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 **27th September 2023** at **8.30 am to 12.25pm** in the **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.	**Patient 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:	Verbal	David Clayton-Smith	Note	
	b) Conflicts of Interests	Verbal	David Clayton-Smith	Note	
	c) Minutes of the Meeting dated 26th July 2023	Enclosure	David Clayton-Smith	Approve	
	d) Matters Arising: Action Log	Enclosure	David Clayton-Smith	Approve	
3.	**Chair's Comments**	Verbal	David Clayton-Smith	Note	9.00-9.10
4.	**CEO Update**	Enclosure	Matthew Bryant	Note	9.10-9.25
5.	**Balanced Scorecard** • System Performance Update	Enclosure	Nick Johnson Executives	Note	9.25-9.40
6.	**Board Assurance Framework** (Sept RAC)	Enclosure	Nick Johnson Phil Davis	Note	9.40-9.50
7.	**Corporate Risk Register** (Sept RAC)	Enclosure	Jo Howarth Mandy Ford	Note	9.50-10.00
8.	**Board Sub-Committee Escalation Reports** (Aug 2023 and Sept 2023) a) Quality Committee b) Finance and Performance Committee c) People and Culture Committee d) Risk and Audit Committee e) Working Together Committee in Common f) Charitable Funds Committee	Enclosures	Committee Chairs and Executive Leads	Note	10.00-10.25
Coffee Break 10.25-10.40					
9.	**Finance Report**	Enclosure	Chris Hearn	Note	10.40-10.50

10.	**Safe Staffing Mid-Point Review** (August QC)	Enclosure	Jo Howarth	Note	10.50-11.05
11.	**Maternity Update** Including Maternity Incentive Scheme (Sept QC)	Enclosure	Jo Hartley	Note	11.05-11.20
12.	**Fit and Proper Persons Framework Briefing** (September PCC)	Enclosure	Nicola Plumb	Note	11.20-11.35
13.	**Learning from Deaths Report** (August QC)	Enclosure	Alastair Hutchison	Approve	11.35-11.50
14.	**GMC Survey and Action Plan** (September PCC)	Enclosure	Alastair Hutchison Paul Murray	Note	11.50-12.00
15.	**Infection Prevention and Control Annual Report** (September QC)	Enclosure	Jo Howarth	Note	12.00-12.10
16.	**Questions from the Public**	Verbal	David Clayton-Smith	Note	12.10-12.15
	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 12.15-12.20
	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.				
17.	**Guardian of Safe Working Quarterly Report** (August PCC)	Enclosure	Kyle Mitchell	Note	-
18.	**ICB Board Minutes Part 1** (Standing Item)	Enclosure	Matthew Bryant	Note	-
19.	**Any Other Business** Nil notified	Verbal	David Clayton-Smith	Note	12.20-12.25
20.	**Date and Time of Next Meeting**				
	The next part one (public) Board of Directors' meeting of Dorset County Hospital NHS Foundation Trust will take place at **8.30am** on **Wednesday 29th November 2023** in the **Board Room, Trust Headquarters, Dorset County Hospital, Dorchester** and via **MS Teams.**				

Part 2 items

- Lucy Letby Reflections
- Medium Term Financial Plan
- Dorset Electronic Patient Record
- NHP Enabling Works Contract – for approval

- Expanding and Protecting Elective Capacity
- Consent Items:
    - Contracts for Approval:
        - Stryker Trauma Contract Renewal
        - Ridgeway 24 Bed Works Contract
- Working Together Programme Update

Minutes of a public meeting of the Board of Directors of Dorset County NHS Foundation Trust held at 8.30am on 26th July 2023 at Board Room, Trust Headquarters, Dorset County Hospital and via MS Teams videoconferencing.

Present:		
Eiri Jones	EJ	Non-Executive Director (Deputy Chair)
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
Claire Lehman	CL	Non- Executive Director
Stuart Parsons	SP	Non- Executive Director
Anita Thomas	AT	Chief Operating Officer
In Attendance:		
Trevor Hughes	TH	Head of Corporate Governance (Minutes)
Jo Hartley	JHa	Head of Midwifery (attended via videoconference) (item BoD23/053)
Members of the Public (attending via videoconference):		
Tony Alford	TA	Governor
Sarah Cake	SC	Safeguarding Lead
Judy Crabb	JC	Governor
Trudy Goode	TG	DCHFT Matron, Staff Story
Kathryn Harrison	KH	Lead Governor
Jean Pierre Lambert	JPL	Governor
Lynne Taylor	LT	Governor
Apologies:		
Matthew Bryant	MBr	Chief Executive
Margaret Blankson	MB	Non-Executive Director
Dawn Dawson	DD	Chief Nurse, Dorset Healthcare
David Clayton-Smith	DCS	Trust Chair
Nicola Plumb	NP	Chief People Officer
Stephen Tilton	ST	Non-Executive Director
David Underwood	DU	Non-Executive Director

BoD23/039	**Staff Story**	
	JH introduced TG, Matron and RCN member, to discuss her involvement in the industrial action taken by nurses earlier in the year. TG had been a member of the RCN Committee reviewing derogations. TG commented that many staff were conflicted about the action and she discussed the impact that the action had on staff morale. TG outlined her career history over the previous 40 years, many of which had been within DCH. TG had been a member of the RCN throughout as the organisation was a professional union for nurses and previously had a no strike policy. During the recent periods of industrial action however, there had been no 'work to rule' option and the only options were to strike or not. TG represented the trust on the RCN Strike Committee which discussed derogations and had been honoured to do so. These meetings informed	

	staffing levels on wards during periods of action. TG had found the role challenging and often presented conflicts in her own loyalties despite the RCN's commitment to working for patients and staff. During the January action TG had been the interface between the trust and the RCN and had assisted in derogations on the days of action if required. She also ensures that staff on the strike line adhered to the trust's values and behaviours. Members of the public and other staff had been hugely supportive, delivering scarves to staff on the picket line and hot drinks and chocolate. TG extended her thanks to the Damers Restaurant for their support also. Senior clinical and non-clinical staff had also visited the picket line. Many staff found the experience emotional, whilst many staff supported the action they also felt conflicted about leaving their areas of work. Members of the press and staff from other organisations had also shown their support – even Billy Bragg attended the picket line for a sing along. TG ensured that discussions with the press were clear that the nurses' discontent was with the government and not the trust and other unions without an appropriate mandate to strike, did not join the picket line. TG concluded that the experience acting as the interface between the trust and the union had been interesting and that negotiations had led to actions that maintained patient safety. The Board thanked TG for her impartial reflections that had provided learning for the Board. It had been evident that Board members had been supportive of staff whatever their individual thoughts about taking action. The experience had been new for all involved and had been surrounded by uncertainty as to how many staff would take action as there was no requirement to declare individual intentions. The Board noted the risk to team coherence resulting from ongoing action being taken by medical staff and some discord subsequently, and their responsibilities is supporting teams to regroup. TG thanked the Board for the opportunity to discuss her own reflections over the period in which she had felt valued for her experience, knowledge of the trust and her contribution to maintaining patient safety, standing up for staff and patients through the derogations process. TG advised that she would take the Board's thanks back to colleagues and acknowledged the supportive actions taken provided a good example of the open culture that existed within DCH.	
	Resolved that: the Staff Story be heard and noted.	
BoD23/040	**Formalities**	
	The Chair declared the meeting open and quorate and welcomed CL to the meeting as a new Non-Executive Director on the Board, and Governors to the meeting.	

	Apologies for absence were received from David Clayton Smith, Matthew Bryant, Margaret Blankson, Nicola Plumb, Stephen Tilton and Dave Underwood.	
BoD23/041	**Conflicts of Interest**	
	There were no conflicts of interest declared in the business to be transacted on the agenda.	
BoD23/042	**Minutes of the Meeting held on the 31st May 2023**	
	The Minutes of the meeting dated 31st May 2023 were approved as an accurate reflection of the meeting.	
	Resolved: that the minutes of the meeting held on 31st May 2023 were approved.	
BoD23/043	**Matters Arising: Action Log**	
	The action log was considered and updates received in the meeting were recorded within the log with approval given for the removal of completed items.	
	Resolved: that updates to the action log be noted with approval given for the removal of completed items.	
BoD23/044	**Chair's Comments**	
	EJ presented DCS report outlining his activities and engagements over the previous month as follows: • A site visit for the new EDI and involvement in the Charity fundraising event in Poundbury. • A visit to Radiology and Histopathology with the Chief Medical officer and meetings with the service leads • A series of focussed to the trust's community hospitals in Swanage, Wareham, Portland, Weymouth and Alderney. • Attendance at the Dorset hospitals event at the Mowlem Centre, Swanage, meeting with Rob Whiteman, Chair UHD and the establishment of regular 1:1s and quarterly meetings with MBr and the UHD CEO. • A meeting with David Sidwick, Police and Crime Commissioner for Dorset, Chair and CEO of Lewis-Manning. • Meetings with Richard Drax, MP and Chris Loder MP last week and Tobias Elwood MP this week. • A meeting with Patricia Miller, ICB CEO to discuss the role DHC has working with primary care networks to strengthen physical and mental healthcare delivery locally. • A meeting with Cecilia Bufton, ICP Chair. An ICP workshop and an ICP meeting were scheduled over the next two weeks. No questions were raised in connection with the report.	
	Resolved: that the Chair's Comments be noted.	
BoD23/045	**CEO Update**	

	NJ presented the following highlights from the report: • Industrial action – noting huge impact on services and cancelled activity and the indirect costs associated with planning. The need to continue to respect individual choices was reiterated. • The NHS long term Workforce Plan had recently been published. This was the first time that such a plan had been published. Some questions remained regarding funding and delivery and the longer term nature of the plan did not provide solutions to immediate workforce issues. • Regarding the Barge for asylum seekers docked in Portland, the Board hear that the trust would not be providing direct services and acknowledge the challenges the people residing their had faced. The trust would continue to work with partners on further healthcare requirements. • The ICB Forward Plan had been published outlining ambitions over the coming five-year period. The Board acknowledged the positive shift in focus to that of delivering outcomes: o We will improve the lives of 100,000 people impacted by poor mental health. o We will prevent 55,000 children from becoming overweight by 2040. o We will reduce the gap in healthy life expectancy from 19 years to 15 years by 2043. o We will increase the percentage of older people living well and independently in Dorset. o We will add 100,000 healthy life years to the people of Dorset by 2033. • The Board noted CL's interest in these areas and that the outcomes would be fed through the subcommittees of the Board and inform further discussion. • Collaboration with DHC – the Board was informed of the positive progress on the Weymouth Research Hub. • the trust remained in segment 2 of the Single Oversight Framework, reflecting good recovery on elective activity. • The West Annex had been demolished and positive comments had been received from the public about how this work had been undertaken. • Barriers in car park were now operating. • The trust welcomed the CQC the current inspection visits to the maternity service and awaited the formal report. The Board noted the extensive work undertaken and commitment by the Digital team to protect the trust's systems following the recent digital difficulties experienced by the Ambulance service. The team had worked long hours through the night. Communications with the ambulance service were now being re-established. Thanks were also extended to all staff for their continued hard work and commitment in what continued to be difficult operating circumstances.	
	Resolved that the CEO Update be noted.	
BoD23/046	**Balanced Scorecard**	

	NJ presented key highlights from the report that had been reformatted to incorporate feedback from previous discussions. 65-week elective care targets and SHMI were now included as well as a link to the dynamic live data and an escalation report highlighted areas for the Board's attention. Respective metrics would be reviewed to ensure supporting commentary included actions taken and cross references to committee items. NJ summarised that the trust was performing relatively well, delivering on trajectories and maintaining quality metrics. However, theatre utilisation was failing below target raising questions as to whether interventions were impactful. There had been sustained improvement on Electronic Discharge Summaries although further intervention was needed in order to sustain and improve performance going forward. Similarly, further intervention was required to improve appraisal rate compliance. The Board heard that the SHMI was within the normal range and that the recruitment of clinical coders was in progress. The Board was assured that data from other sources did not give rise to any areas of concern and that the southwest region had one of the lowest mortality rates in the England, with DCH having one of the lowest mortality rates in the southwest. Board members noted the shift towards outcomes reporting and commented positively on the improved format of the report which would support triangulation with the Board Assurance Framework. Ward and care group level dashboards were also being developed and would inform the overall report going forward. In the medium to longer term, the ambition was to implement service line reporting. **System Performance Update** The Board noted the report provided and the relative good performance by DCH in delivering the 65-week trajectory. there had been growth in the number of dermatology and urology referrals and pressure within urgent and emergency care services persisted. System-wide discussion to review plans to reduce the numbers of patients with No Reason to Reside and to deliver trajectories were ongoing. **Elective Priorities** This paper was noted.	**Execs**
	Resolved that: the Balanced Scorecard, System Performance Update and Elective Priorities be received and noted.	
BoD23/047	**Board Subcommittee Escalation Reports**	
	The following subcommittee Escalation Reports were taken as read. Committee Chairs drew attention to the following key points: **Finance and Performance Committee** • Successful digital firewall implementation. • Mitigation of the SPLUNK risk. • Improved performance across metrics • The financial deficit remained a concern. An update system position was sought.	

	• Estates master plan noted a potential risk to electricity supply associated with the New Hospitals Programme. • Demand at front door remained high. • DCH provided the best renal centre in county. • Greater scrutiny and assurance relating to the Premises Assurance Model submission. **People and Culture Committee** The report was taken as read. The Board noted several key consultant appointments in recent months and an increase in the number of staff leaving the trust with retirement being the top reason. **Quality Committee** • Continued close monitoring of SHMI and triangulation with other metrics to provide assurance. • Loss of accreditation in the Microbiology service. Further evidence had been submitted and a revisit was expected. A review of inspection and accreditation programmes had commenced led by the Chief Medical and Chief Nursing Officers with support from the Quality Assurance Manager. The Board noted a review of the risk tolerance associated with these visits. • Industrial action as previously discussed. • A Venous thromboembolism deep dive was planned. • Work was underway review nutrition under the current PLACE arrangements. NHS Charities Together had approved use of funds to improve staff facilities as part of this review. • Elective priorities as previously discussed. • The CQC inspection of maternity services currently underway. • The Housekeeper and Ward Clerk roles were under review in order to support the Healthcare Assistant role which continued to experience recruitment difficulties. **Risk and Audit Committee** • The Internal Audit Progress Report had commented on the timing of actions being scheduled at year end and the need to review given other year-end pressures. • The Board Assurance Framework and Corporate Risk Register were being aligned with partners and all risks scoring 15 or above would now be automatically escalated. • The Clinical Audit Assurance Report was due to be presented in September. **Charitable Funds Committee** The report was taken as read and noted. CH noted good progress on the capital appeal to support the New Hospitals Programme.	
	Resolved that: Board subcommittee Escalation Reports be received and noted.	
BoD23/048	**Finance Report**	
	CH advised that the new format Month 3 Finance Report was being reported to the public session of the Board meeting in order to promote transparency and that the report would be further developed based on	

	feedback received. He drew attention to the following points within the report:
	• The Year-to-date deficit was driven by inflationary pressures linked to energy. Mitigations were in place and included an external review of energy contracts and fast tracking of sustainability plans.
	• Energy linked contracts also seeing inflationary pressures.
	• Drug expenditure was £0.5m above plan due to inflation and increased activity.
	• Agency spend had increased and was linked to industrial action and the need to staff 30 unfunded beds. Local processes were being kept under review.
	• The Value Delivery Board had been established to ensure sustainable financial delivery and were considering:
	  • Productivity workstreams
	  • Delivery of the efficiency target of £10.4m.
	  • sustainable workforce and growing the Bank.
	  • operational efficiency
	• Capital expenditure was £800k behind plan driven by the timing of plans.
	• Cash remained above plan due to capital underspends.
	
	JH reminded the Board of the impact of the pay award paid in June on spend and advised that the Safe Staffing Group noted the correlation between patient acuity and increased temporary staffing spend. The Bank fill rate stood at circa 92% with more shifts being requested and less being filled Increases in the number of patients in hospital with No Reason To Reside, operating 30 unfunded beds and the opening of escalation beds were contributory factors in the increased spend.
	
	Creative solutions to maintain safe staffing levels included a review of existing roles and areas of cross cover. The overall level of 'Headroom' remained lower than that of partners at 18% and this was to be reviewed again in the autumn, although the pipeline to fill any investment in headroom would take time to deliver. The approach to recruitment events was also under review as these were not converting to the anticipated number of successful appointments. A referral to the Finance and Performance Committee was made to review agency expenditure and to seek further assurances.
	
	Further system scrutiny of the level of agency spend was expected and it was emphasised that the trust needed to demonstrate that all internal measures were being taken to manage the spend and operate according to best practice. The Board also requested an update report at the next meeting and requested that the report should demonstrate the extent to which external system drivers were impacting on the trust i.e. increasing NRTR numbers, need to open unfunded or escalation beds, supporting mental health patients in acute hospitals.
	
	CL acknowledged the need to ensure an appropriate balance and to ensure that staff took their planned leave. Further discussion would be had outside the meeting on unfunded beds with CH.
		FPC
		
		JH / NP
		
		CH

	Resolved that: the Finance Report be noted.	

BoD23/049	**Board Assurance Framework**	
	The Board noted that an incorrect version of the front sheet was attached to the report and that the Board Assurance Framework had been reviewed by the Risk and Audit Committee in June. Two workforce related risks scoring 20 or above and ten risks scoring 16 or above were included. Prior discussion of the SHMI risk by the Board was noted. NJ highlighted that the strategic financial risk tended to be scored lower at the at the beginning of the financial year and questioned whether the scoring needed to be higher given the difficult operating environment and financial challenges in the current year. Discussion followed that the risk scoring matrix used by the trust was being aligned with that of partners, although the 5 x 5 matrix would be retained. Longstanding risks were being reviewed and cleansed by working groups reporting to respective committees. AT that the No Reason to Reside risk was currently the subject of system-wide discussion and that the narrative would be updated for the next report. The commented on the alignment of the BAF risks with issues reported in the performance dashboard and assurances were sought that mitigating actions were sufficient. The previously tolerated workforce risk was also under review following the completion of the risk appetite review. Changes as a result of the Board risk workshop were being worked through and an updated action plan, informed by the risk maturity audit currently in train, would be returned to the Board via the Risk and Audit Committee and other committees in September. Divisional risk reports would be formally included in future performance meetings. The risk training offer to staff had also been reviewed, providing four levels of training.	**JH / NJ**
	Resolved: that the Board Assurance Framework be received and noted.	
BoD23/050	**Corporate Risk Register**	
	JH noted the ongoing housekeeping review of the content of the report and drew the Board's attention to the following: Revision of the risk appetite statement clarifying that the 'appetite' to take risks or otherwise related to strategic risks. The Risk Management Policy remained under review and aimed to promote clarity about the nature of risks, more clearly identify the mitigations and identify the interrelationship between corporate and strategic risks. It was clarified further that the Board Assurance Framework denoted strategic risk and mitigation and that the Corporate Risk Register denoted operational risks, which collective may have an impact on delivery of the trust's strategic goals. The Board felt assured that they were sighted on the key risks.	

	Resolved: that the Corporate Risk Register be received and noted.	
BoD23/051	**Committee Priorities**	
	NJ reminded of the discussion about the Forward Plan and the five outcomes earlier in the meeting and questioned how committees would measure their contribution to delivering these or reflect the impact of more integrated working in respective committee priorities. The committees would keep these points under review and would include these in the annual committee effectiveness review process going forward. The committee priorities were approved.	
	Resolved: that the Committee Priorities be approved.	
BoD23/052	**Complaints Annual Report 2022-23**	
	JH presented the report and highlighted a small decrease in the number of formal complaints received during the reporting period. JH advised that work had commenced with the recently appointed new Patient Experience Manager to develop the trust's PALS response as this most often provided a more satisfactory response and experience for complainants. The complaint policy was also under review to reflect this approach and to better coordinate the process. JH advised that 12% of complaints were reopened and outlined plans to initiate earlier discussion with complainants should there be any follow up to complaints responses, in order to extract greater learning. The new complaints standards emphasised the need to adopt a just culture going forward and for swift informal responses. The standards would be published in the autumn. The majority of complaints related to communications and included system generated communications such as appointment letters as well as communications by members of staff relating to attitude etc. 50 % of complaints related to consultants and the Board noted the need for further analysis of this. A correlation between increased activity levels and increased communications complaints was noted. The Patient Experience and Engagement and the End of Life Steering Groups would follow up respective aspects of communication complaints and the Leadership Development programmes would include discussion of complaints and behaviours going forward. The ambition was to move to a position where the trust had a higher level PALs resolutions and lower level of formal complaints as current performance did not compare well with neighbouring organisations. Discussions had commenced with DHC in order to acquire learning, inform development of the policy and to develop action plans. EJ reflected discussion by the Quality Committee that had indicated that the report provided a lot of data and could be improved by asking complainants about their experience of the complaint process and involving them in process codesign, changing practice and production of reports going forward. The Patient Experience Annual Plan would include	

	development of the complaints process and report on progress made in the current year via Quality Committee.	
	Resolved: that the Complaints Annual Report 2022-23 be received and noted.	
BoD23/049	**Maternity Update**	
	JH joined the meeting for this item and apologised for the late circulation of the report. JH highlighted: • An increasing trend in staffing incidents reported and the impact on activity. • Three incidents of missed injections following VTE risk assessment that were being explored via local governance routes. The findings would be reported to Quality Committee. • The Serious Incident report had been updated and anonymised for the Board's attention. • A new risk relating to the management of the second theatre in an emergency had been added to the risk register. • The report included safety and quality and safety enhancements that had been made. • One complaint about patient's experience had been made and was being resolved by the PALS team. learning acquired would inform future mandatory training. • Mandatory training compliance continued to improve. • A recent survey of patient experience was currently being analysed. The Board sought clarity on the Year 5 Maternity Incentive Scheme requirements. Dashboard reflecting the requirements were being collated. Key actions for the Board included the need to ensure that Non-Executive (NED) colleagues were sighted on culture, quality, safety and leadership discussions and to provide assurance of neonatal safety. Visibility of the NED Safety Champion and Executives was a key component and concerns raised by staff would be incorporated into the safety walkabout programme. The Board needed to demonstrate awareness of progress made and to evidence delivery of the action plan. Regular updates, alongside perinatal mortality and neonatal deaths would be included in future reports to the Quality Committee. The Board noted the increasing focus on maternity services nationally and subsequent increasing demands of NED time. The Maternity Incentive Scheme would enable maternity governance roles to be substantivised and this would be discussed further outside the meeting. Discussion followed about the longer-term morbidity impact arising from possible brain injury at birth. All cases were reported to NHS Resolution and were investigated, and further information was provided by consultant led baby clinics and claims received. In all cases, the outcomes and feedback were analysed to extract and share learning.	**CH / JH**

	The Board noted the CQC inspection currently in process and that an update on the outcome would be provided in due course.	
	Resolved: that the Maternity Update be received and noted.	
BoD23/054	**Safeguarding Children and Adults Annual Report 2022-23**	
	The Board were reminded of prior discussion of the report by the Quality Committee and that the report had been presented in line with statutory requirements. SC reported that there had been heightened activity throughout the year as a consequence of the impacts of austerity and increasing deprivation. A key challenge had been increasing numbers of children presenting with pyscho-social behaviours issues and increases in drug and alcohol intake. Cases were being reviewed on a weekly basis to identify themes and for escalation to partner agencies. The small team had recently successfully recruited a new learning disability and autism lead. The recently introduced Oliver McGowan training e-learning programme, commissioned by NHS Dorset, was encountering roll out difficulties. The training was supplemented by an e-learning package and was mandated for all. Further discussions with the ICB were felt could be useful in supporting further rollout of the programme. Service visits were in place to promote staff understanding of the safeguarding service. In terms of challenges, SC reported that a lack of appropriate communication reduced service user experience quality and outcomes for individuals. Level 3 training compliance remained difficult to achieve and a suite of training opportunities, working with the education team, had been rolled out to staff to improve compliance. Whilst overall compliance was improving, the trust was not yet achieving the target. Whilst a significant amount of work had been undertaken nationally and locally, implementation of the expected Liberty Protection Safeguarding (LPS) legislation that was to replace Deprivation of Liberty Safeguards (DoLS) had been further delayed nationally until after the next general election. The increase in the number of DoLS applications locally was commented upon and the Board was assured that referrals were appropriate and reflected prompt notification and the needs of a large older people population. The Safeguarding Group continued to monitor red rated documentation indicators. The service continued to operate paper systems and support from the highly pressurised Digital team to implement digital solutions was awaited. Clinical Practice Educators were supporting the monitoring of documentation in practice. The Board sought assurance that supervision for safeguarding practitioners was taking place and requested that future reports to the Quality Committee provided updates on this.	

	In response to a question regarding the Mary Anning Unit, safeguarding learning and triangulation with metrics, the Board heard that an internal audit was due to be undertaken by the trust's Internal Auditors the following week and that the outcome would be reported to the Risk and Audit Committee. The board extended their thanks to the safeguarding team for the work throughout the year.	
	Resolved: that the Safeguarding Children and Adults Annual Report 2022-23 be received and noted.	
BoD23/055	**Infection Prevention and Control Annual Report 2022-23**	
	JH reported that review of water safety and ventilation would be added to the report as appendices in the near future and summarised key aspects of the report as follows: • The trust remained under the Clostridium Difficile and bacteraemia trajectories. There remained a continued focus on antimicrobial resistance and a new Microbiologist was expected to commence employment with the trust in August. • The requirement to use COVID personal protective equipment (PPE) had been stepped down in April 2023. The considerable efforts of teams across the trust during the pandemic were acknowledged. • There had been a minimal number of norovirus cases during the year although there were a couple of recorded incidents currently. • Water safety capacity challenges were noted and a new leadership arrangement had been recently implemented. Capacity challenges within the estates team were also noted. Once complete, the report would be returned to the Quality Committee and then be presented to the Board as a consent item. The Board commended the Infection Prevention and Control team for their dedication to maintaining safety for staff and patients during what had been another tough year.	**JH**
	Resolved: that the Infection Prevention and Control Annual Report 2022-23 be received and noted and that the final report would be returned to the Board via Quality Committee once complete.	
BoD23/056	**Questions from the Public**	
	In response to the question submitted by JPL in advance of the meeting regarding theatre utilisation, AT advised that the waiting list informed decisions on utilisation and that the manual system currently being used was being replaced in order to capture more meaningful data. Comparisons could then be drawn with partners across the region and learning and improvements could be shared. Current variations in utilisation across theatres was being reviewed in order to identify and share best practice.	

	KH enquired whether Board members participated in 'back to the floor' visits to services as the high-level Board discussions appeared to be remote from what happened within the hospital on a daily basis. In response, the Board heard that NEDs were actively involved in safety walkarounds. The Board function was to ensure delivery of the strategy although members were regularly involved and engaged in discussions with the front line through staff and patient stories. Board members participated in the planned weekly walkarounds which used the 15 Steps Challenge approach, talking to staff and patients about the issues and challenges they faced. Issues or concerns raised were recorded and reported back to the Executive Management team. the Board noted the open-door approach adopted by Executive team and the multiple ways in which staff could raise concerns within the trust, including via the Freedom to Speak Up Guardian. A question was raised regarding the proportional apportionment of costs associated with joint appointments between DCH and DHC. It was clarified that the Memorandum of Understanding outlined the approach agreed by both trusts to sharing costs and that the aim of the collaboration with DHC was to deliver benefits to patients. Joint appointments aimed to be mutually beneficial and the division of time within each trust was expected to be equally split.	
	CONSENT SECTION	
	The following items were taken usually without discussion. No questions were previously raised by Board members prior to the meeting.	
BoD23/057	**Working Together Committee in Common** • Memorandum of Understanding • Data Sharing Agreement • Terms of Reference	
	Resolved: that the Working Together Committee in Common o Memorandum of Understanding o Data Sharing Agreement o Terms of Reference **be received and noted.**	
BoD23/058	**Medical Revalidation Report**	
	Resolved: that the Medical Revalidation Report be received and noted.	
BoD23/058	**Digital Services Report**	
	Resolved: that the Digital Services Report be received and noted.	
BoD23/060	**Organ Donation Report**	
	Resolved: that the Organ Donation Report be received and noted.	

BoD23/061	**ICB Board Minutes Part 1**	
	Resolved: that the ICB Board Minutes Part 1 be received and noted.	
BoD23/062	**Any Other Business**	
	No other business was raised or notified.	
BoD23/063	**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** and via **MS Teams.**	

Action Log – Board of Directors Part 1

Presented on: 27th September 2023

Minute	Item	Action	Owner	Timescale	Outcome	Remove? Y/N
Meeting Dated: 26th July 2023						
BoD23/046	**Balanced Scorecard**	To further develop the supporting narrative relating to metrics within the report.	**Executives**	September 2023		
BoD23/048	**Finance Report**	An assurance report outlining adherence to best practice and implementation of internal controls on agency expenditure to be returned to the Board.	**JH / NP**	September 2023		
		The report is to include the extent to which external system drivers are impacting – i.e. increased NRTR numbers	**CH**	September 2023	Included in finance report	**Y**
BoD23/049	**Board Assurance Framework**	An updated action plan, informed by the outcomes of the risk maturity audit, to be returned to the Board via respective sub committees and RAC.	**JH / NJ**	September 2023		
BoD23/049	**Board Assurance Framework**	Further discussion regarding substantivizing maternity governance roles, funded by the Maternity Incentive Scheme, to be had.	**CH / JH**	September 2023.	Conversations continuing as part of establishment review.	
Meeting Dated: 31st May 2023						
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**

Actions from Committees…(Include Date)						

Actions to Committees…(Include Date)

BoD23/048 **From Board 26.7.23**	**Finance Report**	To review agency expenditure and to seek further assurances. To consider the impact of contributory factors including NRTR, Unfunded beds and the opening of escalation beds.	**To FPC**	September 2023		

Report Front Sheet

1. Report Details			
Meeting Title:	Board of Directors		
Date of Meeting:	Wednesday 27th September		
Document Title:	CEO Report		
Responsible Director:	Matthew Bryant, CEO	Date of Executive Approval	20.09.23
Author:	Jonquil Williams, Corporate Manager		
Confidentiality:	No		
Publishable under FOI?	Yes		
Predetermined Report Format?	No		

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

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

4. Key Issues

National

- Lucy Letby Trial - Following the outcome of the trial the trust has received letters from NHS England and the National Guardians Office setting out the key actions to take in advance of the public inquiry. These require trusts to urgently ensure
- Industrial Action - A four-day period of industrial action by junior doctors took place from 11-15 August 2023. Consultants who are members of the British Medical Association (BMA) took 48 hours of national strike action from 7am on Thursday 24 August until 7am on Saturday 26 August 2023.

