 days of infection.	Prevention Group (IPG). Delays in RCA progress will be reported at IPCG on the Divisional Dashboards. Face to Face RCA meetings to be re-established with Executive Lead.			
		Achieve trajectory for Gram-negative blood stream infections (BSI) TBC cases 2022-2023	Undertake IPC led data analysis of all hospital acquired cases of gram-negative BSI – escalate to full RCA if lapses in care identified	All cases of Gram-negative BSI will have investigation and relevant action plan if deficits identified.	ADIPC	March 2023	See dashboards
		Ensure the Trust is robustly prepared for Seasonal variations in IPC.	Support staff vaccination programme for seasonal influenza/COVID-19 Reinforce Respiratory Guidance/Seasonal Influenza Policy and Pandemic Influenza Policy	The Trust will be able to function effectively during the variance in season IPC activity and Infection Control standards are maintained	ADIPC	October 2022	Dec 2022- Vaccination programme in place Dec 2022- IPCT reinforcing policies via IMT/Ward rounds/training.

	Health & Safety Act Criterion	Objective	Action	Measure of Success	Responsibility/ Operational Lead	Date of Completion	Evidence
			Ensure staff are familiarised with the Outbreak/Noro/COVID -19 policy				
		Ensure Trust remains aligned to United Kingdom HS Agency (UKSHA) COVID-19 Infection Control Guidance.	Maintain COVID-19 Board Assurance Framework and report bi-monthly to IPCG, Quality Committee and Trust Board	The Trust will be able to support the demands of the COVID-19 pandemic	ADIPC	Ongoing	Sept 2022 – Await V1.11 to be formalise via NHSE. Dec 2022 – IPCG to approve current version – await final approval Jan 2023
6	Ensure that all staff and those employed to provide care in all settings are fully involved in the process of preventing and controlling infection	High standards of hand hygiene practice throughout the Trust.	Hand hygiene audits to be undertaken by all clinical wards/departments. Wards/departments that achieve<90% to present action plan to IPG.	Hand hygiene results >95% and sustained at this level for all wards/departments. Departmental Managers to report to IPG with action plan when hand hygiene results <90%.	Divisional Heads of Nursing / Quality / Matrons	Monthly	See dashboards
			Validation of hand hygiene audits	High level compliance with WHO 5 moments of care hand hygiene standards.	IPCT/ External auditors	Bi-Monthly	See dashboards

	Health & Safety Act Criterion	Objective	Action	Measure of Success	Responsibility/ Operational Lead	Date of Completion	Evidence
			Participate in national infection control promotion events	Staff engage with IPCT promote best practice.	IPCT	October 2022	Oct 2022 - Completed
		Education	Support DCHFT mandatory training programme and other IPC training within educational packages Via e-learning and face to face training	Education reflects national and local requirements for mandatory IPC training.	IPCT	March 2023	See dashboard
7	Provide or secure adequate isolation facilities.	Ensure the risk of cross infection is reduced Trust wide	Undertake annual audit of isolation precautions to ensure appropriate signage, PPE precautions are in place. Ensure that audit incorporates patients who should be in isolation. Undertake quarterly PPE audit to confirm compliance with policy.	Audit identifies appropriate precautions to effectively manage patients with infections.	IPCT	March 2023	
		Ensure adequate isolation facilities in new build and any new build has the pandemic planning as part of process	IPCT to be involved in: • ED15 • New build Critical Care	New build is fit for purpose for isolation requirements and pandemic preparedness	ADIPC	March 2023	

	Health & Safety Act Criterion	Objective	Action	Measure of Success	Responsibility/ Operational Lead	Date of Completion	Evidence
			• New build ED • South walks				
8	Secure adequate access to laboratory support as appropriate	IPCT to support and be involved in the county wide pathology project ensuring delivery of safe patient care is not affected	IPCT at DCHFT to continue to support development of ICNet 'single instance' across Dorset - Dorset-Wide ICNet project. IPCT to continue to monitor efficacy of data since transfer to single instance laboratory system. Dorset Healthcare to go live Summer 2022	One ICNet system across Dorset	ADIPC	October 2022	Sept 2022- ICNET now integrated across ICS
9	Have and adhere to policies, designed for the individual's care and provider organisations that will help to prevent and control infections	Audit programme- to audit compliance with Key IPC policies	PVC audits undertaken to ensure compliance with observation standard	PVC observations will be observed every shift and recorded on Vital Pac	IPCT	Quarterly	See dashboard
			Urinary catheter documentation audits undertaken to ensure compliance with observation standard.	Urinary catheters will be reviewed on a daily basis and care documented on Vital Pac	IPCT	Monthly	See dashboard

	Health & Safety Act Criterion	Objective	Action	Measure of Success	Responsibility/ Operational Lead	Date of Completion	Evidence
			Audit compliance with CPE screening recommendations. Divisional Matrons to review results with wards and develop action plans dependant on results of audits	Audit identifies that documentation supports appropriate risk assessment is undertaken for patients admitted to Trust	IPCT Divisional Matrons	Biannually	See dashboard
			Participation in mandatory Surveillance of Surgical Site Infections for Orthopaedics and Breast. Review results with clinicians. *Orthopaedic surveillance SSI cases to be discussed at Orthopaedic Governance meetings.* If required, action plan to be developed and implemented. Results to be presented at Divisional Governance Meetings and IPCG	Surgical site surveillance meets national mandatory requirement. Rates of SSI are within acceptable parameters	IPCT Divisional Consultant Leads Divisional Matrons	March 2023	
10	Ensure, so far as is reasonably practicable, that care workers are free of and are	Reduce the number of sharps injuries caused by sharps disposal	Undertake annual Sharps Audit to ensure Trust wide adherence to recommended practice. Action plan	Audit identifies compliance with safe management of storage and	IPCT	Sept 2022 (IPCT) Oct 2022 (Provider)	Sept 2022 – Quarterly feedback via July IPCG Sharps audit complete July 2022

	Health & Safety Act Criterion	Objective	Action	Measure of Success	Responsibility/ Operational Lead	Date of Completion	Evidence
	protected from exposure to infections that can be caught at work and that all staff are suitably educated in the prevention and control of infection associated with the provision of health and social care		with Divisions to reduce risks identified on audit.	disposal of sharps			
		Prepare all clinical staff to provide direct patient care for those requiring airborne precautions	Divisional fit mask testers in place to support evolving needs created continuous change of suppliers of masks influenced by COVID-19 pandemic	All clinical staff will have access to FFP3 training and able to care for patients using airborne precautions	Lead Fit Mask Tester	Bi-monthly feedback via IPCG/H&SG	Sept 2022- Feedback via FFP3 lead Dec 2022- Feedback via FFP3 lead – training programme in place
		Staff at DCHFT are equipped with the knowledge, skills and equipment to care for 'high risk' infectious patients	Ensure all 'IPC Emergency Boxes' are maintained and in date. Ensure all relevant policies are up to date and staff are aware of roles and responsibilities in relation to 'high risk' patients.	All clinical staff are aware and able to support the emergency preparedness of the trust for IPC issues	IPCT/ Lead Emergency Planner	October 2022	Dec 2022 – IPCT to provide update via IPCG
		Environmental controls are in place to ensure ventilation meets standard for respiratory pandemic precautions	Estates to ensure clinical and non-clinical areas have documented assessment and controls in place to support pandemic guidance	DCHFT can demonstrate compliance	Estates Lead	September 2022	Sept 2022- Feedback from Estates required

There are 10 criteria set out by the *Health and Social Care Act 2012* which are used to judge how we comply with its requirements for cleanliness and infection control. This is reflected in the *Care Quality Commission Fundamental Standards Outcome 8* and detailed above in the annual work plan which is monitored by the Trust's Infection Prevention and Control Group.

Emma Hoyle Deputy Chief Nursing Officer /Associate Director Infection Prevention & Control Jan 2023 V4

APPENDIX B

Infection Prevention and Control Board Assurance Framework Winter 2022

1. Systems to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks their environment and other users may pose to them			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure that: • A respiratory plan incorporating respiratory seasonal viruses that includes: o point of care testing (POCT) methods for infectious patients known or suspected to have a respiratory infection to support patient triage/placement according to local needs, prevalence, and care services. o segregation of patients depending on the infectious agent taking into account those most vulnerable to infection e.g. clinically immunocompromised. o A surge/escalation plan to manage increasing patient/staff infections. o a multidisciplinary team approach is adopted with hospital leadership, operational teams**,** estates &	POCT in place in Emergency Department for COVID-19, influenza, Respiratory Syncytial Virus (RSV) – symptomatic adult children and young people (CYP) tested. Isolation triage in place via ICNET and infection prevention and control team (IPCT) Clinical Site Managers access database to assist placement of patients requiring contact, airborne and protective isolation. This is a risk RAG rated database updated by IPCT. Thrice daily bed meetings attended by IPCT assess current situation in the Trust and		

facilities, IPC teams and clinical and non- clinical staff to assess and plan for creation of adequate isolation rooms/cohort units as part of the plan.
 	
• Organisational /employers risk assessments in the context of managing infectious agents are:
  ○ based on the measures as prioritised in the hierarchy of controls.
  ○ applied in order and include elimination; substitution, engineering, administration and PPE/RPE**.**
  ○ communicated to staff.
  ○ further reassessed where there is a change or new risk identified eg. changes to local prevalence.
 	
• the completion of risk assessments have been approved through local governance procedures, for example Integrated Care Systems.
 	
• risk assessments are carried out in all areas by a competent person with the skills, knowledge, and experience to be able to recognise the hazards associated with the infectious agents.
	cohort/isolation plans agreed. In the event of outbreak and ward closure IPCT lead and manage response in accordance with policy - http://sharepointapps/clinguide/CG%20docs1/1038-ward-closure.pdf.
	
	Estates completed full site review 2020/2021 of ventilation and risk assessment of patient locations for aerosol generating procedures (AGPs) and high-risk infections.
	
	Operational capacity risk managed via bed meetings and documented via situations reports (sitrep) reported via ICS and as required via region.
	
	Standard weekly Communication email in place with additional comms where required.
	
	Prevalence of infection/variants of concern – risk assessments in place for personal protective equipment use (PPE) and action cards to support Action cards - All Documents
	
	Risk assessments requiring prompt action are agreed via specialist teams and escalated to the weekly Incident Management Team (IMT) Trust decision escalated to ICS IPC group for system agreement. IMT review any escalations or emerging risks. Risks agreed via Incident Management Team and entered onto the Trust Risk Register (COVID-19 is on the Corporate Risk		

• ensure that transfers of infectious patients between care areas are minimised and made only when necessary for clinical reasons. • resources are in place to monitor and measure adherence to the NIPCM. This must include all care areas and all staff (permanent, flexible, agency and external contractors). • the application of IPC practices within the NIPCM is monitored e.g. 10 elements of SICPs • the IPC Board Assurance Framework (BAF) is reviewed, and evidence of assessments are made available and discussed at Trust board level. • the Trust Board has oversight of incidents/outbreaks and associated action plans. • the Trust is not reliant on a single respirator mask type and ensures that a range of predominantly UK made FFP3 masks are available to users as required.	register). Governance in place for sub-board committees to oversee risk assessments and escalate to the Trust Board. IMT consisted of leads of departments and services. Annual risk assessments for all areas (clinical and non-clinical) managed via Health and Safety. Minimised where possible and plans to cohort agreed by IPCT to support reduction of moves out of hours. Daily IPCT ward rounds in place to monitor compliance and address on-compliance issues. Monthly departmental and ward hand hygiene audits in place. Peer audits also actioned. Indwelling device audits in place and results reported via Divisions to Infection Prevention and Control Group (IPCG). All 10 Standard Infection Control Precautions (SICPs) C1636-national-ipc-manual-for-england-v2.pdf are audited and results and subsequent actions/learning reported via IPCG to Quality Committee. Escalation to Trust Board if performance is not maintained. All IPC incidents are escalated via the governance route. DCHFT utilises and tests staff on various respirator brands and have access to 5 options.		

2. Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**

Systems and processes are in place to ensure that:
• the Trust has a plan in place for the implementation of the National Standards of Healthcare Cleanliness and this plan is monitored at board level.
• the organisation has systems and processes in place to identify and communicate changes in the functionality of areas/room
• cleaning standards and frequencies are monitored in clinical and non-clinical areas with actions in place to resolve issues in maintaining a clean environment.
• enhanced/increased frequency of cleaning should be incorporated into environmental decontamination protocols for patients with suspected/known infections as per the NIPCM (Section 2.3) or local policy and staff are appropriately trained.
• manufacturers' guidance and recommended product 'contact time' is followed for all cleaning/disinfectant solutions/products.
• For patients with a suspected/known infectious agent the frequency of cleaning should be increased particularly in:
  ○ patient isolation rooms
  ○ cohort areas
  ○ donning & doffing areas – if applicable
	Cleaning Policy and audit process updated and agreed via September 2022 IPCG
	
	PAS team is able to share this and do so as required. IPCT update Housekeeping accordingly. Ad hoc increase in cleaning requirements achieved via IMT/IPCT comms
	
	Monthly cleaning audits reported via Divisional Dashboards at IPCG.
	
	Daily update and as required via IPCT directly to Housekeeping supervisors
	
	Regular training supported by manufacturers in place e.g. Clinell
	
	Full cleaning RAG rating process in place and communicated via training and posters on wards/clinical areas.
	Commode cleaning audits in place		

○ 'Frequently touched' surfaces e.g., door/toilet handles, chair handles, patient call bells, over bed tables and bed/trolley rails. ○ where there may be higher environmental contamination rates, including: ▪ toilets/commodes particularly if patients have diarrhoea and/or vomiting. • The responsibility of staff groups for cleaning/decontamination are clearly defined and all staff are aware of these as outlined in the National Standards of Healthcare Cleanliness •	Reinforced via Cleaning Policy		
• A terminal clean of inpatient rooms is carried out: ○ when the patient is no longer considered infectious ○ when vacated following discharge or transfer (this includes removal and disposal/or laundering of all curtains and bed screens). ○ following an AGP if clinical area/room is vacated (clearance of infectious particles after an AGP is dependent on the ventilation and air change within the room).	Action cards and reinforced via cleaning policy	Monitoring and assurance required from housekeeping leads via database	
• reusable non-invasive care equipment is decontaminated: ○ between each use ○ after blood and/or body fluid contamination ○ at regular predefined intervals as part of an equipment cleaning protocol ○ before inspection, servicing, or repair equipment.	Decontamination Policy in place and actioned. Additional support offered via IPC/Equipment Library in relation to new equipment e.g. respiratory hoods		
• compliance with regular cleaning regimes is monitored including that of reusable patient care equipment.			

• ventilation systems, should comply with HBN 03:01 and meet national recommendations for minimum air changes https://www.england.nhs.uk/publication/specialised-ventilation-for-healthcare-buildings/ • ventilation assessment is carried out in conjunction with organisational estates teams and or specialist advice from the ventilation group and/ or the organisations, authorised engineer and plans are in place to improve/mitigate inadequate ventilation systems wherever possible. • where possible air is diluted by natural ventilation by opening windows and doors where appropriate	Cleaning products supplied in all areas. Staff aware to clean between patients. Red and green 'I am clean' labels in use. Cleaning schedules in use in all areas. Ventilation Safety Group in place. Needs to report up to IPCG as escalation report Use of 'air scrubbers' in poorly ventilated areas e.g., Southwalks House OPD Areas that have windows advised to ensure opened to maintain ventilation. Posters circulated reminding staff of this.	Need Divisional Assurance via IPCG Assurance required for Estates and/or derogation of risk	
3. Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**

Systems and process are in place to ensure that:
• arrangements for antimicrobial stewardship (AMS) are maintained and a formal lead for AMS is nominated
• NICE Guideline NG15 https://www.nice.org.uk/guidance/ng15 is implemented – Antimicrobial Stewardship: systems and processes for effective antimicrobial medicine use
• the use of antimicrobials is managed and monitored:
  ○ to optimise patient outcomes
  ○ to minimise inappropriate prescribing
  ○ to ensure the principles of Start Smart, Then Focus https://www.gov.uk/government/publications/antimicrobial-stewardship-start-smart-then-focus are followed
• contractual reporting requirements are adhered to, and boards continue to maintain oversight of key performance indicators for prescribing including:
  ○ total antimicrobial prescribing;
  ○ broad-spectrum prescribing;
  ○ intravenous route prescribing;
adherence to AMS clinical and organisational audit standards set by NICE: https://www.nice.org.uk/guidance/ng15/resources
• resources are in place to support and measure adherence to good practice and quality improvement in AMS. This must include all care areas and staff (permanent, flexible, agency and external contractors)
	AMS lead in place with AMS lead consultant via microbiology
	
	AMS meeting in place and reports to IPCG, format of process built around NICE recommendations.
	