Dorset Integrated Care System

- Dorset ICS is one of two pilot sites selected to support the CQC in testing its ICS assessment framework single assessment framework.
- Medium Term Financial plan Work has continued at pace to finalise the system Medium Term Financial Plan, which is due for submitted to NHS England by 28 September 2023.
- Dorset Council is developing its housing strategy, which will set out its vision for future housing in the Dorset Council area.

Dorset County Hospital

- The new Discharge Lounge for patients who are ready to leave hospital has opened at Dorset County Hospital (DCH).
- Dorset Council (DC) have approached DCHFT looking for a site in Dorchester to locate a new reablement facility, focusing on short term recovery and rehabilitation. Particularly the site where DCHFT THQ and the Diabetes Centre currently sits, extending into the gravel car park to the South.
- Trust-wide rollout of both COVID and flu vaccinations will begin later in

	September or early October • Work to refurbish Ridgeway Ward and turn it into a 24-bedded space, which will be ringfenced for orthopaedic elective surgery, is due to start soon.
5. Action recommended	1. **NOTE**

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 the Board on national and local topics of interest.

2. National Topics of Interest

Lucy Letby Trial Verdict

2.1 At the heart of the Lucy Letby trial and the events at Countess of Chester Hospital are the families whose children have died or been harmed by an individual who has fundamentally betrayed the trust that is given to all of us who work in healthcare to care for patients and families at the most vulnerable moments of people's lives.

2.2 There are a number of other wider issues that come out of the case – including how we speak up and listen in healthcare when we feel that things are not right, the culture of healthcare organisations, and how boards assure themselves of the safety of services, and that colleague and patient voices are being heard. These themes will be the subject of the independent public inquiry that has been announced by the Department of Health and Social Care that will have statutory powers.

2.3 In advance of this both boards have spent development time reflecting on the events, as we currently understand them, that took place at the Countess of Chester and the impact for us in terms of how we take assurance at board level on the above issues.

2.4 Considerable reflection has also been taking place within teams across both organisations. As CEO I have led discussions with both senior teams and have also reflected at length via my CEO bulletin. I have stressed the importance of listening, acting on concerns, speaking up when things are not right, and the responsibility we all have to create the right culture in healthcare that values civility, kindness and compassion.

2.5 These conversations have also highlighted the more formal Freedom to Speak up routes, the importance of colleague networks, and the introduction of the new Patient Safety Incident Framework from this month. I have regular meetings with both trust Freedom to Speak up Guardians, and colleagues across the trust have the opportunity to meet me in person in slots that I make available on a regular basis.

2.6 In both trusts the Chief Nursing Officers have worked closely with clinical colleagues to discuss the case and the impact it has had. The importance of speaking up has been emphasised in these conversations and specific support has been offered to colleagues working in clinical environments such as the special care baby unit, based on resources prepared by NHS England.

2.7 In both trusts we are currently undertaking a self-assessment against the national freedom to speak up framework and the outcome of this will be reported through to each board.

2.8 Following the outcome of the trial the trust has received letters from NHS England and the National Guardians Office setting out the key actions to take in advance of the public inquiry. These require trusts to urgently ensure:

- All staff have easy access to information on how to speak up;
- Relevant departments are aware of the national Speaking Up Support Scheme and actively refer individuals to the scheme;
- Approaches/mechanisms are put in place to support members of staff who may have cultural barriers to speaking up or who are in lower paid roles and may be less confident to do so, and also those who work unsociable hours and may not always be aware of or have access to the policy or processes supporting speaking up. Methods for communicating with staff to build healthy and supporting cultures where everyone feels safe to speak up should also be put in place;
- Boards seek assurance that staff can speak up with confidence and whistleblowers are treated well; and
- Boards are regularly reporting, reviewing and acting upon available data.

Industrial Action

2.9 A four-day period of industrial action by junior doctors took place from 11-15 August 2023. Consultants who are members of the British Medical Association (BMA) took 48 hours of national strike action from 7am on Thursday 24 August until 7am on Saturday 26 August 2023.

2.10 During September junior doctors and consultants have coincided strikes for the first time on 20 September and this will be repeated in October, with action planned from 2-4 October. There will be a greater impact on service delivery from this action than in previous rounds of strikes, with elective surgery expected to cease and 'Christmas Day cover' arrangements employed more widely. Colleagues continue to work closely together to minimise this impact, and to maintain the safe delivery of the services we provide. The strike days will be carefully planned and coordinated. The Trust fully recognises and respects the right of colleagues to participate in industrial action.

2.11 In a re-ballot for continued junior doctor strike action by the British Medical Association (BMA), 98 percent of junior doctors in the UK voted in favour of continuing their planned strikes for the upcoming months, providing the BMA with a six month mandate for continued industrial action.

Fit and Proper Persons Test for Board Members

2.12 The NHS have published new standards for NHS Board members to strengthen leadership and governance in response to the 2019 Kark review. The Fit and Proper Person Test framework will be taken into account when making Board appointments from 30 September 2023 to ensure NHS executive and non-executive directors are 'fit and proper' for their roles. A separate report setting out the requirements and the proposed Trust approach in more detail is included separately on the September Board agenda.

Women's Health Hubs

2.13 The publication of the Women's Health Strategy for England in August 2022 set out a range of commitments to improve the health of women over the next 10 years. This included a commitment for the expansion of women's health hubs around the country and other models of 'one-stop clinics', bringing essential women's services together to support women to maintain good health and create efficiencies for the NHS. In March 2023, Department for Health and Social Care announced a £25m investment for women's health hub expansion and allocation of funding investment was confirmed to ICBs in July 2023. Work is now underway to identify how NHS Dorset will support the establishment of a women's health hub for Dorset, providing services in a way that best meets the population needs, reduces health inequalities and delivers on the ambition in the Women's Health Strategy.

Department of Health and Social Care Major Conditions Strategy

2.14 On 21 August 2023 the Department of Health and Social Care published the Major Conditions Strategy, which sets out how the government's approach to health and care delivery will evolve to improve outcomes and better meet the needs of the population, recognising the population is becoming older and living with multimorbidity. The strategy focuses on addressing lifestyle drivers of ill-health and disease, early intervention to reduce complications (secondary prevention), early diagnosis/intervention and quality treatment, and supporting people as they manage living with major conditions.

3. Dorset Integrated Care System

Dorset Integrated Care System (ICS) CQC Pilot Assessment

3.1 Dorset ICS is one of two pilot sites selected to support the CQC in testing its ICS assessment framework single assessment framework. The aim is for CQC to understand how integrated care systems are working to tackle health inequalities and improve outcomes for people. This means looking at how services are working together within an integrated system, as well as how systems are performing overall. The reviews take into consideration the core purpose of integrated care systems, as referenced in NHS England's design framework and focus on the three themes outlined in the legislation: quality and safety, integration, and leadership. An inspection report will be published following the pilot assessment, but it is not clear whether the Dorset System will receive a rating.

3.2 The Trust has supported NHS Dorset in its preparations for the assessment, including responding to information requests. On 14 September 2023 the Chief Executive joined ICS partners to give a presentation to the CQC to set out how we work as a system.

3.3 The CQC assessment will be conducted in October 2023 and their visits will include focus groups and meetings with key ICS individuals identified by the CQC. Senior colleagues from across the Trust will continue to fully engage in and support the assessment.

Dorset ICS Medium Term Financial Plan

3.4 Work has continued at pace to finalise the system Medium Term Financial Plan, which is due for submitted to NHS England by 28 September 2023. System leaders met on 14 September 2023 to refine the plans, and the final plan is included on the Board agenda for approval as a separate item.

Dorset ICS Winter Plan

3.5 Dorset ICS has started early preparation to develop a system winter plan. The Trust has been fully engaged in the system winter planning group which has met weekly to progress this work. The purpose of the winter plan is to ensure we provide the safest and highest quality care possible for the Dorset population by balancing the clinical risk within and across all acute, community, mental health, primary care, and social care services. System partners are focused on increasing capacity and operational resilience in urgent and emergency care throughout winter.

Dorset Council Housing Strategy and BCP Council Draft Plan

3.6 Dorset Council is developing its housing strategy, which will set out its vision for future housing in the Dorset Council area. A public consultation on the strategy has opened to inform the final strategy which is due to be published by the end of 2023.

3.7 BCP Council is finalising its new Council Plan, which will set out the council's longer-term priorities and high-level actions. The Council Plan will be underpinned by a council-wide delivery plan of actions for the next four years. Again a public consultation is underway.

3.8 Dorset HealthCare and other key system partners will continue to support the development of the Dorset Council Housing Strategy and BCP Council Plan.

Portland Asylum Seeker Accommodation

3.9 A provider has been commissioned to provide GP primary care services on board the Bibby Stockholm barge at Portland. The provider has extensive experience through working with asylum seekers currently accommodated in hotels in the Bournemouth area. Access to out of hours and emergency healthcare remains available via the core NHS offer. The first asylum seekers arrived on board week commencing 7 August. However following legionella identified in the water supply on the barge, the Home Office relocated the residents on 11 August 2023.

4. Strategy

Working Together Programme (WTP)

4.1 Twelve months on from the decision to recruit a joint CEO and joint Chair, a review of the WTP has begun. Following the progression through phase 1 (decision), phase 2 (appointments) and phase 3 (establishing the programme), the review will ensure that we continue to deliver on our goals, whilst shaping the forward plan for the next 12

months. This will pay particular attention to balance across the Integrated Care System and the need to work closely with all partners.

4.2 Key priorities emerging from the first Joint Leadership Group meeting on 10 August that will inform the focus of the WTP and planning for future sessions include:

- The role of leaders in the Working Together Programme;
- The support leaders and teams need through change;
- How a shared culture and purpose can support this.

4.3 A Board to Board meeting is scheduled for 25 September 2023 to provide the Boards with an update on progress, flagship and case study presentations and an opportunity to consider the next steps.

4.4 The recruitment process is underway for a joint Director of Corporate Affairs, with interviews due to take place in late November 2023. This joint role will help to simplify the way we work across the two Trusts, whilst ensuring that each organisation continues to meet its statutory requirements in terms of governance. Julie Dawes has joined Dorset HealthCare to provide interim cover as Director of Corporate Governance.

5. Dorset County Hospital

Discharge Lounge

5.1 The new Discharge Lounge for patients who are ready to leave hospital has opened at Dorset County Hospital (DCH). DCH secured £2millon from NHS England as part of plans to expand hospital discharge lounges and ambulance hubs across the country. Discharge lounges are dedicated areas for patients who are waiting for their medication or transport once they are medically fit to leave hospital. The funding was used to install a single-storey modular building in front of North Wing Entrance 2 that was pre-made and assembled on site.

5.2 Known as the Portesham Unit, the new building provides a much larger, purpose-built space for patients to stay while they wait to be discharged, freeing up inpatient beds in the meantime for patients who need to be admitted. It also includes additional, flexible clinical space with side rooms and bed bays to be used by other hospital services. Open from 8am until 8pm, the Discharge Lounge has comfortable seating, recliner chairs, beds and refreshment facilities. The Discharge Lounge team can carry out final tests and tasks, plus help link families up with local voluntary support for patients as they return home.

Reablement Facility

5.3 Dorset Council (DC) have approached DCHFT looking for a site in Dorchester to locate a new reablement facility, focusing on short term recovery and rehabilitation.

Particularly the site where DCHFT THQ and the Diabetes Centre currently sits, extending into the gravel car park to the South.

5.4 The new centre would significantly increase the capacity for the number of people receiving recovery and rehabilitation care and provide a modern fit-for-purpose facility for the future of care delivery for all our residents.

5.5 The proposal is the first development of a programme to ensure Dorset Council has the required care capacity, with up to £80 million ear marked for the purpose from its capital account, and this will build on work already progressed to support residents who are discharged from hospital or are recovering after a fall or illness in their own home.

Emergency care at Dorset County Hospital

5.6 Dorset County Hospital (DCH) is continuing to provide good urgent and emergency care despite the unprecedented pressures faced by Emergency Departments throughout the country. The Care Quality Commission's latest national Urgent and Emergency Care Patient Survey highlights the experiences of thousands of people across the country who used A&E services during September 2022.

5.7 Responses were received from 438 people who attended Dorset County Hospital's Emergency Department, with many reporting a positive experience of the care and treatment they received. People were asked to answer questions about different aspects of their care and treatment. Based on their responses, each NHS trust was given a score out of 10 for each question (the higher the score the better). Each trust also received a rating of 'Much better', 'Better', 'Somewhat better', 'About the same', 'Somewhat worse', 'Worse' or 'Much worse'.

5.8 DCH compared well with other trusts, receiving 'about the same' or 'better than expected' scores for all nine areas people were asked about. Aspects of care that were highlighted as particularly positive included not having to wait too long before first speaking to a doctor or nurse, not having to wait too long before being examined by a doctor or nurse, and hospital staff discussing transport arrangements for leaving the Emergency Department.

Winter planning - Staff Vaccination

5.9 Trust-wide rollout of both COVID and flu vaccinations will begin later in September or early October, but in the meantime we will be offering staff and patients in higher risk areas the chance to have a COVID-19 booster from Tuesday 12th September.

Ridgeway Ward decant

5.10 Work to refurbish Ridgeway Ward and turn it into a 24-bedded space, which will be ringfenced for orthopaedic elective surgery, is due to start soon. This is part of our

Patient Pathway Improvement Programme (PIPP) which includes the ongoing work to create a permanent Outpatient Assessment Centre at South Walks House.

5.11 The first phase is to move our patients and staff out of the ward on Monday (11 September) to the 14-bedded area in the Portesham Unit (the new modular building which houses the new Discharge Lounge). The second phase is five weeks of pre-works, set to start once the ward is empty. The third phase is the refurbishment of the ward, which we expect to start on 6 November.

6. Recommendation

6.1 The Board is asked to note the report.

Matthew Bryant, Chief Executive
September 2023

Report 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

[Executive Dashboard - Sept 2023 Board - Power BI Report Server (dchft.nhs.uk)]

Quality and Safety

- National Joint Registry has identified a new risk with the number of reported Grade 2 heel ulcers in patients admitted with Hip Fractures.
- Trust wide focus continues in training and competencies regarding assessing, preventing and managing risks of pressure damage.

Performance

- Cancer - For August 2023, the Trust achieved the 31 day to treatment target. All other constitutional cancer standards were missed.
- Elective - The Referral to Treatment standard (18 weeks) was not met for August 2023, with 54.77% of patients being treated within 18 weeks. For the reporting month of July, the national RTT performance was 58.6% and the South West Region was 59.2%.
- Urgent and Emergency Care - Demand at the front door continues to be far above the level set in the operating plan, with year-to-date growth of 8.49%. Performance against the 4-hour standard remained above trajectory, but did reduce slightly, with the number of patients with no reason to reside increasing in month.

People

- Sickness absence increased in Month 4 to 4.1% with the biggest increase being in short term sickness.
- Substantive workforce capacity remained relatively static in month 5 but bank capacity increased. Turnover continues to reduce.
- The Trust appraisal rate reduced by 1% but work is underway to identify

	appraisals that have been completed but not recorded. **Finance** • Adjusted Financial Position: Impact of inflationary pressures • Agency Spend: Higher than planned agency usage with allocate on arrival usage and HCA cover by RN agency continuing to be high. • Capital Expenditure: The position is currently behind plan year to date 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 operational pressures
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			
	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**	

Dorset County Hospital Balance Scorecard

1. Introduction

September 2023 Executive summary dashboard.

1. Quality and safety

- National Joint Registry has identified a new risk with the number of reported Grade 2 heel ulcers in patients admitted with Hip Fractures and reported on the National Joint Registry. Work underway to review the Hip Fracture pathway and to ensure compliance with pre-alerts, use of pressure relieving equipment in ED and appropriate assessments and interventions to mitigate risk.
- Ongoing monitoring of the environment. All clinical areas are currently conducting a strategic cleaning review with IPC/Housekeeping, several areas have been deep cleaned during July and August 23. Housekeeping Lead is developing an ongoing deep clean plan.
- Recruitment in progress for Tissue Viability Lead Nurse and a reset of the Pressure Ulcer Group to focus on prevention and compliance with Trust policies.
- Trust wide focus continues in training and competencies regarding assessing, preventing and managing risks of pressure damage.
- Water safety checks of the new discharge lounge have come back as passed with no signs of legionella. Flushing regime has been implemented as part of the cleaning processes.

2. Performance

- Cancer - For August 2023, the Trust achieved the 31 day to treatment target. All other constitutional cancer standards were missed. The total waiting list size increased by 12 patients, the backlog (over 62 days) decreased by 5 patients to 90 and the backstop (over 104 days) increased by 7 patients to 28. This is an improved position compared to the previous month and continued improved against the 28 day to diagnostics standard has been achieved, with the 28 day standard meeting trajectory, although missing the target.
- Elective - The Referral to Treatment standard (18 weeks) was not met for August 2023, with 54.77% of patients being treated within 18 weeks. For the reporting month of July, the national RTT performance was 58.6% and the South West Region was 59.2%. The total waiting list increased by 101 patients compared to the previous month; the total waiting list size is 749 patients larger than the 2023/24 trajectory. The 2022/23 planning guidance requires the Trust to have no patients, waiting over 78 weeks for treatment at the end of 2022/23. At the end August 2023, DCH had 4, either due to patient choice, or complex pathways, the forecasted position for September is zero. The 2023/24 waiting list target is to have zero patients waiting over 65 weeks at the end of March 2024. DCH are 78 patients behind plan for the month of August. As part of the operating plan, there was a requirement to submit a 52-week trajectory, which shows improvement ahead of the 2024/25 target to reduce this to zero. DCH are 370 patients behind plan against the 52+ week trajectory. DCH has now eradicated all patients waiting over 104 weeks and continues to maintain this position. Activity levels are below plan, driven by industrial action which now accounts for 30 days of reduced activity year to date. For diagnostic performance, the Trust achieved 75.07% against a target of 99% in August. This is a decrease of 2.2% compared to the previous month. The backlog increased by 81 patients and the total waiting list size decreased by 46 patients, August a high annual leave month, which has driven this growth.
- Urgent and Emergency Care - Demand at the front door continues to be far above the level set in the operating plan, with year-to-date growth of 8.49%. Performance against the 4-hour standard remained above trajectory, but did reduce slightly, with the number of patients with no reason to reside increasing in month. Demand at the front door and an increasing no reason to reside number, has resulted in a decline in ambulance handover delays performance, although the Trust remains a top performer within the Region. In response to demand increases, the trust did have an average of 325 open beds, against a plan of 279, which translates to a cost

pressure of £499,100 assuming a bed day cost of £350, for the month of August 2023. The month of August had the highest number of open beds year to date.

3. People

- Sickness absence increased in Month 4 to 4.1% with the biggest increase being in short term sickness. The wellbeing offer for staff was extended in month 5 through the introduction of the wellbeing platform called Your Care.
- Substantive workforce capacity remained relatively static in month 5 but bank capacity increased. Turnover continues to reduce.
- The Trust appraisal rate reduced by 1% but work is underway to identify appraisals that have been completed but not recorded.

4. Finance

- 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 23 unfunded beds also contributing to the position.
- Agency Spend: Higher than planned agency usage with allocate on arrival usage and HCA cover by RN agency continuing to be high. Cover during peak industrial action periods has impacted the year to date position as has supporting 23 unfunded beds
- Capital Expenditure: The position is currently behind plan year to date 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 operational pressures including 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 September 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

2023-09-13 12:15:17
data last refreshed:

30 April 2019
metric data from:

31 August 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

Balanced Scorecard

Select an icon to view relating metrics

Variation

Assurance

PERFORMANCE

Metric Name	Assurance	Variation	Value	Target
Cancer - 28 Day Faster Diagnosis Standard Performance			69.82%	75%
Cancer - 31 Day Treatment Performance			96.19%	96%
Cancer - 62 Day Performance			83.11%	85%
Diagnostic - Percentage of Patients waiting less than 6 weeks for a diagnostic test	F	L	75.07%	99%
ED - 12 Hour Waits		H	260	
ED - Ambulance Handover Delays Average Time Lost per Day			15.78	
ED - Overall 4 Hour Performance %		H	79.02%	76%
Elective Recovery - Day Case Activity vs 2019/20		H	110.47%	104%
Elective Recovery - Elective Inpatients Activity vs 2019/20	F		74.6%	104%
Elective Recovery - Outpatient Activity vs 2019/20			100.5%	104%
Elective Recovery - Total Elective Activity vs 2019/20			101.36%	104%
Inpatient - Percent Bed Occupied by No RTR		L	17.53%	
Outpatient - Virtual Activity %	F	H	21.36%	25%
RTT - 52+ week waits			1462	1093
RTT - 65+ week waits	F	L	336	258
RTT - 78+ week waits		L	4	
RTT - Waiting List Size	P	H	21005	20256
Theatre - Utilisation	F		72.16%	85%

PEOPLE

Metric Name	Assurance	Variation	Value	Target
Appraisal rate	F		74%	90%
Essential Skill Rate	F	H	90%	90%
Sickness rate (one month in arrears)		H	4%	3%
Staff Turnover Rate	P	H	11%	12%
Vacancy Rate (substantive)	F	H	10%	5%

QUALITY

Metric Name	Assurance	Variation	Value	Target
Complaints - Total Number Received (Informal & Formal)		H	153	
Friends and Family - Overall - Recommend Rate			92%	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			68	
Incidents - Pressure Ulcers - Hospital acquired (grade 3) confirmed avoidable			1	
Incidents - Serious Incidents investigated and confirmed avoidable			0	0
Infection Control - C-Diff Hospital Onset Healthcare Associated			3	3
Infection Control - Gram Negative Blood Stream Infections			6	5
Inpatient - % Emergency Re-Admissions (16+ & <30 Days) (1 month arrears)	P		8.76%	13%
Inpatient - Percentage of EDS available within 24 hours of discharge	F	H	79.16%	90%
Inpatient - Percentage of EDS available within 7 days of discharge	F		86.51%	100%
Inpatient - SHMI Value		L	0	

FINANCE

Metric Name	Assurance	Variation	Value	Target
Adjusted Financial Position			-762	7
Agency Spend (Monthly)	F		1330	833
Capital Expenditure (Monthly)			2091	1590
Efficiency Delivery	P	H	513	900
Off Framework Agency Spend			139	83

Matrix Overview

Dorset County Hospital NHS Foundation Trust

Assurance

Variance	P	?	F		Total
H		2	3		5
L			2	3	5
	1	12	5	4	22
H	3	1	1	2	7
L			1		1
				1	1
Total	4	15	12	10	41

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	153	
Incidents - Never Events	F	L	0	0.02
Inpatient - Percentage of EDS available within 24 hours of discharge	F	H	79.16%	90%
Inpatient - Percentage of EDS available within 7 days of discharge	F		86.51%	100%

Commentary

National Joint Registry has identified a new risk with the number of reported Grade 2 heel ulcers in patients admitted with Hip Fractures and reported on the National Joint Registry. Work is underway to review the Hip Fracture pathway and to ensure compliance with pre-alerts, use of pressure relieving equipment in ED and appropriate assessments and interventions to mitigate risk.

Ongoing monitoring of the environment. All clinical areas are currently conducting a strategic cleaning review with IPC/Housekeeping, several areas have been deep cleaned during July and August 23. Housekeeping Lead is developing an ongoing deep clean plan.

Recruitment in progress for Tissue Viability Lead Nurse and a reset of the Pressure Ulcer Group to focus on prevention and compliance with Trust policies.

Trust wide focus continues in training and competencies regarding assessing, preventing and managing risks of pressure damage.

PERFORMANCE

Metric Name	Assurance	Variation	Value	Target
Diagnostic - Percentage of Patients waiting less than 6 weeks for a diagnostic test	F	L	75.07%	99%
ED - 12 Hour Waits		H	260	
Elective Recovery - Elective Inpatients Activity vs 2019/20	F		74.6%	104%
Outpatient - Virtual Activity %	F	H	21.36%	25%
RTT - 65+ week waits	F	L	336	258
RTT - Waiting List Size	P	H	21005	20256
Theatre - Utilisation	F		72.16%	85%

Commentary

Urgent and Emergency Care - Demand at the front door continues to be far above the level set in the operating plan, with year-to-date growth of 8.49%. Performance against the 4-hour standard remained above trajectory, but did reduce slightly, with the number of patients with no reason to reside increasing in month. Demand at the front door and an increasing no reason to reside number, has resulted in a decline in ambulance handover delays performance, although the Trust remains a top performer within the Region. In response to demand increases, the trust did have an average of 325 open beds, against a plan of 279, which translates to a cost pressure of £499,100 assuming a bed day cost of £350, for the month of August 2023. The month of August had the highest number of open beds year to date.

Elective - The Referral to Treatment standard (18 weeks) was not met for August 2023, with 54.77% of patients being treated within 18 weeks. For the reporting month of July, the national RTT performance was 58.6% and the South West Region was 59.2%. The total

PEOPLE

Metric Name	Assurance	Variation	Value	Target
Appraisal rate	F		74%	90%
Essential Skill Rate	F	H	90%	90%
Sickness rate (one month in arrears)	?	H	4%	3%
Staff Turnover Rate	P	H	11%	12%
Vacancy Rate (substantive)	F	H	10%	5%

Commentary

Sickness absence increased in Month 4 to 4.1% with the biggest increase being in short term sickness. The wellbeing offer for staff was extended in month 5 through the introduction of the wellbeing platform called Your Care.
Substantive workforce capacity remained relatively static in month 5 but bank capacity increased. Turnover continues to reduce.
The Trust appraisal rate reduced by 1% but work is underway to identify appraisals that have been completed but not recorded.

FINANCE

Metric Name	Assurance	Variation	Value	Target
Agency Spend (Monthly)	F		1330	833
Efficiency Delivery	P	H	513	900

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.

Agency Spend: Higher than planned agency usage with allocate on arrival usage and HCA cover by RN agency continuing to be high. Cover during peak industrial action periods has impacted the year to date position as has supporting 23 unfunded beds

Quality and Safety

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

Group: 0 - Total

Metric Name: All

NHS Dorset County Hospital NHS Foundation Trust

Commentary
National Joint Registry has identified a new risk with the number of reported Grade 2 heel ulcers in patients admitted with Hip Fractures and reported on the National Joint Registry. Work is underway to review the Hip Fracture pathway and to ensure compliance with pre-alerts, use of pressure relieving equipment in ED and appropriate assessments and interventions to mitigate risk.
Ongoing monitoring of the environment. All clinical areas are currently conducting a strategic cleaning review with IPC/Housekeeping, several areas have been deep cleaned during July and August 23. Housekeeping Lead is developing an ongoing deep clean plan.
Recruitment in progress for Tissue Viability Lead Nurse and a reset of the Pressure Ulcer Group to focus on prevention and compliance with Trust policies.
Trust wide focus continues in training and competencies regarding assessing, preventing and managing risks of pressure damage.
Water safety checks of the new discharge lounge have come back as passed with no signs of legionella. Flushing regime has been implemented as part of the cleaning processes.

VariationIcon	Pass	Hit or Miss	Fail	Empty	Total
Improvement			2	1	3
Common Cause	1	4	1	3	9
Concern				1	1
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	Jul-23	8.76%	13%	-4.24%	7.94%	6.32%	8.76%		
Effectiveness	Inpatient - Percentage of EDS available within 24 hours of discharge	0 - Total	Aug-23	79.16%	90%	-10.84%	78.19%	83.16%	79.16%		
Effectiveness	Inpatient - Percentage of EDS available within 7 days of discharge	0 - Total	Aug-23	86.51%	100%	-13.49%	88.44%	93.18%	86.51%		
Experience	Complaints - Total Number Received (Informal & Formal)	0 - Total	Aug-23	153			94.53	84	685		
Experience	Friends and Family - Overall - Recommend Rate	0 - Total	Aug-23	92%	94%	-2.00%	91.83%	91%	92%		
Safety	Incidents - Never Events	0 - Total	Aug-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	Aug-23	0			0.23	0	0		
Safety	Incidents - Number of Medication Incidents	0 - Total	Aug-23	68			56.42	68	343		
Safety	Incidents - Pressure Ulcers - Hospital acquired (grade 3) confirmed avoidable	0 - Total	Aug-23	1			0.6	0	2		
Safety	Incidents - Serious Incidents investigated and confirmed avoidable	0 - Total	Aug-23	0	0	0.00	0.49	0	2		
Safety	Infection Control - C-Diff Hospital Onset Healthcare Associated	0 - Total	Aug-23	3	3	0.00	2.64	5	18		
Safety	Infection Control - Gram Negative Blood Stream Infections	0 - Total	Aug-23	6	5	1.00	3	3	15		
Safety	Inpatient - SHMI Value	0 - Total	Apr-23	0			1.12	1.14	0		

Performance

Group: 0 - Total

Metric Name: All

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

NHS Dorset County Hospital NHS Foundation Trust

Commentary

Cancer - For August 2023, the Trust achieved the 31 day to treatment target. All other constitutional cancer standards were missed. The total waiting list size increased by 12 patients, the backlog (over 62 days) decreased by 5 patients to 90 and the backstop (over 104 days) increased by 7 patients to 28. This is an improved position compared to the previous month and continued improved against the 28 day to diagnostics standard has been achieved, with the 28 day standard meeting trajectory, although missing the target.

Elective - The Referral to Treatment standard (18 weeks) was not met for August 2023, with 54.77% of patients being treated within 18 weeks. For the reporting month of July, the national RTT performance was 58.6% and the South West Region was 59.2%. The total waiting list increased by 101 patients compared to the previous month; the total waiting list size is 749 patients larger than the 2023/24 trajectory. The 2022/23 planning guidance requires the Trust to have no patients, waiting over 78 weeks for treatment at the end of 2022/23. At the end August 2023, DCH had 4, either due to patient choice, or complex pathways, the forecasted position for September is zero. The 2023/24 waiting list target is to have zero patients waiting over 65 weeks at the end of March 2024. DCH are 78 patients behind plan for the

VariationIcon	Pass	Hit or Miss	Fail	Empty	Total
Improvement		2	2	2	6
Common Cause		6	2	1	9
Concern	1		1	1	3
Neither					
Empty					
Total	**1**	**8**	**5**	**4**	**18**

Metric Group	Metric	Group	Latest Month	Value	Target	Variance to Target	Mean	PY - Month Value	YTD Value	Variation	Assurance
Cancer	Cancer - 28 Day Faster Diagnosis Standard Performance	0 - Total	Aug-23	69.82%	75%	-5.18%	66.99%	69.45%	69.82%		
Cancer	Cancer - 31 Day Treatment Performance	0 - Total	Aug-23	96.19%	96%	0.19%	96.94%	99.15%	96.19%		
Cancer	Cancer - 62 Day Performance	0 - Total	Aug-23	83.11%	85%	-1.89%	70.95%	60.14%	83.11%		
Elective	Elective Recovery - Day Case Activity vs 2019/20	0 - Total	Aug-23	110.47%	104%	6.47%	95.07%	112.71%	110.47%		
Elective	Elective Recovery - Elective Inpatients Activity vs 2019/20	0 - Total	Aug-23	74.6%	104%	-29.40%	68.68%	68.65%	74.6%		
Elective	Elective Recovery - Outpatient Activity vs 2019/20	0 - Total	Aug-23	100.5%	104%	-3.50%	91.92%	96.22%	100.5%		
Elective	Elective Recovery - Total Elective Activity vs 2019/20	0 - Total	Aug-23	101.36%	104%	-2.64%	92.09%	96.48%	101.36%		
Elective	Theatre - Utilisation	0 - Total	Aug-23	72.16%	85%	-12.84%	71.27%	64.99%	72.16%		
Outpatient	Diagnostic - Percentage of Patients waiting less than 6 weeks for a di…	0 - Total	Aug-23	75.07%	99%	-23.93%	77.92%	68.26%	75.07%		
Outpatient	Outpatient - Virtual Activity %	0 - Total	Aug-23	21.36%	25%	-3.64%	19.9%	22.97%	21.36%		
Outpatient	RTT - 52+ week waits	0 - Total	Aug-23	1462	1093	369.00	1290.47	1305	1462		
Outpatient	RTT - 65+ week waits	0 - Total	Aug-23	336	258	78.00	600.09	617	336		
Outpatient	RTT - 78+ week waits	0 - Total	Aug-23	4			278.28	267	4		
Outpatient	RTT - Waiting List Size	0 - Total	Aug-23	21005	20256	749.00	17285.91	18512	21005		
Urgent and Emergency Care	ED - 12 Hour Waits	0 - Total	Aug-23	260			131.06	389	1159		
Urgent and Emergency Care	ED - Ambulance Handover Delays Average Time Lost per Day	0 - Total	Aug-23	15.78			14.39	28.65	15.78		
Urgent and Emergency Care	ED - Overall 4 Hour Performance %	0 - Total	Aug-23	79.02%	76%	3.02%	74.5%	73.37%	79.02%		
Urgent and Emergency Care	Inpatient - Percent Bed Occupied by No RTR	0 - Total	Aug-23	17.53%			27.64%	25%	17.53%		

People

Group: 0 - Total

Metric Name: 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
Sickness absence increased in Month 4 to 4.1% with the biggest increase being in short term sickness. The wellbeing offer for staff was extended in month 5 through the introduction of the wellbeing platform called Your Care.
Substantive workforce capacity remained relatively static in month 5 but bank capacity increased. Turnover continues to reduce.
The Trust appraisal rate reduced by 1% but work is underway to identify appraisals that have been completed but not recorded.

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	Aug-23	90%	90%	0.00%	88.74%	90%	90%		
Looking After Our People	Appraisal rate	0 - Total	Aug-23	74%	90%	-16.00%	75.55%	70%	74%		
Looking After Our People	Sickness rate (one month in arrears)	0 - Total	Jul-23	4%	3%	1.00%	3.75%	5%	4%		
Looking After Our People	Staff Turnover Rate	0 - Total	Aug-23	11%	12%	-1.00%	9.42%	12%	11%		
Looking After Our People	Vacancy Rate (substantive)	0 - Total	Aug-23	10%	5%	5.00%	7.17%	9%	10%		

Finance

Group: 0 - Total

Metric Name: All

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

Dorset County Hospital NHS Foundation Trust

Commentary
Adjusted 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 23 unfunded beds also contributing to the position.
Agency Spend: Higher than planned agency usage with allocate on arrival usage and HCA cover by RN agency continuing to be high. Cover during peak industrial action periods has impacted the year to date position as has supporting 23 unfunded beds
Capital Expenditure: The position is currently behind plan year to date 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 operational pressures including 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	1		3
Concern	1				1
Neither					
Empty				1	1
Total	**1**	**2**	**1**	**1**	**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	Aug-23	2091	1590	501.00	1917.42	3474	8998		
Revenue	Adjusted Financial Position	0 - Total	Aug-23	-762	7	-769.00	-268.95	-738	-3158		
Value Board	Agency Spend (Monthly)	0 - Total	Aug-23	1330	833	497.00	1211.38	1201	6337		
Value Board	Efficiency Delivery	0 - Total	Aug-23	513	900	-387.00	170.77	415	1923		
Value Board	Off Framework Agency Spend	0 - Total	Aug-23	139	83	56.00	178.6		893		

Glossary

MetricName
All

Dorset County Hospital NHS Foundation Trust

MetricName	MetricDescription
Cancer - 28 Day Faster Diagnosis Standard Performance	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 Somerset Cancer Register (SCR).
Cancer - 31 Day Treatment Performance	Percentage of cancer patients (based on 1st Treatment for DCH treated patients) treated within 31 days of a decision to treat. Sourced from Somerset Cancer Register (SCR).
Cancer - 62 Day Performance	Percentage of patients (based on DCH accountability) with an urgent GP cancer referral receiving treatment with 62 Days. Sourced from Somerset Cancer Register (SCR).
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.

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

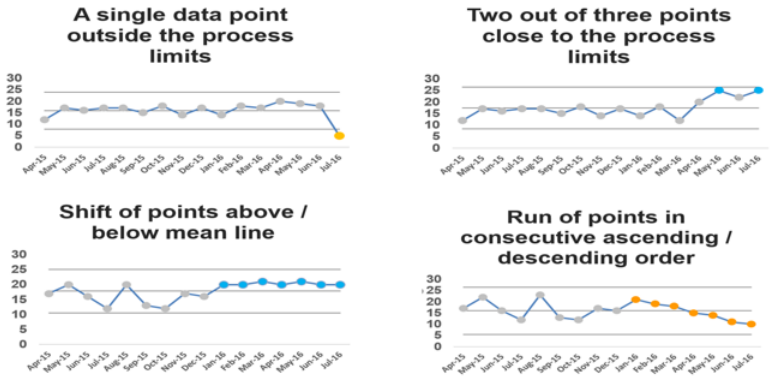
Dorset County Hospital
NHS Foundation Trust

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?

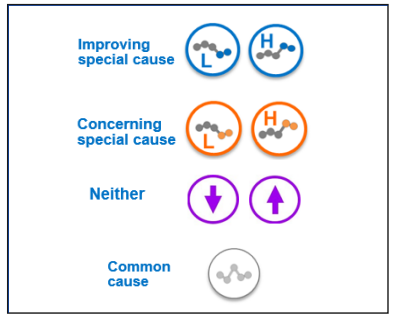
Blue icons indicate significant improvement or low pressure.

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?

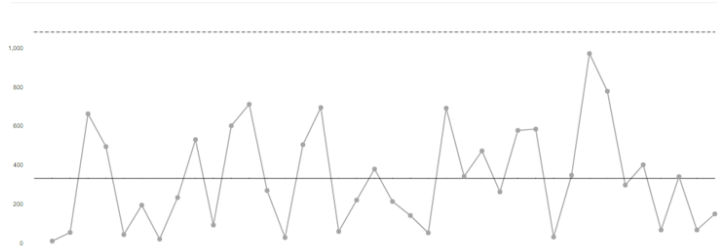
Moving range chart (seen on right) helps to assess the variation in a process by taking the absolute difference between consecutive points.

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

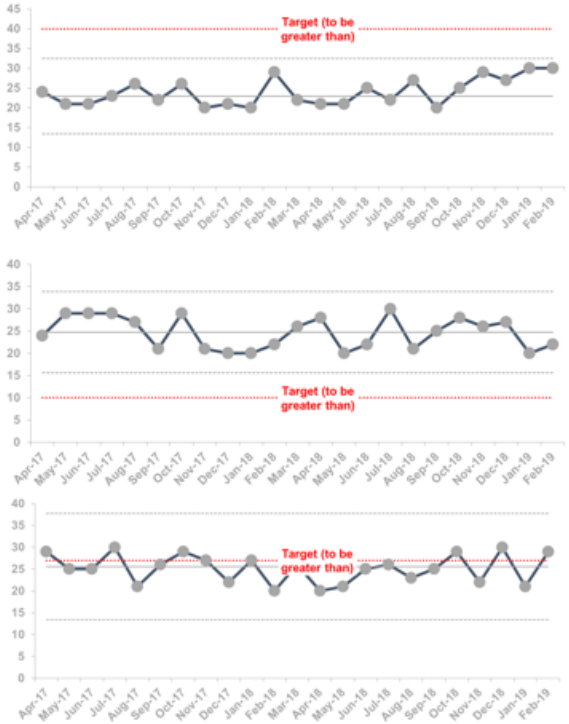
Variance	Assurance: P	Assurance: ?	Assurance: F	Assurance: ○
H	Special cause of an improving nature where the measure is significantly **HIGHER**. This process is capable and will consistently **PASS** the target.	Special cause of an improving nature where the measure is significantly **HIGHER**. This 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.

Understanding Assurance

Dorset County Hospital NHS Foundation Trust

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

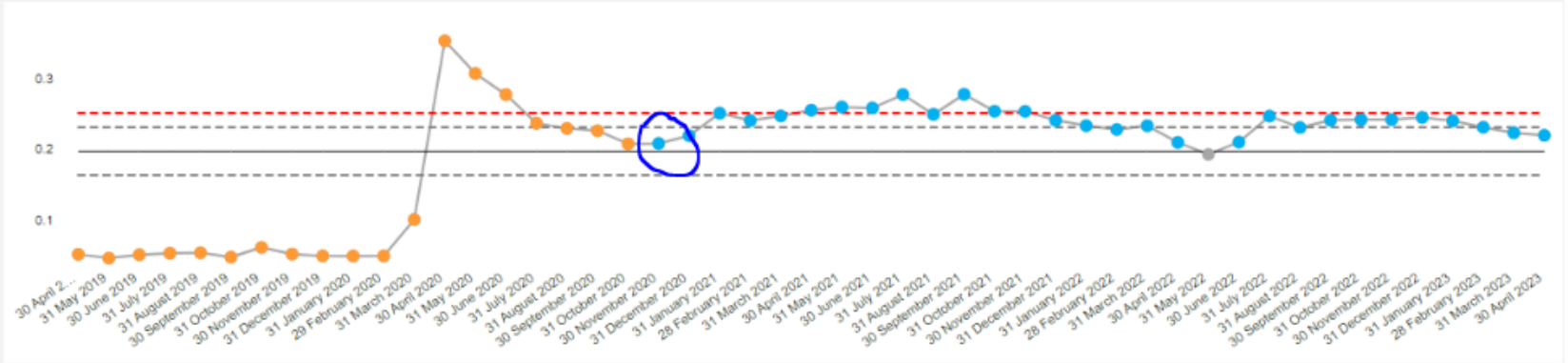
target way below the process limits so it's a capable process and likely to always meet the target and we use a blue P for PASS

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 27th September		
Document Title:	System Performance Report		
Responsible Director:	Matthew Bryant, Chief Executive	Date of Executive Approval	19.07.23
Author:	Jonquil Williams, Business Manager		
Confidentiality:	If Confidential please state rationale: No		
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	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 7th September Extracted Key Issues: In response to the guidance NHS Dorset submitted the system's annual operating plan for 2023/24 to NHS England Southwest at the end of April 2023. Within the submission, the system commits to achieve all standards except three: • Reduction in total waiting list • 25% reduction in follow-up outpatients • 92% bed occupancy Although the three standards will not be achieved, the system holds trajectories outlining expected performance for each and they continue to be monitored. The submission recognised some key risks to delivery. Delivery is linked to the system achieving the planned reduction in no criteria to reside, which will support increasing flow and bed occupancy, enabling delivery of both elective recovery and the 76% four-hour emergency department standard. It is important to note the 2023/24 planning submission did not include the impact of industrial action. There is a financial risk associated with the level of unidentified and high-risk efficiency included in the plan, including a system transformation ambition inherent in plans. In addition, there is an income risk relating to							

	Payment by Results (PbR) if elective recovery is not in line with trajectories which is not included within the plan or the reported position to date. The purpose of the report is to provide an overview of performance at the end of quarter 1 against the national operating plan trajectories for 2023/24, identify areas of concern, detail mitigating actions, and highlight areas for additional focus.
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**	

NHS Dorset Integrated Care Board

Meeting Title	ICB Board
Date of Meeting	7 September 2023
Paper Title	Performance Report
Responsible Chief Officer	Dean Spencer, Chief Operating Officer
Author	Natalie Violet, Head of Planning and Oversight

Confidentiality	Not confidential
Publishable Under FOI?	Yes

Prior Discussion and Consultation		
Job Title or Meeting Title	**Date**	**Recommendations/Comments**
Chief Operating Officer, NHS Dorset	15 August 2023	Performance updates approved following the report to SEG in July.
System Executive Group	28 July 2023	Discussed, areas highlighted include virtual wards, mental health, audiology, and no criteria to reside.
Chief Operating Officer, NHS Dorset	25 July 2023	Approved
Chief Operating Officers and Performance Leads at provider organisations	24 July 2023	Shared, comments received, and report updated
University Hospitals Dorset Provider Relationship Meeting	20 July 2023	Discussions regarding performance
Dorset HealthCare Touchpoint Meeting	18 July 2023	Discussions regarding performance
Heads of Service and Deputy Directors at the ICB	July 2023	Narrative for service areas has been written with the Heads of Service and/or Deputy Directors
Finance and Performance Committee	24 August 2023	Performance update presented

Purpose of the Paper	The purpose of the report is to provide an overview of performance at the end of quarter 1 against the national operating plan trajectories for 2023/24, identify areas of concern, detail mitigating actions, and highlight areas for additional focus.						
	Note:	☐	Discuss:		Recommend:		Approve:
Summary of Key Issues	The following areas are performing as expected at the end of June 2023 when compared to the trajectories supporting the 2023/24 operating plan submission: • An increase in primary care appointments.						

- Patient initiated follow-ups.
- Advice and guidance.
- Day case rates.
- Diagnostic performance (except for audiology).
- Four-hour Emergency Department standard.
- Category 2 response times.
- Dementia diagnosis rate.
- Reducing the reliance on inpatient care for people with a learning disability and autism.

The following areas are not performing as expected at the end of June 2023 when compared to the trajectories supporting the 2023/24 operating plan submission:

- Two-hour urgent care contacts.
- Two-week primary care access.
- Virtual ward utilisation.
- Patient waiting beyond 65 weeks.
- Achieving 109% activity compared to 2019/20.
- Theatre utilisation.
- Cancer faster diagnosis standard.
- 62-day cancer standard.
- The number of patients in hospital with no criteria to reside.
- Reducing mental health adult acute out of area placements.
- Increasing the number of adults and older people accessing psychological therapies (NHS Talking Therapies).
- Overall access to core community mental health services for adults and older adults with severe mental illness.
- Improving access to perinatal mental health services.
- Children and young people mental health service access.
- Annual health checks for people aged over 14 on GP learning difficulties register.

There are several areas which require additional focus due to underperformance against the trajectories at the end of the first quarter of 2023/24, these are:

Two-Hour Urgent Care Response
Performance against the two-hour urgent care response standard is underperforming against trajectory with an average of 720 contacts expected for each month of the quarter. Information is only available up to the end of May with an average of 408 contacts over the two months. Although, 80% of patients are responded to within the two-hour requirement further work is required to understand why activity numbers are less than anticipated. Consequently, Dorset HealthCare have been asked to investigate this performance to establish the reason, mitigating actions, and when performance against trajectory will be recovered. This is due to be discussed at the Integrated Neighbourhoods and Communities Oversight Group on 17 August 2023.

Audiology
A detailed and robust recovery plan is required to illustrate how performance will improve during 2023/24. This was discussed at Dorset HealthCare's touchpoint meeting in July 2023 and further engagement is taking place to ensure a detailed and robust recovery plan is developed. On 08 August 2023, a meeting was held with Dorset HealthCare to agree the content of the Audiology recovery plan. It was agreed a detailed demand and capacity exercise, taking into consideration seasonal variation and planned recruitment with clearly articulated assumptions would be undertaken. This will allow Dorset HealthCare to illustrate the current waiting list position and when they expect to achieve the diagnostic standard. Dorset HealthCare are developing the recovery plan with support from NHS Dorset ahead of presentation to the Elective Care Recovery Group on 01 September 2023.

No Criteria to Reside
Patients in hospital with no criteria to reside have seen a sharp rise in June 2023 compared to May 2023 performance and this has continued to operate at higher levels than planned in July 2023. The deterioration of the Dorset position prompted a second follow-up meeting with the national discharge team (headed by Lesley Watts, Chief Executive of Chelsea and Westminster NHS Foundation Trust) on 27 July 2023 and NHS England South West. An increase had been seen at University Hospitals Dorset following a change in their reporting methodology on 05 June 2023 with data now being taken from the Health of the Ward System. The new data collection revealed one ward of 30 patients at Poole Hospital has incorrectly been excluded from the data returns. Therefore, an increase of 30 it was expected. On further analysis of the data held by the single point of access for those patients who need to be discharged with support either in their own home or in a care facility, showed that a reduction of around 50 to 70 since April. University Hospitals Dorset are undertaking a validation process on their data collection for reporting no criteria to reside to establish why there has been an increase in patients waiting for discharge.

During the meeting NHS Dorset provided an overview of the current situation including a two-month sustained improvement in performance before the change in reporting methodology at University Hospitals Dorset. Feedback following the meeting is yet to be received. In terms of next steps, an audit of all patients has been agreed and the audit scope is currently being agreed. The main issue appears to be patients classed as no criteria to reside once they have passed their expected discharge date. A small sample of these patients have been reviewed and it appears despite passing their expected discharge date the patients were not medically fit for discharge. This was also discussed at the Touchpoint Meeting between University Hospitals Dorset and NHS Dorset on 01 August 2023 where it was agreed colleagues from NHS Dorset's Chief Nursing Officer's Team will visit the Trust and provide a 'fresh eyes' review on the no criteria to reside list. The first visit is taking place on 21 August 2023.

Mental Health
Conversations are taking place with Dorset HealthCare to establish the way forward in improving performance in all areas relating to mental health. Initial conversations have taken place with the Chief Executive and a deep dive into the Child and Adolescent Mental Health Services (CAMHS) took place at the Provider Relationship Meeting between Dorset HealthCare and NHS

	Dorset in July. A deep dive into Mental Health performance was presented to Finance and Performance Committee in August 2023.

Action recommended	The ICB Board is recommended to **NOTE** the report.

Governance and Compliance Obligations		
Legal and Regulatory	**YES**	Under the NHS England 2023/24 Priorities and Operational Planning Guidance all systems are required to submit an annual operating plan and monitor progress against plan.
Finance and Resource	**YES**	Financial standards are included in the operating plan and performance against these are included within the report.
Risk	**YES**	There are potential clinical risks associated with poor performance against the operating plan standards, especially in respect of ambulance response times, cancer services, and long waiting patients.

Risk Appetite Statement	
ICB Risk Appetite Statement	The ICB has a low to moderate appetite for risks impacting the ICB's ability to meet the required performance indicators.

Impact Assessments		
Equality Impact Assessment (EIA)	**NO**	N/A
Quality Impact Assessment (QIA)	**NO**	N/A

Fundamental Purposes of Integrated Care Systems	
Improving population health and healthcare **Tackling unequal outcomes and access** **Enhancing productivity and value for money** **Helping the NHS to support broader social and economic development**	The NHS England 2023/24 Priorities and Operational Planning Guidance outlines three key tasks – recover core services and productivity, make progress in delivering the key ambitions of the NHS Long Term Plan, and continue to transform the NHS for the future. Systems are expected to do this whilst considering the four fundamental purposes of Integrated Systems.

System Working	
System Working Opportunities	The 2023/24 Operating Plan is a system wide plan, developed in partnership across the Dorset system. Both the ICB and providers monitor progress against the standards.

Performance Report

1. Introduction

1.1. The NHS England 2023/24 Priorities and Operational Planning Guidance outlines three key tasks – recover core services and productivity, make progress in delivering the key ambitions of the NHS Long Term Plan, and continue to transform the NHS for the future.

1.2. In response to the guidance NHS Dorset submitted the system's annual operating plan for 2023/24 to NHS England Southwest at the end of April 2023. Within the submission, the system commits to achieve all standards except three:

- Reduction in total waiting list
- 25% reduction in follow-up outpatients
- 92% bed occupancy

Although the three standards will not be achieved, the system holds trajectories outlining expected performance for each and they continue to be monitored.

1.3. The submission recognised some key risks to delivery. Delivery is linked to the system achieving the planned reduction in no criteria to reside, which will support increasing flow and bed occupancy, enabling delivery of both elective recovery and the 76% four-hour emergency department standard. It is important to note the 2023/24 planning submission did not include the impact of industrial action.

1.4. There is a financial risk associated with the level of unidentified and high-risk efficiency included in the plan, including a system transformation ambition inherent in plans. In addition, there is an income risk relating to Payment by Results (PbR) if elective recovery is not in line with trajectories which is not included within the plan or the reported position to date.

1.5. The purpose of the report is to provide an overview of performance at the end of quarter 1 against the national operating plan trajectories for 2023/24, identify areas of concern, detail mitigating actions, and highlight areas for additional focus.

2. Performance Overview

2.1. An overview of the performance against the operating plan standards can be found in Appendix 1. This is broken down by provider, where applicable.

2.2. **Primary and Community Care**
Positively, primary care has seen an increase in appointments during quarter 1 exceeding the trajectory. However, performance against the two-hour urgent care response standard, two-week primary care access performance, and virtual ward utilisation are below trajectory.

Performance against the two-hour urgent care response standard is underperforming against trajectory with an average of 720 contacts expected for each month of the quarter. Information is only available up to the end of May with an average of 408 contacts over the two months. Although, 80% of patients are responded to within the two-hour requirement further work is required to understand why activity numbers are less than anticipated. Consequently, Dorset HealthCare have been asked to investigate this performance to establish the reason, mitigating actions, and when performance against trajectory will be

recovered. This is due to be discussed at the Integrated Neighbourhoods and Communities Oversight Group on 17 August 2023.

Performance against the two-week primary care access standard is underperforming against trajectory however, there are some data accuracy issues. The performance information comes from the NHS Digital General Practice Appointment Data (GPAD) Platform which measures practices on all patients attending which includes patients booked beyond two-weeks for reasons associated with their care i.e., routine reviews or patient choice. Routine reviews are a significant part of general practice and will increase as new ways of working are embedded. The data accuracy issues have been escalated to NHS England and it is proposed appointments beyond two-weeks for clinical reasons will not be counted however, timescales to rectify this are currently unknown. The ICB proactively reviews the two-week data as part of the General Practice Assurance Group (GPAG) whereby any outliers in waiting times are discussed. The Primary Care Team do not have any current concerns with this performance standard and expects to see a significant improvement in performance once the data accuracy issues have been resolved.

Virtual ward performance is underperforming against trajectory with 52% utilisation against the planned 73% at the end of June 2023. On average, the system is seeing 55% utilisation across virtual wards. There are some data issues which are being worked through with NHS England; some capacity adjustments are required which are currently impacting the overall percentage occupied. However, performance is on an upward trend with compliance against the standard expected by September 2023. There is some positive work underway to improve utilisation; Dorset County Hospital are performing well following the introduction of a Pathway Support Worker to support the utilisation of virtual wards through case finding. University Hospitals Dorset's children and young people's virtual ward is working well, consistently exceeding capacity. Dorset HealthCare are looking to link with the acutes to implement a new way of working by discharging patients directly to the frailty pathway into virtual wards. Clinician confidence and risk adversity along with workforce challenges are barriers to performance however these are being worked through. A communication campaign for both staff and the public are being launched with the aim to increase clinical confidence and encourage the public to request a virtual ward. Video stories with both patients and clinicians working in the virtual ward are being captured to support this. Virtual wards are an integral part of the out of hospital model and the system-wide bed demand and capacity modelling includes a stepping up of virtual ward beds as winter approaches. As part of preparedness for winter daily reporting of virtual ward occupancy and capacity will be included in provider resilience alerts. Revised demand and capacity modelling and monitoring of capacity against the agreed trajectory will take place monthly to ensure the offset of admissions expected is being achieved. The table below illustrates the position as at the end of July 2023:

Operational Plan Metric	Metric Definition	Data Frequency		Apr-23	May-23	Jun-23	Jul-23
The number of patients that the virtual ward is able to simultaneously manage	Total number of virtual ward beds available at the end of the month	end of period position	Trajectory	119	140	160	200
			Actual	123	126	126	126
			Variation	4	-14	-34	-74

A percentage of the available beds were due to be utilised for remote monitoring, however this was delayed as clinical approval was only granted at the end of June. Virtual ward performance was discussed at the System Executive Group at the end of July and is due to be discussed at the Integrated Neighbourhoods and Communities Oversight Group on 17 August 2023. A further update on performance is expected following this meeting.

2.3. **Planned Care**

Patient initiated follow-ups, advice and guidance, and day case rates are all performing well. However, concerns lie with reducing the number of patients who are waiting beyond 65-weeks, total activity, and theatre utilisation.

Positively, patients waiting beyond 65-weeks at Dorset County Hospital are below trajectory with an additional 68 patients being treated beyond the total expected. However, University Hospitals Dorset did not meet the trajectory of 1,023 being 30 above. Operational pressures, theatre capacity, and continued industrial action are negatively impacting this standard. University Hospitals Dorset are expecting to see an improvement in theatre capacity following recruitment of 17 full-time theatre staff.

Focussed work is being undertaken to review patients waiting beyond 65-weeks by specialty to ensure targeted support is in place. As mentioned in the introduction, the impact of industrial action was not factored into the planning submission therefore modelling based on the impact of previous industrial action is being developed to allow scenarios to be modelled demonstrating the impact on the trajectory should further strikes occur.

Systems were asked to eliminate waits of over 78-weeks by April 2023, however the system has 39 patients waiting beyond 78-weeks at the end of June 2023, 2 at Dorset County Hospital and 37 at University Hospitals Dorset. The long-waiting times are attributed to industrial action, complexity, patient choice, international procurement issues, and Community Paediatrics.

In terms of Community Paediatrics, there are 13 patients waiting beyond 78-weeks at the end of June at University Hospitals Dorset. Conversations are currently taking place with NHS England regarding the reporting of this group nationally. There are different approaches with both acute providers. Dorset County Hospital do not report Community Paediatrics against the referral to treatment standard and University Hospitals Dorset now are. Both organisations should be reporting in the same way, once resolved the number of patients waiting beyond 78-weeks and 65-weeks could increase should these patients be included from Dorset County Hospital. Alternatively, it will decrease should they not be reportable. None-the-less, a reduction in waiting times is vital and therefore an outsourcing solution for Community Paediatrics is due to commence in August. As a consequence of this situation, the Planned Care Team are liaising with providers to understand the size and wait times associated with non-RTT waiting lists.

It is anticipated a total of 38 patients will be waiting beyond 78-weeks at the end of July 2023. 4 at Dorset County Hospital and 34 at University Hospitals Dorset. Independent sector providers do not have any patients waiting beyond 78-weeks.

For August 2023, it is anticipated the system will have 54 patients waiting beyond 78-weeks which is attributed to further industrial action taking place from 11 August 2023 to 15 August 2023. 1 at Dorset County Hospital and 53 at University Hospitals Dorset.

Assuming no further industrial action takes place, no patient should be waiting beyond 78-weeks at the end of September 2023. University Hospitals Dorset have highlighted concerns with a cohort of patients in colorectal and gynaecology as potential breaches but are aiming to treat these patients ahead of the end of September.

As part of recovery, the system is required to undertake 109% activity compared to 2019/20. At the end of June 2023, activity was 9.8% lower than anticipated which is believed to be attributed to the industrial action. June saw three days of industrial action

with Junior Doctor strikes taking place from 14 – 17 June 2023. It is important to note the link between delivery of activity and the elective recovery fund. If the required activity levels are not achieved, it may impact income, the exact details of what is being counted against this are with NHS England to confirm. On 12 July 2023, Julian Kelly, Chief Finance Officer at NHS England, verbally notified all Chief Finance Officers this standard is going to be reduced by 2%. For Dorset this means moving from 109% to 107%. Systems await a letter of confirmation following this verbal notification to understand the associated impact. Further details are outlined in the Finance ICS Update.