	Audits in place for AMS, lead AMS and lead consultant meet to review AMS
	
	Resources for auditing noted as difficult to achieve
		AMS lead leaving Trust early 2023
		
		Minimal resource to support audit and extended practice
			Pharmacy lead seeking alternative resource

4. Provide suitable accurate information on infections to service users, their visitors and any person concerned with providing further support or nursing/ medical care in a timely fashion.			
• **Key lines of enquiry**	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure that: • IPC advice/resources/information is available to support visitors, carers, escorts, and patients with good practices e.g. hand hygiene, respiratory etiquette, appropriate PPE use • visits from patient's relatives and/or carers (formal/informal) should be encouraged and supported whilst maintaining the safety and wellbeing of patients, staff and visitors • national principles on inpatient hospital visiting and maternity/neonatal services will remain in place as an absolute minimum standard. national guidance on visiting patients in a care setting is implemented. • patients being accompanied in urgent and emergency care (UEC), outpatients or primary care services, should not be alone during their episode of care or treatment unless this is their choice. • restrictive visiting may be considered by the incident management team during outbreaks within inpatient areas This is an organisational decision following a risk assessment and should be communicated to patients and relatives. • there is clearly displayed, written information available to prompt patients' visitors and staff to comply with handwashing, respiratory hygiene and cough etiquette. The	Resources in place and updated in accordance with requirement or change in guidance. Visits from patient relatives carers in place. Restricted visiting in place in cases of high incidence of infection e.g. outbreak area however visitors managed in this situation on a case by case process e.g. end of life care. Carers and relatives of attendees to the Trust encouraged and supported.		

use of facemasks/face coverings should be determined following a local risk assessment. • if visitors are attending a care area to visit an infectious patient, they should be made aware of any infection risks and offered appropriate PPE. • Visitors, carers, escorts who are feeling unwell and/or who have symptoms of an infectious illness should not visit. Where the visit is considered essential for compassionate (end of life) or other care reasons (e.g., parent/child) a risk assessment may be undertaken, and mitigations put in place to support visiting. • Visitors, carers, escorts should not be present during AGPs on infectious patients unless they are considered essential following a risk assessment e.g., carer/parent/guardian. • implementation of the supporting excellence in infection prevention and control behaviours Implementation Toolkit has been adopted where required C1116-supporting-excellence-in-ipc-behaviours-imp-toolkit.pdf (england.nhs.uk)	Local/system risk assessment in place PPE available for visitors/carers Communication in place and reinforced via external communication e.g. website Visiting Hours (dchft.nhs.uk) If attendance required e.g. child with parent PPE will be provided Toolkit supported via IPCT training, visits, communications	Posters across the Trust in place but noted a refresh and improve on current messaging	IPCT, Comms and Estates have completed a site visit and refresh plan in place
5. Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure that:			

• all patients are risk assessed, if possible, for signs and symptoms of infection prior to treatment or as soon as possible after admission, to ensure appropriate placement and actions are taken to mitigate identified infection risks (to staff and other patients). • signage is displayed prior to and on entry to all health and care settings instructing patients with symptoms of infection to inform receiving reception staff, immediately on their arrival (see NIPCM). • the infection status of the patient is communicated prior to transfer to the receiving organisation, department or transferring services ensuring correct management /placement • triaging of patients for infectious illnesses is undertaken by clinical staff based on the patients' symptoms/clinical assessment and previous contact with infectious individuals, the patient is placed /isolated or cohorted accordingly whilst awaiting test results. This should be carried out as soon as possible following admission and a facemask worn by the patient where appropriate and tolerated. • patients in multiple occupancy rooms with suspected or confirmed respiratory infections are provided with a surgical facemask (Type II or Type IIR) if this can be tolerated. • patients with a suspected respiratory infection are assessed in a separate area, ideally a single room, and away from other patients pending their test result and a	All non-elective patients triage via ED and POCT performed if symptomatic. Any patient with respiratory symptoms are reviewed, swabbed and isolated/cohorted (even if previously swabbed and negative result) Patients attending the Trust for routine appointments are requested not to do so if they have symptoms – telephone and video clinics in place to reduce the requirement for patients to visit the hospital. Noted Dorset wide ICNET in place to manage system patients. Out of area transfers managed generally as non-elective so triaged and swabbed accordingly e.g. renal, haematology Triage is carried out by trained staff and patients triaged according to pathway. Face masks offered to patients to wear but noted staff cannot enforce wearing of face masks for patients. Face masks available for patients and as above advised to wear. Confirmed with ED Matron triage in place in accordance with UKSHA guidance, updated as necessary with new guidance eg. Foreign travel history taking. Isolation facilitated and transfer	Poster review as above	

facemask worn by the patient where appropriate and tolerated (unless in a single room/isolation suite). • patients with excessive cough and sputum production are prioritised for placement in single rooms whilst awaiting test results and a facemask worn by the patient where appropriate and tolerated only required if single room accommodation is not available. • patients at risk of severe outcomes of infection receive protective IPC measures depending on their medical condition and treatment whilst receiving healthcare e.g., priority for single room protective isolation. • if a patient presents with signs of infection where treatment is not urgent consider delaying this until resolution of symptoms providing this does not impact negatively on patient outcomes. • The use of facemasks/face coverings should be determined following a local risk assessment. • patients that attend for routine appointments who display symptoms of infection are managed appropriately, sensitively and according to local policy. • Staff and patients are encouraged to take up appropriate vaccinations to prevent developing infection • Two or more infection cases linked in time, place and person trigger an incident/outbreak investigation and are reported via reporting structures.	to isolation on wards managed via CSMs supported by IPCT. IPCT RAG rate isolation requirements and this is shared with CSMs to support out of hours placements. ICS approach to face mask wearing via a RAG rating taking into account current regional pressures of infections. Staff and patient vaccination programmes supported for flu and COVID-19. ICNET provides a linked alert system to ensure any linked infections trigger a review with the prospect of an outbreak being declared.		
6. Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**

Systems and processes are in place to ensure that: • IPC education is provided in line with national guidance/recommendations for all staff commensurate with their duties. • training in IPC measures is provided to all staff, including: the correct use of PPE. • all staff providing patient care and working within the clinical environment are trained in hand hygiene technique as per the NIPCM and the selection and use of PPE appropriate for the clinical situation and on how to safely put it on and remove it (NIPCM); • adherence to NIPCM, on the use of PPE is regularly monitored with actions in place to mitigate any identified risk • gloves and aprons are worn when exposure to blood and/or other body fluids, non-intact skin or mucous membranes is anticipated or in line with SICP's and TBP's. • hand hygiene is performed: o before touching a patient. o before clean or aseptic procedures. o after body fluid exposure risk. o after touching a patient; and o after touching a patient's immediate surroundings. • the use of hand air dryers should be avoided in all clinical areas. Hands should be dried with soft, absorbent, disposable paper towels from a dispenser which is located close to the sink but beyond the risk of splash contamination (NIPCM)	IPC Training remains fluid and adapting to the national guidance changes as and when they occur. Ad hoc training supported by IPCT as required. All staff are supported with training and guidance on PPE and IPC practices. Including non-clinical staff with mask wearing PPE and Hand hygiene audits in place and monitored via Divisional Dashboard No hand dryers actively in use at DCHFT		

• staff understand the requirements for uniform laundering where this is not provided for onsite.	Detailed via action cards Staff laundry bags for home laundering available for staff. Extra scrubs ordered for medical and non-uniform clinical staff		
7. Provide or secure adequate isolation facilities			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure: • that clear advice is provided; and the compliance of facemask wearing for patients with respiratory viruses is monitored (particularly when moving around the ward or healthcare facility) providing it can be tolerated and is not detrimental to their (physical or mental) care needs. • patients who are known or suspected to be positive with an infectious agent where their treatment cannot be deferred, care is provided following the NIPCM. • patients are appropriately placed i.e.; infectious patients are ideally placed in a single isolation room. If a single/isolation room is not available, cohort patients with confirmed respiratory infection with other patients confirmed to have the same infectious agent. • standard infection control precautions (SIPC's) are applied for all, patients, at all times in all care settings • Transmission Based Precautions (TBP) may be required when caring for patients with known / suspected infection or colonization	National guidance advises symptomatic patients to wear facemasks if tolerated in an area with other patients e.g. cohort. PPE pathways via action cards in place Action cards - All Documents Daily reviews in place via IPC ward rounds and supporting Clinical Site Team if pressures evolve with patient placement. IPCT and the Clinical Site Team work closely to ensure isolation facility availability in place to support requirement. Surge plan in place if isolation capacity is reduced. Negative pressure suite on Lulworth Ward is dedicated to patients who are undergoing AGPs. Areas with confirmed respiratory cases cohorted are based on Moreton Ward and national IPC guidance.	Compliance with facemask wearing by patients is low.	IPCT reinforce on ward rounds when required

	IPCT available to support ward and clinical area queries with any PPE or infection related issue. New Isolation Posters in place to remind staff on precautions required		
8. Secure adequate access to laboratory support as appropriate			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
There are systems and processes in place to ensure: • Laboratory testing for infectious illnesses is undertaken by competent and trained individuals. • patient testing for infectious agents is undertaken promptly and in line with national guidance. • staff testing protocols are in place for the required health checks, immunisations and clearance • there is regular monitoring and reporting of the testing turnaround times, with focus on the time taken from the patient to time result is available. • inpatients who go on to develop symptoms of infection after admission are tested/retested at the point symptoms arise. **COVID-19 Specific** • patients discharged to a care home are tested for SARS-CoV-2, 48 hours prior to discharge (unless they have tested positive within the previous 90 days), and result is communicated to receiving organisation prior to	Accredited microbiology/virology lab utilised on site. Guidance in place to support staff – process already established as throat and nose swabs taken frequently by Trust staff for other organisms. Refresher training in place via IPCT. Symptomatic patients tested on admission via POCT units in ED. Other testing managed via the main lab. Monitored via lab team and reported to IPC if any delayed results. Action cards in place to direct staff on testing regime if patients are symptomatic and require swabbing, All patients discharged to a care home are swabbed as per national guidance – compliance monitored via DATIX		

discharge. Coronavirus (COVID-19) testing for adult social care services - GOV.UK (www.gov.uk) • for testing protocols please refer to: COVID-19: testing during periods of low prevalence - GOV.UK (www.gov.uk) C1662_covid-testing-in-periods-of-low-prevalence.pdf (england.nhs.uk)			
9. Have and adhere to policies designed for the individual's care and provider organisations that will help to prevent and control infections			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure that • resources are in place to implement, measure and monitor adherence to good IPC and AMS practice. This must include all care areas and all staff (permanent, flexible, agency and external contractors). • staff are supported in adhering to all IPC and AMS policies. • policies and procedures are in place for the identification of and management of outbreaks of infection. This includes the documented recording of an outbreak. • all clinical waste and infectious linen/laundry used in the care of known or suspected infectious patients is handled, stored and managed in accordance with current national guidance as per NIPCM	Audit dashboard presented bi-monthly to IPCG, adherence monitored by IPCT, IPC Doctor, Matrons, Heads of Nursing. Additional training provided as required to embrace policy and action plans in place following formal audit with measured learning outcomes reported to IPCG. Policy in place. http://sharepointapps/clinguide/CG%20docs1/1038-ward-closure.pdf ICNET supports outbreak module to ensure documentation accessible. Waste streams in place. PPE supply and availability confirmed on w weekly basis via IMT		

• PPE stock is appropriately stored and accessible to staff when required as per NIPCM			
10. Have a system in place to manage the occupational health needs and obligations of staff in relation to infection			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**

Systems and processes are in place to ensure that:
 	
• staff seek advice when required from their occupational health department/IPCT/GP or employer as per their local policy.
• bank, flexible, agency, and locum staff follow the same deployment advice as permanent staff.
• staff understand and are adequately trained in safe systems of working commensurate with their duties.
 	
• a fit testing programme is in place for those who may need to wear respiratory protection.
 	
• where there has been a breach in infection control procedures staff are reviewed by occupational health. Who will:
  ○ lead on the implementation of systems to monitor for illness and absence**.**
  ○ facilitate access of staff to treatment where necessary and implement a vaccination programme for the healthcare workforce as per public health advice.
	Optima Health provide Occupational Health Services for DCHFT. Local action cards/policies in place to support staff. Reinforced and additional support via Human Resources team.
	
	IPCT involved in Trust Induction and mandatory training reinforces safe systems of working.
	
	Fit Mask Testing lead in post and actioning programme to maintain fit testing at DCHFT. Bi-monthly update on progress to IPCG.
	
	Any breach in IPC procedures and requirement to access support, seek public health advice, human resources input and maintain sitrep. Human resources lead on sickness and absence monitoring as OH an external company. IPCT, Human resources, divisions and pharmacy work on vaccine programme to support access for staff to flu and COVID-19 vaccinations.
		Agency staff induction needs to be robust. Pack previously in place requires updating.	Local induction

○ lead on the implementation of systems to monitor staff illness, absence and vaccination. ○ encourage staff vaccine uptake. • staff who have had and recovered from or have received vaccination for a specific respiratory pathogen continue to follow the infection control precautions, including PPE, as outlined in NIPCM. • a risk assessment is carried out for health and social care staff including pregnant and specific ethnic minority groups who may be at high risk of complications from respiratory infections such as influenza or severe illness from COVID-19. ○ A discussion is had with employees who are in the at-risk groups, including those who are pregnant and specific ethnic minority groups**.** ○ that advice is available to all health and social care staff, including specific advice to those at risk from complications**.** ○ Bank, agency, and locum staff who fall into these categories should follow the same deployment advice as permanent staff**.** ○ A risk assessment is required for health and social care staff at high risk of complications, including pregnant staff. • testing policies are in place locally as advised by occupational health/public health. • NHS staff should follow current guidance for testing protocols: C1662_covid-testing-in-periods-of-low-prevalence.pdf (england.nhs.uk) • staff required to wear fit tested FFP3 respirators undergo training that is compliant with HSE guidance	Action cards in place to support safe return to work post respiratory infection. COVID-19 risk assessments in place and it is the Divisional Lead responsibility to complete and update the assessment on a regular basis. Guidance for All Staff (dchft.nhs.uk) Action cards in place and reflect current national guidance re COVID-19 testing Full rolling training programme in place – bi monthly feedback by FFP3 testing lead to IPCG. This feedback includes: • Number of staff FFP3 fit mask tested • Number of available trainer • Models currently in use and relevant training provided		

and a record of this training is maintained by the staff member and held centrally/ESR records. • staff who carry out fit test training are trained and competent to do so. • fit testing is repeated each time a different FFP3 model is used. • all staff required to wear an FFP3 respirator should be fit tested to use at least two different masks • those who fail a fit test, there is a record given to and held by employee and centrally within the organisation of repeated testing on alternative respirators or an alternative is offered such as a powered hood. • that where fit testing fails, suitable alternative equipment is provided. Reusable respirators can be used by individuals if they comply with HSE recommendations and should be decontaminated and maintained according to the manufacturer's instructions • members of staff who fail to be adequately fit tested: a discussion should be had, regarding re deployment opportunities and options commensurate with the staff members skills and experience and in line with nationally agreed algorithm. • a documented record of this discussion should be available for the staff member and held centrally within the organisation, as part of employment record including Occupational health. • boards have a system in place that demonstrates how, regarding fit testing, the organisation maintains staff safety and provides safe care across all care settings. This system should include a centrally held	Powered hoods available from the Equipment Library Health and Safety led risk assessment of reusable respirators and deemed high risk due to complexities of cleaning – not in use at DCHFT Alternative PPE can be provided via respirator hoods. Divisional leads will be responsible in this instance to keep a record of staff redeployed for this reason – currently no staff redeployed (Dec 2022) Bi-monthly report via FFP3 Lead Action cards in place		

record of results which is regularly reviewed by the board. • staff who have symptoms of infection or test positive for an infectious agent should have adequate information and support to aid their recovery and return to work.			

C1501 DCHFT response to national requirement for BAF

Emma Hoyle December 2022

Report Front Sheet

1. Report Details			
Meeting Title:	**Board of Directors**		
Date of Meeting:	**26 July 2023**		
Document Title:	**Establishing Shared Governance Arrangements across Dorset County Hospital and Dorset HealthCare for the Working Together Programme**		
Responsible Director:	**Nick Johnson, Deputy Chief Executive and Working Together Senior Responsible Officer**	**Date of Executive Approval**	**15.5.23**
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**
Working Together Programme Board	16.5.23	Recommended to DCH and DHC Boards for approval.
Trust Board, Part 2	31.5.23	Approved

3. Purpose of the Paper	To set out key documents governing the approach to establishing greater integration and collaboration across Dorset County Hospital (**DCH**) and Dorset HealthCare (**DHC**) – the Working Together Programme.							
	Note (✓)		*Discuss (✓)*		*Recommend (✓)*		*Approve (✓)*	
4. Key Issues	**Executive Summary** This paper comprises a highlight report from the Working Together Programme and three documents that set out the proposed programme governance approach between Dorset County Hospital and Dorset Healthcare. The additional documents govern how DCH and DHC will support: • greater integration and collaboration across DHC and DCH to deliver better outcomes for patients – the Memorandum of Understanding. • The sharing of information between DCH and DHC in support of greater collaboration – Data Sharing Agreement. • simplifying decision-making processes relating to the Working Together Programme and ensuring accountability to the DCH and DHC Boards of Directors – Working Together Committee Terms of Reference. **Memorandum of Understanding (MoU)** The Memorandum of Understanding establishes the priorities and principles for partnership working and the process for establishing operational arrangements and agreeing transformation priorities between Dorset County Hospital and Dorset Healthcare. This MoU set outs: • the purpose and principles for collaboration;								

	• the intent to establish programme arrangements; and • the agreement practicalities such as funding and information sharing. The intent of the MoU is not legally binding but aims to provide an overview of the key elements and principles of the agreement to collaborate between DCH and DHC. It is not intended to provide content or details which will be provided in a Strategic Outline Programme Case or equivalent. **Data Sharing Agreement** The Data Sharing Agreement accompanies the MoU and provides that only corporate data may be shared to support each of DCH and DHC's executive functions. Person identifiable information is not expected to be shared in respect to the Working Together Programme itself. The agreement acknowledges the future potential need to share person identifiable information in support of specific collaboration programmes and sets out that Data Protection Impact Assessments (DPIA) and Personal Information Sharing Agreements (PISA) may need to be drafted and approved separately to support these areas of work. **Working Together Committee Terms of Reference** A Working Together Committee is to be established to provide a line of communication and accountability to each of the DCH and DHC Boards of Directors in respect of the Working Together Programme. It is proposed that membership of this committee comprises the joint Chair and joint CEO, the Senior Responsible Officer for the Working Together Programme from each of DCH and DHC and Executive and Non-Executive membership from each of DCH and DHC. The committee will operate as a committee in common (a committee of the DCH Board of Directors and a committee of the DHC Board of Directors, meeting together as a committee in common to reach consensus and simplify decision making). Members of each of DCH and DHC committee will have delegated authority to make decisions in respect of the Working Together Programme on behalf of each of DCH and DHC Board of Directors as set out in the Terms of Reference. More information about committees in common can be found Here. **These three documents are presented to the DCH and DHC Boards of Directors for approval.**
5. Action recommended	The Boards of Directors is requested to **note** the Working Together Programme Highlight Report and **approve** the: • Memorandum of Understanding • Data Sharing Agreement • Working Together Committee Terms of Reference.