The table below illustrates a crude revised trajectory, assuming the 2% reduction takes place from July.

	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
UHD	102.36%	102.87%	118.82%	106.04%	105.97%	111.44%	111.12%	106.00%	100.60%	111.15%	111.41%	91.92%
DCH	92.39%	94.57%	108.06%	99.02%	94.92%	99.36%	108.31%	103.07%	98.24%	108.45%	109.69%	92.14%
System	104.90%	110.20%	110.70%	110.20%	110.20%	110.20%	109.50%	109.90%	109.90%	108.90%	107.70%	107.70%

Theatre utilisation was below trajectory with 74% utilisation against the target of 85%. Both providers have Theatre Improvement Programmes in place. Dorset County Hospital's Theatre Transformation Programme is being placed in mandated enhanced support, under the Trust's Performance and Accountability framework and within that process, a recovery trajectory will be developed and shared. University Hospitals Dorset's programme focuses on digital theatres, efficient theatres, and workforce. They have specific issues within Orthopaedics and are undertaking a specialty specific review aiming to improve utilisation through addressing late starts and early finishes. Conversations are taking place with University Hospitals Dorset to establish the anticipated timescale to meet this standard. The progress against Theatre Improvement Programmes is on both touchpoint meeting agendas for Dorset County Hospital and University Hospitals Dorset in August.

2.4. **Cancer**

Both standards associated with cancer, faster diagnosis and the 62-day backlog, are underperforming against trajectory.

Dorset County Hospital specifically, experienced a drop in performance against the faster diagnosis standard in May 2023 with the two biggest driving forces being colorectal and dermatology. For colorectal, they saw a growth of 26% in terms of demand last year, with much of that in the last quarter which has been carried over to this year. Since introducing faecal immunochemical tests (FIT) less than 10 and the reduction in media coverage recently, referral demand has returned to levels seen in 2021/22, coupled with some additional clinics to clear the backlog, they are starting to see improvements. The service is in internal enhanced support measures and given the return to a more "normal" referral pattern and an improved staffing picture a demand and capacity review, with a supporting trajectory for the rest of the year is being produced. For Dermatology, demand is driving the performance. For quarter 1, referrals are 12% up on last year, which is 23% up on 2021/22. Dorset County Hospital have signed a new insourcing agreement for two-week wait referrals, something they have never done before and so far, it is working well, with good clinical and patient feedback. As a result, performance is improving and the additional capacity is in place until December 2023, with an option to extend. The cost associated with this is unaffordable and Dorset County Hospital are working through some ideas around a better approach to triage and closer working with the community provider. Dorset County Hospital are now able to take a referral and picture from e-RS and ingest it directly into their Digital Patient Record solution, opening the door to teledermatology which until now, has not been possible. Testing has been completed and Dorset County Hospital are starting to

work up plans and options about how they can move this forward in this financial year and what benefits could apply to the rest of the system. Upon review of the unverified position for the end of July, Dorset County Hospital are expected to be back in line with trajectory. The faster diagnosis standard has been impacted by industrial action, volume of referrals, and workforce challenges. The most pressured tumour sites include colorectal, gynaecology, upper gastrointestinal, dermatology, and urology. It is anticipated this standard will be achieved by September 2023.

The successful introduction of faecal immunochemical tests (FIT) has reduced two-week wait referrals to colorectal services although there has been an increase in non-two-week wait colorectal referrals. Despite this, there is an overall reduction at Dorset County Hospital and a similar overall volume at University Hospitals Dorset. Dorset County Hospital is beginning to recover this standard for colorectal and is piloting e-triage from mid-August for patients awaiting a first appointment. This is expected to reduce first appointment duration from 25 minutes to 10-15 minutes, consequently increasing productivity. University Hospitals Dorset is beginning configuration for e-triage however this is not expected to go live until quarter 4.

At the University Hospitals Dorset Provider Relationship Meeting at the end of July, concerns were raised with regards to colorectal two-week wait referrals being received without faecal immunochemical tests (FIT). Since this meeting a pack has been sent out from NHS Dorset demonstrating the proportion of referrals received, by Primary Care Network (PCN) without a FIT test which has generated interest within PCNs and requests for the information broken down by practice.

On 04 August 2023, the Elective Care Oversight Group supported a proposal relating to teledermatology and artificial intelligence ahead of clinical approval at the Clinical and Professional Reference Group followed by the System Executive Group. The proposed teledermatology approach will see photo clinics set up at the Outpatient Villages at Beales and South Walks with the aim to reduce GP appointments. The artificial intelligence proposal will take this a step further and analyse the images and offer advice to GPs as to the most appropriate next step. Consequently, advice and guidance requests to dermatology should reduce.

In terms of gynaecology, agreement has been gained from lead sonographers at University Hospitals Dorset for a GP direct access pathway pilot for women and people with a cervix with post-menopausal bleeding and taking hormone replacement therapy. This is planned to go live by the end of quarter 2 and is expected to reduce gynaecology 2 week wait referrals supporting improvement of this standard. Agreement is being sought for this pathway at Dorset County Hospital.

Urology recovery had a set back at University Hospitals Dorset with the resignation of their lead local anaesthetic template biopsy clinician. The service is being redesigned to nurse led including local anaesthetic template biopsies which is expected to recover this standard however this will not be in place until quarter 4. The introduction of local anaesthetic template biopsies is progressing at Dorset County Hospital.

The upper gastrointestinal pathway is challenged across Dorset due to first outpatient capacity and the Site-Specific Group meetings have not gone ahead this year due to capacity. The plan to get these meetings back on track is being discussed with one of the Dorset Cancer Programme Clinical Leads.

University Hospitals Dorset did not reduce the number of patients waiting beyond 62-days to meet the expected trajectory however, the recovery actions are expected to deliver

trajectory at the end of quarter 2 pending any further industrial action. The reason for this is attributed to the challenges outlined above in achieving the faster diagnosis standard as well as theatre capacity issues in gynaecology for complex surgery despite mutual aid being explored.

The C the Signs campaign launched in all but four GP practices in August 2023. The initiative aims to increase the number of two-week wait referrals rather than through alternative routes to improve early diagnosis and support achievement of the faster diagnosis standard. C the Signs provides the option to mandate specific fields within referrals which is not currently active, however discussions are taking place to establish where this would be effective whilst balancing the ability to make a two-week wait referral if concerned.

The Dorset Cancer Partnership Steering Board in June 2023 approved additional funding from the Wessex Cancer Alliance to improve cancer performance. Additional funding has been provided to both University Hospitals Dorset and Dorset County Hospital to both reduce the number of patients waiting beyond 62-days for treatment and support the faster diagnosis standard because performance against this standard contributes to the 62-day backlog. Specialties include Colorectal, Gastroenterology, Urology, Skin, and Gynaecology. There is a specific focus on transforming colorectal cancer services at University Hospitals Dorset since the merger including setting up e-triage.

2.5. **Diagnostics**

Diagnostic performance is in line with trajectory with a slight underperformance at Dorset County Hospital when looking at all modalities. However, Audiology is causing concern. Audiology is challenged due to increased demand exacerbated by workforce shortages. Dorset County Hospital's audiology services are being transferred to and Dorset HealthCare during 2023/24. A new clinical system (AuditBase) will be implemented in July 2023 which will improve reporting and forecasting however it is anticipated performance will reduce during this time. Recruitment plans include apprenticeships, skill mix reviews, and international recruitment. Improvement in performance is expected from September 2023 with achievement of the standard by November 2024. At the June Elective Care Oversight Group, a recovery plan was prepared with recommendations for additional investment, as a result further engagement is taking place to ensure a detailed and robust recovery plan is developed.

On 08 August 2023, a meeting was held with Dorset HealthCare to agree the content of the Audiology recovery plan. It was agreed a detailed demand and capacity exercise, taking into consideration seasonal variation and planned recruitment with clearly articulated assumptions would be undertaken. This will allow Dorset HealthCare to illustrate the current waiting list position and when they expect to achieve the diagnostic standard. From the conversations, it is clear the Audiology service demand is outweighing the current capacity. There are several areas of focus, including pathway reviews, obtaining more space for a locum for immediate support, and addressing challenges related to the transfer of the service from Dorset County Hospital including managing waiting lists using a consistent approach. In terms of next steps, Dorset HealthCare are developing the recovery plan with support from NHS Dorset ahead of presentation to the Elective Care Recovery Group on 01 September 2023.

2.6. **Urgent and Emergency Care**

Performance against the four-hour Emergency Department standard and category two ambulance response times are performing as expected against trajectory. However, those patients with no criteria to reside are above trajectory with 10 more patients than expected at the end of June.

Patients in hospital with no criteria to reside have seen a sharp rise in June 2023 compared to May 2023 performance and this has continued to operate at higher levels that planned in July 2023. This has been exacerbated by an inclusion of an additional 30 delayed patients at University Hospitals Dorset which were not previously recorded on the no criteria to reside national returns. Although this group of patients were known to the community teams and the Single Point of Access (SPA) and continue to be managed through Discharge Teams with no impact on patient care. Deterioration in performance can be seen across all providers. There are several factors contributing to this worsening position including reduced flow in core intermediate care services (including community hospitals and discharge to assess beds) and a growing number of people with higher needs on discharge who cannot be easily supported in these spaces. Targeted work is in train with all core intermediate care providers to support improved flow but this is reliant on timely assessment and sourcing of ongoing care which remains a system constraint. Acute pressures are being further exacerbated by lack of flow in mental health units which is causing delays in hospital.

Three multi-agency discharge events (MADE) took place in July and August, focussed on the Harbour Ward at the St Ann's site. The aim was to bring together people working on the ward and support services within the community to identify and unblock delays focussed on all patients with no criteria to reside. Representation included colleagues from NHS Dorset, both local authorities, and Dorset HealthCare. The overall objective was to apply learning to improve the wider system flow within mental health services, identify any constraints, challenge discharge processes, and to benchmark Harbour Ward against best practice in the mental health community challenge metrics. Consequently, themes from the events were collated comprising capacity in the community, access to services, home treatment options, specialist services, transformation, reasonable timescales, home office constraints, legal duties and process, housing, information on delayed patients, and non-commissioned pathways. In terms of next steps, the themes are going to be reviewed and the Discharge and Flow Cell will work with Dorset Healthcare and wider system colleagues to resolve the issues raised**.** The Discharge and Flow Cell will report progress into the Weekly Intelligence Group and the Home First Programme. In addition, a system wide workshop to specifically focus on housing is being scheduled with local authority partners for September.

For providers specifically, Dorset County Hospital are seeing a higher level of complex patients (Pathway 3) which is contributing to their deteriorating position, with a different picture in the east. A MADE event has taken place in early July to address these and actions will continue to be monitored over coming week. The profile of no criteria to reside delays in University Hospitals Dorset appears to have changed with a reduced proportion of delays attributed to supported discharge (Pathways 1 to 3). Previously this sat at circa 80% of no criteria to reside delays but is now circa 50%. There does not appear to have been any reduction in demand for supported discharge over this period which would indicate there are higher numbers of people waiting for simple discharge (Pathway 0). During the July 2023 Provider Relationship Meeting with University Hospitals Dorset, it was clear they have seen a considerable reduction in patients with no criteria to reside for pathways 1 to 3 (additional support at home/usual residence, rehab +/- reablement in a temporary bedded setting, and complex) over the last six months, circa 100 patients with the aim to reduce this further to 50 – 70 patients. Methodology of reporting was also discussed, with University Hospitals Dorset reaching out to Dorset County Hospital to share their methodology to ensure 'one version of the truth' across the system. Further analysis is taking place to understand this picture with a deep dive coming to the Finance and Performance Committee in August 2023.

In addition, system partners have agreed to accelerate additional interventions over the coming weeks that are anticipated to have a material impact on no criteria to reside

reduction. This is largely focused on streamlining processes for allocation and management of community capacity and transfer of care arrangements. Work to be scoped in August with partners for delivery by end of September 2023.

A meeting with the national team took place on 27 July 2023, between NHS England, the Department of Health and Social Care and Helen Whately, Minster for Social Care to review the Dorset no criteria to reside position. It was assumed the meeting was as a consequence of a rise in patients. An increase had been seen at University Hospitals Dorset following a change in their reporting methodology on 05 June 2023 with data now being taken from the Health of the Ward System. However, University Hospitals Dorset the number of patients requiring a supported discharge on pathways P1 to P3 had been consistently reducing since April. During the meeting NHS Dorset provided an overview of the current situation including a two-month sustained improvement in performance before the change in reporting methodology at University Hospitals Dorset. Feedback following the meeting is yet to be received.

In terms of next steps, an audit of all patients has been agreed and the audit scope is currently being agreed. The main issue appears to be patients classed as no criteria to reside once they have passed their expected discharge date. A small sample of these patients have been reviewed and it appears despite passing their expected discharge date the patients were not medically fit for discharge. This was also discussed at the Touchpoint Meeting between University Hospitals Dorset and NHS Dorset on 01 August 2023 where it was agreed colleagues from NHS Dorset's Chief Nursing Officer's Team will visit the Trust and provide a 'fresh eyes' review on the no criteria to reside list.

Unverified end of July data illustrates the four-hour emergency care standard is expected to be 66% against a trajectory of 68% for this point in the year. Bed occupancy and system flow remain a challenge, winter planning has commenced to ensure preparation across the system.

The Operational Pressure Escalation Levels (OPEL) Framework 2023/24 was published on 08 August 2023. The framework aims to provide a unified, systematic, and structured approach to detection and assessment of acute hospital urgent and emergency care operating pressures; provide a consistent framework for the proportional representation of each acute Trust hospital's OPEL score toward the corresponding system, region, and NHS England nationally.

2.7. **Mental Health**

Mental health performance, across all but one standard, is of concern. Performance against all standards outlined in the operating plan are under the expected trajectory except for dementia diagnosis rates. The standards are:

- Reducing mental health adult acute out of area placements.
- Increasing the number of adults and older people accessing psychological therapies (NHS Talking Therapies).
- Overall access to core community mental health services for adults and older adults with severe mental illness.
- Children and young people mental health service access.
- Improving access to perinatal mental health services.

The system has been experiencing high volumes of referrals outweighing the available beds exacerbated by limited flow. To support this, additional capacity has been booked at Marchwood Priory Hospital. Analysis, review, and regular system flow meetings take place

for immediate support. Work is underway to transform community services, including early help, as well as an additional 10 beds being created on the St. Anns site, expected to open

in 2025/26. Compliance with this standard is expected by March 2024.

At the end of June 2023, the system reported 748 out of area bed days for quarter 1 2023/24. It has been confirmed, the Marchwood Priory beds have been included in these figures and Dorset HealthCare have since amended their monthly performance report (the DMG) to separate out those patients admitted to Marchwood Priory. The table below outlines the out of area bed days from April to July 2023.

	Apr-23	May-23	Jun-23	Jul-23
Marchwood Priory (bed days)	300	367	435	530
Marchwood Priory (patients)	6	10	7	4
Other Providers (bed days)	80	102	226	340
Other Providers (patients)	2	6	6	5
Total (bed days)	380	484	746	870
Total (patients)	7	16	12	9

Three multi-agency discharge events (MADE) took place in July and August, focussed on the Harbour Ward at the St Ann's site. The aim was to bring together people working on the ward and support services within the community to identify and unblock delays focussed on all patients with no criteria to reside. Representation included colleagues from NHS Dorset, both local authorities, and Dorset HealthCare. The overall objective was to apply learning to improve the wider system flow within mental health services, identify any constraints, challenge discharge processes, and to benchmark Harbour Ward against best practice in the mental health community challenge metrics. Consequently, themes from the events were collated comprising capacity in the community, access to services, home treatment options, specialist services, transformation, reasonable timescales, home office constraints, legal duties and process, housing, information on delayed patients, and non-commissioned pathways. In terms of next steps, the themes are going to be reviewed and the Discharge and Flow Cell will work with Dorset Healthcare and wider system colleagues to resolve the issues raised**.** The Discharge and Flow Cell will report progress into the Weekly Intelligence Group and the Home First Programme.

Increasing the number of adults and older people accessing psychological therapies (NHS Talking Therapies) is below trajectory. This is a picture mirrored nationally with NHS Talking Therapies struggling to recover access standards since the pandemic. In addition, with Dorset having a large rural locality, higher than the national average, older adults accessing services is challenged and is an area which requires attention. It is important to note the Head of Clinical Programme for NHS Talking Therapies at NHS England South West advised services to prioritise initiatives to reduce waiting times rather than those that increase referrals. The influencing factors associated with the underperformance include a reduction in referral rates anecdotally attributed to people generally less inclined to seek support following the pandemic, supporting services in crisis, undertaking pilot projects for future service development, and workforce capacity issues. In terms of mitigating actions, the service continues to employ a Communications Officer with the aim to increase referrals including older adults, a relaunch of the website including the Wysa chatbot, and a strategy to reduce waiting lists.

Overall access to core community mental health services for adults and older adults with severe mental illness is underperforming against trajectory. Compliance against this standard is expected by quarter 4. Existing workforce challenges are impacting the ability to achieve this standard along with some concerns over data accuracy, missing attendances. There is ongoing work to progress the community mental health transformation programme with implementation expected during 2023/24 and 2024/25. This is large scale transformation which will be done iteratively, PCN by PCN, and involve significant change

to existing care provision. The new model will introduce a universal mental health offer with additional workforce significantly increasing activity.

Access to children and young people's mental health services remains challenged due to workforce issues exacerbated by high levels of demand. It has been identified the Dorset Gateway development is not delivering the originally anticipated benefits and therefore a review of the model is required. An internal Dorset HealthCare rapid improvement event is being planned to identify short-term effective change. Additionally, there are plans for a system wide joint health and social care transformation programme for children and young people's mental health and emotional wellbeing services.

During the Dorset HealthCare/NHS Dorset Provider Relationship Meeting on 26 July 2023. A 'deep dive' into CAMHS (Child & Adolescent Mental Health Services) was presented. This provided an overview of the current service and the transformation.

The CAMHS access gateway was launched in 2020 in BCP (Bournemouth, Christchurch and Poole) and expanded to Pan-Dorset in January 2022. The gateway model aims to see referrals within 4-weeks however there are issues with the 4-week wait standard ahead of national requirements due to an unstable workforce and the impact of COVID. The service is struggling with referral demand and complexity of cases which were not anticipated in the initial scope. The initial ambition of the gateway model was to see patients and direct them on to support or other services however children and young people are getting 'stuck' in gateway where there needs cannot be met and the service now holds a caseload. There is a gap between CAMHS Gateway and Core CAMHS, both of which are not delivering the service required for children and young people of Dorset.

CAMHS are receiving neurodiversity referrals which make up 70% of the current caseload they are holding. A case is being developed to improve the offer for this cohort of patients. DNA (Did Not Attends) rates are higher than adult services which is not unusual for CAMHS services. Processes are being put into place as to how to minimise DNAs (Did Not Attends). Using text message reminders are not always possible for this group because you must be certain you have the child or young person's mobile details rather than their parent or carer.

The current model may not be compatible with the children and young people, providing them a service in the places they go rather than expecting them to come to the service is one possibility. Not all schools have an outreach model and capacity to do this in the current service model is not there. In addition, there is a view the way the current service model is structured does not treat the whole person, it treats the diagnosis.
In terms of workforce, the current service is heavily reliant on agency and there is an aim to stabilise this and move to more experience clinicians.

In the long term there is a Children and Young People's Transformation Programme aligned to the Joint Forward Plan which will link with Place Based Partnerships, both of which have identified children and young people as a priority. The Chief Commissioning Officer at NHS Dorset is leading on a review of the scope of this programme to ensure clear and robust governance and oversight is in place with the right people in the room to move this forward.

Access to perinatal mental health services is showing an improving picture, however, is not performing to trajectory. Concerns have been raised around pace due to delays in recruitment to support expansion. A recovery plan has been agreed and monthly progress

reviews are in place which include weekly monitoring of assessment uptake, and an updated clinical pathway has been developed to ensure clarity of function and access. A

targeted education programme is being implemented across certain settings to support improved referral rates. The referral screening threshold has been lowered to ensure moderate-to-complex cases are accepted (historically referrals have focused on severe-complex). Compliance with this standard is expected by December 2023.

Although the dementia diagnosis rate has met trajectory, the target remains challenging. The system has seen a large reduction in diagnosis rates since the COVID pandemic which is in keeping with national trends. Specific factors affecting Dorset's current achievement of the national target are linked to an increase in referrals to the Memory Assessment service alongside limited gaps within the medical workforce resulting in long times between assessment and confirmation of diagnosis. Full implementation of the revised workforce model outlined in the Dementia Services review supporting the use of Advance Clinical Practitioners is yet to be completed due to a mix of COVID related delays and associated training requirements for the role. Teams continue to work with service leads to consider recovery action planning.

Due to concerns with achievement of these standards, a deep dive into the mental health performance will be presented to the Finance and Performance Committee in August.

2.8. **Learning Difficulties**

Reliance on inpatient care is as expected at this point in the year. Performance against people aged over 14 on GP learning difficulties registers receiving an annual health check is underperforming against trajectory. However, there are several key initiatives to support performance against this standard during 2023/24 including an annual audit tool launch in July 2023, asking practices to carry out self-evaluation of their systems and processes, a co-produced register inclusion tool expected to be launched in August, and a young people's campaign being soft launch during the summer holidays with the main launch in September 2023. During quarter 4 of last financial year, the system saw the highest uptake to date, consequently annual health checks for this cohort of patients will not take place until quarter 3 or 4 of this year. Quarterly drop-ins are delivered throughout the year to support practices with challenges and issues. In addition, a training programme continues to be rolled out this year for all practice staff to enhance their skills, knowledge, and expertise and to build confidence when working with people with learning difficulties.

2.9. **Prevention and Health Inequalities**

There are two standards associated with prevention and health inequalities outlined in the planning submission there are:

- Increase % patients hypertension treated to National Institute for Health and Care Excellence (NICE) guidance to 77%.
- Increase % patients between 25 and 84 with cardiovascular disease (CVD) risk score > 20% on lipid lowering therapies on 60%.

This information is available through the national Hypertension CVD Prevent Audit Data. The most recent data illustrates:

- **CVDP002HYP:** Percentage of patients aged 18 to 79 years with GP recorded hypertension, in whom the last blood pressure reading within the preceding 12 months is equal to 140/90 mmHg or less – 57.5%.
- **CVDP003HYP:** Percentage of patients aged 80 years or over with GP recorded hypertension, in whom the last blood pressure reading within the preceding 12 months is 150/90 mmHg or less – 71.52%.

- **CVDP007HYP:** Percentage of patients aged 18 and over, with GP recorded hypertension, in whom the last blood pressure reading (measured in the preceding 12 months) is below the age-appropriate treatment threshold – 61.23%.
- **CVDP003CHOL:** Percentage of patients aged 18 and over with no GP recorded CVD and a GP recorded QRISK score of 20% or more, on lipid lowering therapy – 52.48%

Moving forward the Health Inequalities and Population Health Delivery Group will monitor performance against these standards.

The system is required to submit an update on progress on prevention and health inequalities each quarter. A copy of the quarter 1 submission for 2023/24 can be found in Appendix 2. The Deputy Director of Health Inequalities and Population Health Management commenced in post during quarter 1 to provide focussed leadership and coordination of cross organisational and system activity to address health inequalities. Health inequality leads across the system are coming together to develop a collaborative system wide plan.

The Dorset Five-Year Joint Forward Plan was published at the end of June which is underpinned by action on health inequalities. This work is focused on the five key priorities of restoring services inclusively, mitigating against digital exclusion, complete and timely datasets, accelerating preventative programmes, strengthening leadership and accountability as well as the CORE20PLUS5 both for adults and children and young people.

2.10. **Maternity**

As part of the operational plan standards for 2023/24 systems are required to demonstrate progress towards the national safety ambition to reduce stillbirth, neonatal mortality, maternal mortality, and serious intrapartum brain injury and to increase fill rates against funded establishment.

Rates of stillbirth are difficult to assess annually and need at least three-years data to interpret trends. Office of National Statistics national data showed a 25% reduction in stillbirths in 2020, with the rate rising to 20% in 2021 with the onset of the COVID pandemic. Since 2017 there have been fluctuations in the stillbirth rate in Dorset but overall, it has remained fairly stable. A comparison of this against the decreasing rate nationally, Dorset is just below the national average. Work continues towards the national saving babies' lives (SBL) bundle and there will be quarterly meetings implemented to monitor progress with each Trust. Compliance with SBL is overseen through the Local Maternity and Neonatal System Safety Forum.

Nationally, neonatal mortality rates have reduced by around 30%, with most improvement occurring in babies born less than 28-week gestation. Neonatal mortality rates within Dorset appear to be reducing with rate now below the national average however more time is required to understand if this is a sustained improvement. Neonatal morbidity and mortality are monitored through the Local Maternity and Neonatal System Safety Forum with Consultant Neonatologists providing clinical expertise.

Incidents of serious brain injury are investigated by the Healthcare Safety Investigation Branch (HSIB). Assurance of the progress and learning from HSIB investigations is provided through the Local Maternity and Neonatal System Safety Forum and the regional Perinatal Quality Safety Surveillance Group. There is now a nationally agreed definition of serious intrapartum brain injury. Work is required to understand local rates and to establish a baseline of local data for comparison. An initial review, using HSIB cases for 2023, approximate rates of serious intrapartum brain injury for Dorset are:

	National Target by 2025	University Hospitals Dorset	Dorset County Hospital
Serious intrapartum brain injury per 1000 births	2.16	0.56	1.37

It is important to note, caution is advised in the interpretation of the above figures in isolation because the numbers are small, and the time period is insufficient to draw any reasonable conclusions. More detailed information is expected next quarter.

From a recruitment point of view, midwifery vacancies across the system continue to improve. Dorset County Hospital currently have minimal midwifery vacancy rates and are progressing with a business plan relating to their midwifery workforce. University Hospitals Dorset's vacancy rates have decreased to approximately 13% with an ongoing action plan in place to increase recruitment. Substantive and bank turnover rates continue to decrease from 14.79% in June 2022 to 10% in May 2023. NHS Dorset is working with providers to improve the data accuracy of the provider workforce return and develop a midwifery and maternity support worker faculty. In order to achieve the deliverable of the NHS England three-year delivery plan for maternity and neonatal services further work is required to understand workforce strategies across medical and neonatal nursing.

2.11. **Finance**

As demonstrated in the Dorset ICS Finance Update, the system is currently reporting a £5.6M deficit against plan. However, capital expenditure is currently compliant.

The efficiency programme is broadly on track as per month 3 reporting however, it is recognised much of the programme is phased into latter months and the level of unidentified remains high which is reflected in the risks.

Agency spend remains high across the Dorset provider footprint, with quarter 1 spend at £4.7M above planned levels. This partially relates to the industrial action, but several mitigating actions have been put into place with further mitigations required in order to contain the level of expenditure.

Further information on the financial position against plans is detailed in the Finance ICS Update.

3. Areas of Focus

3.1. Several areas require additional focus due to underperformance against trajectory at the end of the first quarter of 2023/24.

3.2. **Two-Hour Urgent Care Response**

Performance against the two-hour urgent care contacts standard is underperforming against trajectory with an average of 720 contacts expected for each month of the quarter. Information is only available up to the end of May with an average of 408 contacts over the two months. Although, 80% of patients are responded to within the two-hour requirement further work is required to understand why activity numbers are less than anticipated. Consequently, Dorset HealthCare have been asked to investigate this performance to establish the reason, mitigating actions, and when performance against trajectory will be recovered. This is due to be discussed at the Integrated Neighbourhoods and Communities Oversight Group on 17 August 2023.

3.3. **Audiology**

A detailed and robust recovery plan is required to illustrate how performance will improve during 2023/24. This was discussed at Dorset HealthCare's touchpoint meeting in July 2023 and further engagement is taking place to ensure a detailed and robust recovery plan is developed. On 08 August 2023, a meeting was held with Dorset HealthCare to agree the content of the Audiology recovery plan. It was agreed a detailed demand and capacity exercise, taking into consideration seasonal variation and planned recruitment with clearly articulated assumptions would be undertaken. This will allow Dorset HealthCare to illustrate the current waiting list position and when they expect to achieve the diagnostic standard. Dorset HealthCare are developing the recovery plan with support from NHS Dorset ahead of presentation to the Elective Care Recovery Group on 01 September 2023.

3.4. **No Criteria to Reside**

Patients in hospital with no criteria to reside have seen a sharp rise in June 2023 compared to May 2023 performance and this has continued to operate at higher levels that planned in July 2023. A meeting with the national team took place on 27 July 2023, between NHS England, the Department of Health and Social Care and Helen Whately, Minster for Social Care to review the Dorset no criteria to reside position. It was assumed the meeting was as a consequence of a rise in patients. An increase had been seen at University Hospitals Dorset following a change in their reporting methodology on 05 June 2023 with data now being taken from the Health of the Ward System. However, University Hospitals Dorset the number of patients requiring a supported discharge on pathways P1 to P3 had been consistently reducing since April. During the meeting NHS Dorset provided an overview of the current situation including a two-month sustained improvement in performance before the change in reporting methodology at University Hospitals Dorset. Feedback following the meeting is yet to be received. In terms of next steps, an audit of all patients has been agreed and the audit scope is currently being agreed. The main issue appears to be patients classed as no criteria to reside once they have passed their expected discharge date. A small sample of these patients have been reviewed and it appears despite passing their expected discharge date the patients were not medically fit for discharge. This was also discussed at the Touchpoint Meeting between University Hospitals Dorset and NHS Dorset on 01 August 2023 where it was agreed colleagues from NHS Dorset's Chief Nursing Officer's Team will visit the Trust and provide a 'fresh eyes' review on the no criteria to reside list.

3.5. **Mental Health**

Conversations are taking place with Dorset HealthCare to establish the way forward in improving performance in all areas relating to mental health. Initial conversations have taken place with the Chief Executive and a deep dive into the Child and Adolescent Mental Health Services (CAMHS) took place at the Provider Relationship Meeting between Dorset HealthCare and NHS Dorset in July. A deep dive into Mental Health performance was presented at Finance and Performance Committee in August 2023.

4. Conclusion

The ICB Board is recommended to **NOTE** the report.

Author's name and title: Natalie Violet, Head of Planning and Oversight

Date: 15 August 2023

Report Front Sheet

1. Report Details			
Meeting Title:	Board of Directors, Part 1		
Date of Meeting:	27 Sep 2023		
Document Title:	**Board Assurance Framework (BAF)**		
Responsible Director:	Nick Johnson – Deputy CEO	Date of Executive Approval	11/09/23
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**
Board Sub-Committees	18 and 19 September	Noted
CNO	08/09/23	Additional feedback from Jo Howarth regarding BAF risks pertaining to COO.
COO	08/09/23	Additional feedback from Anita Thomas regarding BAF risks pertaining to COO.
EMT Meeting	18/08/23	Discussed and agreed BAF needs additional checking and input from COO, CPO and CNO.

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** - The BAF is in its 11th iteration, having run bimonthly reviews after publication of the Trust Strategy in Nov-21, before changing to quarterly reviews in Mar-23. **Risk & Audit Committee Risks Scored >15 (High Risk):** **PL1.11 Owned by RAC, with CIO as Accountable Exec. Score 16.** 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. Mitigations include hire of new Coding manager and increasing banding to attract new staff/trainees, to shift off agency reliance. **Changes to Risk Scores since Jun-23 BAF** - PL1.11 has shifted to risk score 16 (down from 20) - PL1.5 has shifted to risk score 20 (up from 16) - PL1.6 has shifted to risk score 16 (up from 12) - PL 1.10 has shifted tom risk score 12 (down from 16) **Other:**							

	Please not that since Jun-23 the BAF has incorporated new risk scoring 4x4 measurement, in an effort to harmonize the risk scoring across Dorset. Also that the remaining actions from the Board Development day, will be added to CPO and PCC risks at the Dec-23 BAF review.
5. Action recommended	The Board is recommended to: 1. **NOTE** the Sep version of BAF 2. **Review** and **Comment** on those risks scoring 16 or higher, and the adequacy of the mitigations and controls in place, and also the changes in risks between Jun-23 and Sep-23. 3. **Recommend** that the changes that in this iteration (marked in Red) be accepted. .

6. Governance and Compliance Obligations				
Legal / Regulatory Link			**No**	
Impact on CQC Standards		**Yes**		Clinical Plan is closely focused on improving Patient Outcomes & Patient Experience, and People Plan strongly focused on staff wellbeing
Risk Link		**Yes**		
Impact on Social Value		**Yes**		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**		
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)			**No**	
Quality Impact Assessment (QIA)			**No**	

BOARD ASSURANCE FRAMEWORK - SUMMARY
DATE **Sep-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. (an additional 2 risks originally identified in 2022 have now been dropped off)

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 PL1.10 PL2.2	16 PE1.1, PL1.2, PL1.11, PL1.10, PA2.1, PL1.1 PL 2.2, PL1.3, PL1.5 PL1.6	20. PL1.1 PL1.5
3	Moderate	3	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 • Value-based recruitment - HCA workforce	• People Plan • People Dashboard - PCC • PCC reports & workplan • Divisional performance reviews • Recruitment control panel • System workforce plan	Good	Good	15	Nov-22 All mitigations in place.	
									Gaps in Control and Actions: National workforce supply challenges - system workforce planning & new ways of working						
People Objective 2 We will create an environment where everyone feels they belong, they matter and their voice is heard															
PE 2.1	PCC	CPO	Head of OD	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 place and reports to Quality Committee and in turn to Board. Pateint Safety Specilaists appointed. PSIRF plan for approval September 2023	• People performance Dashboard - PCC • PCC workplan - FTSU report, review of whistleblowing arrangements • Implementation of just & learning culture • Inpatient surveys • Datix Implementation of PSIRF	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						

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PE 3.4	QC	CMO	CMO	1644	**Risk description:** If DCH is not actively pursuing and encouraging research aims in line with its 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 in conjunction with DHC, Bournemouth University, Wessex NIHR and the Weymouth Research Hub.	3	2	6	• Strong clinical research and innovation programme. • Research Strategy in place for 2022/23 with plans to review in 2023. • Now active collaboration with Dorset Healthcare and Wessex NIHR via Weymouth Research Hub • Linden Unit partially refurbished as joint Vaccine Research Hub and opened 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. • First covid vaccine study fully recruited and successfully completed end of July 2023	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 CNO - Quality and safety CMO - Clinical Strategy and GIRFT	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	4	16	See People objective • Recruitment and retention policies and work streams • International recruitment • Wellbeing support • Maximise use of opportunities through Health Education England and NHSE funding streams • Maximise apprenticeships and clincial placements for trainees • 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 HCSW retention programme - Retention Lead appointed 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 and workforce producitivty planning • Clinical pathways design and system working to early clinical intervention at the right time, right place to support admission avoidance and reduced length of stay • 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 Collaborative • ICS governance framework and Clincial Strategy • 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 23 - 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 Lead (including security)m Emergency Accountable Officer and suitbly trained Deputy Emergency Accountable Officer Established de-brief protocol which informs change in practice and updated business continuity plans Internal Audit action plan work in progress to delvier against recommended improvements in business continuity planning cycle EPRR Framework and associated workplan based on 2022/23 standards - self assessment submitted to FPC in August 2023 - Green status as at this time System Local Resilience Forum and Partnership including Executive level LRF presence	• 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	3		

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									Gaps in Control and Actions: The 2023/24 standards have been self assessed as GREEN and submitted to ICB for review - review takes place in late Sept 2023 **Do not have a designated NED for EPRR**						
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	5	20	• 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. Continued improvement in NRTR noted through Q2 Workign Together Program focus on admission avoidance for Winter 23/24	• 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. 10% increase in ED presentations by mid-Quarter 2 noted - Planning Guidance and DCH submision based on 1.8% growth only. Continued growth not built into modelling. Mitigation thoruhg the UEC focus on schemes for winter including right-sizing out of hospital offers including step up bed capacity						
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	4	4	16	• Home First Board memebrship feeding into Integrate Neighbourhood Committee • 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: Funding in place, models growing in delivery - reduced length of stay for medical outliers/number of outliers, increased patients not admitted for >24hrs, reduced NRTR - all reported by mid Q2 23/24 • Patient Flow program management - short, medium and longer term plans - • VSCE support into new increased Discharge Lounge capacityTrusted Assessor reporting improved measures on returning to original home, extnding to assessments for new homes and improved LoS associated wit this pathway (Q2 23/24) Clinical and People Strategies for front door response. Target date: strategies agreed - key feature is Em Zone with phased delivery from 23/24	Home First Board papers UECB papers Divisional reporting to FPC Performance Report - FPC ROI reporting to UECB on investments into patient flow schemes Patient Flow Improvement Steering group papers. Q2 continued improvement in key metrics despite increase in UEC presentation and admission numbers	Requires Improvement	Requires Improvement	12	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 may invite inspections by regulators.	4	3	12	• 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	31/03/2024	
									Gaps in Control and Actions: - Lack of adherence to and application of agreed processes, budget holder training being developed						

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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 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	• Regular reporting to Strategy and Transformation SLG • Annual reporting on Green Plan to FPC and Board	Good	Good	9	Ongoing	
									Gaps in Control and Actions:						
Place Objective 3: We will utilise digital technology to better integrate with our partners and meet the needs of patients															
PL 3.1	FPC	CIO	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.						

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 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, assuming 4.2% efficiency delivery.	• Value Delivery Board with Exec led workstreams to target atnd track financial improvements. • ICS Financial framework and Financial Strategy • Reporting to Board, FPC.	Good	Requires Improvement	12	31/03/2024	
									Gaps in Control and Actions: Risk to traction of newly implemented Value Delivery Board						
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	• Transformation and Finance facilitating ideas for savings etc and increasing dedicated workforce resource. • Value Delivery Board, FPC and Board monitoring CIP plans and delivery	• Value Delivery Board, including Model hospital, GIRFT reviews, Reference costs index, Corporate services benchmarking. • System Recovery Group	Good	Good	9	31/03/2024	
									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 - 3	Very low risk
4 - 6	Low risk
8 -12	Moderate risk
15 - 25	High risk

Likelihood score (L)

The Likelihood score identifies the likelihood of the consequence occurring.

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

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

Identifying Risks

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

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

Scoring & Grading

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

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

DOMAIN C1: SAFETY, QUALITY & WELFARE

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

DOMAIN C2: IMPACT ON TRUST REPUTATION & PUBLIC IMAGE

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

DOMAIN C3: PERFORMANCE OF ORGANISATIONAL AIMS & OBJECTIVES

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

DOMAIN C4: COMPLIANCE WITH LEGISLATIVE / REGULATORY FRAMEWORK

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

DOMAIN C5: FINANCIAL IMPACT OF RISK OCCURING

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

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

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

Scoring matrix changed at this point !!
Adoption of DHC methodology

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	01-Sep-23	Trend vs Mar-23		Trend vs Nov-21	
PE 1.1	16	16	16	16	16	16	16	16	16	16	16	0	Unchanged	0	Unchanged
PE 1.2	20	20	20	20	20	20	20	20	20	20	20	0	Unchanged	0	Unchanged
PE2.1	12	12	12	12	12	12	12	12	12	12	12	0	Unchanged	0	Unchanged
PE 3.1	8	8	8	8	8	8	8	8	8	8	8	0	Unchanged	0	Unchanged
PE 3.2	12	12	15	15	15	15	15	15	15	15	15	0	Unchanged	3	Worsening
PE 3.3	12	12	12	12	12	12	12	12	12	12	12	0	Unchanged	0	Unchanged
PE 3.4	6	6	6	6	6	6	6	6	6	6	6	0	Unchanged	0	Unchanged
PL 1.1	20	20	20	20	20	20	20	20	20	20	16	-4	Improving	-4	Improving
PL 1.2	16	16	16	16	16	16	16	16	16	16	16	0	Unchanged	0	Unchanged
PL1.3	16	20	20	20	20	20	16	16	16	16	16	0	Unchanged	0	Unchanged
PL 1.4	6	6	6	6	6	6	6	6	6	6	6	0	Unchanged	0	Unchanged
PL 1.5	20	20	20	20	20	20	20	20	20	16	20	0	Unchanged	0	Unchanged
PL 1.6	12	12	12	12	12	12	12	12	12	12	16	4	Worsening	4	Worsening
PL1.7	12												Unchanged	-12	Improving
PL1.8	16												Unchanged	-16	Improving
PL 1.9	2	2	2	2	2	2	2	2	2			-2	Improving	-2	Improving
PL 1.10	16	16	16	16	16	16	16	16	16	16	12	-4	Improving	-4	Improving
PL 1.11			16	16	16	16	16	16	16	16	16	0	Unchanged	16	Worsening
PL 2.1	15	20	15	15	15	10	10	10	10	10	10	0	Unchanged	-5	Improving
PL 2.2	16	16	20	16	16	16	16	16	16	16	12	-4	Improving	-4	Improving
PL 2.3	9	9	9	9	9	9	9	9	9	9	9	0	Unchanged	0	Unchanged
PL 3.1	6	9	3	3	3	3	3	3	3	3	3	0	Unchanged	-3	Improving
PL 3.2		12	12	12	12	12	12	12	12	12	12	0	Unchanged	12	Worsening
PL 3.3		12	12	12	12	12	12	12	12	12	12	0	Unchanged	12	Worsening
PL 4.1	12	12	12	12	12	12	12	12	12	12	12	0	Unchanged	0	Unchanged
PL 4.2	12	12	12	12	12	12	12	12	12	12	12	0	Unchanged	0	Unchanged
PA 1.1	8	8	8	8	8	8	8	8	8	8	8	0	Unchanged	0	Unchanged
PA 1.2	9	9	9	9	9	9	9	9	9	9	9	0	Unchanged	0	Unchanged
PA 1.3	6	6	6	6	6	6	6	6	6	6	6	0	Unchanged	0	Unchanged
PA 1.4	12	12	12	12	12	12	12	12	12	12	12	0	Unchanged	0	Unchanged
PA 2.1	20	20	20	16	16	16	16	16	16	16	16	0	Unchanged	-4	Improving
PA 2.2	12	12	12	12	12	12	12	12	12	12	12	0	Unchanged	0	Unchanged
PA 2.3	6	6	6	6	6	6	6	6	6	6	6	0	Unchanged	0	Unchanged
PA 3.1	8	8	8	8	8	8	8	8	8	8	8	0	Unchanged	0	Unchanged
PA 3.2	8	8	8	8	8	8	8	8	8	8	8	0	Unchanged	0	Unchanged
PA 3.3	16	16	16	12	12	12	12	12	12	12	12	0	Unchanged	-4	Improving
PA 4.1	9	9	9	9	9	9	9	9	9	9	9	0	Unchanged	0	Unchanged

1. Report Details			
Meeting Title:	Board of Directors, Part 1		
Date of Meeting:	27 September 2023		
Document Title:	Corporate Risk Register		
Responsible Director:	Jo Howarth Interim Chief Nursing Officer	Date of Executive Approval : 12.09.2023	Approved by Emma Hoyle Deputy CN
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,
Board Sub-Committees	18 and 19 September	Noted

3. Purpose of the Paper	The Corporate Risk Register assists in the assessment and management of the high level operational risks. 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. The Risk Management Framework has been reviewed and ratified following the revision of the Risk appetite.							
5. Action recommended	The Board is recommended to: • review the current Corporate Risk Register • note the High risk areas and mitigations • 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

Board of Directors
Corporate Risk Register as at 31.08.2023

Executive Summary
The Board are ultimately responsible and accountable for the comprehensive management of risks faced by the Trust.

In line with the Trust's Risk Management Framework, the Board will receive and review the Corporate Risk Register via the Board Assurance Committees and the Board Assurance Framework quarterly, which identify the principal risks and any gaps in assurance regarding those risks.

The Board Assurance Framework (BAF) forms part of the Trust's Risk Management Framework and is the framework for identification and management of strategic risks. All operational risks on the Risk Register will be linked to the Trust's strategic objectives, regardless of risk score at time of addition or review.

Following the implementation of the revised Risk Management Framework, each Board Assurance Committee will commence receiving the Corporate Risk Register report with the specific risks assigned to them.

The Committees will formally review and scrutinise the risks within their remit. These reports will be received at least once a quarter together with the Board Assurance Framework.

As defined in the Framework, any risk register items scored 15 or above will be reported to the Risk and Audit Committee and will be automatically escalated to the Corporate Risk register.

An ongoing 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. This is also being reviewed alongside the governance arrangements within the Divisions to ensure that they are aligned appropriately.

The current highest areas of risk for the organisation are:

- 461 High volume of patients with no clinical reason to reside (High Risk scoring 20)
- 472 Community Paediatric Long Waits for ASD patients (High Risk scoring 20)
- 866 External Multiagency Delays Resulting in Delayed Discharge of Complex Paediatric Patients (High Risk scoring 20)
- 1221 Tackling the backlog of elective care (High Risk scoring 20)
- 1642 Failure to attract and retain the right people with the right skills (High Risk scoring 20)
- 1646 Financial Sustainability 2023/24 (High Risk scoring 20)

1. Introduction

1.1 This report provides an update to the report presented to the May 2023 Risk and Audit Committee meeting. This is the first report that is reflective of the revised Risk Management Framework.

1.2 The Corporate Risk Register is the central repository for the most significant operational risks scoring 15+ arising from individual services, Care Groups or Divisional risk registers that are currently not fully mitigated, or controlled, or they are risks that have significant impact on the whole organisation and require oversight and assurance on their management. These risks represent the most significant risks impacting the Trust ability to execute its strategic objectives and therefore align with the principal strategic risks overseen by the Board.

1.3 The Board sub-committees will be receiving quarterly Corporate Risk Register reports to ensure that the risks that are relevant to those Committees are being managed effectively, and that the risks are being shared across the organisation.

1.4 Risks on the risk register are aligned and linked to the Board Assurance Framework. Not every high scoring risk on the Corporate Risk Register will appear on the BAF, and not all BAF entries will appear on the Corporate Risk Register, which is the tool for the management of operational risk.

1.5 Through the Board sub-committees, the Board will receive assurance that the BAF and Corporate Risk Register has been used to:

- inform the planning of audit activity (Risk and Audit Committee)
- inform financial decision making and budget setting (Finance and Performance Committee)
- inform quality and governance decisions (Quality Committee)
- inform workforce; human resources; training and development decisions (People and Culture Committee)

1.6 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. Corporate Risk register

2.1 There are currently 78 risks on the risk register that are scored 15 or above. This has reduced from 223 risks, at the beginning of August 2023, as services work through their risk registers to align with the new framework and as part of their governance review processes.

2.2 The complete revision of the remaining 78 risks are due to be completed by the end of October 2023. This was originally planned for completion by the end of September, however due to operational pressures, various industrial action and August holidays, this has slipped. Whilst managing risk is paramount for the services, operational pressures (due to industrial action and failed generator) often means that staff are dealing with issues happening at the time, and rather than spending time reviewing risk registers, it is one of the first tasks to be put on hold.

However, with the introduction of the revised Framework and the planned training programme this should assist in keeping this high on staff members' agenda.

3. Corporate Risk Register updates. (From previous report)

3.1 1646 – Financial Sustainability 2023/24 (20 HIGH (Major (4) x Certain (5))

3.1.1 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.

3.1.2 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, the achievement of a breakeven position will be challenging, with significant risk of delivery.

3.1.3 Mitigation:

Value Delivery Board has been established focussing on in year and longer-term financial sustainability, and is a formal sub group of the Finance and Performance Committee.

3.1.4 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 £2.4m worse than plan for the Trust at month 4 with mitigating actions targeted and challenged through the Value Delivery Board

3.2 1645 – Mortality Indicator (SHMI) (12 MODERATE (Major (4) x Possible (3) previously HIGH (Major (4) x Likely (4))

3.2.1 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.

3.2.2 In the last two reporting periods, our SHMI has decreased 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, which is in progress.

3.2.3 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).

3.2.4 This will be the last update to this Committee on this risk, as it will be reported from the Hospital Mortality Group, to the Clinical Effectiveness Group and escalated as necessary to the Quality Committee.

3.3 1561 – Maintaining business as usual during construction phase of NHP (HIGH (Major (4) x Likely (4)) ⇔

3.3.1 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.

3.3.2 A business and usual Plan has developed to a single option involving keeping the ED front door open and accessible to vehicles until the final build/refurbishment phase (construction of the link corridor). At this point the NHP build will be operational. Tilbury Douglas now working with Clinicians to ensure BAU can be maintained during the final phase with a focus on intra hospital transfers, access to theatres and diagnostic imaging.

3.3.3 This will be the last update to this Committee, these risks will be reported through the Finance and Performance Committee moving forward.

3.4 1642 – Failure to attract and retain the right people with the right skills. (20 HIGH (Catastrophic (5) x Likely (4)) ⇔

3.4.1 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.

3.4.2 Sitting beneath the overarching risk, is a number of service specific risk registers relating to staffing, which are detailed in the appendices. Those which have been scored at 15 or above have been automatically escalated to the Corporate Risk Register as per the revised Risk Management Framework.

3.4.3 This has added an additional 34 risks to the Corporate Risk Register relating to staffing. Of those 34 risks:

- 5 risks have decreased in score (but still remain scored between 15 and 19)
- 16 risks have remained static (scored between 15 and 19)
- 13 risks have increased in score (but remain between 15 and 19)

3.4.4 The specific detail of these risks will be reported to the People and Culture Committee, and the Quality Committee due to the potential patient safety risks.

3.5 1221 - Tackling the backlog of elective care (20 HIGH (Major (4) x Certain (5)) ⇔

3.5.1 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.

3.5.2 This risk remains scored as ‘HIGH’ 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.

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

3.5.4 Industrial action undertaken by the Junior Doctors and the Consultants has also impacted on this risk over the last few months, which has made recovery difficult. Patients are being clinically prioritized.

3.5.5 The specific details of this risk will be reported to the Quality Committee moving forward.

3.6 461- High volume of patients with no reason to reside (16 HIGH (Major (4) x Likely (5) previous score: 15 HIGH (Moderate (3) x Certain (5)) 

3.6.1 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 11.09.2023. This is the same figure as reported in the last report.

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

3.6.3 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.

3.6.4 The specific details of this risk will be reported to the Quality Committee moving forward.

3.7 1251 – Critical Failings in hospital blood bank (12 MODERATE Moderate (3) x Likely (4) (previously 20 HIGH Major (4) x Certain (5)) 

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

3.7.1 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

3.7.2 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.

3.7.3 The specific details of this risk will be reported to the Quality Committee moving forward should the risk be scored 15 or above.

3.8 472: Community Paediatric Long Waits for ASD Patients (20 HIGH (Major (4) x Certain (5)) ⟺

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

3.8.2 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.

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

3.8.4 Increasing numbers of complaints have been received over the past two months in relation to ASD waiting times. Ongoing System wide discussions around ASD Service.

3.8.5 The specific details of this risk will be reported to the Quality Committee moving forward.

3.9 1509 – Mental Health patients delays in care pathway and services support (20 HIGH (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))

3.9.1 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.

3.9.2 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.

3.9.3 As an additional mitigation, one of the Mental Health Safe rooms has been identified as part of EDAU, which means that a patient can be admitted to that room and Sectioned.

3.9.4 The specific details of this risk will be reported to the mental health Steering group with escalation, as necessary, to the Quality Committee moving forward.

4. Emerging Risks from Divisions:

4.1 Urgent and Integrated Care

4.1.1 Pharmacy service (UPDATE)

- **1502 Pharmacy Regional Quality Assurance Audit (20 HIGH (Major (4) x Certain (5)) ⟺**

  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.

  Update (12.08.23):

  Audit undertaken 10.08.2023. The auditors were pleased with the progress that we have made and commented that we have clearly listened to their feedback and are working through solutions. They have kept us as High Risk, however they did emphasise the improvements since last time. There was one critical deficiency which had been addressed immediately, and the others will be picked up once we have the audit report.

  Generally, the feedback was that the team have the ideas, but are struggling with the capacity to fully implement these changes. This of course is something we are acutely aware of, and with some of the recent developments in the service with locums, apprentices, purchasing in more ready made products, and the Quality Manager the service will be able to support implementing these.

  The service did also successfully recruit an internal candidate into the Accountable Pharmacist position for Aseptics, which was really positive. The successful candidate is about to go on maternity leave, but will commence the role on her return. The post is currently covered until that point. The service have offered the second candidate a deputy position in aseptics, and are waiting to hear back.

4.1.1.1 The specific details of this risk will be discussed at Medicines Committee and escalated through to Quality Committee as appropriate.

4.1.2 662 Pharmacy Workforce - vacancy rate (15 HIGH (Moderate (3) x Certain (5)) ⟺

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.

4.1.2.1 The specific details of this risk will be discussed at Medicines Committee and escalated through to People and Culture Committee as appropriate moving forward.

4.5.2 Family Services and Surgical Division

4.5.2.1 **1475 Ophthalmology Long wait new patients (12 MODERATE (Moderate (3) x Likely (4))** ⟷

Update provided:06.09.2023

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
- Focus meetings with Pathways, Access & Business Manager to ensure plans in place for long waiters
- Plans around cataract and mutual aid
- Diabetic - Retired consultant returns for additional sessions
- All other sub specialties - Exploring extra sessions with medical team

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.
- Current longest waits:
  Cataract - 54 weeks (696)
  Diabetic - 54 weeks (41)
  Glaucoma - 42 weeks (289)
  Macular - 18 weeks (1)
  Oculoplastic - 44 weeks (148)
  Not assigned - 59 weeks (729) *Action to discuss with BI to add all subspecialties

4.5.2.2 The specific details of this risk will be discussed at Quality Committee moving forward.

4.5.3 **1474 Ophthalmology FOWL long waiters (16 HIGH (Major (4) x Likely (4))** ⟷

Update provided:14.08.2023

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:

- 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.
- Continue focus on FOWL, needing stability within nursing establishment to maximise clinical activity.
- Request going to SUG to complete work to increase clinical space available in REI.
- Due to Maternity leave, there is a delay in further support being provided from non-medical workforce.
- Full action plan includes plans to address lack of capacity with Ophthalmology

4.5.3.1 The specific details of this risk will be discussed at Quality Committee moving forward.

4.5.4 **1477 Ophthalmology Clinical Space (16 HIGH (Major (4) x Likely (4))** 

Update provided:06.098.2023

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:

- Paper submitted to Space Utilisation Group (SUG) to create additional clinic rooms.
- Capital available for work to be undertaken.
- Estates team have drawn up proposals, with different options to increase clinical space.
- SUG agreed proposals 17.08.2023 to increase clinical space within REI. Plans being drawn up, timescale to be confirmed.

4.5.4.1 The specific details of this risk will be discussed at Quality Committee and Finance and Performance Committee moving forward.

4.5.5 561 – Volume of patients on the Orthopaedic Admitted waiting list (16 HIGH (Major (4) x Likely (4) previous Score 20 (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 number of lists being cancelled due to limited beds and Orthopaedic theatre Staff

Update: 06.09.2023

- Currently dating 78-week breaches in month, making some gains but not enough capacity to gain on achieving 65 weeks. Achieving by March will be a risk as theatre lists are not protected over summer. Lists are still being stood down for Trauma.
- At PTL meetings we have planned down to all August breaches. Some August capacity at risk due to annual leave. Service aware and proactively working on August rota to put capacity where the demand is needed.
- The LLP have recently signed a contract which enables them to undertake trauma during the weekend. This should prevent some weekday cancellations.
- There will still be some elective cancellations due to surgeon specific trauma however this should now be kept to a minimum.

4.5.5.1 The specific details of this risk will be discussed at Quality Committee moving forward.

5 Digital Technology & Infrastructure (DTI)

5.1 A full review of all the risks identified on the DTI registers has been undertaken. A full report on the DTI risk register items will be included in the next report to the Finance and Performance Committee to enable the Chief Information Officer and the Head of Risk Management to undertake a full review of the register.

5.2 There are currently 8 risks on the DTI risk register that are scored 15 or above. These are (for information only)

- DPR - Unity Connected Record - Fortrus Linux servers end of life Apr 2019 (20 HIGH) ⇔
- Trust Integration Engine (16 HIGH) ↓ (previously 20 HIGH)
- Data Warehouse Server end of life and failing (16 HIGH) ⇔
- Careflow - ED patients sometimes show as unknown location (16 HIGH) ⇔
- Spacelabs 24 hour ECGs - server end of life (16 HIGH) ⇔
- SystemC – Supplier (16 HIGH) ⇔
- PPID server environment (16 HIGH) ↑ (previously 12 MODERATE)
- No op notes available for Cancer MDT (16 HIGH) ↑ (previously 9 MODERATE)

6. Conclusion

Risks continue to be regularly reviewed and have been aligned with the revised Risk Management Framework and are 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 High-risk areas.
- consider overall risks to strategic objectives and BAF.
- request any further assurances.