6. Governance and Compliance Obligations			
Legal / Regulatory Link	**Yes**		*Having robust and transparent programme governance arrangements in place will ensure that both DCH and DHC continue to meet their license and other regulatory compliance conditions.*
Impact on CQC Standards	**Yes**		*Contributes to effective governance and meets the Well Led requirements.*
Risk Link	**Yes**		*The Working Together Committee will support the Working Together Programme, simplifying decision making and ensuring accountability to the DCH and DHC Boards of Directors. The Working Together Programme supports delivery of the strategic programme aims and mitigation of risks to the effective integration, collaboration and transformation workstreams.*
Impact on Social Value	**Yes**		*The Working Together Programme aims to optimise opportunities to promote social value and address health inequalities.*
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 Working Together Programme supports multiagency working, mutual aid and new ways of working.*		
	Place	*The Working Together Programme. supports Place Based Partnerships and collaborative multiagency working.*		
	Partnership	*The Working Together Programme. supports Place Based Partnerships and collaborative multiagency working.*		
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**		*The Working Together Programme aims to address these issues for the benefit of residents and patients.*
Tackling unequal outcomes and access		**Yes**		*The Working Together Programme aims to address these issues for the benefit of residents and patients.*
Enhancing productivity and value for money		**Yes**		*The Working Together Programme aims to address these issues for the benefit of residents and patients.*
Helping the NHS to support broader social and economic development		**Yes**		*The Working Together Programme aims to address these issues for the benefit of residents and 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**	

NHS
Dorset HealthCare
University
NHS Foundation Trust

NHS
Dorset County Hospital
NHS Foundation Trust

MEMORANDUM OF UNDERSTANDING

between

Dorset County Hospital NHS Foundation Trust

and

Dorset HealthCare University NHS Foundation Trust

the priorities and principles for

partnership working

and

the process for establishing operational

arrangements and agreeing transformation

priorities.

1. Parties

1.1 This Memorandum of Understanding (MOU) is made on [date] between:

- Dorset County Hospital NHS Foundation Trust of Williams Avenue, Dorchester, Dorset DT1 2JY (**DCH**); and
- Dorset HealthCare University NHS Foundation Trust of Sentinel House, 4-6 Nuffield Road, Poole, Dorset BH17 0RB (**DHC**).

1.2 DCH provides acute care and a full range of district general hospital services, including emergency department, critical care and maternity services to around 250,000 people in the west of Dorset and renal services for approximately 850,000 patients throughout Dorset and South Somerset. It has an annual budget of £256 million and approximately 3,500 staff. It has strong links with satellite services in Dorset's community hospitals operated by DHC.

1.3 DHC is a large, varied and geographically spread organisation providing physical, mental health and learning disability services to 800,000 residents of Dorset and Hampshire, including people who are also served by DCH. It has facilities on over 300 sites, including 12 community hospitals and five mental health units. DHC employs around 6,800 staff has an annual budget of £342 million.

1.4 DHC and DCH are partners within Dorset's integrated care system (**ICS**), Our Dorset, which brings together the health and care services in Dorset, with the aim to remove barriers between services so people can access the support and care they need from NHS and social care services when they need it.

2 Background and Context

2.1 On 7 September 2022 the boards of directors of DCH and DHC agreed to establish a joint leadership model through the recruitment of both a joint chief executive officer (**CEO**) and a joint chair for DCH and DHC. This followed discussions between the leadership of DCH and DHC over a period of six months, which included commissioning external advisory support to examine the case for greater collaboration between DCH and DHC and meetings and communications with staff and stakeholders including NHS England South West regional team, NHS Dorset Integrated Care Board, Bournemouth, Christchurch and Poole Council, Dorset Council and University Hospitals Dorset NHS Foundation Trust.

2.2 The aim of the joint leadership model was to improve the delivery of care to communities by helping to reduce variation and improve quality with the objective of providing responsive, high-quality healthcare for local people with a focus on:

- prevention of ill health;
- tackling health inequalities;
- parity of esteem and better integration between physical and mental health; and
- joined-up workforce planning and development.

2.3 This approach recognises that the challenges faced by health and care providers can be better dealt with by working in partnership and building on existing strong partnership working and learning from our collective response in Dorset to the challenges presented by the pandemic and the vision for the Dorset Integrated Care System as set out in Dorset Integrated Care Partnership's Strategy for Dorset.

3 This MoU

3.1 This MoU set outs:

- the purpose and principles for collaboration;
- the intent to establish programme arrangements; and
- the agreement practicalities such as funding and information sharing.

3.2 The intent of this MoU is to provide an overview of the key elements of the agreement to collaborate between DCH and DHC. It is not intended to provide content or details which will be provided in a Strategic Outline Programme Case or equivalent.

3.3 This MoU is not intended to be legally binding. It describes the understanding that has been reached between DCH and DHC and has been approved by the boards of directors of both DCH and DHC.

3.4 This MoU will sit alongside existing legal and regulatory frameworks that apply to NHS foundation trusts and the individual constitutions of DCH and DHC. The board of directors of each of DCH and DHC will retain responsibility for exercising all powers of the individual trusts subject to delegation in accordance with their respective constitutions under the leadership of a joint chair.

4 Purpose

4.1 The joint arrangements between DCH and DHC aim to create a partnership strengthened by shared leadership, that will drive a more integrated approach to quality of care and patient experience, by improving joint working and simplifying decision-making.

4.2 In line with strategic objectives identified by DCH and DHC, the Integrated Care Partnership strategy for Dorset and nationally, DCH and DHC will seek to deliver in key areas including:

- taking a preventative approach to wellbeing and ill health in the first place;
- care enabled by patient self-management, better partnership working and integration across public services including the NHS;
- supporting a needs-based, patient-focus approach; delivering care where it is needed, by the most suitable team in the most appropriate setting to facilitate improved lifetime outcomes;
- tackling health inequalities and ensuring everyone has the same excellent access and experience of care and services regardless of postcode or demography;
- encouraging a parity of esteem across mental and physical health through integrating the offering for patients;
- focussing on staff wellbeing including driving diverse career opportunities to encourage retention and recruitment of the best local talent; and
- working together more and working together better to serve as a conduit for improved system working with partners at all levels.

4.3 To support the delivery in these areas DCH and DHC will:

- appoint to the roles of joint CEO and joint chair for DCH and DHC and enter into agreements with the individuals in those roles and/or each other to facilitate their effective joint working and remuneration;
- in addition to the overall aim of reducing variation and improving the quality of care through the delivery of responsive, high-quality healthcare for local people; define a series of clear objectives and benefits against which the success of the collaboration can be measured and reported;
- ensure that any potential conflicts of interest arising as a result of the appointment of a joint CEO and joint chair are declared and managed appropriately and authorised by the board of directors of each of DCH and DHC in a way that facilitates the Trusts working together and sharing of information and the full participation of the joint CEO and joint chair in decision-making;
- continue to engage with stakeholders in a coordinated and proactive way defined by a joint partner impact assessment;
- identify ongoing opportunities for the leadership of both organisations to come together and develop through joint meetings of executive teams, members of the boards of directors, non-executive directors and governors; and
- establish a programme with appropriate and proportionate governance and appropriate resources to support successful and meaningful partnership and the delivery of shared objectives.

5 Underpinning Principles

5.1 DCH and DHC will, individually and together, continue to work as partners in the Dorset ICS to deliver the integrated care partnership strategy and the five-year delivery plan agreed with partners in the Dorset ICS and as members of Dorset Health and Care Partnership, NHS Dorset Integrated Care Board and Our Dorset Provider Collaborative.

5.2 DCH and DHC will adopt the values of the Dorset ICS in their partnership working:

- **Working together with people and communities**. We will co-design and co-produce services with the people and communities of Dorset, putting them at the heart of decision-making, governance, service planning and delivery to improve outcomes and experience. https://nhsdorset.nhs.uk/wp-content/uploads/2022/06/working-together-with-people-and-communities.pdf
- **Respect, dignity and inclusion**. We value every person – whether patient, their families or carers, or staff - as an individual. We respect their differences, their aspirations and commitments in life, and seek to understand their priorities, needs, abilities and limits. We will be inclusive.
- **Commitment to quality of care**. We earn the trust placed in us by insisting on quality and striving to get the basics of quality of care – safety, effectiveness and patient experience – right every time.

- **Compassion**. We ensure that compassion is central to the care we provide and respond with humanity and kindness to each person's pain, distress, anxiety or need.

- **Improving lives**. We strive to improve health and wellbeing and people's experiences of the NHS.

- **Everyone counts**. We maximise our resources for the benefit of the whole community, and make sure nobody is excluded, discriminated against, or left behind.

6 Programme Arrangements

6.1 A programme board with appropriate and proportionate programme and project governance and products will be established to deliver the vision, aims and objectives.

6.2 The boards of directors of DCH and DHC may decide to establish committees in common to have oversight of and support the work of the programme board and/or project team.

6.3 Any powers currently exercisable by the board of directors of each of DCH and DHC, committees of those boards of directors or individual executive directors will continue to be exercisable in this way and any delegation of powers to support the collaboration will require approval by the appropriate board of directors.

7 Information Sharing and Confidentiality

7.1 DCH and DHC agree to facilitate information sharing to support the objectives of their partnership working in accordance with applicable legislation and guidance. DCH and DHC will enter into a separate information sharing agreement governing the sharing of information for this purpose. This is attached as an Annex to this MoU.

7.2 Each of DCH and DHC will respect the confidentiality of the other's information, taking all reasonable precautions to prevent any third party (other than employees, agents or consultants under a similar duty of confidentiality) from having access to it.

7.3 Neither DCH or DHC will use the other's confidential information for any other purpose than in connection with this MoU and delivering the benefits and objectives of their partnership working.

7.4 Where either DCH or DHC receives a request under the Freedom of Information Act 2000 or Environmental Information Regulations 2004 for confidential information disclosed to it by the other, it will immediately notify the other and DCH and DHC will work together to agree a response while recognising the decision about what to disclose and whether information is exempt from disclosure must be made by the organisation receiving the request for information.

8 Monitoring delivery of this MoU

8.1 DCH and DHC recognise the need to review the scope and nature of their partnership working on a regular basis, and that they will need to be flexible and responsive to changes in circumstances locally and nationally.

8.2 The programme board will monitor delivery of this MoU and the risks to delivery on an ongoing basis, escalating any concerns and agreeing a recovery plan with the joint CEO. Should the recovery plan fail to resolve the issue, the concerns will be escalated to the board of directors of each of DCH and DHC.

8.3 The board of directors of each of DCH and DHC will receive regular updates on the progress and delivery of the Working Together Programme and carry out a more detailed assessment of their partnership relationship annually.

9 Funding

9.1 DHC and DCH have committed to funding the remuneration for the joint CEO and joint chair in equal proportions.

9.2 This MoU does not represent a commitment to other funding, although both DCH and DHC commit to release reasonable resources as required on an equitable basis to deliver the expected benefits.

10 Duration and Review Periods

10.1 This MoU will become effective on the date of signature and will remain in effect until terminated by any one of DCH or DHC or by mutual consent.

10.2 A review will take place on or around every anniversary of the MoU coming in to effect. This review will be undertaken jointly. The outcome of the review, including any proposed amendments, will be reported to the boards of directors of DCH and DHC.

10.3 This MoU can be terminated by either DCH or DHC or by mutual consent, provided the following process has been followed:

- executive directors from both DCH and DHC have worked together in an attempt to address the matters giving rise to the request to terminate;
- the termination will be authorised by the board of directors of either DCH or DHC or both (as applicable) and will be made in writing and provide for a minimum period of 6 months' notice prior to the termination date;
- a termination programme will be overseen by the programme board and subject to the terms and conditions of the agreements with the individuals in the joint CEO and joint chair roles; and
- the programme board will identify any confidential information relating to either DCH or DHC held by the other and agree arrangements for returning such information or removing it from computers or other devices.

10.4 This MoU may only be varied by written agreement of both parties, following review and approval by the boards of directors of both DCH and DHC.

11 Signatories to this MoU

11.1 Each signatory to this MoU has been authorised to sign the MoU by the board of directors of their respective organisation.

Name	
Position	
Organisation	
Address	
E-mail	
Signature	

Name	
Position	
Organisation	
Address	
E-mail	
Signature	

NHS
Dorset County Hospital
NHS Foundation Trust

NHS
Dorset HealthCare
University
NHS Foundation Trust

2023 Working Together Programme - Data Sharing Agreement

Between **Dorset County Hospital NHS Foundation Trust**

and

Dorset HealthCare University NHS Foundation Trust

THIS AGREEMENT is made on [insert date]

Between **Dorset County Hospital NHS Foundation Trust (DCH)** and **Dorset HealthCare University NHS Foundation Trust (DHC)**

This Data Sharing Agreement is to accompany the Memorandum of Understanding that was agreed by the DCH/DHC Working Together Programme Board on 20 June 2023 and recommended to the board of directors of each of DCH and DHC (the **Boards**).

Definitions – see Annex A

1. **Purpose, objectives of the data sharing:**
   Only corporate data may be shared at outset to align both organisation's executive function and further the aims of the Working Together Programme as described in the Working Together Memorandum of Understanding. Whilst corporately specific sensitive information may be shared between the two organisations, person identifiable information is not expected to be shared in respect of the Working Together Programme itself. Identifiable information may need to be exchanged in the future to support some of the specific programmes of work that will sit underneath the overall programme of work - in these instances any sharing of identifiable information must be lawful, and proportionate. The Data Protection Officers (DPO) for each Trust must be approached for guidance and support. If required Data Protection Impact Assessments (DPIA) and Personal Information Sharing Agreements (PISA) may need to be drafted and approved.

   As the programme develops, there are likely to be three levels of data sharing:

   Strategic - Data would be non-identifiable by patient or staff, however, it may include statistical numbers and high level anonymised or pseudonymised data
   Operational - At this level there is the potential for the data to be identifiable data for staff (for example exploring opportunities for staff development or improved staff structures). Patient identifiable data is less likely; and at an operational level this should be anonymised.
   Front-line care - As teams develop integrated working around shared patients, professionals will need to share patient level data to improve the pathway of care for individuals.

2. **Data Controller(s)**
   The organisations are joint data controllers

3. **How will the data sharing be carried out?**
   Describe the method to share corporate data – email addresses? Cloud? Teams?

   Whilst the listed options above will be covered by existing IT and Data Protection systems and protocols, any different methodologies for sharing information may be required to be assessed for cyber security, compatibility and Data Protection. A DPIA may be required if identifiable data is to be shared using any new technology.

4. Subject Rights

Each organisation will be responsible for responding to individual subject rights requests such as Data Subject Access Requests of FOI Requests. Where there is a jointly provided source of data, the lead organisation where a request is received will work with the other party to ensure that the request is answered fully and lawfully where appropriate and that any exemptions or refusal to provide data are applied, and that both parties agree with the response.

5. Retention period

NHS Records Management Code of Practice 2021 applies to all corporate records.

6. Each organisation signed up to this agreement will:

- comply with its obligations under UK Data Protection Legislation, the Freedom of Information Act 2000 and The Environmental Information Regulations 2004 and comply with data guidance. The Parties acknowledge that once a Party has received data under this agreement it will be responsible for ensuring that its own processing of that data complies with this clause.
- use the information shared solely for the purposes identified and shall not process the information for any other purposes.
- agree to treat the data received by them under the terms of this agreement as confidential and shall safeguard it accordingly. Respect for the privacy of individuals will be afforded at all stages of processing.
- notify the other parties to this agreement of any breach of this agreement in particular connected to the sharing of information under this agreement within 24 hours of first suspecting the breach. This obligation extends to breaches concerning the systems on which the data shared under this agreement are held, even if the data shared under this agreement is not directly affected.
- notify the other parties to this agreement of any complaint received from any person about the sharing of data under this agreement or any correspondence from the Information Commissioner's Office or other regulator regarding the sharing of data under this agreement; and
- assist each other, in responding to requests made under the Freedom of Information Act 2000 or The Environmental Information Regulations 2004 in relation to the information shared under this agreement to ensure a co-ordinated and consistent response.

7. Future data sharing

When data sharing occurs, the following areas will need to be considered for each activity:

- Data Protection Impact Assessment (DPIA)
- Legal powers for processing the data/information
- Privacy notices – articles 13 and 14
- Data items to be processed
- Article 6 condition – all Personal Data
- Article 9 condition – special categories of Personal Data
- Compliance with confidentiality and privacy rights
- Common law duty of confidentiality

8. Data Protection Officers

Dorset County Hospital NHS Foundation Trust - Diane Gravett,
informationgovernance@dchft.nhs.uk

Dorset HealthCare University NHS Foundation Trust - Dave Way,
dhc.informationgovernance@nhs.net

9. Commencement of agreement

This agreement will commence on approval of this document by the Boards of Dorset County Hospital NHS Foundation Trust and Dorset HealthCare University NHS Foundation Trust.

10. Lifecycle of agreement

As operating models are developed this document must be reviewed and expanded on where necessary.

The corporate governance teams in both organisations should ensure that the agreement is reviewed at each change, and annually as a minimum ongoing. There must be one single named individual who takes responsibility for the document.

Both Boards must approve the framework agreement.

Should the joint leadership system between organisations cease both parties will retain any data in line with the retention polices as outlined at point 5.

11. Review of agreement

As this is a developing project, this agreement will be reviewed within 12 months of approval by both DCH and DHC Boards.

12. Person responsible for the development and review of this agreement

Matthew Bryant, joint Chief Executive Officer for Dorset County Hospital NHS Foundation Trust and Dorset HealthCare University NHS Foundation Trust will be the responsible person for the development and review of this document. Review this agreement will be discharged jointly by the Corporate Governance teams within Dorset County Hospital NHS Foundation Trust and Dorset HealthCare University NHS Foundation Trust.

13. Termination

Either party may terminate this agreement by serving six months' notice of their intention to cease collaborative working and sharing of the respective Board Chair and or Chief Executive Officer roles between DCH and DHC. Where both Trusts have shared data, they undertake to return or destroy any data that both parties agree is unique and sensitive to either party on cessation of the agreement. Where the retention of shared data is required for each party under NHS Data Retention Polices, both parties will undertake to securely hold for the required retention period any data that needs to be retained and undertake to destroy said data on reaching the end of any retention periods.