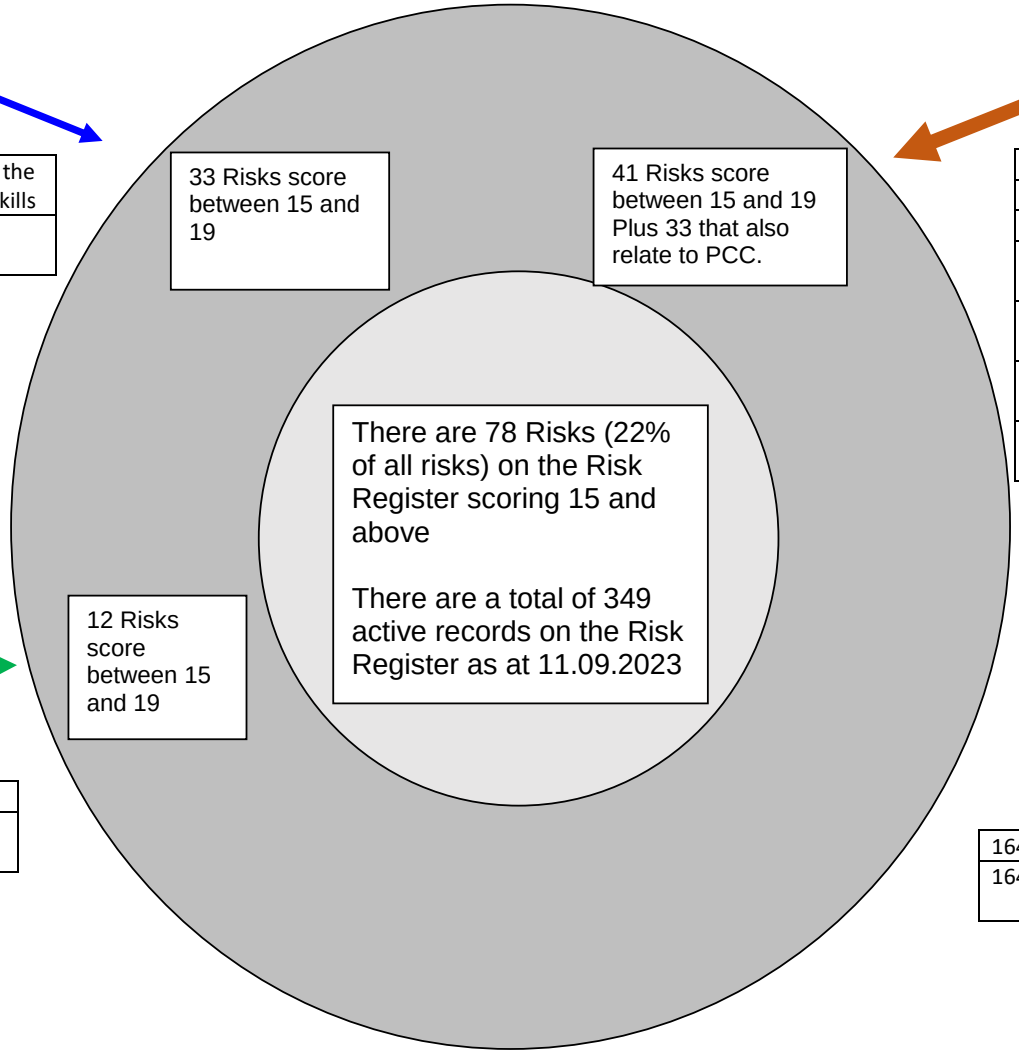
Name and Title of Author:
Mandy Ford, Head of Risk Management and Quality Assurance
Date: data correct as at 11.09.2023
Appendices

- Heat Map (Appendix 1)
- Corporate Risk Register items by Board Sub Committee (Appendix 2)

Corporate Risk Register – Risks scoring 20 or above

People and Culture Committee

1642	Failure to attract and retain the right people with the right skills
472	Community Paediatric Long waits for ASD patients



Quality Committee

1221	Tackling the backlog of elective care
1516	Radiology reports not being viewed
1502	Pharmacy Aseptic unit
1340	McKesson Cardiology – non-compliance with IRMER
472	Community Paediatric Long waits for ASD patients
1642	Failure to attract and retain the right people with the right skills
871	Level of Entonox Exposure on Maternity Unit

Finance and Performance

1646	Financial Sustainability
1348	DPR- Unity Connected record

Risk and Audit Committee

1646	Financial Sustainability
1642	Failure to attract and retain the right people with the right skills

Corporate Risk Register

THIS RISKS SCORING 15+ WILL BE REPORTED IN DETAIL TO THE QUALITY COMMITTEE

Ref	Score		Description
1221	20	⟷	Tackling the backlog of elective care

Ref	Current Score		Previous Score	Description
505	16	⟷	16	Gastroenterology Demand & Capacity
506	8	↓	20	Volume of Patients on the Urology Outpatient Waiting List
561	16	↓	20	Volume of Patients on the Orthopaedic Admitted Waiting List
743	12	↓	20	Colorectal and Upper GI Clinic Capacity
765	15	⟷	15	Reduced Theatre Capacity & Longer Waiting Lists due to Closure of Weymouth DSU
1224	12	↓	16	Increase in OMF Cancers due to long waits
1445	12	⟷	12	Delay in Derrmatology Follow up
1474	16	↓	20	Ophthalmology FOWL long waiters
1605	15	⟷	15	General Paediatric Outpatient Waiting Lists
1163	6	↓	12	Remote Monitoring following Colorectal Cancer Treatment

THE RISKS SCORING 15+ WILL BE REPORTED IN DETAIL TO THE QUALITY COMMITTEE

Ref	Current Score		Previous Score	Description
1570	16	↑	20	Bed Storage on DCH Site
1516	20	↔	20	Radiology Reports not being reviewed
1509	15	↓	20	Mental Health patients delays in care pathway and services support
1502	20	↔	20	Pharmacy Aseptic Unit - High risk to patient safety
1477	9	↓	20	Ophthalmology Clinical Space
1340	20	↔	20	McKesson Cardiology - non-compliance with IRMER
841	12	↓	20	CCN Team Information Sharing (Community Children's Nursing)
1722	16	↔	16	Patients at risk of hospital acquired pressure damage
1688	16	↔	16	Dental equipment end of life and unreliable
1674	16	↔	16	Obsolete Stryker Camera Stack Components
1656	16	↔	16	Temperature Issues in Theatres
1645	16	↔	16	Mortality Indicator (SHMI)
1627	16	↔	16	Careflow - ED patients sometimes show as unknown location
1626	12	↓	16	Careflow - missing patients on C/Flow without named clinician
1579	16	↔	16	Patient Transport Trolleys (Thirteen of our Thirty trolleys will no longer be maintained by Anetic Aid and need to be replaced. Current maintenance contract has expired).
1508	12	↓	16	Surgical Admissions Lounge Lack of Space Utilisation & Capacity
1496	16	↔	16	Lack of Gynaecology Theatre Capacity
1489	12	↓	16	OMF Clinical Space
1479	12	↓	16	Ophthalmology Equipment and Network
1393	12	↓	16	Risk Management - Datix – loss / not fit for purpose
1352	12	↓	16	DPR - Unity Connected Record - break glass groups (Users are viewing potentially extremely sensitive information without realising it due to how the groups have been setup).
1351	12	↓	16	Blood360 - blood tracking
1183	16	↔	16	Stability of LIMS (New Pathology LIMS is unstable and frequently losing interface connectivity affecting reporting of results through downstream systems into ICE impacting on service provision of clinical diagnostics).
1094	16	↔	16	ESTATES: Lack of staff accommodation
1086	16	↔	16	Impact of late GP deliveries on quality of results and laboratory service

1054	16		16	Lack of Paediatric Tissue Viability Service
844	15		16	Inadequate Space to Accommodate Face to Face & Virtual Clinical Consultations
827	12		16	Increased Activity using Flexible Endoscopes vs Capacity to Decontaminate
784	12		16	Nurse call systems
755	16		16	i Communicator - ED Failure to Comply with NPSA 16 Requirements
723	12		16	CRCU Demand vs Capacity
533	16		16	Access to Appropriate Psychiatric Care for Patients within the ED (Adult or Paediatric)
1617	15		15	Clinical USB devices are being blocked by SOPHOS
1591	12		15	Procurement Delays (24 beds) Patient Pathway Improvement Programme
1578	15		15	triage and the use of BSOTS (Birmingham Symptom Specific Obstetric Triage System))
1573	9		15	VitalPAC server hardware end of support
1545	10		15	Failure to Upgrade existing PACS system
1515	12		15	Brief/Debrief Logbook saved on SharePoint or database (maternity)
1498	15		15	Inappropriate Discharge of Patients from First Stage Recovery
1491	15		15	Failure to purchase a POC machine for eGFR testing in Radiology
1485	15		15	Emergency Out of Hours Equipment ENT - Yeovil
1416	10		15	PAS system has Clear Text Network Traffic
1347	12		15	Mosaic Chemotherapy system - DCH to Poole
1287	10		15	DPR - Unity Connected Record - loss of access
1281	12		15	eMed Renal Information Systems - system failure
1278	10		15	JAC Pharmacy Stock Control - Loss of access as a result of damage etc.
1162	12		15	Risk of on the day cancellations with over night opening of day surgery
1134	15		15	Trauma Bed Capacity on Purbeck
1131	12		15	Insufficient Elective Theatre Exposure for Training Ortho Registrars
1099	9		15	recording of carers or parental responsibility on electronic systems
1080	10		15	Inappropriate management of adult eating disorder (and related) admissions
1035	15		15	Nutrition Hydration Failures
871	15		15	Levels of Entonox Exposure on Maternity Unit
765	15		15	Reduced Theatre Capacity & Longer Waiting Lists due to Closure of Weymouth DSU
657	9		15	Failure to reach target turnaround time for hsTNI for ED patients
647	12		15	Continuous Breach of <5 Day Turnaround Times for Blood Films Referred to Consultant Haematologists
635	15		15	Critical Care Discharge Delays Over 24hrs and Lack of Flow for Ward Level Patients
495	12		15	Maternity Delivery Rooms Ventilation
472	20		15	Community Paediatric Long Waits for ASD Patients
461	16		15	High volume of patients with no reason to reside
1719	12		12	Paper based patients notes are not filed in correct order creating multiple risks

1718	12		12	Regular opening of clinic rooms in ortho OPD for in-patients out of hours
1711	12		12	Impact on research of not having on site Oncology
1691	12		12	Safe Storage of Medicines (including Fluids and Controlled Drugs)
1690	8		12	Controlled Drugs Second Check
1687	12		12	Transition to combined Health Records and scanning service in maintaining scanning volumes for day forward and legacy.
1684	12		12	Agyle Reporting not linking to BI systems
1675	4		12	Medtronic Valleylab FX Diathermy machines
1652	12		12	Emergency Call Bell System
1632	12		12	level 3 training safeguarding children compliance
1612	12		12	Lack of ability to search for control tissue in Histology archive
1601	12		12	Loss of Colorectal Oncology Clinics on Site
1599	16		12	PPID server environment
1569	12		12	Birthing room out of action on The Cove
1567	9		12	Kingfisher Medical Air Supply
1542	16		12	Lack of compliance to the Pathology QMS system in Microbiology
1536	12		12	NHP CT Scanner Provision
1535	12		12	Loss of decant beds/Maud Alexander bed spaces resulting from NHP refurbishment spaces
1532	12		12	Lack of Admitting Area for MTOP / MMOP Patients Across Surgical Wards
1528	12		12	Respiratory Medicine Patient Databases
1503	9		12	Use Of Day Rooms for Inpatient Beds - Stroke
1492	9		12	Clinic Capacity in Paediatric Diabetes
1484	12		12	Community Equipment for ENT Service
1468	8		12	Dermatology Clinical Space
1464	12		12	CT 1 scanner reliability
1446	12		12	The lack of Cardiac MRI capacity within DCH services
1438	12		12	Regular opening of two unfunded beds in Purbeck's dayroom
1297	9		12	CD View - Non supported OP system: Server 2003
1284	12		12	Careflow - total system failure
1263	12		12	Replacing Maquet operating tables - Aplhamaxx & Alphastarr
1262	12		12	Replacement of Faxitron Biovision Diagnostic X-ray Machine s/n 30378
1230	12		12	Insufficient relative and patient areas in ICU during refurbishment
1182	12		12	Flooding on Kingfisher during heavy rain
1163	6		12	Remote Monitoring following Colorectal Cancer Treatment
1155	9		12	Lumenis Laser Replacement
1139	12		12	Storage of Archive Material for Histology is not fit for purpose

1124	12		12	CYP with Eating Disorders Requiring Prolonged Acute Admissions
1112	16		12	CEPOD Booking - Theatre Emergency Listing System Improvement
1062	12		12	Clinical Services Review - Somerset/Dorset
771	15		10	Inappropriate food/meal provision to those with special dietary needs: allergy, texture modification
1685	9		9	Absence of a diabetes specific clinical database.
1672	9		9	Respiratory Department Accreditation
1174	15		9	Lack of Disabled Facilities for CYP on Kingfisher & The Children's Centre
1679	16		6	Concerns over wait for patients needing Oncology Access and Brachy (Patients being referred to Poole Hospital are facing extended waits for their Brachy treatment).
1714	15		5	Electrical incoming supply MCB failure for South Wing Main
866	15		4	External Multiagency Delays Resulting in Delayed Discharge of Complex Paediatric Patients

THIS RISK IS REPORTED IN DETAIL TO THE PEOPLE AND CULTURE COMMITTEE AND QUALITY COMMITTEE

Ref	Score		Description
1642	20	⟷	Failure to attract and retain the right people with the right skills.

Ref:	Current Score		Previous Score	Description
1272	16	↓	20	Trust Integration Engine (loss of key skills and knowledge of TIE to manage over 40 system interfaces between corporate clinical systems)
1251	12	↓	20	Critical failings in hospital blood bank (staffing shortfalls leading to the Quality management system not being maintained, resulting in tests not being reported in a timely manner)
1246	12	↓	20	Lack of OT in Orthopaedics
1040	5	↓	20	Elective Arthoplasty Nurse Practitioner Vacancy
1037	16	↓	20	Vacancy for Transition Nurse Specialist for Young People to Improve Health Outcomes
1032	12	↓	20	Failure to Meet Clinical Typing Target Head & Neck and Specialist Medicine (Admin team has not been increased even though the Medical teams have grown significantly.
884	12	↓	20	Urology Consultant Workforce
857	16	↓	20	OMF Capacity and Impact on Cancer Pathways
662	15	↓	20	Pharmacy Workforce - vacancy rate
641	12	↓	20	Clinical Coding workforce
1673	12	↓	16	Stroke Service: Recruitment to Medical staffing vacancies / understanding staffing model for the service. Recruitment to Nursing & Therapy vacancies to ensure optimal experience for patients and consistent approach to patient pathways in line with national guidance.
1671	16	↓	12	Chemotherapy Nursing Capacity
1668	16		15	Clinical Haematology Capacity for Dual Reporting of Bone Marrow Cases
1659	16	⟷	16	ENT Deanery Gap - Junior Doctor
1556	16	⟷	16	Theatre Staffing Sustainability
1529	16	⟷	16	lack of capacity of Neurodevelopment Nursing (Business planning for a band 6 1.0wte to support succession within the team as well as support to meet the increasing demands of CYP who require support with a diagnosis of ASD/ADHD)
1500	16	↑	6	NHP Digital Resourcing (Lack of sufficient skilled digital/project Trust staff to support the implementation of the solution).
1495	16	⟷	16	CRCU Nursing Workforce Education Gap
1481	16	↑	12	Dermatology Clinical Workforce
1466	16	⟷	16	Inability to support and finance 'growing our own' skilled staff (strategic estates)
1225	16	⟷	16	Consultant staffing in Elderly Care and Stroke services

1210	12		16	CRCU Clinical Psychologist
1165	16		16	Radiology, Digital Team & Service capacity to support implementation of Stroke Artificial Intelligence Solution
1152	12		16	Current Digital Staffing levels present risk to both operational and strategic activities
1081	9		16	Lack of dietetic support for several areas across Neonatal & Paediatric services: (0.1WTE funding from Ockendon for Dietetic input for SCBU. To be covered by existing dietitian, 0.3WTE remaining from 1.0WTE post only partially filled, so with back fill for 0.1WTE for SCBU - 0.4WTE post out to advert).
933	12		16	Medical Cover of Fortuneswell Ward
748	16		16	Orthopaedic Junior Doctor Vacancies
730	16		16	Critical Care Outreach Under Resourced
1678	15		15	Oncology Medical Staffing (Outpatients)
1661	15		15	Staffing within Fracture Liaison Service (FLS)
1555	10		15	Kingfisher staffing levels
1540	15		15	No substantive nursing establishment funding for South Walks Assessment OPD Centre
1480	9		15	Dermatology CNS Workforce
1475	9		15	Ophthalmology Long wait new patients (Business case - 1 WTE Orthoptist to release members of the team to support with Glaucoma clinics and Macular injection)
1471	12		15	Rheumatology Workforce
1244	10		15	Dermatology Advice and Guidance Impacted By Departure of Consultant
1235	15		15	OT vacancies
1218	12		15	Inadequate Cover for GI Bleed Rota
1154	15		15	Regular movement of Ortho nursing staff to other wards to support their staffing levels
801	10		15	Unfunded Staffing Shortfall in Outpatients
775	15		15	Care of the Elderly Nursing staffing levels
729	15		15	Pharmacy Support in CRCU
647	15		12	Continuous Breach of <5 Day Turnaround Times for Blood Films Referred to Consultant Haematologists (Capacity of existing staff and shortfalls in staffing)
472	20		15	Community Paediatric Long Waits for ASD Patients (vacancy within the team)
1713	9		12	Workforce capacity PHH (Current workforce capacity might not be able to support early testing before Feb 2024 and utilisation of old discharge lounge)
1712	8		12	Business Planning PPIP PHH (If business planning timelines are not aligned with PPIP PHH timeline we could have an impact on ability to recruit and sustain services).
1687	12		12	Transition to combined Health Records and scanning service in maintaining scanning volumes for day forward and legacy. (To maintain running health records as BAU and including the scanning bureau requires adequate work force).
1670	9		12	Oncology Counsellor Capacity at DCH (External funding sought from charitable sources to increase counselling capacity within the trust and reduce the backlog of patients).
1665	12		12	Lack of capacity to provide consultant led care to women at risk of premature birth
1658	8		12	Ward Clark - Kingfisher Ward

1649	12		12	Lack of specific skill and expertise to support digital requirements for specialist Cardiologysystems
1590	12		12	Industrial Action Impact
1568	12		12	Community Dietetic Service (We are currently employing agency staff to provide this service as have been unable to recruit substantive and have one member of staff on maternity leave returning in Autumn 2023).
1559	12		12	Gap in workforce for an Endocrine Specialist Nurse
1527	12		12	Palliative Care Staffing
1522	6		12	High Level of Vacancy / Sickness within Access
1490	12		12	ENT Nursing Workforce
1488	12		12	Head & Neck CNS Establishment
1467	12		12	Insufficient revenue funding available to achieve the required staffing levels (New CRCU Unit)
1445	12		12	Delay in Derrmatology Follow up (Lack of clinical space within the department as well as workforce impacts on available follow up capacity causing patients to be delayed in their planned pathway).
1443	12		12	Unable to recruit into vacant plaster technician hours
1227	12		12	Provision of the smoking cessation service to pregnant women (The smoking cessation lead midwife is on LTS and the service is being managed (very well) by a band 4 MSW).
1196	16		12	Backlog of Paediatric & Ocular Motility Appointments (1 consultant - clinic every week but due to staff absences a lot have been cancelled)
1194	12		12	Day Surgery Staff Resignations due to Use as Inpatient Ward
1034	8		12	H@N Technician (Currently establishment for 1 wte H@N tech only (37.5hrs per week), therefore service only covered three nights per week, where it is required seven days. No resilience/ cover for sick or annual leave).
991	12		12	Paediatric Dietetic Staffing for Outpatient Activity
959	12		12	DAIRS Nurse Staffing
876	12		15	Maternity Staffing
837	4		12	Paediatric Palliative/End of Life Care
758	8		12	Failure to Meet Internal Standards for Reporting Turnaround Times (Due to vacancy, flexible retirement, paternity leave and sickness the reporting is backlogged with significant delays in all areas. Vacancy monies being used to insource and outsource to catch up)
735	16		12	In patient SACT/Chemotherapy capacity within the Trust (Lack of consistent clinical staff to deliver safe SACT/Chemotherapy treatment capacity within Fortuneswell Ward).
566	9		12	Lack of Resources for Reporting of Referral Tests
1606	15		10	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).
1473	10		10	Iontophoresis clinics (Currently not providing this service due to space and staffing numbers)
769	16		10	Inadequate HEN staffing
1701	9		9	Fortuneswell pharmacy - Lack of staffing resilience

1558	9	⟷	9	Clinical Psychologist - Paediatric Epilepsy
1544	9	⟷	9	No Paediatric CPE in post
1472	6	↓	9	Allergy Testing in ENT (Currently not providing the Allergy Skin Prick testing service due to available clinical space and appropriately trained staff)
721	16	↑	9	Shortfall in Cardiac Physiology Staffing for Remote Monitoring Service
1643	8	⟷	8	Staff feeling unable to raise concerns about safety and quality
1619	15		8	Pharmacy provision in Maud (No pharmacy provision for Maud Acute Admissions Unit therefore no medicines reconciliation)
1696	5	⟷	5	On call Respiratory Physiotherapy Service (Dorset County Hospital does not provide a 24/7 respiratory physiotherapy on call service to Critical Care).
836	16	↑	4	Children's Community Nursing Staffing
839	16	↑	2	Specialist Epilepsy Paediatric Service
565	15	↑	2	Lack of Consultant Cover in Histopathology

THIS RISK IS REPORTED IN DETAIL TO THE FINANCE AND PERFORMANCE COMMITTEE

Ref	Score		Description
1646	20	⟷	Financial Sustainability

Ref:	Current Score		Previous Score	Description

1593	12	↓	20	Patient Pathway Improvement Programme - Delivery within business scale timescale (Time)
1589	12	↓	20	Seasonal Pressures
1584	12	↓	20	Impact on Finance of change on design and spend on Patient Pathway Improvement Programme
1583	12	↓	20	Budget and Affordability - Patient Pathway Improvement Programme
1348	20	↔	20	DPR - Unity Connected Record - Fortrus Linux servers end of life Apr 2019
1272	16	↓	20	Trust Integration Engine (Independent Systems Integrators is a small organisation that is owned and run by a single individual. This presents a major risk in the event the supplier opts or has to cease trading or providing the support service)
1688	16	↔	16	Dental equipment end of life and unreliable
1674	16	↔	16	Obsolete Stryker Camera Stack Components
1641	16	↔	16	Data Warehouse Server end of life and failing
1479	12	↓	16	Ophthalmology Equipment and Network (Inadequate number of equipment to manage the demand on the service and outdated equipment which is no longer fit for purpose).
1466	16	↔	16	Inability to support and finance 'growing our own' skilled staff in sufficient numbers to run new services and deliver workforce transformation
1393	12	↓	16	Risk Management – Datix not fit for purpose
1339	16	↔	16	Spacelabs 24 hour ECGs - server end of life
1183	16	↔	16	Stability of LIMS (New Pathology LIMS is unstable and frequently losing interface connectivity affecting reporting of results through downstream systems into ICE impacting on service provision of clinical diagnostics).
1168	12	↓	16	System revenue affordability pressures
1094	16	↔	16	ESTATES: Lack of staff accommodation
844	15	↓	16	Inadequate Space to Accommodate Face to Face & Virtual Clinical Consultations
784	12	↓	16	Nurse Call systems
1591	12	↓	15	Procurement Delays (24 beds) Patient Pathway Improvement Programme
1573	9	↓	15	VitalPAC server hardware end of support
1545	10	↓	15	Failure to Upgrade existing PACS system
1416	10	↓	15	PAS system has Clear Text Network Traffic (existing PAS system has been identified as having cyber security risks)
725	15	↔	15	CRCU Building Regulations
1712	8	↓	12	Business Planning PPIP PHH
1702	12	↔	12	SystemC clinical system supplier excessive contract terms
1680	12	↔	12	Charlton Down Emergency Alarm System
1675	4	↓	12	Medtronic Valleylab FX Diathermy machines (Medtronic have sent a letter of obsolesce for the Force FX diathermy machine. They will no longer service or provide parts after February 2025).
1652	12	↔	12	Emergency Call Bell System
1599	12	↓	16	PPID server environment

1590	12		12	Industrial Action Impact
1576	12		12	Relocation of BT/telecoms pole and services for enabling works
1547	12		12	Commercial Deficit (Research Departmental deficit (expected to be 500,000 in 2023) and capability or capacity of making up for it through commercial work. Year end 22/23 was 134k to the Trust).
1536	12		12	NHP CT Scanner Provision
1263	12		12	Replacing Maquet operating tables - Aplhamaxx & Alphastarr
1262	12		12	Replacement of Faxitron Biovision Diagnostic X-ray Machine s/n 30378
1182	12		12	Flooding on Kingfisher during heavy rain (due to roof issues)
1265	10		10	Data Cabling (Large sections of data cabling have been installed without meeting Electrical, Fire or Construction, Design Management regulations, that is they are poorly designed and installed so as to cause potential hazards and inhibit access to operate and maintain systems)
1174	15		9	Lack of Disabled Facilities for CYP on Kingfisher & The Children's Centre
1491	15		15	Failure to purchase a POC machine for eGFR testing in Radiology

THIS RISK IS REPORTED IN DETAIL TO THE RISK AND AUDIT COMMITTEE

Ref	Score		Description
1646	20		Financial Sustainability

Ref	Score		Description
1642	20		Failure to attract and retain the right people with the right skills.

Details are in the body of the report.

INTEGRITY | RESPECT | TEAMWORK | EXCELLENCE

NHS
Dorset County Hospital
NHS Foundation Trust

Escalation Report

Committee: Quality Committee

Date of Meeting: 22nd August 2023

Presented by: Eiri Jones

Significant risks / issues for escalation to Board for action	• Detailed discussion of the Lucy Letby case throughout the meeting. Actions are underway to gain assurance and to understand the Trust's position. • SHMI now in the upper limit of the normal range; work ongoing to gain a deeper understanding of the causes.

Key issues / matters discussed at the Committee	The committee received, discussed and noted the following reports:
	• Quality and Safety Performance Report noting:
	  ○ Positive in maternity infection prevention and control
	  ○ Deep dive re C. Diff with some concerns still ongoing
	  ○ Developments in how complaints are managed
	  ○ Improvement in the number of patients being discharged directly home from ICU
	• CQC Update noting that a response was awaited from the CQC.
	• Maternity Safety Report, MIS Update, PMRT Report, ATAIN Report and Staffing Report.
	  ○ The reports summarised where the Trust was an outlier or outstanding and the actions in place.
	  ○ It is recommended that a Board Development Session is held on the responsibilities of individual Board members re maternity.
	  ○ Assurance provided re staffing plan and that 1-1 labour is provided.
	• Safe Staffing Mid-Point Review was now going through the business planning process. Uplift in headroom supported. Further assurance required re skill mix of staff.
	• Learning from Deaths Q1 – discussions around mortality as an indicator of quality.
	• Transformation Update noting the Trust-wide transformation map.
	• Sub Group Terms of Reference
	  ○ Medicines Committee
	  ○ Clinical Effectiveness Committee
	  ○ Mental Health Steering Group
	  ○ Patient Safety Committee
	  ○ Infection Prevention and Control Committee
	  ○ Patient Experience and Public Engagement
	  ○ Research Steering Group
	  ○ Safeguarding
	• Escalation Reports from the following subgroups:
	  ○ Research Steering Group, noting the need to grow commercial research within the Trust.

Decisions made by the Committee	• Patient Safety Incident Response Framework (PSIRF) recommended to the Board for approval.
Implications for the Corporate Risk	• Nil new

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

INTEGRITY | RESPECT | TEAMWORK | EXCELLENCE

NHS
Dorset County Hospital
NHS Foundation Trust

Escalation Report

Committee: Quality Committee

Date of Meeting: 19th September 2023

Presented by: Eiri Jones

Significant risks / issues for escalation to Board for action	• Microbiology is proposing to voluntarily stepping down from UKAS accreditation, this has Executive support. This differs from what the committee has been told in recent months therefore further assurance was sought from the team requested for November to ensure that a safe service is still being provided.

Key issues / matters discussed at the Committee	The committee received, discussed and noted the following reports:
	• Quality Report noting a new risk re heel ulcers in patients with hip fractures – this is being further explored and hip fracture pathways reviewed. There was also an increasing demand of patients presenting with mental health needs.
	• Maternity Safety Report, MIS Update and PMRT Report noting:
	  ○ Improvements in some quality metrics, such as CO monitoring and number of women smoking at birth.
	  ○ Ongoing focus on understanding the Trust's high level of post-partum haemorrhage over 1500ml. Assurance was provided including seeking external support from Trusts with low rates.
	  ○ Recognition of a need to focus on morbidities of babies, as well as mortality
	• Quality Risk Report and Board Assurance Framework noting that these are both live documents. Questions were asked around whether they accurately reflect the current risks experienced by front line staff.
	• Paediatric CQC Action Plan Update providing good assurance, noting the ongoing action plan and the cultural improvement seen in the team.
	• Quality Improvement Strategy
	• Infection Prevention and Control Annual Report
	• Escalation Reports from the following subgroups:
	  ○ Safeguarding
	• ICB Quality Committee Minutes

Decisions made by the Committee	• Nil
Implications for the Corporate Risk Register or the Board Assurance Framework (BAF)	• Consideration that current key issues and risks are fully covered. Assurance provided through the new governance arrangements
Items / issues for referral to other Committees	• Nil

Escalation Report

Executive / Committee: Finance and Performance Committee

Date of Meeting: Monday 21st August 2023

Presented by: Stephen Tilton

Significant risks / issues for escalation to Committee / Board for action	Further discussion of the: • strategic direction for the OMF service • The medium-term financial plan to be had by the Board the following week. The following are recommended to the Board for approval: • Premises Assurance Model. • Sustainability Policy • Microsoft EA Variation for approval.

Key issues / matters discussed at the Committee	The meeting considered the following items:
	• Urgent and Integrated Care Divisional report noting:
	  ○ A significant increase in Emergency Department attendances in month.
	  ○ Maintenance of ambulance handover times
	  ○ Continued focus on the further identification of cost improvement schemes.
	  ○ Pathology recovery and reduced turnaround times.
	  ○ Continued efforts to achieve the four-hour stroke admission standard.
	• Family and Surgical Services Divisional Report noting:
	  ○ Continued focus on the further identification of cost improvement schemes.
	  ○ The impact of continued industrial action on performance
	  ○ A reduction in listed theatre sessions in month.
	• The Performance Report noted:
	  ○ Continued achievement of the four-hour A&E trajectory for 23/24 despite increases in demand.
	  ○ Sustained increase in referrals (demand)
	  ○ A growth in the size of the waiting list and the number of people waiting 52 weeks for treatment.
	  ○ Improved cancer service performance and re-alignment with the trajectory for the 28-day standard.
	  ○ Demand and capacity review ongoing within cardiology diagnostic services (DMO1 driver for current non-achievement of the 23/24 trajectory).
	• Finance Report noting:
	  ○ The trust was £0.8m adverse to plan in month 4. Key drivers included:
	  ▪ High cost agency expenditure
	  ▪ Non delivery of efficiency trajectory
	  ▪ Inflation.
	  ▪ Continued periods of industrial action.

	• Medium Term Financial Plan noting further discussion of the draft plan by the Board the following week.
	• Escalation Reports from the following subgroups were noted:
	  ○ Capital Planning and Space Utilisation Group
	  ○ Sustainability Working Group
	  ○ Information Governance Group
	  ○ DCH Subco Ltd and Q1 Performance Report.
	  ○ Emergency Planning and Resilience Group.