Data Sharing Agreement

Signatures

Signed for and on behalf of:

Dorset County Hospital NHS Foundation Trust
Williams Avenue
Dorchester
Dorset
DT1 2JY

Name: Dawn Dawson

Signature:

Role: Caldicott Guardian:

Date:

Signed for and on behalf of:

Dorset HealthCare University NHS Foundation Trust
Sentinel House
4-6 Nuffield Road Industrial Estate
Poole
Dorset
BH17 0RB

Name: Alastair Hutchison

Signature:

Role: Caldicott Guardian

Date:

Annex A

Definitions

In this agreement the following words have the following meanings:

Business Day	means a day other than a Saturday, Sunday, or public holiday in England when banks in London are open for business
Controller	shall take the meaning given in the Data Protection Legislation
Data Guidance	means any applicable guidance, guidelines, direction or determination, framework, code of practice, standard or requirement regarding information governance confidentiality, privacy or compliance with the Data Protection Legislation (whether specifically mentioned in this agreement or not) to the extent published and publicly available or their existence or contents have been notified to the Supplier by NHS England and/or any relevant Regulatory or Supervisory Body. This includes, but is not limited to, guidance issued by NHS England, the National Data Guardian for Health & Care, the Department of Health, the Health Research Authority, Public Health England, and the Information Commissioner's Office
Data Privacy Impact Assessment (DPIA)	shall take the meaning given in the Data Protection Legislation
Data Protection Legislation	means (i) the Data Protection Act 2018 (ii) the General Data Protection Regulation (GDPR), the Law Enforcement Directive and any applicable national Laws implementing them as amended from time to time (iii) the UK GDPR (iv) all applicable law concerning privacy, confidentiality or the Processing of Personal Data including but not limited to the Human Rights Act 1998, the Health and Social Care (Safety and Quality) Act 2015, the common law duty of confidentiality and the Privacy and Electronic Communications (EC Directive) Regulations
Data Protection Officer or DPO	shall take the meaning given in the Data Protection Legislation
Data Subject	shall take the meaning given in the Data Protection Legislation
Joint Controller	shall take the meaning given in the Data Protection Legislation
Party	means a party to this agreement
Personal Data	shall take the meaning given in the Data Protection Legislation
Process	shall take the meaning given in the Data Protection Legislation
Processor	shall take the meaning given in the Data Protection Legislation
Regulatory or Supervisory Body	means any statutory or other body having authority to issue guidance, standards or recommendations with which the relevant Party and/or Staff must comply or to which it or they must have regard, including: (a) Care Quality Commission (CQC) (c) NHS England (d) Department of Health and Social Care (e) NICE (f) Healthwatch England and Local Healthwatch (g) UK Health Security Agency (h) General Pharmaceutical Council (i) Healthcare Safety Investigation Branch (j) Information Commissioner's Office (k) European Data Protection Board

Special Categories of Personal Data	As defined in Article 9 of the UK GDPR - personal data revealing: (a) racial or ethnic origin (b) political opinions (c) religious or philosophical beliefs (d) trade union membership (e) genetic data or biometric data identifying a natural person (f) data concerning health (g) data concerning a natural person's sex life or sexual orientation

(a) Reference to any legislative provision shall be deemed to include any statutory instrument, by-law, regulation, rule, subordinate or delegated legislation or order and any rules and regulations which are made under it, and any subsequent re-enactment, amendment, or replacement of the same.

(b) The annexes form part of this agreement and shall have effect as if set out in full in the body of this agreement. Any reference to this agreement includes the annexes.

(c) References to clauses and annexes are to be clauses and annexes to this agreement

Terms of Reference
DCH and DHC Working Together Committee

1. Constitution

1.1. On 7 September 2022 the Boards of Directors of Dorset County Hospital (**DCH**) and Dorset HealthCare University (**DHC**) NHS Foundation Trusts agreed to establish a joint leadership model through the recruitment of both a joint Chief Executive Officer (**CEO**) and a joint Chair for DCH and DHC.

1.2. The Board of Directors of each of DCH and DHC (each a **Board** and together, the **Boards**) have agreed to establish a committee to operate as a committee in common with the corresponding committee of the other trust, which will be collectively known as the Working Together Committee (the **Committee**). The committee established by the Board of each of DCH and DHC will vote and take decisions independently on behalf the Board of DCH and DHC, as applicable, working collaboratively to reach decisions by consensus with the committee from the other trust.

1.3. The membership of the Committee will comprise both Non-Executive Directors and Executive Directors from the DCH and DHC Boards.

1.4. The Committee has no executive powers other than those specifically delegated to it in these terms of reference.

2. Authority

2.1. The members of the Committee from the DCH Board have delegated authority to act on behalf of the DCH Board and the members of the Committee from the DHC Board have delegated authority to act on behalf of the DHC Board, in each case as described in section 7 (Duties of the Committee) below. The Joint Chair and Joint CEO will have delegated authority from both Boards as members of the committee established by the Board of each of DCH and DHC.

2.2. The Committee is empowered to investigate any activity within these terms of reference, and to seek any information it requires from staff, who should co-operate with any request from the Committee.

2.3. The Committee is authorised by the DCH and DHC Boards to obtain independent legal and professional advice. The costs of obtaining this advice will be shared equally by DCH and DHC.

2.4. Financial decisions will be referred to the appropriate Executive Directors or DCH and DHC Board committees and/or the respective Boards for approval.

Purpose

2.5. The Committee is established in order to strengthen collaboration, promote integration and to simplify decision-making relating to the collaboration and integration programme (the **Working Together Programme**) for the benefit of patient care and experience and population health.

2.6. The purpose of the Committee is to maintain oversight of the Working Together Programme; scrutinising delivery of programme aims, objectives, strategy outcomes and expected patient and organisational benefits in order to provide assurance to the DCH and DHC Boards that risks to delivery of the programme are being managed appropriately and goals are being achieved.

2.7. The Committee will provide a decision-making forum on behalf of DCH and DHC Boards in respect of the Working Together Programme. The Committee will approve programme initiatives and seek assurances that all aspects of programme governance, patient safety, experience and the expected benefits are subject to scrutiny and are being met on behalf of the DCH and DHC Boards regarding the programme aims of:

2.7.1. prevention of ill health;
2.7.2. tackling health inequalities;
2.7.3. parity of esteem and better integration between physical and mental health; and
2.7.4. joined-up workforce planning and development.

3. Membership

3.1. Membership of the Committee will be appointed by the DCH and DHC Boards and will have a majority of Non-Executive Directors as members. The Committee will comprise:

3.1.1. Joint Chair (DCH and DHC);
3.1.2. Joint CEO (DCH and DHC);
3.1.3. Vice Chair (DCH);
3.1.4. One Non-Executive Director (DCH);
3.1.5. Two Non-Executive Directors (DHC);
3.1.6. Deputy CEO (DCH) (Executive Director and joint Senior Responsible Officer for the Working Together Programme);
3.1.7. Chief Nursing Officer (DHC) (Executive Director and joint Senior Responsible Officer for the Working Together Programme);
3.1.8. One clinical Executive Director (DCH); and
3.1.9. Chief Medical Officer (DHC).

3.2. The chair of the Committee will be the joint Chair of DCH and DHC (the **Committee Chair**). In the absence of the Committee Chair, a Non-Executive Director from each of DCH and DHC will chair the committee of their respective trust (separate chairs for the DCH committee and DHC committee) and the meeting (jointly chairing the committees meeting in common).

3.3. Only members of the Committee have the right to attend and vote at Committee meetings. Members of Committee from the DCH Board will be entitled to attend and vote as members of the committee established by the DCH Board and members of the committee of the DHC Board will be entitled to attend and vote as members of the committee established by the DHC Board. Each member will have one vote.

4. Attendees

4.1. The following will be invited to attend meetings of the Committee on a regular basis:
- 4.1.1. Head of Corporate Governance (DCH);
- 4.1.2. Director of Corporate Governance (DHC); and
- 4.1.3. Working Together Programme Manager.

4.2. Other directors and officers of DCH and DHC may be required to attend all or part of any meeting, as and when appropriate and necessary, particularly when the Committee is considering areas of the Working Together Programme that are the responsibility of a particular area, manager or individual.

4.3. Individuals from outside DCH and DHC with relevant experience and expertise and independent advisers may be invited to attend meetings of the Committee to assist the Committee in its consideration of the Working Together Programme or workstreams, where it considers this necessary.

5. Deputies

5.1. Members of the Committee should aim to attend every meeting and should attend at least half of all meetings held in each financial year.

5.2. Members are expected to nominate suitable deputies to attend Committee meetings in their place should circumstances prevent members' own attendance. Members should notify the Committee Chair if a deputy is attending the meeting on their behalf.

5.3. Deputies will not count in the quorum or be able to vote at meetings of the Committee unless they are a Non-Executive Director or Executive Director of DCH or DHC.

6. Quorum

6.1. The quorum for the Committee will be six members (three from each of DCH and DHC), including at least one Non-Executive Director and one Executive Director from each of DCH and DHC.

6.2. Members of Committee from the DCH Board will count in the quorum of the committee established by the DCH Board and members of the DHC Board will count in the quorum of the committee established by the DHC Board.

6.3. A duly convened meeting of the Committee at which a quorum is present will be competent to exercise all or any of the authorities, powers and duties vested in or exercised by the Committee, operating as a committee in common.

Frequency of Meetings

6.4. The Committee will meet as a committee in common not less than six times in each financial year. The Committee Chair may convene additional meetings as they deem necessary.

7. Duties of the Committee

7.1. The Committee has the following duties and functions:

7.1.1. Ensure the implementation of all duties and obligation within the agreed Memorandum of Understanding, including overseeing the review process.

7.1.2. To receive and review the overall Working Together Programme that will identify and deliver collaborative working practices across DCH and DHC.

7.1.3. Identify opportunities for improving resilience and optimising the use of resources, productivity and efficiency across both organisations.

7.1.4. Agree workstreams and monitor delivery of the same through key workstream metrics.

7.1.5. Review exception reports and action plans for those targets and indicators where delivery is at risk.

7.1.6. Scrutinise risks and mitigations to delivery of the strategic aims of the Working Together Programme, reporting or escalating these to DCH and DHC Boards.

7.1.7. Ensure that stakeholders, both internal and external, are actively engaged in identifying areas for greater integration and can improve population health, address inequality, improve patient experience and provide excellent value for money.

7.1.8. Ensure that stakeholders, both internal and external, are actively engaged in and are supported in the co-design and implementation of transformational change programmes.

7.1.9. Approve transformational change programmes within the delegated remit of the Committee.

7.1.10. Ensure consistency of approach with place-based partnerships, the Our Dorset Provider Collaborative and the Dorset Integrated Care Partnership.

7.1.11. Identify capture, report and share areas of good practice, benefits realised and learning across both organisations and with key partners and stakeholders.

7.1.12. Approve the alignment of policy where this could reduce duplication of effort, reduce costs or simplify decision-making.

8. Reporting

8.1. The Committee Chair will report in writing to the DCH and DHC Boards at the meetings that follows the Committee meeting. This report will summarise the main

issues of discussion and the Committee Chair will ensure that attention is drawn to any issues, risks or decisions that require escalation to DCH or DHC Boards for action or decision, with a recommendation from the Committee.

8.2. The Committee will receive highlight reports from the Collaboration Programme Board setting out progress and delivery of the programme plan.

9. Administration of Meetings

9.1. Meetings of the Committee will be convened by the secretary of the Committee at the request of the Committee Chair.

9.2. Meetings may be held at such times and places as the Committee Chair may determine and may be held in person, by telephone or using video or computer links.

9.3. The agenda of items to be discussed at the meeting will be agreed by the Committee Chair with support from the [Joint CEO]. The agenda and supporting papers will be distributed to each member of the Committee and the regular attendees, no later than [five] days before the date of the meeting. Distribution of any papers after this deadline will require the agreement of the Committee Chair.

9.4. The Head of Corporate Governance at DCH and Director of Corporate Governance at DHC or their nominee will act as secretary of the Committee. The secretary of the Committee will minute the proceedings of all meetings of the Committee, including recording the names of those present and in attendance and any declarations of interest.

9.5. Draft minutes of Committee meetings and a separate record of the actions to be taken forward will be circulated promptly to all members of the Committee.

10. Declarations of Interest

10.1. All members and attendees of the Committee must declare any relevant actual or potential conflicts of interests, whether professional or personal, financial or non-financial at the commencement of any meeting.

10.2. The Committee Chair will determine if there is a conflict of interest such that the member and/or attendee will be required to not participate in a discussion or otherwise limit their involvement in the meeting or their ability to count in the quorum.

10.3. Where the Committee Chair considers an item of its business may give rise to a potential conflict by meeting in common, the Committee may refer that business to the Boards of DCH and DHC.

11. Review of Terms of Reference and Appraisal of Performance and Effectiveness

11.1. At least once a year the Committee will review these terms of reference. Any proposed changes to the terms of reference will be recommended to the Boards of each of DCH and DHC for approval.

11.2. The Committee will annually appraise its performance and effectiveness in fulfilling the duties set out in these terms of reference and supporting the Working Together Programme goals and will report the results of this review to the DCH and DHC Boards.

Approved by the Working Together Committee on Date 2023

Ratified by the DCH Board of Directors on Date 2023

Ratified by the DHC Board of Directors on Date 2023

Report Front Sheet

1. Report Details			
Meeting Title:	Board of Directors, Part 1		
Date of Meeting:	26 July 2023		
Document Title:	**Medical Revalidation Annual Report**		
Responsible Director:	Alastair Hutchison, Chief Medical Officer	Date of Executive Approval	01/06/23
Author:	Dr Julie Doherty, Responsible Officer		
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	19 June 2023	Approved

3. Purpose of the Paper	In line with the Framework of Quality Assurance (FQA) for Responsible Officers and Revalidation the Trust is required to submit an annual report and statement of compliance, approved by the Trust Board and signed by the CEO prior to submission to NHSE/I. This report is relevant to all Doctors excluding Doctors in Training.							
	Note (✓)	✓	*Discuss (✓)*		*Recommend (✓)*		*Approve (✓)*	✓

4. Executive Summary	All doctors are required to have an annual appraisal that covers a doctor's whole practice, which takes account of all relevant information relating to the doctor's fitness to practice (for their work carried out in the organisation and for work carried out for any other body in the appraisal period), including information about complaints, significant events and outlying clinical outcomes. The annual appraisal it a requirement of the 5-year revalidation cycle. The Trust continues to meet all statutory duties in relation to medical revalidation and Responsible Officer regulations. Of the 289 Drs connected to DCHFT at 31 March 2023, 259 were due to hold an appraisal in the time they remained connected. Of these 259: 243 held an appraisal (93.8%). Within this figure will be Drs whose appraisal was initially approved for postponement and subsequently held as well as those having a 'completed appraisal' in line with their appraisal anniversary. Of those not holding an appraisal: 11 had an approved missed / incomplete appraisal (4.2%) 5 had an unapproved missed appraisal (1.9%) 20 Doctors revalidated and two were deferred and rescheduled dates have been set. There were no cases deferred due to non-engagement.

	Within the last year a bid was submitted for funding of sufficient educational supervisors for Locally Employed Doctors (LEDs) to support their appraisal via an Annual Review of Competency Progression (ARCP) equivalent panel (where appropriate) The bid was successful, and the LED panel model is functioning effectively. Whilst overall appraisal compliance is above 90%, our main risk remains the number of appraisers; this is linked to capacity and funding. It should be noted that a doctor is not permitted to have the same appraiser for more than three consecutive years. There is a plan in place to ringfence funding for appraisal within the CMO budget, providing more clarity and facilitating appraiser activity within job plans.
5. Action recommended	The Board is asked to: 1. **NOTE and APPROVE** the Medical Revalidation Report.

6. Governance and Compliance Obligations				
Legal / Regulatory Link		**Yes**		Statement of Compliance to be signed by CEO once approved in preparation for submission to NHSE/I. RO holds statutory role in medical regulation.
Impact on CQC Standards		**Yes**		Well-led
Risk Link		**Yes**		Adhering to requirements of annual appraisals to support revalidation
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	RO is accountable for the local clinical governance processes, focusing on the conduct and performance of doctors, including evaluating a doctor's fitness to practise, and liaising with the GMC over relevant procedures.		
	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**	

Classification: Official

Publication reference: PR1844

NHS England

A framework of quality assurance for responsible officers and revalidation

Annex D – annual board report and statement of compliance

Version 1.1 Feb 2023

Contents

Introduction:

The Framework of Quality Assurance (FQA) for Responsible Officers and Revalidation was first published in April 2014 and comprised of the main FQA document and seven annexes A – G.

In 2019 a review of the Annual Organisational Audit (AOA), Board Report template and the Statement of Compliance concluded with a slimmed down version of the AOA (Annex C) and a revised Board Report template (Annex D), which was combined with the Statement of Compliance (previously listed as Annex E) for efficiency and simplicity.

The AOA exercise has been stood down since 2020, but has been adapted so that organisations have still been able to report on their appraisal rates.

Whilst a designated body with significant groups of doctors (e.g. consultants, SAS and locum doctors) will find it useful to maintain internal audit data of the appraisal rates in each group, the high-level overall rate requested in the table provided is enough information to demonstrate compliance.

The purpose of this Board Report template is to guide organisations by setting out the key requirements for compliance with regulations and key national guidance, and provides a format to review these requirements, so that the designated body can demonstrate not only basic compliance but continued improvement over time. Completion of the template will therefore:

a) help the designated body in its pursuit of quality improvement,
b) provide the necessary assurance to the higher-level responsible officer,
c) act as evidence for CQC inspections.

Designated Body Annual Board Report

Section 1 – General:

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

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

Action from last year: Nil Comments: : Dr Julie Doherty is the RO for DCHFT DCHFT has a split Chief Medical Officer (CMO) / RO role. This is managed by good communication and regular 1:1 meetings between the CMO and RO. Professor Alastair Hutchison is the CMO. He has access to GMC Connect and there is resilience within the team should the RO be on unexpected or extended leave. We regularly review whether to continue with the split CMO / RO role. An alternative option that has been considered is for the RO role to be within the remit of the CMO and duties delegated to a revalidation officer. This arrangement is not thought to be the most appropriate for DCHFT at this time.

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

Yes Action from last year: Bid in progress for funding of sufficient educational supervisors for LED to support their appraisal via ARCP equivalent panel (where appropriate) Comments: Bid successful & LED Panel functioning effectively. There is still a challenge to recruiting new and sufficient appraisers. There is a plan in place to ringfence funding for appraisal within the CMO budget. Action for next year: Funding for appraisal within CMO budget providing more clarity and facilitating appraiser activity within job plans.

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

Action from last year:Nil

Comments: Compliant

Action for next year: nil

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

Action from last year: Nil

Comments: The Medical Appraisal Policy has been reviewed during 2022-23 with updates on appraisal process for As & When Drs and for LED (due to discontinuation of MAG4 form)

Action for next year: Complete the changes required to policy and seek ratification via LNC & PCC

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

Comments: DCHFT had an external visit from the HLRO NHSEI South West on 9 July 2019. Formal written feedback was not provided, verbal feedback was provided at the time of the review Action for next year: To invite the HLRO to conduct a visit during 2024

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

Action from last year: Nil Comments: Drs will be supported to engage in departmental governance & educational meetings. Internal Scope of Practice form being adapted for use to support provision of feedback for locums Medical Appraisal Policy reviewed & being updated in respect of appraisal offers and requirements for connection to DCHFT as their designated body Action for next year: Nil

Section 2a – Effective Appraisal

7.

All doctors in this organisation have an annual appraisal that covers a doctor's whole practice, which takes account of all relevant information relating to the doctor's fitness to practice (for their work carried out in the organisation and for work carried out for any other body in the appraisal period), including information about complaints, significant events and outlying clinical outcomes.[1]

[1] For organisations that have adopted the Appraisal 2020 model (recently updated aby the Academy of Medical Royal Colleges as the Medical Appraisal Guide 2022), there is a reduced requirement for preparation by the doctor and a greater emphasis on verbal reflection and discussion in appraisal meetings. Organisations might therefore choose to reflect on the impact of this change. Those

Action from last year:

Promote the use of the Appraisal 2020 model at quarterly appraiser meetings.

Awaiting further updates from NHSEI regarding appraisal templates for 2022

Comments: All Drs connected to DCHFT are expected to hold an annual appraisal. Appraisal rates are monitored with a view to continued improvement and a target of >90%. Reasons for missed / postponed appraisals are recorded (**Appendix 1**).

MAG4 is being discontinued and we are in the process of switching Drs using MAG4 to our electronic RMS (currently PReP IT for substantive medical staff). PReP IT now has the option for the new 2022 template.

Appraisal inputs & outputs are quality assured via audit.

Of the 289 Drs connected to DCHFT as at 31 March 2023 259 were due to hold an appraisal in the time they remained connected.

Of these 259:

243 held an appraisal (93.8%)

Of those not holding an appraisal:

11 had an approved missed / incomplete appraisal (4.2%)

5 had an unapproved missed appraisal (1.9%)

In addition to the 243 Drs holding a due appraisal, 3 of our connected Drs held their appraisal early

Action for next year: Continue to monitor appraisal rates. Continue QA of appraisal.

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

Action from last year:

organisations that have not yet moved to the revised model may want to describe their plans in this respect.

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

Comments:

The administrator for medical appraisal & revalidation monitors appraisal dates for those with a prescribed connection to DCHFT. There has been additional resource (a new member of staff recruited) to support the administrator tasks. Compliance with annual appraisal monitored and reviewed at the monthly appraisal meetings attended by the RO / CMO and appraisal lead. QA and governance overseen at RAGG. Reasons for missed / postponed appraisals are recorded via postponement forms with requests scrutinised via the RO or appraisal lead.

Liaison occurs between RO, CMO and DDs as well as the appraisal & revalidation administration team to determine how to best resource and implement monitoring of appraisal rates.

Action for next year: Ongoing review of process for scrutiny & monitoring of appraisal rates

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

Action from last year: Nil

Comments: The Medical Appraisal Policy has been reviewed during 2022-23 with updates on appraisal process for As & When Drs and for LED (due to discontinuation of MAG4 form)

Action for next year: Complete the changes required to policy and seek ratification via LNC & PCC

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

Action from last year: Facilitate the provision of an ES for all LED in a training grade equivalent role

Comments: Action completed and LED Panel functioning effectively. This has reduced the demand for medical appraisers whilst also benefitting LEDs.

Even so, there has been some turnover within appraiser numbers and some issues regarding remuneration within divisions to support senior Drs taking on the role of a medical appraiser despite their interest in doing so. The RO has met with the senior executive team to discuss the challenges and there is an agreement to ringfence funding for medical appraisal within the CMO budget.

Action for next year: Funding for medical appraisal within CMO budget for greater clarity and to facilitate appraiser role within agreed job plans

11. Medical appraisers participate in ongoing performance review and training/ development activities, to include attendance at appraisal network/development events, peer review and calibration of professional judgements (Quality Assurance of Medical Appraisers[2] or equivalent).

Action from last year: The appraisal lead recommended repeating the audit of 'quality of inputs to appraisal' (2022-2023) to look at trends and identify areas of improvement.

Comments: We hold quarterly appraiser meetings for peer support. The meetings are supplemented by a newsletter which includes updates from ROAN meetings and the GMC ELA. Appraisers attend formal update training every 3 years (with reminders when expired).

The RO and appraisal lead conduct audits for QA (inputs as above and via ASPAT) with feedback to appraisers individually. Appraisers are invited to meet with the RO should they wish face to face feedback or if there are any concerns regarding performance or feedback from appraisees.

Outcome of audit of quality of inputs to appraisal 2022/23:

A steady change noted in quality of documentation provided by appraisees – which may reflect the move to appraisal lite. Certain documentation is required to determine whether a Dr meets standards of good medical practice framework, for revalidation and to agree a PDP. Appraisers are reminded of an appraisal checklist which documents key supporting evidence to be discussed at appraisal.

Results were discussed at the quarterly appraisers meeting and via email to appraisers

Action for next year:

Continue regular audit for QA.

To continue to promote the value of appraisal amongst Drs.

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

To continue to seek IT / digital support for inputs to appraisal (currently limited by resource within the digital team)

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

Action from last year: 1. Repeat audit of quality of inputs to appraisal planned 2. Continue to monitor quality of appraisal output via ASPAT and feedback to appraisers 3. Self-Assessment (at RAGG) against Principles in 'Effective Clinical Governance for the Medical Profession' and make progress with actions from RAGG Comments: Inputs and outputs from Appraisal are quality assured as noted above. The Board receive an annual report on medical appraisal and revalidation. RAGG meeting during 2022 had not been as regular as scheduled due to workforce & capacity issues. RAGG last met on 19 /04 / 23. At that meeting we self assessed against Principle 2 of effective Clinical Governance for the Medical Profession and discussed the results of QA audits. Action for next year: Ongoing monitoring & QA of appraisal

Section 2b – Appraisal Data

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

Name of organisation:	
Total number of doctors with a prescribed connection as at 31 March 2023	**289**
Total number of appraisals undertaken between 1 April 2022 and 31 March 2023	**246**
Total number of appraisals not undertaken between 1 April 2022 and 31 March 2023	**43**
Total number of agreed exceptions	**38**

Section 3 – Recommendations to the GMC

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

Action from last year: Nil

Comments:

20 doctors revalidated this year.

There were 2 recommendations to defer revalidation due to insufficient evidence –relating to patient feedback not having been completed & 1 also due to colleague MSF incomplete. Of the 2 deferral recommendations 1 doctor subsequently revalidated and 1 is due for a recommendation to be made beyond 31 March 2023.

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

The RO makes the recommendation directly to the GMC via GMC Connect or PReP IT. All recommendations were submitted on time.

The number of deferrals due to incomplete patient feedback has started to reduce since reminders were issued to doctors to better ensure that patient feedback collection is started in good time to facilitate it being complete & available for reflection at their pre- revalidation appraisal.

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

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

Action for next year: Continue to submit recommendations to the GMC on time.

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

Action from last year: Nil

Comments:

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

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

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

Action for next year: Nil

Section 4 – Medical governance

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

Action from last year:Nil

Comments:

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

Copies of self – assessments available.

Action for next year:

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

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

Action from last year:

Update on progress for annual reviews

Comments:

It is believed that reintroducing annual review linked with job planning and appraisal for specialist grade and consultants would better ensure completion of internal scope of practice forms for appraisal as well as better linking PDPs to job plans. The previous proposed documentation to support such is likely too onerous and in some aspects repetitive and has been reconsidered. A pilot within Paediatrics has been proposed to demonstrate the ease with which an annual review could be conducted and not be too time consuming.

Relevant information is available to doctors for their appraisal but can be time consuming to collate. This places a burden on doctors and impacts their enthusiasm for and engagement with appraisal in some cases. Exploration of whether there are any digital solutions to better facilitate collation of incident reporting and complaints information to doctors has identified that at the current time the resource available to the digital team is insufficient to support such.

Whilst appraisal lite / 2022 template was intended to reduce the burden on Drs for appraisal it has not been consistently demonstrated to do so.

Action for next year: Look to identify ways to support Drs in collating supporting information and reduce the burden of appraisal. By this means we hope to change perception (reported by some Drs) of appraisal & enhance its value.

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

Action from last year: Nil

Comments:

Maintaining High Professional Standards is the approved policy used for responding to concerns.

Fitness to Practice issues are discussed at the RO / CMO / GMC ELA meetings which are held quarterly. The GMC ELA is available for informal / formal discussion by MS Teams / telephone between meetings.

Practitioner Performance Advice (PPA) service is an additional support for the CMO / deputy CMO (RO). Regular meetings are scheduled with the Trust's allocated advisor from PPA

Action for next year: Nil

4. The system for responding to concerns about a doctor in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group. Analysis includes numbers, type and outcome of concerns, as well as aspects such as consideration of protected characteristics of the doctors.[3]

Action from last year:

1. HR (with RO & CMO support) Audit of case investigation and management against standards in MHPS and GMC governance handbook
2. Evaluate progress of establishing a peer support group for case investigators at DCHFT

Comments:

Audit not yet commenced due to other priorities and workforce capacity in HR. We are aware of time delays in progress of case investigations under MHPS. We can experience delays in identifying a case investigator due to work capacity for internal case investigators meaning that we need to look externally.

Case investigation and case management training with UHD (University Hospitals Dorset) attended by DCH staff.

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

Analysis of 'Responding to Concerns' cases for 2022/23: See **appendix 2**

Action for next year:

Establish a peer support group for case investigators at DCHFT

Include protected characteristics in analysis reports

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

5. There is a process for transferring information and concerns quickly and effectively between the responsible officer in our organisation and other responsible officers (or persons with appropriate governance responsibility) about a) doctors connected to your organisation and who also work in other places, and b) doctors connected elsewhere but who also work in our organisation.[4]

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

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

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

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

Section 5 – Employment Checks

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

Action from last year: Nil

Comments:

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

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

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

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

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

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

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

Action for next year: Nil

Section 6 – Summary of comments, and overall conclusion

- **General review of actions since last Board report:**

  We have made good progress with establishing the LED Panel and thus improving educational / clinical supervision & appraisal for LED. This has to some extent improved our capacity for appraisal for consultant and Specialist grade Drs.

- **Actions still outstanding:**

  To establish peer support for case investigators.

- **Current Issues:**

  To ring fence funding for medical appraisal within the CMO budget

- **New Actions:**

  To include protected characteristics in analysis reports for 'responding to concerns'

  To invite a HLRO review of appraisal & revalidation at DCHFT during 2024

Overall conclusion:

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

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

Section 7 – Statement of Compliance:

The Board of Dorset County Hospital NHS FT has reviewed the content of this report and can confirm the organisation is compliant with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013).

Signed on behalf of the designated body

[(Chief executive or chairman (or executive if no board exists)]

Official name of designated body: Dorset County Hospital NHS Foundation Trust

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

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

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

NHS England
Skipton House
80 London Road
London
SE1 6LH

This publication can be made available in a number of other formats on request.

Publication reference: PR1844

Annual Report Template Appendix 1

Audit of all missed or incomplete appraisals audit

Doctor factors (total) as at end March 2023	**9**
Maternity leave during the majority of the 'appraisal due window'	2
Sickness absence during the majority of the 'appraisal due window'	1
Prolonged leave during the majority of the 'appraisal due window' (sabbatical)	1
Suspension during the majority of the 'appraisal due window'	1
New starter within 3 month of appraisal due date	
New starter more than 3 months from appraisal due date	
Postponed due to incomplete portfolio/insufficient supporting information:	4
Appraisal outputs not signed off by doctor within 28 days	
Lack of engagement of doctor	
Total Appraisals postponed: • **Special Circumstances:** • **Administrators long-term absence:** • **Study / Annual leave:**	**7** 4 2 1
Appraiser factors(total)	0
Unplanned absence of appraiser (approved late appraisal)	0
Appraisal outputs not signed off by appraiser within 28 days	0
Other appraiser factors (describe): Failure to agree appraisal date	
Organisational factors • **Organisational factors: includes work capacity**	**11**
Administration or management factors	0
Failure of electronic information systems	0
Insufficient numbers of trained appraisers	0
Other organisational factors (describe)	0

Annual Report Appendix 2

Audit of concerns about a doctor's practice

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

Concerns about a doctor's practice	Total
Number of doctors with concerns about their practice in the last 12 months leading to formal case investigation & case management (MHPS or equivalent) Explanatory note: Enter the total number of doctors with concerns in the last 12 months. It is recognised that there may be several types of concern but please record the primary concern	
Capability concerns (as the primary category) in the last 12 months	1
Conduct concerns (as the primary category) in the last 12 months	2
Health concerns (as the primary category) in the last 12 months	
Some Other Substantial Reason (as the primary category) in the last 12 months	1
Remediation/Reskilling/Retraining/Rehabilitation	
Numbers of doctors with whom the designated body has a prescribed connection as at 31 March 2023 who have undergone formal remediation between 1 April 2022 and 31 March 2023 *Formal remediation is a planned and managed programme of interventions or a single intervention e.g. coaching, retraining which is implemented as a consequence of a concern about a doctor's practice* *A doctor should be included here if they were undergoing remediation at any point during the year*	
Consultants (permanent employed staff including honorary contract holders, NHS and other government /public body staff)	1
Staff grade, associate specialist, specialty doctor (permanent employed staff including hospital practitioners, clinical assistants who do not have a prescribed connection elsewhere, NHS and other government /public body staff)	
Trainee: doctor on national postgraduate training scheme (for local education and training boards only; doctors on national training programmes)	
Temporary or short-term contract holders (temporary employed staff including locums who are directly employed, trust doctors, locums for service, clinical research fellows, trainees not on national training schemes, doctors with fixed-term employment contracts, etc) All Designated Bodies	
Other (including all responsible officers, and doctors registered with a locum agency, members of faculties/professional bodies, some management/leadership roles, research, civil service, other employed or contracted doctors, doctors in wholly independent practice, etc) All Designated Bodies	

Other Actions/Interventions	
Local Actions:	
Number of doctors who were suspended/excluded from practice between 1 April 2022 and 31 March 2023: Explanatory note: All suspensions which have been commenced or completed between 1 April and 31 March should be included	2
Duration of suspension: Explanatory note: All suspensions which have been commenced or completed between 1 April and 31 March should be included Less than 1 week 1 week to 1 month 1 – 3 months 3 - 6 months 6 - 12 months	 1 1
Number of doctors who have had local restrictions placed on their practice in the last 12 months?	2
GMC Actions: Number of doctors who:	Number
Were referred by the designated body to the GMC between 1 April and 31 March	1
Underwent or are currently undergoing GMC Fitness to Practice procedures between 1 April and 31 March	1
Had conditions placed on their practice by the GMC or undertakings agreed with the GMC between 1 April and 31 March	1
Had their registration/licence suspended by the GMC between 1 April and 31 March	
Were erased from the GMC register between 1 April and 31 March	
Practitioner Performance Advice Service actions:	Number
Number of doctors about whom the Practitioner Performance Advice Service (PPAS) has been contacted between 1 April and 31 March for advice or for assessment	4
Number of PPAS assessments performed	0

Revalidation ACTION PLAN

Area for development for DCHFT as RO service provider	Action	Responsibility	Timescale	Assurance	Progress (as at April 2023)
1. Improve appraisal rates (in line with peers)	i) Liaison with DD's, CD's and DM's to identify potential appraisers with agreed remuneration & resourced time for appraisers. ii) Meeting to be scheduled between RO / MD and Director of HR / Deputy Director HR to discuss contract for doctors at DCHFT (relating to appraisal requirements) iii) Review arrangements for acceptance of a prescribed connection and appraisal scheduling for short term contract / As &When Drs iv) Liaison with Care Group leads to improve their	RO with DD & DM RO / CMO / CPO RO / Revalidation administrator with HR advisor Appraisal Lead / CDs and service managers with HR admin support	i)Quarterly monitoring in line with NHSE returns ii)Complete iii)Complete iv)Partially complete as some departmental monitoring of appraisal rates include medical staff. Revised date Dec2021	Appraiser to doctor ratio nearer 1:6 Improving appraisal rates	i)Liaison with DD's & DM's ongoing to try to recruit more appraisers. New appraisers have undertaken training, however a similar number of appraisers have relinquished this role. Business case for LEDs access to ES/ CS ARCP equivalent Panels in place for specified LED following successful pilot. ii &iii)Meeting held and medical appraisal & revalidation policy updated. Discussions affirmed the contractual requirement for annual appraisal. No agreement or decision to take forward at

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

	‘contract of expectations’ iii) Review of contract to consider introduction of a minimum period of work per 6 or 12 month contract to support revalidation			Employment contract update Medical Appraisal & Revalidation Policy	Awaiting template locum exit forms from NHSE/I- not received thus in house development. Outcome: To adapt the scope of practice forms for use. ii) Contract of Expectation to be drawn up. Discussion held at Quarterly Appraiser meeting. Requires reminder at Care Group CG meetings to embed- Decided against CofE at RAGG 3 Nov 2021 iii)Updated medical appraisal & revalidation policy complete
Strengthen the governance & QA processes for appraisal & Revalidation	Introduction of a Revalidation & Appraisal Governance Group (RAGG)at DCHFT. TOR for such groups available via Regional network.	RO with Board / HR support	Jan 2020 Partially complete; revised date Dec 2020	RAGG TOR / minutes	RO & Exec team agreed expenses reimbursement for lay member. TOR written. First quorate meeting held 3 March 2021.