Decisions made by the Committee	• The Premises Assurance Model submission was recommended to the Board.
	• The Emergency Preparedness, Resilience & Response (EPRR) Annual Assurance 2023/24 submission to the ICB was approved.
	• Sustainability Policy was approved.
	• Microsoft EA Variation was recommended to the Board for approval.
	• Approval of the following contracts:
	  ○ OMF business case- insourcing smarter – noting further discussion of the strategic direction of the service to be had by the Board.
	  ○ Contract Change Notice- East Dorset Dialysis Unit, Annual Indexation.
	  ○

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

INTEGRITY | RESPECT | TEAMWORK | EXCELLENCE

NHS
Dorset County Hospital
NHS Foundation Trust

Escalation Report

Executive / Committee: Finance and Performance Committee

Date of Meeting: Monday 18th September 2023

Presented by: Stephen Tilton

Significant risks / issues for escalation to Committee / Board for action	The following are recommended to the Board for approval: • Medium Term Financial Plan • Protecting and Expanding Elective Capacity. The following contracts were reviewed and are recommended to the Board for approval: • Ridgeway 24-Bed Works Contract Award – delegation to the CFO sought. • NHP Enabling Work Contract noting further planned discussion at the Part 2 Board meeting. • Stryker Trauma Contract Renewal

Key issues / matters discussed at the Committee	The meeting considered the following items:
	• The Performance Report which noted:
	  ○ Continuing high levels of demand with 10% increase in urgent and emergency care demand and increasing numbers of referrals, up 4-5%.
	  ○ Meeting planned trajectories for the percentage of patients with No reason to Reside although numbers remain high due to additional beds being open.
	  ○ Stable waiting time and performance in the Emergency Department.
	  ○ The 65 week target had not been met.
	  ○ The inclusion of health inequalities data presented an unchanged picture
	• Finance Report noting:
	  ○ Deteriorating position of £800k in month. High levels of agency expenditure continued although there had been a slight reduction in month.
	  ○ High numbers of patients remaining with No Reason to Reside driving the opening of unfunded beds and compounding cost pressures.
	  ○ Delivery of the cost improvement efficiencies and savings was £1m behind plan year to date. Current year savings had been identified.
	• Medium Term Financial Plan
	• Protecting and Expanding Elective Capacity
	• Dorset Electronic Patient Record noting ongoing system discussions.
	• RAAC Assurance – the committee requested further assurances on the trust's estate.
	• Patient Pathway Improvement Programme Update
	• Board Assurance Framework
	• Escalation Reports from the following subgroups were noted:
	  ○ CPSUG
	  ○ Digital Transformation and Assurance Group
	  ○ New Hospitals Programme Board

	○ Emergency Planning and Resilience Group – not presented. ○ Strategic Estates Board • ICB Finance and Performance Committee Minutes. • The committee noted a DHSC consultation on pooled budgets and a collective rather than individual responses was felt to be more influential.
Decisions made by the Committee	• Medium Term Financial Plan was discussed and recommended to the Board for approval prior to submission the NHSE. • The Protecting and Expanding Elective Capacity brief was approved and recommended to the Board. • The following contracts were reviewed and are recommended to the Board for approval: ○ Ridgeway 24-Bed Works Contract Award ○ NHP Enabling Work Contract ○ Stryker Trauma Contract Renewal
Implications for the Corporate Risk Register or the Board Assurance Framework (BAF)	• The Board Assurance Framework was noted.
Items / issues for referral to other Committees	• Nil new

INTEGRITY | RESPECT | TEAMWORK | EXCELLENCE

NHS
Dorset County Hospital
NHS Foundation Trust

Escalation Report

Executive / Committee: People and Culture Committee

Date of Meeting: Monday 18th September 2023

Presented by: Margaret Blankson (Chair)

Significant risks / issues for escalation to Board for action	The following reporting group Terms of Reference were approved: ○ Operational Education Group ○ International Recruitment Oversight Group
Key issues / other matters discussed by the Committee	The committee considered the following items: • People and Performance Report and Dashboard noting: ○ A positive increase in the number of reports to the Freedom to Speak Up Guardian – no significant safety or quality concerns raised. ○ An increase in short term sickness absence. ○ A slight reduction in appraisal compliance rates. ○ Six international nurses had taken up post. ○ An increase in pay expenditure and vacancies. • Divisional Reports from ○ **Family and Surgical Services Division noting:** ○ The report was taken as read. ○ **Estates and Facilities noting:** ○ Level of long-term sickness absence. ○ Aging workforce population. ○ Improved appraisal compliance. • Quarter 1 Bank and Agency Usage and Expenditure report noting: ○ Lower usage of Bank and Agency although this had increased in month 3. ○ Relaunch of the High-Cost Agency Project. ○ A deep dive to review the previous quarter position had commenced and will be shared at next meeting. ○ Recruitment of Bank RNs remained challenging. • Undergraduate Learner Feedback Report – feedback was generally positive. • The Library Services Annual Report and work of the small team was commended by the committee. • Inclusive Recruitment Update – the committee proposed the inclusion of additional narrative to further enhance understanding in some areas. • Fit and Proper Persons Test Briefing on changes being implemented. • Escalation Reports from: ○ Medical and Dental Local Negotiating Committee (LNC) ○ Equality, Diversity and Inclusion Steering Group ○ Partnership Forum • ICB People Committee Minutes
Decisions made by the Committee	The following were approved by the committee: • GMC Survey Action Plan

	• The following reporting group Terms of Reference were approved:
	  ○ Operational Education Group
	  ○ International Recruitment Oversight Group

Implications for the Corporate Risk Register or the Board Assurance Framework (BAF)	• The Risk Report was deferred. • The Board Assurance Framework was deferred.
Items / issues for referral to other Committees	• None

INTEGRITY | RESPECT | TEAMWORK | EXCELLENCE

NHS
Dorset County Hospital
NHS Foundation Trust

Escalation Report

Committee: Risk and Audit Committee

Date of Meeting: 19th September 2023

Presented by: Stuart Parsons

Significant risks / issues for escalation to Board for action	• The refreshed Clinical Audit approach and reporting arrangements going forward were approved. • The Safeguarding Audit provided Limited Assurance

Key issues / other matters discussed by the Committee	The committee considered the following items:
	• Annual Clinical Audit Assurance Report noting the refreshed approach, assurance on actions taken in the previous year and reported via the Quality Account and strengthened oversight of the Clinical Audit programme via the Clinical Effectiveness Group.
	• The Board Assurance Framework was discussed at length noting use of the revised risk scoring matrix and close links with the Corporate Risk Register. The need for committees to ensure continuous review of controls and mitigations was emphasised.
	• Corporate Risk Register – the new reporting format was helpful, and the committee noted the ongoing work to ensure alignment of the risk management approach with DHC.
	• Internal Audit progress Report including the following audit reports:
	  ○ Safeguarding Final Report – provided limited assurance in respect to effectiveness. Areas for improvement included documentation of consent and consistency of approach across care groups.
	  ○ Environmental Sustainability Report outlined themed considerations for Audit Committees resultant from multi-client reviews.
	  ○ Follow Up Report outlined some outstanding actions from prior audits due to competing priorities and timescales.
	• External Audit including:
	  ○ External Audit Progress Report noted discussion of the Annual Report and Accounts, including the Value for Money assessment and presentation to the Council of Governors. DCH Subco audit was nearing completion and would be reported to the next meeting of the committee.
	  ○ Technical Updates
	  ○ The Benchmarking Report was delayed.
	• Subgroup Escalation Reports from
	  ○ Health and Safety Group and Annual Report noting:
	  ▪ FSG23/03 ED-15 Audit and Fire risk assessment still needs to be carried out.
	  ▪ Bournemouth Pathology Works impact on access to Satellite Dialysis Unit – looking for alternate safer routes for patients to be able to access the unit, particularly in poor weather and light conditions.
	• ICB Risk and Audit Committee Minutes – not received.

	• Annual Review of External Audit discussion.
Decisions made by the Committee	• The Board Assurance Framework and Corporate Risk Register were approved.
Implications for the Corporate Risk Register or the Board Assurance Framework (BAF)	• The new reporting format for the Corporate Risk Register was noted.
Items / issues for referral to other Committees	• All committees to ensure regular monitoring of risk mitigations and controls.

Working Together

Dorset County Hospital NHS Foundation Trust

Dorset HealthCare University NHS Foundation Trust

Escalation Report

Executive / Committee: Working Together Committee

Date of Meeting: Monday 7th August 2023

Presented by: David Clayton-Smith (Joint Chair)

Significant risks / issues for escalation to Committee / Board for action	• This was the inaugural meeting of the Working Together Committee in Common.
Key issues / matters discussed at the Committee	The committee in common considered the following items: • Ways of working within the terms of reference and the memorandum of understanding, noting the process for the resolution of any disagreements and that the terms of reference would be reviewed in six-months' time as the role of the committee in common evolved. • Working Together Programme Update including discussion of Flagship and case study examples of collaboration. • Board to Board Draft Agenda. • Other System Partnerships – Place Based Partnerships noting that the Working Together Programme was primarily concerned with partnership working in the west of the county. • Review of the Working Together Programme contribution to the ICB Strategy and Five Pillars of the Forward Plan.
Decisions made by the Committee	• None
Implications for the Corporate Risk Register or the Board Assurance Framework (BAF)	• The Working Together Risk Register was considered and noted the need to further review risks relating to clinical and leadership capacity to support the programme and maintain business as usual.
Items / issues for referral to other committees	• The Working Together Programme Board would monitor and report themes barriers to collaboration.

INTEGRITY | RESPECT | TEAMWORK | EXCELLENCE

NHS
Dorset County Hospital
NHS Foundation Trust

Escalation Report

Executive / Committee: Charitable Funds Committee

Date of Meeting: 19 Sept 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 (19.9.23)** • **DCH Charity Finance/Income 23/24** reports (M5 Aug 2023) received. Total income to date as of end Aug £239,349. Unrestricted funds were £324,338, providing a surplus of £104,338 against the reserves target of £220k. Majority of annual income including notified legacy income expected in Q3/4. DCHC Financial review (6 month) to be held on 31 Oct 2023. • **Capital Appeal (ED/CrCU)** report received. £313K income/pledges to date as of Aug 2023. Public launch on 30th August 2023 in association with Dorset County Show. Very good media/social media coverage. Corporate engagement meetings in progress. Grants funding and donor engagement programme ongoing. • **DCHC Risk Register** – to be reviewed at DCHC Financial review (6mth) on 31 Oct 2023. New Economic risk to be added once circulated to CFC and approved.
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:	27th September 2023		
Document Title:	Finance Report		
Responsible Director:	Chris Hearn, Chief Financial Officer	Date of Executive Approval	14th September 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	18/09/2023	Noted

3. Purpose of the Paper	For Information – income & expenditure report on the finance position of the Trust to month five 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 five of £0.797 million after technical adjustments against a planned surplus of £0.007 million being £0.804 million away from plan.

Year to date the Trust has delivered a deficit of £3.183 million against a planned surplus of £0.036 million being £3.219 million away from plan.

The month five and year to date performance is largely driven by above plan staffing costs including agency and the impact of industrial action incurred. Net costs supporting industrial action amount to £0.548 million year to date.

£0.9 million has been incurred so far with highest Off Framework agencies.

This includes ongoing cover for vacancy and sickness gaps, heightened by operational pressures, with increased acuity and demand whilst supporting circa 23 unfunded beds. The number of patients at the end of August with no criteria to reside was 64.

Ongoing acuity challenges including enhanced nursing and security care has been required for some patients, as well as a continuation of increased cover for medical rota gaps in Unscheduled Care, Medicine for the Elderly, General Medicine and Urology.

Above planned levels of inflation have been incurred year to date with gas 25% higher than planned levels and electricity 65% higher than planned levels, although August has seen some expected seasonal reductions. Drugs, catering supplies, blood product contract and other contract increases are between 8% and 13.5% above planned levels.

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 current trend 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 has delivered £2.2 million of efficiencies for the year against a year to date plan of £3.3 million. 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 above plan at £2.8 million following a catch up in part of delayed expenditure payments previously seen. The year to date position now stands at £0.3 million behind plan due to timings of expenditure payments. The cash position is currently £15.5 million as at August, impacted by heightened expenditure, offset in part by timing delays of capital expenditure payments being made.
5. Action recommended	The Board is recommended to: 1. **NOTE** the financial position to month five 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

August 2023 - Month 5

Chris Hearn
Chief Financial Officer

Outstanding care for our patients in ways which matter to them

Financial Position Update - August 2023

Executive Summary

A summary of progress is presented for the period to August 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 August 2023 of £0.8 million against a planned surplus of £0.007 million after technical adjustments. The year to date position is £3.2 million away from plan.

The adverse position against plan is due to ongoing agency costs covering vacancies & sickness, heightened by operational pressures and increased patient acuity. Circa 23 unfunded beds with circa 64 no criteria to reside (NCTR) patients have been supported during August. Ongoing industrial action is also contributing to the adverse financial position. Above planned levels of inflation continue, with gas, electricity, catering supplies, blood products, drugs and maintenance contracts significantly above planned levels. Agency expenditure has decreased during August however still remains a significant pressure noting heightend usage linked to patient specialling and acuity challenges. Mental health nurse support has also been ongoing and medical rota gaps across ED, General Medicine and Urology are 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 budgets in line with peers and national planning expectations. Full year efficiency delivery so far stands at £2.2 million with the majority of the total target identified, leaving £3.8 million of opportunities requiring key actions to move into fully developed and delivered schemes.

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. This equates to nearly £0.6 million year to date. Patient levels with NCTR did reduce at the start of the financial year only to increase during May and remain at similar levels throughout August.

Non pay is over plan due to high consumable costs including drugs and activity volumes linked to recovery of elective services in conjunction with heightened inflationary pressures, although August has seen an expected seasonal reduction in usage.

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 during month five amounted to £2.1 million against a plan of £1.6m, seeing a catch up of expenditure timing payments. Year to date the capital position is £0.3 million behind plan.

The cash position to August 2023 amounts to £15.5 million; worse than plan due to the heightened level of expenditure being incurred.

Financial Position Update - August 2023

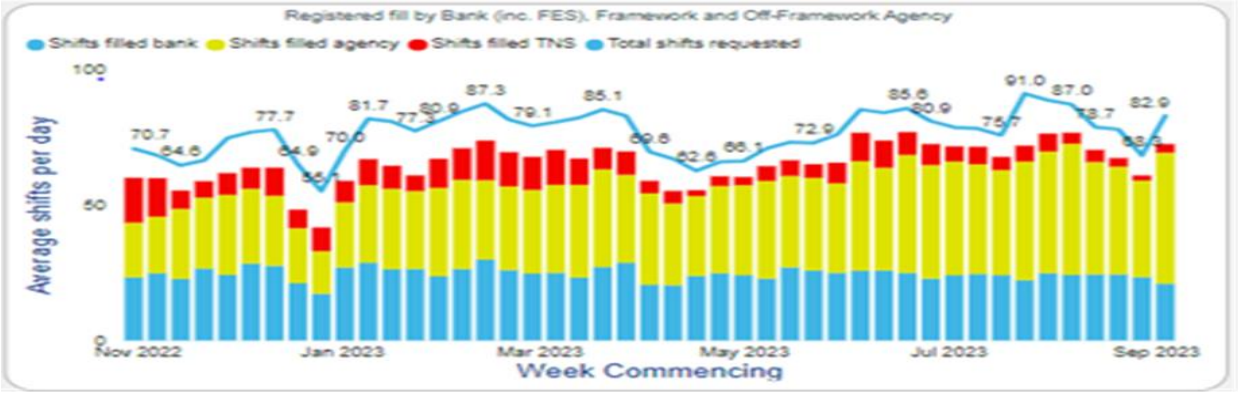
Key Risks

Red Risks:

The Trust has an **efficiency delivery requirement of £10.9 million** in order to reach the planned full year break even position. £2.2 million has been delivered recored at month five. No unidentified amount remains however all efficiency schemes must move into being fully developed and delivered. Without this, the Trust's deficit position will worsen. Efficiencies delivered non recurrently where recurrent is expected will also negatively impact the Trusts underlying deficit position.

The Trusts 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 during the first five months is overspent against plan by £2.1 million, with £0.9 million spent with highest cost off framework suppliers. Active plans 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 - August 2023

Key Risks

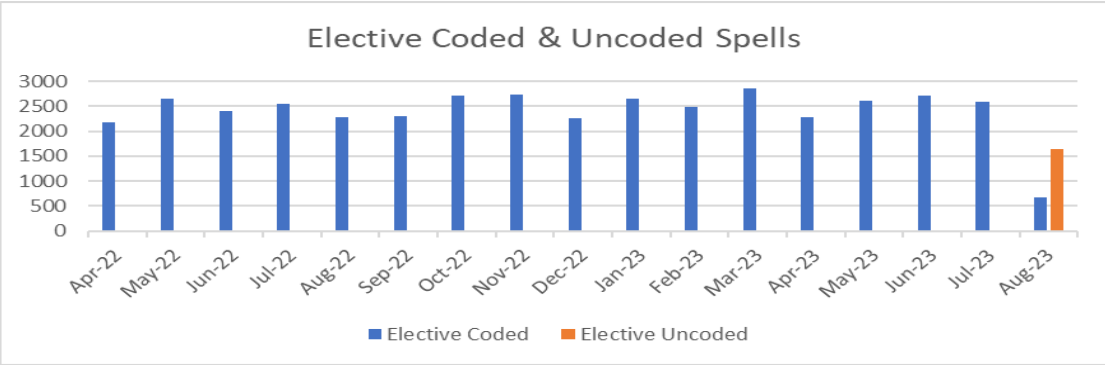
Amber Risk:

Noting Payment by Results (PbR) pays NHS healthcare providers a standard national price or tariff for each patient seen or treated, the tariff takes into account the complexity of the patient's healthcare needs. The tariff for each patient is calculated based on their clinical coding assessment. Coding is operated on a flex/freeze model where final coding must be completed by the freeze date to qualify for payment. The freeze date is typically 7 weeks after the end of the month in which the activity occurred, the full timetable is included for information.

Post COVID the Trust has been exclusively on block contracts with the exception of some Cost & Volume Drugs & Devices. For 2023/24 NHS England has introduced the Elective Services Recovery Fund, where the Trust is paid on a PbR basis for elective activity. Emergency activity remains on a block contract basis

Any elective activity that remains uncoded after the applicable freeze date represents a loss of income for the Trust.

As at August 2023 the Trust has 5,186 uncoded spells, 1,660 are for Elective activity and 3,526 are for Emergency. As demonstrated in the graph below, there is a 2 month lag at the end of each period where coding is completed to meet the applicable freeze dates. Based on coding trends captured from April 2022, no significant coding issues have been incurred to date.



2023-24 Flex/Freeze dates

Month	Flex Date	Freeze Date
Apr-23	Thu 18 May 23	Mon 19 Jun 23
May-23	Mon 19 Jun 23	Wed 19 Jul 23
Jun-23	Wed 19 Jul 23	Thu 17 Aug 23
Jul-23	Thu 17 Aug 23	Tue 19 Sep 23
Aug-23	Tue 19 Sep 23	Wed 18 Oct 23
Sep-23	Wed 18 Oct 23	Fri 17 Nov 23
Oct-23	Fri 17 Nov 23	Mon 18 Dec 23
Nov-23	Mon 18 Dec 23	Thu 18 Jan 24
Dec-23	Thu 18 Jan 24	Mon 19 Feb 24
Jan-24	Mon 19 Feb 24	Tue 19 Mar 24
Feb-24	Tue 19 Mar 24	Thu 18 Apr 24
Mar-24	Thu 18 Apr 24	Mon 20 May 24

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 - August 2023
Income & Expenditure

Income and Expenditure

The overall revenue position is behind plan by £0.8 million in month largely due to inflationary pressures and agency usage including industrial action, with ongoing vacancy & sickness cover and demand requirements, including unfunded beds and NCTR patients.

The Operating Income from patient care activities year to date variance is due to income received outside of contracted values, the agenda for change pay award and high cost drugs, offset by the removal of Elective Recovery Fund income due to adverse performance against baseline performance for months 1 and 2. The in month position is offset by under performance of income linked to the Cancer Drugs Fund & the Elective Services Recovery Fund.

Other Non-Clinical Income is ahead of plan largely due to the phasing of Health Education England income received compared against planned levels.

Pay costs are over plan due to increased costs to cover industrial action, with ongoing bank and agency usage covering vacancies, sickness and supporting operational pressures noting increased patient acuity for Critical care and a number of patients requiring mental health support. The agenda for change pay award was transacted in June 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. Drugs expenditure is also high linked to activity.

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	20,314	20,006	(308)	101,008	102,413	1,405	242,784
Private Patients	95	100	5	492	486	(6)	1,098
Other clinical revenue	37	17	(20)	185	93	(92)	444
Other non-clinical revenue	2,142	2,725	584	10,605	12,032	1,427	26,586
Operating Income	**22,587**	**22,848**	**261**	**112,289**	**115,024**	**2,734**	**270,913**
Charitable income	0	0	0	0	0	0	
Total Income	**22,587**	**22,848**	**261**	**112,289**	**115,024**	**2,734**	**270,913**
Raw materials and consumables used	(3,229)	(3,148)	81	(16,488)	(17,067)	(579)	(38,491)
Employee benefit expenses:							
Substantive	(13,461)	(13,671)	(209)	(68,128)	(66,746)	1,382	(160,699)
Bank	(763)	(1,181)	(418)	(3,332)	(4,938)	(1,606)	(9,356)
Agency	(793)	(1,330)	(537)	(3,471)	(6,289)	(2,818)	(9,960)
Other operating expenses (excl. depreciation)	(3,009)	(3,041)	(32)	(14,213)	(16,874)	(2,660)	(35,694)
Operating Expenses	**(21,255)**	**(22,371)**	**(1,115)**	**(105,632)**	**(111,914)**	**(6,282)**	**(254,201)**
Profit/(loss) from Operations (EBITDA)	**1,332**	**477**	**(855)**	**6,658**	**3,110**	**(3,548)**	**16,712**
Other Non-Operating income (asset disposals)	(2)	0	2	(11)	0	11	(27)
Other Non-Operating expenses (Impairments)	0	0	0	0	0	0	0
Total Depreciation and Amortisation	(941)	(965)	(24)	(4,704)	(4,826)	(122)	(11,363)
PDC Dividend expense	(373)	(373)	0	(1,865)	(1,865)	0	(4,476)
Total finance income	16	99	83	81	488	407	194
Total interest expense	(63)	(66)	(4)	(312)	(256)	56	(752)
Total other finance costs	0	(0)	(0)	(2)	(1)	1	(2)
SURPLUS/ (DEFICIT)	**(31)**	**(828)**	**(797)**	**(156)**	**(3,349)**	**(3,194)**	**286**
Technical Items Adjusted for:							
DONATIONS - CASH FOR ASSETS	0	(6)	(6)	2	(23)	(25)	(729)
DEPRECIATION - DONATED ASSETS	38	38	0	190	189	(1)	447
SURPLUS/ (DEFICIT)	**7**	**(796)**	**(804)**	**36**	**(3,183)**	**(3,219)**	**0**

Financial Position Update - August 2023
Trust Wide Performance: Agency

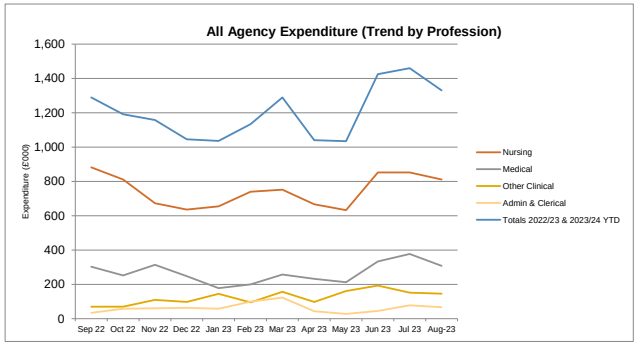
Pay Analysis - Agency

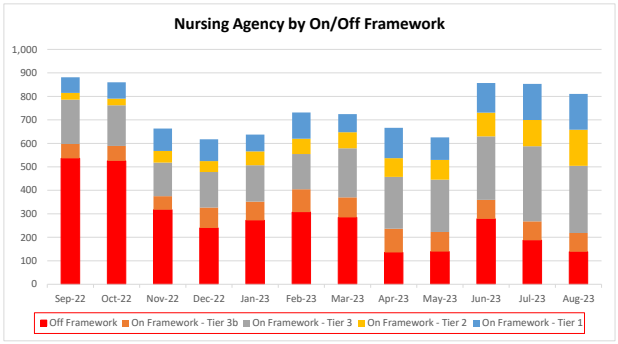
Agency costs equated to £1.330 million of actual expenditure in month against a plan of £0.833 million.

Agency expenditure was 8.2% of total pay and within this highest cost off framework usage was 10.4% equating to £0.139 million in month.

August continues to see significant agency expenditure predominantly due to short term sickness cover and impact of industrial action. RN agency covering Healthcare Assistant gaps and ongoing Allocate on Arrival shifts booked to support safe staffing levels are contributing to the current usage. Abbotsbury and Moreton ward in particular has seen an increase in patient specialling and trained support for mental health patients. Medical agency continues at higher levels within ED, Medicine for the Elderly, General Medicine 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.





Areas Using Off Framework:		£
Crcu	67%	311
Kingfisher Ward	67%	123
Emergency Dept Main Dep	17%	119
Abbotsbury Ward	27%	101
The Mary Anning Unit	20%	48
Day Surgery Unit	36%	32
Scbu	100%	18
Fortuneswell Ward	11%	17
Ilchester Integrated Asses	13%	15
Lulworth Ward	10%	14
Moreton Ward - Respiratc	9%	13
Ridgeway Wd	8%	13
Cardiology Care Ward	11%	12
Purbeck Wd	7%	10
Stroke Unit	8%	10
Surge Area	6%	8
Prince Of Wales	10%	8
Evershot Ward	6%	7
Total Off Framework to M5:		**880**

Agency Spend by Profession (£'000)	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug-23	YTD Actual	YTD Plan	Variance
Nursing	882	811	673	636	655	740	752	666	633	852	853	811	3,815	2,715	1,100
Medical	303	252	314	248	178	200	257	233	213	334	377	308	1,464	905	559
Other Clinical	70	70	110	98	145	95	157	97	161	193	152	145	749	350	399
Admin & Clerical	34	58	61	63	58	99	123	43	28	45	78	67	261	195	66
Totals 2022/23 & 2023/24 YTD	**1,289**	**1,191**	**1,158**	**1,045**	**1,036**	**1,134**	**1,289**	**1,040**	**1,034**	**1,425**	**1,460**	**1,330**	**6,289**	**4,165**	**2,124**

Nursing Agency Category	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23
Off Framework	537	525	317	240	272	307	285	135	140	279	188	139
On Framework - Tier 3b	61	64	58	87	80	97	85	101	83	81	80	80
On Framework - Tier 3	189	173	143	151	155	150	209	221	223	271	320	286
On Framework - Tier 2	29	28	50	47	59	65	68	80	84	101	111	154
On Framework - Tier 1	66	69	95	93	71	111	77	129	96	126	154	153
Orders awaiting allocation	0	-49	0	0	0	0	0	0	8	-5	0	0
Totals 2022/23 & 2023/24 YTD	**882**	**811**	**663**	**617**	**637**	**731**	**724**	**666**	**633**	**852**	**853**	**811**

Pay Metrics	In Month Actual	YTD Actual
Agency expenditure as % of total pay	8.2%	8.1%
Off framework expenditure as % of total agency	10.4%	14.2%

Outstanding care for our patients in ways which matter to them

Financial Position Update - August 2023
Insourcing

Insourcing Narrative

Insourcing spend is above initial budgeted levels year to date due to an acceleration of activity recovery with providers, however plans are in place to ensure activity levels across the entire year will not exceed those budgeted.

Relevant service managers have been engaging with Performance and Finance leads to review the activity levels in order to control the current projected year end overspend of £0.335 million to planned levels.

	Actual	Actual	Actual	Actual	Actual	Forecast	Forecast	Forecast	Forecast	Forecast	Forecast	Forecast	Forecast
	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Outturn
Plan:	**£546**	**£546**	**£546**	**£546**	**£546**	**£546**	**£546**	**£546**	**£546**	**£546**	**£546**	**£546**	**£6,554**
Specialty:													
Orthopaedics	£28	£53	£34	£31	£39	£38	£38	£38	£38	£38	£38	£38	**£447**
Ophthalmology	£62	£48	£113	£57	£58	£44	£44	£44	£44	£44	£44	£44	**£648**
Dermatology	£120	£60	£80	£149	£113	£135	£135	£135	£135	£48	£48	£48	**£1,207**
Gynaecology	£106	£74	£182	£157	£78	£100	£0	£0	£0	£0	£0	£0	**£697**
Urology	£29	£42	£51	£0	£15	£15	£15	£15	£15	£15	£15	£15	**£241**
Endoscopy & Gastro	£156	£143	£124	£146	£113	£75	£75	£75	£75	£75	£75	£75	**£1,207**
Breast	£1	£19	£0	£0	£19	£10	£10	£10	£10	£10	£10	£10	**£105**
Oral Surgery	£88	£110	£187	£159	£198	£125	£125	£125	£125	£125	£125	£125	**£1,617**
Cardiology	£4	£26	£25	£24	£23	£0	£0	£0	£0	£0	£0	£0	**£102**
Radiology/Cardio	£0	£0	£17	£0	£0	£6	£6	£6	£6	£6	£6	£6	**£62**
ENT	£0	£44	£35	£62	£36	£54	£54	£54	£54	£54	£54	£54	**£555**
Total	**£594**	**£620**	**£849**	**£784**	**£690**	**£602**	**£502**	**£502**	**£502**	**£415**	**£415**	**£415**	**£6,889**
Surplus/(Deficit)	**-£48**	**-£74**	**-£303**	**-£238**	**-£144**	**-£56**	**£44**	**£44**	**£44**	**£131**	**£131**	**£131**	**-£335**

Financial Position Update - August 2023
COVID Expenditure

Covid Narrative
Covid spend increased slightly in August to £0.098 million from £0.086 million in July. Pay spend increased marginally in month mainly due to an increase in costs of backfilling substantive Covid related staff sickness. Non-Pay spend increased related to security costs. 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 is now expected to cease from October 2023, with ward based insourcing security costs expected to continue until December 2023. 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	Jul-23	Aug-23	YTD
Plan:		**£191**	**£91**	**£149**	**£113**	**£63**	£607
Expenditure:							
Pay	Substantive	£40	£22	£13	£12	£15	**£102**
	Bank	£9	£13	£8	£8	£9	**£47**
	Agency	£0	£0	£0	£0	£0	**£0**
Total Pay		**£49**	**£35**	**£21**	**£20**	**£25**	£150
Non-pay	Clinical Supplies and Services	£27	£26	£7	£0	£0	**£60**
	Other Non-Pay (security)	£50	£56	£43	£52	£60	**£262**
	Premises and Fixed Plant	£11	£14	£14	£14	£14	**£66**
Total Non-pay		**£88**	**£96**	**£64**	**£66**	**£73**	£388
Total Expenditure		**£137**	**£131**	**£86**	**£86**	**£98**	£538
Total Surplus/(Deficit)		**£53**	**(£40)**	**£63**	**£27**	**(£35)**	£69

Financial Position Update - August 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.