Consider how to improve the QA of case investigation and peer support to case investigators and case managers when responding to concerns about doctors	i) ii) iii)	Review the QA processes & support for case investigation & management in place at DCHFT Compile a list of trained case investigators and managers Liaise with neighbouring RO to determine interest in sharing resources and peer support	Head of People Services RO	June 2020 Partially complete; revised date June 2021	Audit of case investigation & management Buy in to NHS Resolution (PPAS) resources	HR team compiling list of trained case investigators & case managers The Trust had commissioned PPA (formally NCAS) to provide some onsite Case Investigator training in March 2020. Training postponed due to Coronavirus. Awaiting new date. 2 staff attended UHD training. RO to attend UHD case investigators peer group meeting Sept 2022- CMO attended. RO to explore peer support group for case investigators/ managers at DCH To formulate audit of case investigation & management against MHPS. Proposal for formal audit

					subsequently rejected in view of capacity and already an awareness of time slippage/ delay in MHPS processes. Will, as part of annual board report, in future include 'protected characteristics in analysis report on 'responding to concerns'
I confirm that the action plan above has been discussed and agreed with my Board or equivalent		*Responsible officer - Signature & Date*			

Report Front Sheet

1. Report Details			
Meeting Title:	Board of Directors, Part 1		
Date of Meeting:	26th July 2023		
Document Title:	Digital Services Quarterly Workforce Report		
Responsible Director:	Ruth Gardiner, Interim Chief Information Officer	Date of Executive Approval	14/07/2023 (RG)
Author:	Ruth Gardiner, Interim Chief Information Officer		
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**
People and Culture Committee	17th July 2023	Noted

3. Purpose of the Paper	This is the quarterly Workforce for Digital Services and is for PC&C Committee to note and discuss as required.							
	Note (✓)		*Discuss ()*		*Recommend ()*		*Approve ()*	
4. Key Issues	The key points to note from this report are as follows: • Most of the business planning 2023 was successful and recruitment of 27 staff is underway. Recruitment and training should see staff productivity within 6-12 months. • The three re-banded Band 5 Accredited Clinical Coder posts have been out to advert with 2 applicants. Band 4 Clinical Coders will be advertised to fill the recruitment gap. • Digital skills are difficult to recruit, which has been evidenced by recent recruitment attempts for Training, Health Records and Clinical Coding that are competing against both public and private sectors where payscales are higher. • Digital Service plan is in development to support the Working Together Programme for DCH/DHC							
5. Action recommended	The Board is recommended to: 1. **NOTE** the report							

6. Governance and Compliance Obligations			
Legal / Regulatory Link	**Yes**	**~~No~~**	Yes, there are a number of legal and regulatory aspects to the services that are provided, this includes Health Records services as legal custodian of patient casenotes, Business Intelligence reporting to national bodies, Information Governance and Clinical Safety, Information security and management of cyber threats.
Impact on CQC Standards	**Yes**	**~~No~~**	A number of the areas impacted by lack of digital skills and resources will impact CQC, this includes Health Records,

				Cyber, clinical systems and clinical coding
Risk Link		**Yes**	**~~No~~**	Yes, staffing risks across Digital are on the Trust Risk Register. A risk assessment is included in the report.
Impact on Social Value		**~~Yes~~**	**No**	
Trust Strategy Link		**How does this report link to the Trust's Strategic Objectives?** *Please summarise how your report will impact one (or multiple) of the Trust's Strategic Objectives (positive or negative impact). Please include a summary of key measurable benefits or key performance indicators (KPIs) which demonstrate the impact.*		
Strategic Objectives	People	Digital services has a major role to play in supporting the People plan objectives.		
	Place	Digital services has a major role to play in supporting the Place objectives, Clinical safety is a major consideration for digital both in ensuring digital enablers reduce risks associated with clinical safety and in ensuring adequate resourcing for clinical safety testing and sign off in line with DCB0160.		
	Partnership	Digital services has a major role to play in supporting the Partnership objectives, particularly at the current time where digital enablers are seen as critical to supporting organisation independent working.		
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~~**	Population health management is a major development for BI, DCH host DiiS non behalf of the ICS
Tackling unequal outcomes and access		**Yes**	**~~No~~**	Recording of data and reporting is key to supporting monitoring of health inequalities.
Enhancing productivity and value for money		**Yes**	**~~No~~**	Digital developments are a major enablers for enhancing productivity and value for money.
Helping the NHS to support broader social and economic development		**Yes**	**~~No~~**	Digital developments are a major contributor to supporting 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~~**	

Board of Directors
Digital Services
July 2023

1 Introduction

The digital staffing business cases, submitted as part of the 2023/24 business planning process, have resulted in some significant and long awaited investment for the Digital Services workforce. The Trust has recognised and supported the need to address the long standing challenge for DCH, as a smaller acute Trust, in meeting our digital aspirations and addressing the risks associated with maintaining an aging technical infrastructure. With regard to digital workforce we need the same roles and resources to that of larger organisations.

This report to PC&C provides an update on the current position for Digital Services, the investment that has been made this financial year and the remaining issues and risks relating to our digital workforce. In addition the paper covers the Digital workforce response to the DHC/DCH collaboration and the potential opportunities this presents as well as reflection on the recent discussions around a Dorset wide Digital Service.

Appendix A provides a reminder of the Digital teams and skillsets that comprise Digital Services at DCH.

The People and Culture Committee are requested to **note** the content of the report.

2 Workforce Plan for Digital 2023/24

Digital Services presented 7 business cases as part of the 2023/24 business planning process. 5 were approved based on a mixture of revenue and capital based funding. 2 business cases were unable to be supported however and still represent constraints and risks to the provision of operational and strategic digital provision for the Trust.

Given the significant national capital funding for digital currently and anticipated over the next few years, the digital and finance teams have worked closely to find ways of supporting the digital resourcing requirement. Approximately £800k of capital allocation will cover a mixture of permanent and fixed term roles with a further £450k revenue to cover clinical coding, cyber and infrastructure resources. The following table summarises the outcome of the business plan for digital.

2.1 Funded Business Cases

Business Case	Requirement	Outcome, subject to recruitment
Clinical Coding	• Rebanding of clinical coders to be consistent with the level most Trusts are now grading clinical coders. (ACC qualified coders move from band 4 to band 5). This will help in recruitment to long term vacancies to release agency cost covering the current 3 WTE vacancies. • 2 x new band 3 WTE apprenticeship coding posts to	Overall revenue saving of £100k after 2 years in releasing agency costs, dependent on recruitment. Assuming successful recruitment agency will be retained for a period to clear backlog. This will be monitored through clinical coding productivity metrics.

Business Case	Requirement	Outcome, subject to recruitment
	support sustainability of the service.	
Digital Technology and Infrastructure (Emphasis on cyber security)	• 6 WTE technical staff 5 band 6 and 1 band 4). • 2 band 3 fixed term contract posts to support Trust wide replacement of devices to support Windows 11 requirements	Increases cyber team from 1 WTE to 3 WTE improving Trust's focussed response to cyber threat. Infrastructure and networking engineer posts also have a major contribution to reducing cyber threat in securing and maintaining the core technical infrastructure.
Application development, Integration and Testing	• 5 WTE staff band 8A to band 4 to support ongoing internal development, testing and systems integration.	Permanent posts funded from capital allocations and from some senior posts moving to a proportion of capital. This is based on known and anticipated national capital funded projects over the next few years. Band 8A and band 6 integration posts have not been filled as yet after first round of recruitment and are being re-advertised. These are specialist roles and will be difficult to fill given competition with the private sector.
Digital Transformation, Project Management and Training	• 11 WTE staff band 4 to band 8A to provide project management, digital transformation including change and benefits management and increase resource for information assurance, including data quality.	Funded from current and future capital allocations for digital investment. To date successful recruitment of some well qualified staff from within and outside healthcare as well as career progression for internal staff.
Business Intelligence	• 1 band 6 senior intelligence analyst	Urgent requirement agreed to support increased demand for BI support. This has now been recruited.

2.2 Business Cases Not Funded

Business Case	Requirement	Remaining Risk
Business Intelligence	• 1 band 7 population health analyst • 1 band 8a BI data modeller/Data scientist	Inability to move to more advanced analytics.
DTI_Cyber	• 1 band 6 Office365 Trainer	This was proposed as a post to support improved efficiency across the Trust through use of existing desktop technologies replacing paper based processes. Developments such as use of electronic forms and digital approvals processes will be delayed or not implemented in an optimal way without this post.
Service Desk and Clinical Systems Support	• 1 Band 4 service desk analyst • 1 Band 4 systems support officer • 1 Band 5 systems analyst	As the Trust's digital maturity increases and clinicians are more reliant on point of care solutions 24/7, this business case was to support

Business Case	Requirement	Remaining Risk
		extended hours for clinical systems support over 7 days, currently this is 8 to 6 Monday to Friday. Additional service desk provision to reduce response time for first line support was also included. Risk remaining will be delays in response to first line support calls and delays in fix times. This is being monitored through Digital KPI metrics.

2.3 Fixed Term Contracts

There are currently 13 fixed term contracts within Digital Services, most are for 24 month contracts and dedicated to the 2 main digital programmes: Elective Care Pathway and Outpatients and Urgent and Emergency Pathway and Patient Flow. These two programmes include a number of interdependent projects and both have significant change management and associated benefits realisation requirements. They extend over the next 2 years and will be critical in providing the digital enablers for the Trust's major strategic programmes. There will still be a reliance on scarce digital skillsets specifically systems integration. There is also a reliance on new posts coming on stream over the next few months before any significant traction on these key strategic digital programmes will be seen.

Digital Team	WTE	Flexibly employed
Business Intelligence	1	0
Development	2	0
Digital Training	2	8
Health Records (band 2)	2	3
Portfolio	0	0
Digital Transformation	4	0
Digital Technology & Infrastructure	2	0
Grand Total	**13**	**11**

2.4 Interim CIO Arrangements

The interim CIO arrangements have been extended until end of September 2023 until ongoing discussions with regard to the digital response for the DHC/DCH collaboration and the outcome of the next stage of discussions around a Dorset Digital Service.

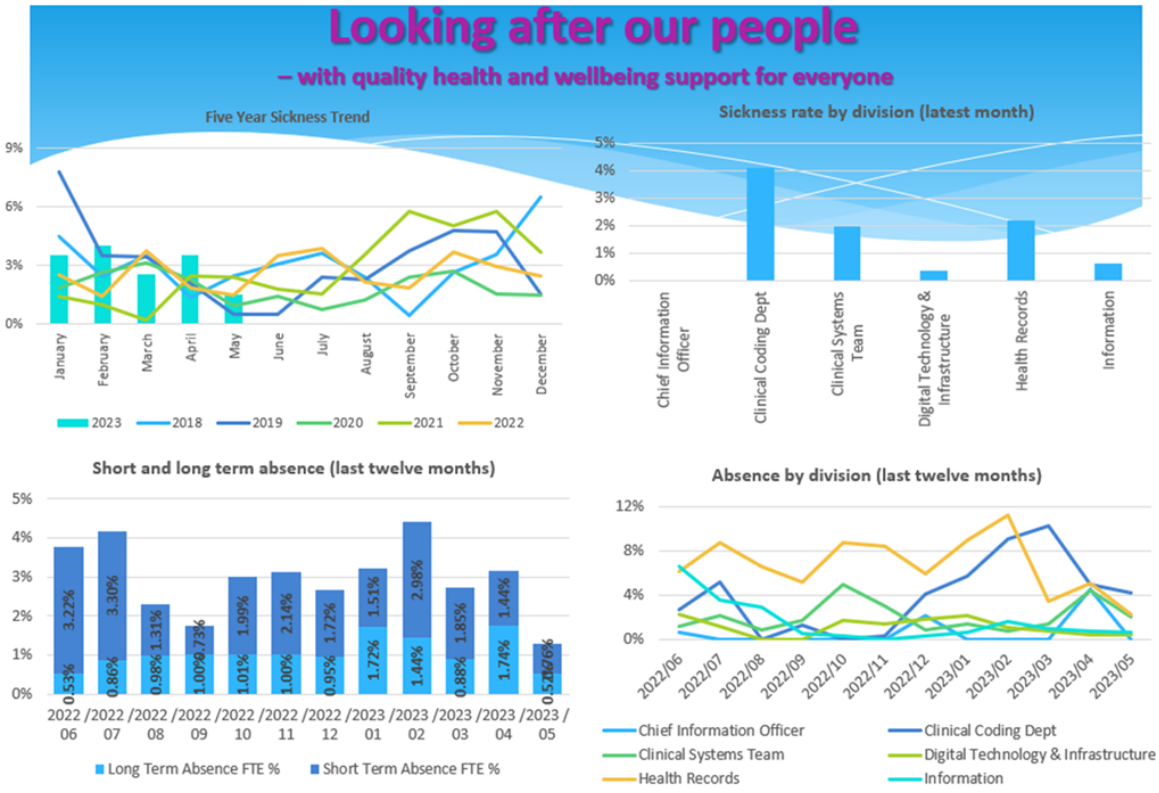
2.5 CMIO and CNIO

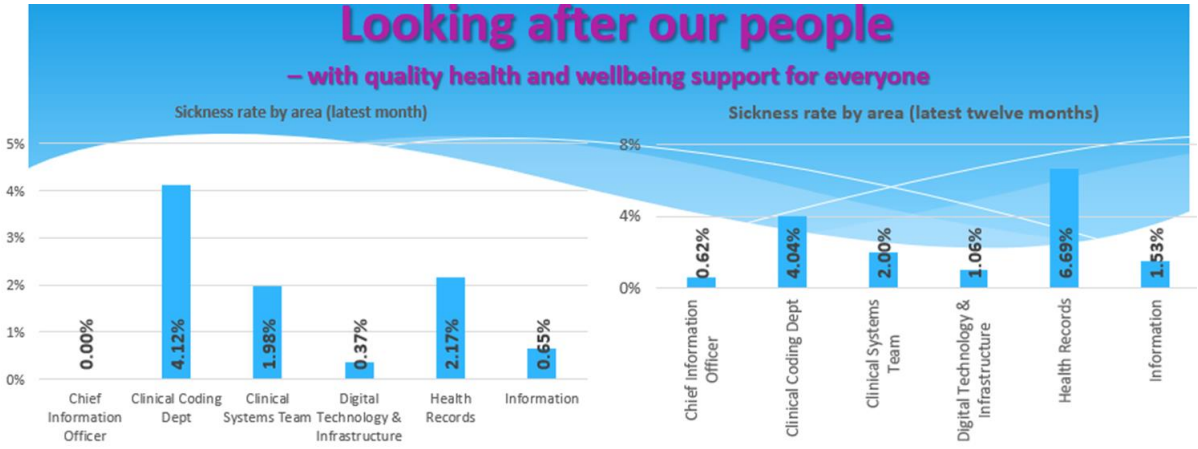
A Chief Medical Information Officer (CMIO) has been successfully recruited. Mr Michail Chatzimichalis, ENT Surgeon, has been appointed and will take up this post for 2 PA sessions per week from September. The Chief Nursing Information Officer, a full-time post, is currently out to advert with interviews planned for later in July. The CNIO role will also incorporate the role of Clinical Safety Officer (CSO) for digital. The CMIO and CNIO posts will report to the CMO and

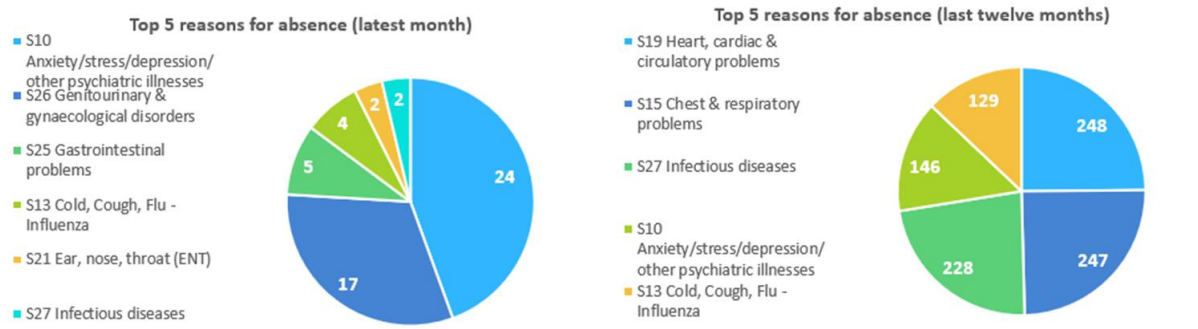
CNO respectively but will work closely with CIO and with counterparts across the ICS. These posts will play a significant role in increasing clinical engagement and in the development of digital competency across the clinical workforce.

3 Digital Service Workforce Metrics

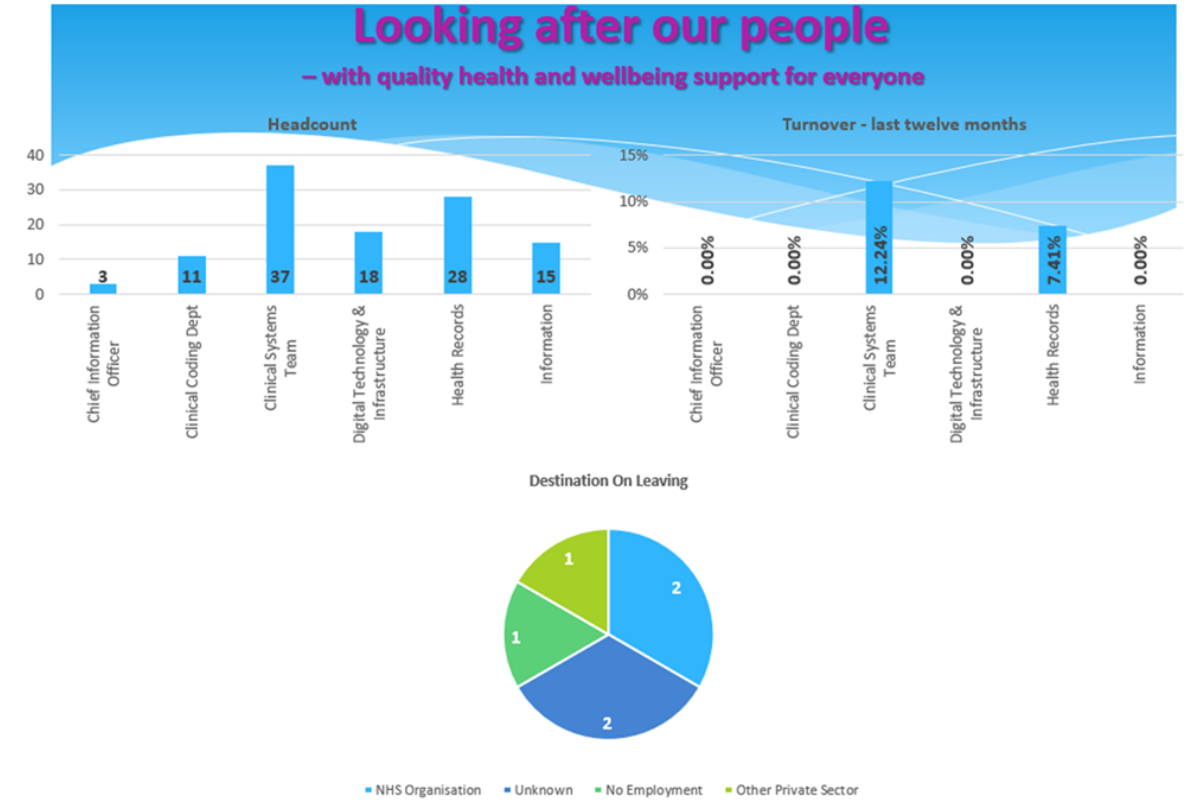
Digital Services appointed a business manager at the beginning of this year as part of the CIO interim arrangements with a particular focus on developing key performance indicators for digital services. This has included work around getting improved visibility and monitoring of our workforce with development supported by the workforce lead for BI. The following charts with regard to workforce metrics on sickness absence and turnover are part of this development. May 2023 is the latest reporting month of validated workforce data.




Looking after our people
– with quality health and wellbeing support for everyone
Sickness rate by area (latest month)
5%
4%
3%
2%
1%
0%
0.00%
4.12%
1.98%
0.37%
2.17%
0.65%
Chief Information Officer
Clinical Coding Dept
Clinical Systems Team
Digital Technology & Infrastructure
Health Records
Information
Sickness rate by area (latest twelve months)
8%
4%
0%
0.62%
4.04%
2.00%
1.06%
6.69%
1.53%
Chief Information Officer
Clinical Coding Dept
Clinical Systems Team
Digital Technology & Infrastructure
Health Records
Information


Top 5 reasons for absence (latest month)
S10 Anxiety/stress/depression/ other psychiatric illnesses
S26 Genitourinary & gynaecological disorders
S25 Gastrointestinal problems
S13 Cold, Cough, Flu - Influenza
S21 Ear, nose, throat (ENT)
S27 Infectious diseases
24
17
5
4
2
2
Top 5 reasons for absence (last twelve months)
S19 Heart, cardiac & circulatory problems
S15 Chest & respiratory problems
S27 Infectious diseases
S10 Anxiety/stress/depression/ other psychiatric illnesses
S13 Cold, Cough, Flu - Influenza
248
247
228
146
129

.


Looking after our people
– with quality health and wellbeing support for everyone
Headcount
40
30
20
10
0
3
11
37
18
28
15
Chief Information Officer
Clinical Coding Dept
Clinical Systems Team
Digital Technology & Infrastructure
Health Records
Information
Turnover - last twelve months
15%
10%
5%
0%
0.00%
0.00%
12.24%
0.00%
7.41%
0.00%
Chief Information Officer
Clinical Coding Dept
Clinical Systems Team
Digital Technology & Infrastructure
Health Records
Information

Destination On Leaving
2
1
1
2
NHS Organisation
Unknown
No Employment
Other Private Sector

Sickness absence in clinical coding earlier this year was largely due to an episode of managed long term sickness. The staff member has now returned to work full time. Similarly in Health Records, higher sickness absence earlier in the year was related to a new starter who experienced a period of long term sickness soon after starting and has since left the Trust.

Turnover within Digital Services overall has been consistently low. The peaks for Clinical Systems has related to staff within the team moving to new posts within Digital Services and 1 member of staff moving to Dorset Healthcare.

4 Digital Service Teams

4.1 Clinical Coding

The Clinical Coding service provides a critical function for the Trust concerned with the allocation of diagnostic and procedure coding for each inpatient consultant episode and day case. Codes are allocated based on a review of the clinical record maintained during the patient's inpatient or day case stay. This can either be through access to the inpatient documentation in paper based casenotes or via the Trust's Digital Patient Record if the paper casenotes have been scanned. Scanned or digitally created records enable clinical coding for qualified coders to be completed remotely which opens up opportunities to recruit staff from outside of Dorset.

The specific risks associated with failure to complete clinical coding in an accurate and timely manner include:

- Reputational risk where national benchmarking metrics such as SHMI[1] and Trust productivity measures are influenced by the accuracy, timeliness and specificity of clinical coding.
- Financial risk of failing to meet timescales for coding of Elective Recovery activity against the elective recovery plan.
- Reputational risk relating to poor performance reporting used by GIRFT and NCIP.
- Failure to have clinically structured data to support local population health needs analysis.
- Failure to contribute to national and international clinical research.

The re-banding of clinical coders took effect from 1st April 2023. The recruitment process to fill the 3 long term vacancies for ACC qualified coders is now at a second attempt. These posts are being offered as remote posts so are not limited to the local workforce but are still proving difficult to fill. The vacancies are currently covered by contract coders at an annual cost of £200k. Two apprenticeship coders posts at band 3 will be recruited in September to ensure.

4.2 Clinical Systems Service:

The Business Plan to extend hours of service by introducing shift based working supported through an additional 3 WTE staff was not able to be supported this financial year. With new point of care solutions in ED introduced in April last year and planned implementation for inpatient developments later this year, the need for increased support for clinical systems remains critical. The additional 3 WTE staff, 1.5 WTE band 5 and 1,5WTE band 4 would also allow for more routine work currently completely by more senior staff, freeing up resource to support more complex new developments and unblocking current delays for digital projects.

2.6 Digital Training:

[1] Summary Hospital-Level Mortality reporting

There are currently 2 vacancies in the Digital Training team which are at recruitment stage.

2.7 Business Intelligence:

The current BI team benchmarks very small with a headcount of 17 with one Senior Intelligence Analyst having been successfully recruited (CCG c24, UHD c40 and DHC c 24). Business Intelligence across all NHS & Local Authority partners is working with very high workloads and the demand for data increases, most recently this has been concerned with the baselining data required to support the Working Together flagship programmes.

Alongside the technical elements of the role BI partnering has become a significant function of a modern BI team with heavy engagement, collaboration, and customer focus elements. Turning data into intelligence to gain insight is much more a partnership with clinicians, managers, and analysts – this requires a significant shift from traditionally delivered data teams. As data literacy and awareness improves across all staff sectors, so will the expectations of stakeholders. This alongside rapid advancements in technology and tools will result in a significant increase in expectation that BI teams also keep pace with these developments and critically, have the capacity to do so.

There is an increasing need for BI teams to have the skills to be able to look forward as opposed to only analysing what has happened. Predictive analytics, machine learning and other next-level data and statistical analytical tools and techniques are becoming more and more understood and accessible. The recent business case for 2 senior positions including a data scientist role was not able to be supported by the Trust at this time but will need to be reviewed again if the reliance on expensive contractors is to be avoided.

2.8 Digital Technology and Infrastructure (DTI):

The 2023/24 business plan approved the recruitment of 2 x band 6 Cyber Security Analysts, a band 6 Network Engineer, a band 4 Mobile Devices MDM Engineer and a band 6 Senior Hardware Engineer. The band 7 Network and Telecommunications Manager has resigned, and the re-banded 8a post is currently out to advert. A contractor has been sourced to cover the recruitment gap in the meantime as until the new there is currently only a single network engineer post covering all networking support and maintenance.

4.3 2.9 Digital Portfolio Team:

A band 8a Senior Digital Project Manager has been successfully recruited to work on the New Hospital Programme. A further 2 x band 6 Project Manager, band 7 Portfolio Analyst and 2 x band 5 PSO are currently being recruited. The Portfolio Team continue to be under pressure and an extensive review of projects though out the whole of Digital Services has been undertaken identifying 126 high priority projects over the next 12 months of varying complexity and scope .

2.10 Health Records:

Health Records are expected to be up to full complement in the short term after remaining vacancies are filled.

Health Records rely on 4 flexibly employed staff making up a 3.6 WTE on a permanent basis.to provide both the paper filing and retrieval services as well as the ongoing scanning of paper into digital form. They also rely on evening staff completing extra hours to 3 WTE employees a week on a permanent basis. Approximately 300 hours a month (490 in May 2023) of additional hours.

New digital developments that will be coming on stream in the next 6 months will automate some of the current processes and improve efficiencies.

5 Digital Workforce Plan to Support Working Together Programme

Detailed discussions between the DCH Interim CIO and CIO at Dorset Healthcare have been progressing well in identifying how the respective digital teams in the two Trusts need to work closer together in supporting the objectives of the DCH/DHC collaboration. This has been done in the context of what has been a broader discussion around a Dorset wide Digital Service. An outline business case was being developed to identify options for how a Dorset digital service could be provided which had been conducted with very open and transparent dialogue with all members of digital teams across Dorset. UHD however had decided that with the current digital workload across Dorset that they were not able to continue with the business case process for a shared service. At the same time the collaboration between DHC and DCH has come into effect.

Given the changed landscape and following some recent meetings it has been agreed that further work on an outline proposal for closer team working across DCH and DHC will progress with digital teams aligned to the principles and objectives of the collaboration. This will be done in conjunction with ICB and primary care digital service colleagues to enable any wider opportunities to be incorporated if appropriate and manageable. There is no intention to move staff from their current organisational reporting lines but there is an intention to bring teams together to focus on specific digital enabling projects for the collaboration.

6 Staffing Risks

Area	Risk	Mitigation
Datix 1581 Project management resource	Project deliverables for major Trust and ICS priority projects cannot be supported due to lack of project management and skilled project delivery resources across the informatics teams.	Recruitment is being undertaken to increase the Portfolio WTE. Recruitment is also underway for dedicated staff to work on large Trust/Dorset wide projects. A review of Digital Portfolio which has identified 126 outstanding high priority projects. The portfolio paper has been escalated to the tier 3 Digital Transformation and Assurance Group (DTAG) for prioritisation and dependency review.
Datix 1687 Health Records	Transition to combined Health Records and scanning service in maintaining scanning volumes for day forward and legacy. High dependency on flexible workers and overtime of evening clerks.	Recruitment has been successful and there are currently no vacancies within Health Records. This could alleviate some need for staff to complete additional hours, but not all. Some of the new digital developments to be implemented in the next 6 months will deliver efficiencies for Health Records.
Datix 1272 Systems Integration	Core clinical systems required to support direct patient care rely on the data recorded in one system being shared with other systems, this is achieved through structured systems interfaces. There are over 40 different interfaces between systems which need day to day management as well as new developments associated with	Additional systems integration post has been agreed as part of business planning but we have failed to recruit from the first recruitment attempt. This post is being re-advertised.

Area	Risk	Mitigation
	service changes, e.g. OneDorset LIMS.	
Datix 1293 Skills shortage for core clinical systems	Currently some of the Trust's core corporate systems are supported by a single individual with all skills and knowledge residing with these individuals. No ability to share management of these systems. This presents a significant risk for continuity of support service and also for development capacity to support service improvements.	2022/23 business plan did not support the one additional post required to provide an effective clinical systems service and ensure succession planning and reducing further the risk of single points of expertise. This will move into 2023/24 business plan. The successful business plan recruitment is underway. Whilst this will benefit the team it won't totally mitigate the risk. It should be emphasised that system management resource that sits with divisional line management such as Radiology, Cardiology and Pathology also need to be addressed where there is the same reliance on a single point of expertise, meetings with divisional management are planned to address these risks. The risks associated with Radiology and Cardiology specifically remain a high risk and are the subject to proposals against the 2023/24 business plan, accepting the financial limitations for the Trust.
Datix 1366 Sickness absence and staff wellbeing	There are significant concerns for staff wellbeing due to excessive working hours for staff across Digital given the number of strategic projects that require digital enablers.	Regular fortnightly team meetings to review staff wellbeing and 1-2-1 sessions with team leaders to monitor staff morale and wellbeing. This risk is still relevant but with the new members of staff this could improve once training period now increasing again despite the fixed term resource that has been agreed and is particularly for senior digital staff, Development Team, Health Records and DTI. Initial review of staff survey see excessive workload as main concern for Digital teams.
Datix 1152	Current digital staffing levels present risk to both operational and strategic activities.	Recruitment for additional staff is underway.
Datix 1301 Service Desk – out of hours support for clinical systems	Increasing numbers of calls to the DTI on call service are exacerbating resource issues via the time and working directive, leaving the service operationally short during working hours.	The frequency of on call has been reviewed with the staff (8 members of DTI participate in a mon-fri / Fri-Mon rota) there are also escalation points to senior managers. The Business Plan 2023/24 for extended hours of work was rejected and will be re-submitted in June 2023.
Datix 1402 DTI upgrade work	DTI infrastructure upgrades and maintenance has to be carried out at unsociable hours to avoid operational	This has increased following the firewall upgrade scheduled for July 2023.

Area	Risk	Mitigation
	impact, this has a negative impact on resource (time and working directive) These works are essential to maintain a robust cyber security posture and mitigate issues around legacy software and hardware (e.g. patching)	
Clinical Coding	Lack of volume of scanned records poses a risk/problem for coding in a number of ways. If coding is completed without access to the full record this can have a significant impact on the accuracy and depth of coding which in turn can impact mortality stats and PbR income. Lack of scanned records is therefore a limiting factor in the workload that can be undertaken by remote coders. Existing Trust based coders can only be offered limited flexible working opportunities. Existing team members may apply for the DCH or other trust remote coding role(s) creating an even bigger gap in the office based workforce.	Business case to scan more casenotes was successful for a 12 month period. This will provide some additional access for remote coding. Office based coders cover the cases where physical case notes are required.
Datix 1648	Under resourced BI Team in a data centred culture	The demand for data is increasing and the 17 strong BI team are under increasing pressure to provide reports for a data centre culture.

The Board is recommended to:

1. **NOTE** the context of this report

Name and Title of Author: Ruth Gardiner (Interim CIO) Jane Slough, Digital Business Manager
Date: 12/7/23

Appendix A : Digital Services Workforce

The structure of Digital Services remains the same:

- **Digital Technology and Infrastructure (DTI) Service**: supports our technical infrastructure including on site hardware, networks and communications, cyber and security, desktop operating systems and applications such as Windows10 and Office 365
- **Systems, Development and Digital Transformation:** Supports the strategic development and operational maintenance and support for core corporate clinical applications in the Trust. This service incorporates Clinical Systems Support Service, application Development team, Digital Transformation, Digital Training and Information Assurance.
- **Health Records management**: This service supports the provision of health records retrieval and library management for paper-based notes as well as the in-house casenote scanning service. The Health Records Manager is the legal custodian for health records for the Trust, digital and paper, and manages other services such as subject access requests, records for adopted patients and the transition to digital records.
- **Digital Portfolio management** is a small team providing project management resources for digital projects and programmes.
- **Business Intelligence**: ensures the Trust complies with Trust, ICS, regional and national data and reporting requirements alongside supporting the Trust's analytical requirements by providing a link between technical and front-line teams to better use data to support decision making. This team works closely with the Development team for DCH BI development and also hosts the Dorset Insight and Intelligence Services for the Dorset ICS.
- **Clinical Coding**: Supports the process of coding our inpatient and day case activity using complex clinical coding structures for diagnoses and procedures.

NHS
Blood and Transplant

www.nhsbt.nhs.uk

May 2023

Dear Mr Bryant and Professor Hutchison,

We continue to see improvements in the number of donors and transplants. In 2022/23 1429 deceased donors proceeded to donation and 3575 patients received a transplant across the UK. We still have a long way to go to return to pre-pandemic activity levels, but we're confident we can get there with your Trust's help. Please accept our recognition and thanks for the effort of your staff as we look to recover further.

This letter explains how your Trust contributed to the UKs deceased donation programme.

Organ and tissue donation and transplantation activity - 2022/23

From 3 consented donors, Dorset County Hospital NHS Foundation Trust facilitated 2 actual solid organ donors resulting in 2 patients receiving a transplant during the time period. Additionally, 2 corneas were received by NHSBT Eye Banks from your Trust.

Quality of care in organ donation - 2022/23

The referral of potential organ donors to our Organ Donation Service and the participation of a Specialist Nurse for Organ Donation in the approach to family members to discuss organ donation are key steps in ensuring the success of organ donation.

- Your Trust referred 25 patients to NHSBT's Organ Donation Services Team; no referrals were missed (100% referral rate) and 2 met the referral criteria for inclusion in the UK Potential Donor Audit.
- A Specialist Nurse was present for 2 organ donation discussions with families of eligible donors. There were no occasions when a Specialist Nurse was absent for the donation discussion.

Up to date Trust metrics are always available via our Power BI reports found here:
https://www.odt.nhs.uk/statistics-and-reports/potential-donor-audit-report/.

What we would like you to do

- Ensure your Trust supports your Organ Donation Committee and Clinical Lead for Organ Donation in promoting best practice as they seek to minimise missed donation opportunities.
- Discuss activity and quality data at the Board with support from your Organ Donation Committee Chair.
- Recognise any successes your Trust has had in facilitating donation or transplantation, especially during the ongoing NHS pressures.

Deemed Consent Legislation - England

On 20 May 2020 the Organ Donation (Deemed Consent) Act 2019, known as Max and Keira's Law, came into force in England. The societal ambition is that the new law will help save and improve even more lives moving forward. In England, during 2022/23, there were 519 occasions when consent was deemed from 935 occasions where deemed consent applied.

Why it matters

In 2022/23, 299 people benefited from a solid organ transplant in the South West. However sadly, 27 people died on the transplant waiting list during this time.

Thank you once again for your vital ongoing support for donation and transplantation.

Yours sincerely,

Anthony Clarkson
Director of Organ and Tissue Donation and Transplantation
NHS Blood and Transplant

Minutes of the meeting of the Part 1 Public ICB (ICB) Board of NHS Dorset
Thursday 4 May 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) (virtual)	ICB Non-Executive Member (virtual)
	Matthew Bryant (MB)	Joint Chief Executive Dorset County Hospital and Dorset HealthCare NHS Foundation Trusts and ICB Board NHS Provider Trust Partner Member
	Jonathon Carr-Brown (JCB)	ICB Non-Executive Member
	Spencer Flower (SF)	Leader Dorset Council and ICB Local Authority Partner Member (West)
	Siobhan Harrington (SH)	Chief Executive University Hospitals Dorset NHS Foundation Trust and ICB NHS Provider Trust Partner Member
	Paul Johnson (PJ)	ICB Chief Medical Officer
	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) (virtual)	ICB Chief Strategy and Transformation Officer
	Louise Bate (LBa) (virtual)	Manager, Dorset Healthwatch
	Cecilia Bufton (CB)	Integrated Care Partnership Chair
	David Freeman (DF)	ICB Chief Commissioning Officer
	Dawn Harvey (DH)	ICB Chief People Officer
	Leesa Harwood (LH)	ICB Associate Non-Executive Member
	Matt Prosser (MP)	Chief Executive, Dorset Council
	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:		
	Liz Beardsall (LBe) (minutes)	ICB Head of Corporate Governance
	Emma Elliott (EE) (virtual)	ICB Business Manager to the CEO
	Kirsty Hillier (for item ICBB23/088) (KH)	ICB Deputy Director of Communications and Engagement
Observing:		
	Rhiannon Beaumont-Wood (RBW)	ICB Non- Executive Member (starting 1 June 2023) (virtual)
Public:		
	One member of the public was present in the room.	

Apologies:		
	Philip Broadhead	Bournemouth, Christchurch and Poole Council and ICB Local Authority Partner Member (East) (member)
	Sam Crowe	Director of Public Health Dorset (participant)
	Graham Farrant	Chief Executive, Bournemouth, Christchurch and Poole Council (participant)
	Andrew Rosser	Chief Finance Officer, SWASFT (participant)
	Manish Tayal	Interim Non-Executive Member (member)

ICBB23/074 Welcome, apologies and quorum

The Chair declared the meeting open and quorate. There were apologies from: Philip Broadhead, Sam Crowe, Graham Farrant, Andrew Rosser and Manish Tayal.

ICBB23/075 Conflicts of Interest

There were no conflicts of interest declared in the business to be transacted on the agenda.

ICBB23/076 Minutes of the Part One Meeting held on 2 March 2023

The minutes of the Part One meeting held on 2 March 2023 were agreed as a true and accurate record.

Resolved: the minutes of the meeting held on 2 March 2023 were approved.

ICBB23/077 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.

ICBB23/078 Patient Story: Manni and Reuben Coe 'Brother do you love me'

The ICB Chief Nursing Officer introduced the patient story regarding the book which brothers Manni and Reuben Coe had written regarding Reuben's experience as an adult with learning difficulties. The brothers were unable to attend in person, but had been interviewed via Teams, a recording of which was presented to the Board. It was noted that the names of care establishments had been changed in the book and video.

The brothers told the story of Reuben's experience in care and the impact on his wellbeing and mental health, including the isolation he faced especially during the pandemic, the difference between 'looking after' and 'caring for' someone, the lack of communication and family involvement in decisions regarding Reuben's care, and the role of pride in Reuben's recovery. Reuben's mission for the book was "to make everyone in the world emotional" and the brothers aimed to give hope to others in similar situations.

The Board discussed the powerful video, noting the positive outcome for Reuben who was now in an assisted living flat with support from People First Dorset. Much had been done in social care to address the lessons in the video including the challenges faced during Covid, the lack of suitable placements, and social care recruitment and retention. Isolation remained a challenge for those in social care, and the role of the voluntary and community sector in supporting this was discussed.

The Board also discussed the role of the ICB in providing environments where the workforce are supported to provide the best care, the need to support people to navigate their way through care pathways, the importance of communication with families and service users to better understand their needs, and the need to challenge stereotypical views regarding those with learning difficulties.

It was requested that People First Dorset be invited to talk to the ICB Board about their work.

ACTION: LB

ICBB23/079 Chief Executive Officer's Report

The ICB Chief Executive Officer (CEO) introduced the previously circulated CEO's Report covering national and local updates, and latest news from the health provider and local authority partners, which was taken as read. Highlights included:

- The Hewitt Review, noting the government response to recommendations was awaited
- Industrial Action, noting that a significant number of unions had accepted the proposed pay deal, but negotiations continued.
- The NHS Dorset Operational Plan had been submitted, noting that there remained some challenges in delivery, especially in relation to finance.
- NHS Staff Survey 2022 had been published on 9 March, with NHS Dorset coming second in the national league table for ICBs and good results for NHS partners. It had previously been agreed that the Integrated Care System would move forward with a single approach to equality, diversity and inclusion and work on this would commence shortly.
- Portland Asylum Seeker Accommodation, noting conversations were underway around funding and health service provision.
- Work was underway on the Integrated Care System Operating Model
- Following work on the discharge process there had been a reduction in No Criteria to Reside patients. Partners were thanked for their hard work in achieving this reduction.

The Board discussed how the Joint Five Year Forward Plan had been developed with partners, including through the ICB Board. There would be further engagement with the Health and Wellbeing Board Chairs, and it would be reviewed again by the ICB Board prior to submission. Delivery of the plan would be monitored by the Integrated Care Partnership.

The role of Place regarding investment in out-of-hospital services and the work that would be led by the ICB Chief Finance Officer on 'one public estate' were noted.

The Chair thanked the CEO and partners for their contributions to the report, and thanked the ICB leadership for their role in the positive Staff Survey outcomes for the organisation.

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

<u>Items for Decision</u>

ICBB23/080 Business Conduct

(a) Standards of Business Conduct Policy

The Head of Corporate Governance introduced the previously circulated ICB Standards of Business Conduct (incorporating Conflicts of Interest) Policy. The revised policy was presented to the Board for approval, following approval and recommendation to the Board by the Risk and Audit Committee. The policy had been updated into the new ICB policy

format and had been reviewed in light of NHS guidance and best practice. There were minor changes to the policy content and these were detailed in the report.

The Board approved the policy.

Resolved: the Board approved the Standards of Business Conduct Policy.

(b) Annual Review of Declarations of Interest, Gifts, Hospitality and Sponsorship
The Head of Corporate Governance introduced the previously circulated Annual Review of Declaration of Interest, Gifts, Hospitality and Sponsorship report, for the Board to note following presentation at the Risk and Audit Committee. Only 13 out of 600 declarations remained outstanding at year end. No declarations of concern had been received during the year and internal audit had provided a substantial opinion of the organisation's process. Revised training for ICBs was expected shortly from NHS England to replace the previously stood-down training modules for Clinical Commissioning Groups. This training would be rolled out to staff once available.

Resolved: the Board noted the Annual Review of Declarations of Interest, Gifts, Hospitality and Sponsorship Report.

Items for Noting/Assurance/Discussion

ICBB23/081 Committee Escalation Reports
The Board Committee Chairs presented the Committee Escalation Reports from the April meeting. All issues discussed were included in the previously circulated reports and key issues included:

- Clinical Commissioning Committee – interconnection, tackling demand and the prevention agenda.
- Finance and Performance Committee – the committee's discussion about 'what does a good committee look like', Personal Healthcare Commissioning, and thanks to the teams for the operational and financial performance.
- People and Culture Committee – staff survey results, and the work required relating to equality, diversity and inclusion.
- Primary Care Commissioning Committee – the general practice model and sustainability, and pharmacy, optometry and dental services delegation.
- Quality and Safety Committee – medicines optimisation and safeguarding governance architecture. The committee escalated to the Board the increase in c-difficile infections, noting that this was in line with a national increase and a tool had been developed to better understand what was driving the increase.
- Risk and Audit Committee – key management judgements on year end, annual plans for internal and external audit and the Mental Health Investment Scheme audit which had been completed and would be discussed further in the Part Two Board meeting.

The Board thanked the corporate governance team for the quality of the escalation reports, and for their support of the Board Committees.

Resolved: the Board noted the Committee Escalation Reports.

ICBB23/082 Quality Report
The ICB Chief Nursing Officer introduced the previously circulated Quality Report. Highlights included:

- The Care Quality Commission (CQC) had published its findings on services at University Hospitals Dorset. There had been detailed discussion of the report at Quality and Safety Committee. All immediate actions were complete and a remedial

action plan had been sent to CQC. Pilots under the new CQC framework would start shortly, with inspections under the framework commencing in September.

- In relation to patient safety, the report detailed the outcomes of the Annual Patient Safety Audit and provided an overview of the national Learning from Patient Safety Events (LFPSE) online recording service and the local pilot which was underway.
- The use of the 'my mhealth' app and the positive impact this was having for users.

In relation to adverse events, the Board asked the Chief Nursing Officer if there were any identifiable reasons for the increase in 'care delivery' related incidents. Also it was queried why Royal Bournemouth Hospital was not listed in the Incidents by Site table (p101/210).

Post meeting note: in the Part Two Board meeting the Chief Nursing Officer provided updates on the two questions above. Firstly, 'care delivery' as a cause 1 had been increasing over the last 2-3 years, and was consistent with regional trends. There had been no change to how these incidents are logged, however there had been a focus on potential harm from patient delays as part of care delivery and therefore an increased awareness of reporting. Secondly, the STEIS system from which the report was pulled does not recognise University Hospitals Dorset as an entity so all incidents for that trust are logged under Poole Hospital but the figure includes Bournemouth data.

Resolved: the Board noted the Quality Report.

ICBB23/083 Performance Report

The ICB Chief Operating Officer introduced the previously circulated Performance Report, which demonstrated continual improvement in almost all areas. Highlights, as detailed in the report, included the progress being made on reducing long waits, meeting the 28 day cancer standard, diagnostic performance, the reduction in No Criteria to Reside patients and the positive impact of the Multi Agency Discharge Events (MADE).

The Board discussed MADE events for mental health service providers, the rise in 52 week waits and how this was being monitored, the need to sustain improvements especially in relation to discharges and how this would be underpinned by prevention work and managing demands, the inequity of dermatology provision in Dorset, and healthcare worker vaccination rates.

The Board welcomed inclusion in the report of measures relating to primary care but requested additional narrative to better understand what the data was showing. It was noted that this would be addressed once the strategic objectives were in place. The need for the introduction of reporting on health inequalities and prevention was also discussed, and this would form part of the discussion on the committee structure at the Board Development Session in June.

Resolved: the Board noted the Performance Report.

ICBB23/084 Dorset ICS Finance Update 2022/23

The ICB Chief Finance Officer introduced the previously circulated Dorset ICS Finance Update for 2022/23 covering the financial position of both the ICB and Integrated Care System NHS providers for the financial year ending 31 March 2023, in addition to an update on the Operational Plan.

The ICS reported a pre-audit surplus of £0.4m for 2022/23 against a breakeven plan; with surplus positions solely attributable to NHS providers and a balanced position reported by NHS Dorset ICB.

The ICB reported a breakeven position against plans for the financial year 2022/23. Several risks had needed to be managed in order to achieve a breakeven position including above contract activity levels with Independent Sector Providers (ISPs), staffing, prescribing and Personal Health Commissioning (PHC).

There was a commitment to have a medium term financial plan submitted by the end of September 2023.

The Board discussed in detail the depiction of ICB spend as cogs (p147/210 in the meeting pack). There was interest in mapping this information against in year reporting and patient volumes. It was noted that some sectors were more expensive than others, and therefore it was important to understand the right place for people to be managed mapped against where they were being managed. This would then demonstrate where resources should be focused and the most efficient use of these resources.

The challenges relating to recurrent/non-recurrent funding and agency spend were discussed. The need for messages relating to a 'value' culture was noted. It was anticipated that this would form part of the Dorset Value Improvement Programme work, which was currently in development.

Resolved: the Board noted the Finance Report.

ICBB23/085 Hewitt Review

The ICB Chief Executive Officer introduced the previously circulated Hewitt Report. The Hewitt Review, reported on 4 April 2023 on the findings of the independent review to consider how the oversight and governance of Integrated Care Systems in England could best support them to succeed. The review encompassed five workstreams, and aimed to produce short term actions around operational challenges and long term priorities for Integrated Care Systems for the next 10-15 years.

The key principle resulting from the review was a reduction in the number of national indicators, which would be grounded in things important to public, with the remainder of the agenda being set locally. This would allow Integrated Care Systems more freedom and space to deliver, within an accountability framework. There was also a recommendation for an increase in funding for prevention.

The Board welcomed the sentiments of the report, especially regarding increased funding for prevention.

The Chief Executive Officer suggested that there was a need for a change in the narrative to explain the movement towards creating healthier communities, and the public's role in supporting this. An approach would be to connect the launch of the Five Year Forward Plan with the NHS's 75th Birthday and to link the narrative to this.

Resolved: the Board noted the Hewitt Review.

ICBB23/086 Urgent and Emergency Care Operations and Recovery Delivery Plan

The ICB Chief Operating Officer presented the previously circulated Urgent and Emergency Care (UEC) Operations and Recovery Delivery Plan which was discussed in detail at the Finance and Performance Committee in April. The plan aligned with the national recovery

plan and provided a clear indication of the system commitment to drive change and deliver in 2023/24.

The plan was built on the successful approach adopted over winter, focusing on covering the today position, the weekly position, and the longer-term commissioning and strategic position.

Delivery of the plan would be monitored through the Performance Report.

Resolved: the Board noted the Urgent and Emergency Care Operations and Recovery Delivery Plan.

ICBB23/087 Infection Prevention and Control Annual Report

The ICB Chief Nursing Officer introduced the previously circulated Infection Prevention and Control Annual report, which provided assurance that the infection prevention and control regime for NHS Dorset remained compliant with the Health and Social Care Act 2008: code of practice on the prevention and control of infections (updated 2022). Highlights included the key role of the Dorset Integrated Care System Infection Prevention and Control meetings and the proactive work around hydration. It was noted that the increase in c-difficile rates had been escalated to the Board (ICBB23/081).

It was noted that the Quality and Safety Committee had taken significant assurance from the report and commended the Infection Prevention and Control Lead Specialist Nurse.

Resolved: the Board noted the Infection Prevention and Control Annual Report.

ICBB23/088 Integrated Care System Brand and Identity

The ICB Deputy Director of Communications and Engagement joined the meeting and introduced the previously circulated Integrated Care System Brand and Identity update, which laid out the approach being taken to develop a refreshed brand and identity for the Dorset Integrated Care System and Integrated Care Partnership.

Stakeholder engagement work on the concept was ongoing, and the final version would be taken to the Integrated Care Partnership for approval. Work to date indicated there was strong identification with 'Our Dorset' and there was little appetite to move away from this. It had been suggested that 'One Dorset' currently formed part of Bournemouth, Christchurch and Poole Council's branding, although this was to be confirmed, and therefore should not be used for the Integrated Care System.

The Board discussed the need for a strapline, noting that this should be broader than 'health and care' to reflect all partners in the Integrated Care System.

The Board thanked the team for their work on the Integrated Care System brand.

Resolved: the Board noted the Integrated Care System Brand and Identity Report.

Items for Consent

The following items were taken without discussion.

ICBB23/089 Integrated Care System People Plan

It was noted that this item had come to the Board as a consent item as it had been discussed in detail at the Board Development Session and by the People and Culture Committee. The ICB Chief People Officer reassured the non-executives that the measures for success for the plan would not be solely based on quantitative or 'hard' measures. The

delivery plan would include qualitative and quantitative measures, and delivery would be monitored by the People and Culture Committee.

Resolved: the Board noted the System People Plan.

ICBB23/090 Questions from the Public
No questions were received in advance of the meeting from members of the public.

ICBB23/091 Any Other Business
It was noted that representatives from both local authorities would be unable to attend the next Board meeting as they would be attending the Local Government Association Conference. The Chair offered to look into this outside the meeting and noted that the timing of the conference would be taken into account when planning the meeting dates for next year.

ACTION: JDT/LB

ICBB23/092 Key Messages from the Meeting
The Chair summarised the key messages from the meeting as:

- The learning from the powerful Reuben and Manni Coe video, especially in relation to isolation of those in social care, supporting staff to provide the best care and family involvement in treatment decisions.
- The increasingly central role of prevention and health inequalities, and how this would link to the development of system performance data, the depiction of trajectories around prevention and to the functions of the ICB's Board Committee.
- Thanks to all the teams involved in delivering the year end performance and finance positions, especially in reducing the number of No Criteria to Reside patients and the positive impact this has for patients and their families.
- Support for the 'Our Dorset' branding for the Integrated Care System as inclusive and outward facing.

ICBB23/093 Date and Time of Next Meeting
The next meeting of the ICB Board would be held on Thursday 6 July 2023 at 10am, in the Boardroom, Vespasian House, Barrack Road, Dorchester, Dorset DT1 1TG

ICBB23/094 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: 06/07/2023