£2.2 million has been delivered full year effect, an improvement of £0.5 million from last month.
A further £3.9 million of schemes are fully developed with £0.9 million of schemes yet to start. £3.8 million of opportunities have been identified and are in the process of being developed into tangible schemes for delivery. This results in the target being identified in full however key emphasis needs to be directed towards those schemes not yet started and those still in the opportunity stage.

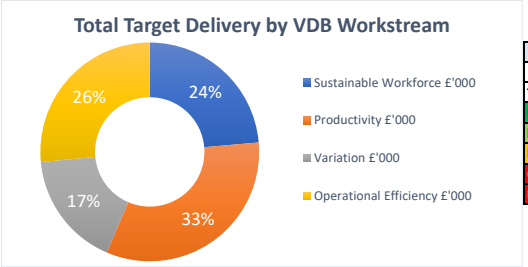
Efficiencies delivered so far include Covid reduction against plan, Corporate savings generated from joint posts, Digital programme delivery and Prothesis programme savings.

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

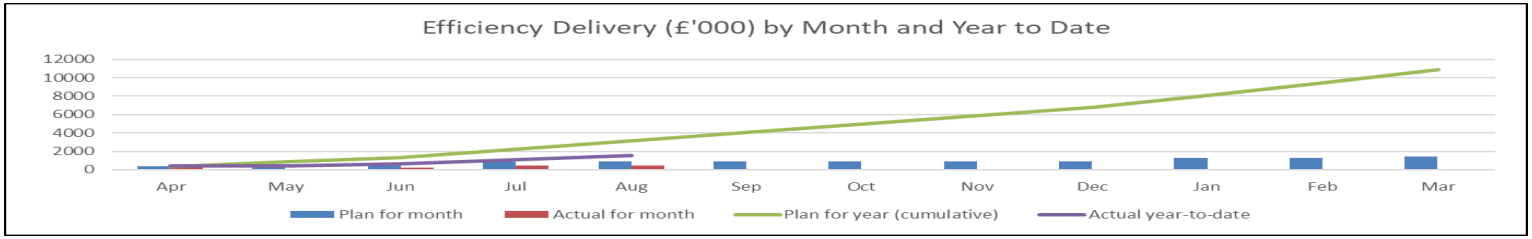
This programme of work has been shared with the Dorset System with collaborative opportunities being actively assessed and reviewed with focus on on flow, bed usage noting improvements to productivity are essential, supported by System partners.

Area	Effciency Performance (£'000)		
	Full Year Plan	Full Year Realised @ M5	Variance to be Delivered
Division A	3,105	863	(2,242)
Division B	3,070	593	(2,477)
	6,175	**1,456**	**(4,719)**
Finance and Resources	717	0	(717)
Digital	311	238	(73)
Nursing	315	0	(315)
Operations	97	0	(97)
Human Resources	108	27	(81)
Corporate	149	125	(24)
Sub-total	**1,697**	**390**	**(1,307)**
Trust Wide schemes	3,000	372	(2,628)
Total CIP	**10,872**	**2,218**	**(8,654)**
Of which:			
Recurrent	6,552	1,039	(5,513)
Non-recurrent	4,320	1,179	(3,141)
Total	**10,872**	**2,218**	**(8,654)**

Value Delivery Board Workstream	Sustainable Workforce £'000	Productivity £'000	Variation £'000	Operational Efficiency £'000	Total £'000	Progress
Delivered	118	9	677	1,414	**2,218**	↑
Identified - in progress	1,720	211	881	1128	**3,940**	↑
Identified - not started	-	247	300	337	**884**	↑
Opportunity	730	3,100	-	-	**3,830**	↑
Unidentified					-	↑
Totals	**2,568**	**3,567**	**1,858**	**2,879**	**10,872**	



At a glance		
	£ 000	No of schemes
Target	**10,872**	N/A
Delivered	2,218	42
Identified - in progre	3,940	
Identified - not yet st	884	37
Opportunity	3,830	12
Unidentified	0	N/A



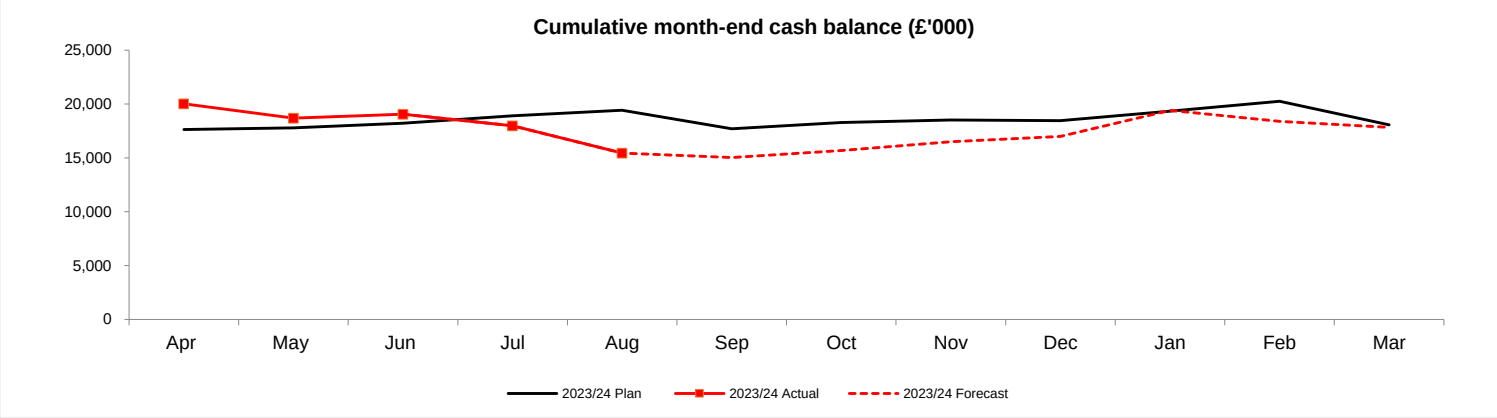
Financial Position Update - August 2023

Cash

Cash Balance incl Forecast

The graph shows the trajectory of the actual and forecast cash balance during the year, with the position being closely monitored.

The cash position is currently £15.5 million as at August, being worse than plan in line with heightened expenditure reported in the I&E, offset by timing delays of capital expenditure payments being made.



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						15,033	15,680	16,511	17,001	19,414	18,384	17,829
2023/24 Actual	20,024	18,694	19,053	17,974	15,452							

Financial Position Update - August 2023

Capital

Capital Programme Narrative

Capital expenditure at the end of August was £0.313 million behind plan.

Internally Funded schemes are overall above plan by £0.531 million due to:

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

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

The above are offset by Estates schemes being marginally behind plan year to date due to timing of purchases to be made.

IFRS 16 Lease Additions is behind plan due to the contractual lease remeasurement of the Multi-Storey Car Park (MSCP) which is due in September 2023.

Externally Funded capital is below planned levels of spend by £0.430 million due to timings of the New Hospitals Programme (NHP) and Community Diagnostics Centre (CDC) expenditure, offset by works on South Walks House (SWH) that have progressed ahead of plan.

Additional external capital funding of £6.6 million has been awarded to the Trust for NHP Enabling works. Electronic Patinet Record (EPR) funding has been reduced to £1 million in line with the re-phasing of this project following discussions within the Dorset System and NHS England (NHSE).

Endoscopy external funding has been removed following guidance from NHSE South West Regional Capital Team, where it has been confirmed that this funding will not be realised in 2023/24.

CAPITAL	CURRENT MONTH			YEAR TO DATE			FULL YEAR 2023/24			
	Actual	Plan	Variance	Actual	Plan	Variance	Committed Spend	Forecast	Annual Plan	Variance
	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000
Estates										
Chemo	0	0	0	0	0	0	0	1,962	1,962	0
Air-Handling Unit	0	50	50	0	50	50	0	375	750	375
Estates Schemes	86	**213**	127	471	**691**	220	1,141	1,405	1,819	414
Digital Services										
Digital Schemes	190	**87**	(103)	949	**482**	(467)	2,005	2,413	2,005	(408)
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	105	52	(53)	440	107	(333)	773	879	498	(381)
Sub-Total Internally Funded Expenditure	**381**	**402**	**21**	**1,861**	**1,330**	**(531)**	**3,963**	**7,466**	**7,466**	**0**
Donated										
Other Donations		0	0	17	0	(17)	87	87	0	(87)
Chemotherapy Unit Refurbishment	0	0	0	0	0	0		646	733	87
Sub-Total Planned DonatedExpenditure	**0**	**0**	**0**	**17**	**0**	**(17)**	**87**	**733**	**733**	**0**
IFRS 16 Lease Additions										
Warehouse		0	0	0	0	0		2,335	2,335	0
Print Management		0	0	397	600	203	397	600	600	0
One Dorset Pathology		0	0		0	0		250	250	0
MSCP Lease remeasurement		0	0		700	700		700	700	0
Accommodation & Vehicle Lease Additions	77	0	(77)	472	0	(472)	470	404	404	0
Sub-Total Planned IFRS 16 Expenditure	**77**	**0**	**(77)**	**869**	**1,300**	**431**	**867**	**4,289**	**4,289**	**0**
Total Internal & Leased Capital Expenditure	**458**	**402**	**(56)**	**2,747**	**2,630**	**(117)**	**4,917**	**12,488**	**12,488**	**0**
Additional funded schemes										
NHP Development	691	207	(484)	2,491	2,534	43	3,037	10,468	3,868	(6,600)
South Walks House & 24 Bedded Bay	530	573	43	3,101	2,365	(736)	6,877	6,877	6,877	0
Mental Health UEC Funding	0	0	0	0	0	0		233	233	0
Digital EPR Funding	12	118	106	49	522	473	140	1,000	2,093	1,093
CDC Funding	400	240	(160)	600	1,200	600	1,646	1,646	1,440	(206)
Endoscopy	0	50	50	0	50	50			2,000	2,000
Total Externally Funded Capital Expenditure	**1,633**	**1,188**	**(445)**	**6,241**	**6,671**	**430**	**11,700**	**20,224**	**16,511**	**(3,713)**
Total Capital Expenditure	**2,091**	**1,590**	**(501)**	**8,988**	**9,301**	**313**	**16,617**	**32,712**	**28,999**	**(3,713)**
Expenditure as a % of Plan			132%			97%				113%

Report Front Sheet

1. Report Details			
Meeting Title:	Trust Board		
Date of Meeting:	27 September 2023		
Document Title:	**Bi-Annual Safer Staffing Report**		
Responsible Director:	Jo Howarth, Interim Chief Nursing Officer	Date of Executive Approval	18/08/23
Author:	Emma Hoyle Deputy Chief Nursing Officer		
Confidentiality:	No		
Publishable under FOI?	Yes		
Predetermined Report Format?	No		

2. Prior Discussion		
Job Title or Meeting Title	**Date**	**Recommendations/Comments**
Quality Committee	22/08/2023	Noted

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

3. Executive Summary

This paper outlines the process and governance within inpatient services to ensure that the Board has assurance that Dorset County Hospital met all of the national workforce requirements for safe staffing within inpatient wards.
The annual establishment review follows the National Quality Board (2016) requirements and the Developing Workforce Safeguards (2018) guidance and provides a comprehensive account which concludes with a series of recommendations to ensure safe staffing and enhance care provision in our inpatient wards.
In addition to the formal review, staffing levels, patient acuity and dependency, and effective utilisation of resources is discussed twice daily at the internal bed/operational flow meetings. Staff are requested to move area of work in order to ensure safe and effective care of our patients. This review is undertaken in conjunction with the Ward Sisters, Matrons and Heads of Nursing responsible for that area.

Summary
The Trust has reviewed the acuity and dependency audits results for the inpatient ward areas and has identified that this bi-annual review has not indicted the need for additional staff. The Trust also remains within the expected limits of the Model Hospital data in relation to nursing and midwifery staffing.

A Lead Nurse for Safer Staffing has recently been recruited and will start their role in Autumn 2023.

The 2023/2024 scheme to embed safe staffing methodology is as follows:

- Invest in a Safe Staffing Clinical Lead role to develop and support the 'Safe Staffing Strategy'
- Embed 'SafeCare' assessment on a daily basis utilising current digital software to support and evidence movement of staff around the Trust to support areas of greatest need base on acuity and dependency alongside

	care hours per patient day. • The requirement to manage safe staffing via allocate • Encourage Safe Staffing Fellowship access by senior nurses The recommendations of this report is to: • invest, advertising and recruitment to the ward housekeeper role for inpatient areas • align the headroom Trust wide to meet national standard • adopt SafeCare daily acuity monitoring to meet national guidance • planned bi-annual review January 2024 NB This report was presented to Quality Committee August 2023.
4. Action recommended	Trust Board is recommended to: 1. **NOTE** the report. 2. **RECEIVE** assurance on actions to address any performance issues. 3. **AGREE** the key points, risks & concerns to be reported to the Board.

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

Board of Directors

Bi-Annual Safe Staffing Review June 2023

Inpatient Wards

Executive Summary

This report outlines the Safer Staffing for acute ward-based nursing following the acuity and dependency audit completed June 2023. The last audit was completed in January 2023 and that report was presented to Trust Board in February 2023. The next planned audit will be January 2024.

The recommendations of this report are to:

- invest, advertise and recruit to the ward housekeeper role for inpatient areas
- align the headroom for ward budgets Trust wide to meet national standards
- adopt Safecare daily acuity monitoring to meet national guidance

This will meet the patient care and safety needs that the Trust is providing and ensure best use of staff resource to ensure productivity and value for money. This will be reviewed again in line with NICE requirements in January 2024.

1. Introduction

The National Quality Board (2016) and Developing Workforce Safeguards (2018) set out mandatory requirements of Trust Boards to ensure that staffing levels are based on patients' needs, acuity, and risks, which are monitored from 'ward to board' and will enable NHS provider boards to ensure that the right staff with the right skills are in the right place at the right time.

- Trust Boards must ensure their organisation has an agreed local quality dashboard that cross-checks comparative data on staffing and skill mix with other efficiency and quality metrics such as the Model Hospital dashboard. Trusts should report on this to their board every month.
- An assessment or re-setting of the nursing establishment and skill mix (based on acuity and dependency data and using an evidence-based toolkit where available) must be reported to the board by ward or service area twice a year, in accordance with NQB guidance and NHS Improvement resources. This must also be linked to professional judgement and outcomes.
- As stated in CQC's well-led framework guidance (2018) and NQB's guidance any service changes, including skill-mix changes, must have a full quality impact assessment (QIA) review.
- Given day-to-day operational challenges, we expect Trusts to carry out business-as usual dynamic staffing risk assessments including formal escalation processes. Any risk to safety, quality, finance, performance, and staff experience must be clearly described in these risk assessments.

- Should risks associated with staffing continue or increase and mitigations prove insufficient, Trusts must escalate the issue (and where appropriate, implement business continuity plans) to the board to maintain safety and care quality. Actions may include part or full closure of a service or reduced provision: for example, wards, beds and teams, realignment, or a return to the original skill mix

As part of the establishment review, the Chief Nursing Officer must confirm in a statement to the board that they are satisfied with the outcome of any assessment that staffing is safe, effective and sustainable.

This review has included all inpatient wards at Dorset County Hospital. Critical Care, Maternity, Special Care Baby Unit (SCBU), Emergency Department and Theatres have not been included in this report.

A separate review of Critical Care nurse staffing and Emergency Department nurse staffing has been conducted in recognition of the ED15 project and New Hospitals Build which is currently in progress. Further work will be undertaken in the first 2 quarters of 2023/2024 to better determine staffing ratios and care hours per patient day (CHPPD) for these areas. Maternity has previously undertaken safer staffing reviews with Birthrate Plus™. The size of the Maternity Service at DCHFT does not align to the current tool used by Birthrate Plus™ and the Deputy Chief Nursing Officer and Maternity Governance Lead are working with the Birthrate Plus™ team to explore options.

2. Methodology

The methodology for determining safer staffing has previously been approved by Trust Board. This incorporates the use of an acuity and dependency evidence-based tool (Safer Nursing Care Tool, SNCT, The Shelford Group 2020), alongside any relevant benchmarking (such as Model Hospital or Royal College of Nursing recommendations), and professional judgement. As advised by the SNCT the acuity audit took place Monday through to Friday for 4 weeks (20 working days).

Safer staffing reviews are expected as part of the regulatory framework in meeting the needs of the patients that use services. Lesson learnt from various national reviews expressed the need for safe staffing reviews to be overseen by Trust Boards (Francis Report (2013) and Keogh Review (2013)).

As part of safe staffing assessments, the skill mix, leadership and any supporting roles, are key to the professional judgement applied to the audit. Having the right number of nurses and healthcare supportworkers, with the right mix of skills and experience, is essential to support safe, high-quality care for patients. National Institute for Health Research (NICE 2019) notes that determining the right number of staff on the wards with a mix of education and skills is not a precise science and depends on a risk assessment based on the best available evidence.

The Royal College of Nursing had set out detailed expectations for employers, national organisations, and regulators to support patient safety and enable the UK's nursing workforce to deliver safe and effective care. The 14 workforce standards, launched by the

college in May 2021 are intended to bring the entire nursing community in the UK, under one set of standards for the benefit of staff and patient safety.

Full engagement of the ward leaders was achieved to ensure the audit was as accurate as possible, with the Matrons holding responsibility for ensuring that the data was collected and that the tool was being applied effectively and consistently across their inpatient wards.

All inpatient wards were required to collect data using the SNCT at the same time in a shift (excluding weekends), to ensure consistency and allow benchmarking across the Trust. The audit took place in June 2023.

Triangulation was applied to ensure validation of information from the following sources.

- Patient Acuity
- Professional Judgement
- Quality indicators

Information regarding staffing vacancies, turnover and sickness rates were also used to inform the recommendations made within this paper.

Divisional analysis and additional information regarding the financial implications were applied.

Current headroom for ward establishments is 20.5% (to include training, annual leave etc), of which 2% is kept centrally for sickness absence cover using temporary staffing. This headroom is currently below the recommended level and revised safe staffing toolkits are unable to calculate below 22.2% uplift. The current headroom for Critical Care and Emergency Department is the same as the inpatient wards and the recommendations are to align this uplift to the national recommendations (see below).

	NQB - Jan 18		NQB - Jun 18		RCEM & RCN	
	Wards		ED & CC		Type 1 ED	
	days	%	days	%	days	%
Annual Leave	29.9	11.6%	29.9	11.6%	29.9	11.6%
Bank Holidays	8.0	3.1%	8.0	3.1%	8.0	3.1%
Sickness	7.7	3.0%	10.3	4.0%	10.3	4.0%
Training/ study	7.7	3.0%	11.6	4.5%	16.8	6.5%
Parenting	2.6	1.0%	2.6	1.0%	2.6	1.0%
Other	1.3	0.5%	2.1	0.8%	2.1	0.8%
TOTAL	**57.3**	**22.2%**	**64.5**	**25.0%**	**69.7**	**27.0%**

[1] The National Quality Board, Safe, sustainable and productive staffing, An improvement resource for adult inpatient wards in acute hospitals, January 2018.
[2] The National Quality Board, Safe, sustainable and productive staffing, An improvement resource for urgent and emergency care, June 2018.
[3] The Royal College of Emergency Medicine together with the Royal College of Nursing, *Nursing Workforce Standards for Type 1 Emergency Departments*, October 2020.

3. Results

There are no areas in this bi-annual review requiring additional staff. Should clinical priorities change then the divisions will be supported in reviewing staffer staffing as required.

Ward	Current WTE Establishment (Excluding Band 7 and Admin Roles)	SNCT Results with 22.5% uplift	Current Vacancies (WTE)	Professional judgement review/Recommendations/Commentary
Abbotsbury Ward (29 Beds)	40.43	39.5	8 RN 3 HCSW	No change to current establishment 4 RN new starters planned Autumn 2023 so vacancies to reduce.
Lulworth Ward (31 beds)	42.95	44.8	2 RN 0 HCSW	Previous review increased establishment. 4 RN new starters planned Autumn 2023 so vacancies to reduce. CPE recruited into post but taken from ward establishment.
Purbeck Ward (27 beds)	39.74	39.8	5 RN 2 HCSW	No change to current establishment. 5 RN 1 HCSW new starters planned Autumn 2023 so vacancies to reduce.
Ridgeway Ward (30 beds)	41.25	35.8	2 RN 5.5 HCSW	No change to current establishment 2 RN new starters planned Autumn 2023 so vacancies to reduce.
Kingfisher Ward (14 beds + PAU)	27.33	13	4 RN 3 HCSW	No change to current establishment – smaller unit principles applied. 7 RN new starters planned Autumn 2023 so vacancies to reduce.
Fortuneswell Ward (17 beds)	26.86	26.5	4 RN 3 HCSW	No change to current establishment. 3.67 RN 1 HCSW new starters planned Autumn 2023 so vacancies to reduce.

Ward	Current WTE Establishment (Excluding Band 7 and Admin Roles)	SNCT Results with 22.5% uplift		Recommendations
Moreton Ward (26 beds)	37.26	40.8	2 RN 6 HCSW	Previous review increased establishment. 5 RN 1 HCSW new starters planned Autumn 2023 so vacancies to reduce. CPE in current ward establishment.
Evershot Ward (14 beds)	30.4	16.4	4.67 RN 3 HCSW	Review of current establishment underway noting smaller unit principles applied. 5 RN 1 HCSW new starters planned Autumn 2023 so vacancies to reduce. To review establishment alongside Mary Anning Unit and Maud Alex.
Cardiac Care Ward (18 beds)	33.23	26.5	4.12 RN 5 HCSW	No change to current establishment – smaller unit principles applied. 5 RN new starters planned Autumn 2023 so vacancies to reduce.
Ilchester Ward (33 beds)	55.82	50.3	6.65 RN 3 HCSW	No change to current establishment. 4 RN new starters planned Autumn 2023 so vacancies to reduce.
Mary Anning Unit (46 beds)	68.78	90.8	6.65 RN 3 HCSW	Previous review increased establishment. 12 RN new starters planned Autumn 2023 so vacancies to reduce. CPE recruited into post but taken from ward establishment. To review alongside Maud Alex and Evershot.
Stroke Unit (24 beds)	38.14	39.5	1.5 RN 4 HCSW	No change to current establishment 2 RN 1 HCSW new starters planned Autumn 2023 so vacancies to reduce.

	ACP 9-5 Mon-Fri, Outreach B6 08:00-20:00 Daily			
Prince of Wales Ward (13 beds)	30.81	19.4	0 RN 3 HCSW	No change to current establishment – smaller unit principles applied
Maud Alexander Ward (10 beds	21.79	14.2	0 RN 3.5 HCA	No change to current establishment – smaller unit principles applied. To review alongside Evershot and Mary Anning Unit.

4. Conclusion

There is a requirement by NHS England to submit information relating to Ward based Nursing Dependency and Acuity audits, recommended twice yearly. DCHFT nursing leads now have a clear process in place to achieve this.

The Safer Nursing Care Toolkit is the recognised method for reviewing safe staffing at ward level and uses a triangulation of metrics to assist decision making and recommendations. The tool is not prescriptive and should be applied alongside the application of professional clinical judgement.

In addition to the formal review, staffing levels, patient acuity and dependency, and effective utilisation of resources is discussed three time as day at the internal bed/operational flow meetings. Twice daily Safe Staffing meetings are in place to support the Divisions with immediate staffing requirements. The first meeting of that day reviews any urgent mitigations, the Chief Nursing Officer or Deputy is present for decision making. Staff are requested to move area of work to ensure safe and effective care of our patients. This review is undertaken in conjunction with the Ward Sister, Matron and Divisional Head of Nursing and Quality responsible for that area.

The Trust has reviewed the acuity and dependency audits results for the inpatient ward areas and has identified that this bi-annual review has not indicted the need for additional staff. The Trust also remains within the expected limits of the Model Hospital data in relation to nursing and midwifery staffing.

However, it has been identified and recommended in the January 2023 report that the headroom is aligned in accordance with the national recommendations and the business partners and finance will be developing a business case for quarter 4 as part of the Trusts business processes.

It has been recognised that following national PLACE audit in 2022 (Patient Led Assessment in the Clinical Environment) that inpatient areas are not demonstrating consistent support of patients nutrition and hydration and an innovative role of ‘ward hostess’ is being developed and will be managed from the health care support worker role. A project group is in place with facilities clinical staff.

Smaller units and recently merged units (Maud Alex, Evershot and Mary Anning Unit) will undergo further review to ensure establishments are appropriate and funding allocated accordingly between them.

A Lead Nurse for Safer Staffing has recently been recruited and will start their role in Autumn 2023. They will be leading on the implementation of SafeCare as a priority.

The 2023/2024 scheme to embed safe staffing methodology is as follows:

- Invest in a Safe Staffing Clinical Lead role to develop and support the ‘Safe Staffing Strategy’
- Embed ‘SafeCare’ assessment on a daily basis utilising current digital software to support and evidence movement of staff around the Trust to support areas of greatest need base on acuity and dependency alongside care hours per patient day.
- The requirement to manage safe staffing via allocate

- Encourage Safe Staffing Fellowship access by senior nurses

5. Recommendations

The recommendations of this report is to:

- invest, advertising and recruitment to the ward hostess role for inpatient areas
- align the headroom Trust wide to meet national standard
- adopt SafeCare daily acuity monitoring to meet national guidance
- planned bi-annual review January 2024

Emma Hoyle, Deputy Chief Nursing Officer, August 2023

Report Front Sheet

1. Report Details			
Meeting Title:	Board		
Date of Meeting:	27 September 2023		
Document Title:	**Maternity Quality and 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?	Yes		

2. Prior Discussion		
Job Title or Meeting Title	**Date**	**Recommendations/Comments**
Quality committee	19/09/23	

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

3. Executive Summary

This report sets out to the Trust Board the quality and safety activity covering the month of August 2023 (in some circumstances July 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.

- SPC charts included but August data not available. Charts up to July 31 2023 shared:

Number of stillbirths
Rate per 1000 of postpartum haemorrhage >1500mls
Number of neonatal deaths
Number of neonatal transfers out
Number of HIE incidents
Admissions to the neonatal unit
CO measurement at booking
Smoking at time of delivery

- Reduced number of datix with only a small number relating to staffing and delayed IOL. However, this doesn't reflect the number of shifts not fully staffed.
- Details of QI project focusing on reducing PPH >1500mls
- All SIs with updates including recommendations as appropriate
- One new risk added to the risk register – the management of abnormally implanted placenta
- Babyloss data included – three losses in August. One will require PMRT review
- The workforce review highlights the number of shifts not fully staffed
- One new complaint concerning overall experience during labour and birth
- Training figures provided in greater detail
- Risk register reviewed with updates

	• The safety Champions meeting action tracker included – awaiting minutes of most recent meeting • ATAIN data for July 5.8%. • I baby transferred to a tertiary unit for escalation in care required • MIS compliance update including risk areas • F&F feedback – I negative and 1 mixed within >90 responses
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**		Directly related to CQC 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	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

September 2023 (August activity)

Submitted by Jo Hartley, Director of Midwifery & Neonatal Services

Executive sponsor: Jo Howarth CNO

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Executive Summary

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

- SPC charts included but August data not available. Charts up to July 31 2023 shared:
  Number of stillbirths
  Rate per 1000 of postpartum haemorrhage >1500mls
  Number of neonatal deaths
  Number of neonatal transfers out
  Number of HIE incidents
  Admissions to the neonatal unit
  CO measurement at booking
  Smoking at time of delivery
- Reduced number of datix with only a small number relating to staffing and delayed IOL. However, this doesn't reflect the number of shifts not fully staffed.
- Details of QI project focusing on reducing PPH >1500mls
- All SIs with updates including recommendations as appropriate
- One new risk added to the risk register – the management of abnormally implanted placenta
- Babyloss data included – three losses in August. One will require PMRT review
- The workforce review highlights the number of shifts not fully staffed
- One new complaint concerning overall experience during labour and birth
- Training figures provided in greater detail
- Risk register reviewed with updates
- Quadrumvirate meeting minutes included
- The safety Champions meeting action tracker included – awaiting minutes of most recent meeting
- ATAIN data for July 5.8%.
- I baby transferred to a tertiary unit for escalation in care required
- MIS compliance update including risk areas
- F&F feedback – I negative and 1 mixed within >90 responses in total

INTEGRITY | RESPECT | TEAMWORK | EXCELLENCE

NHS
Dorset County Hospital
NHS Foundation Trust

DCH Maternity and Neonatal Safety& Quality Strategy

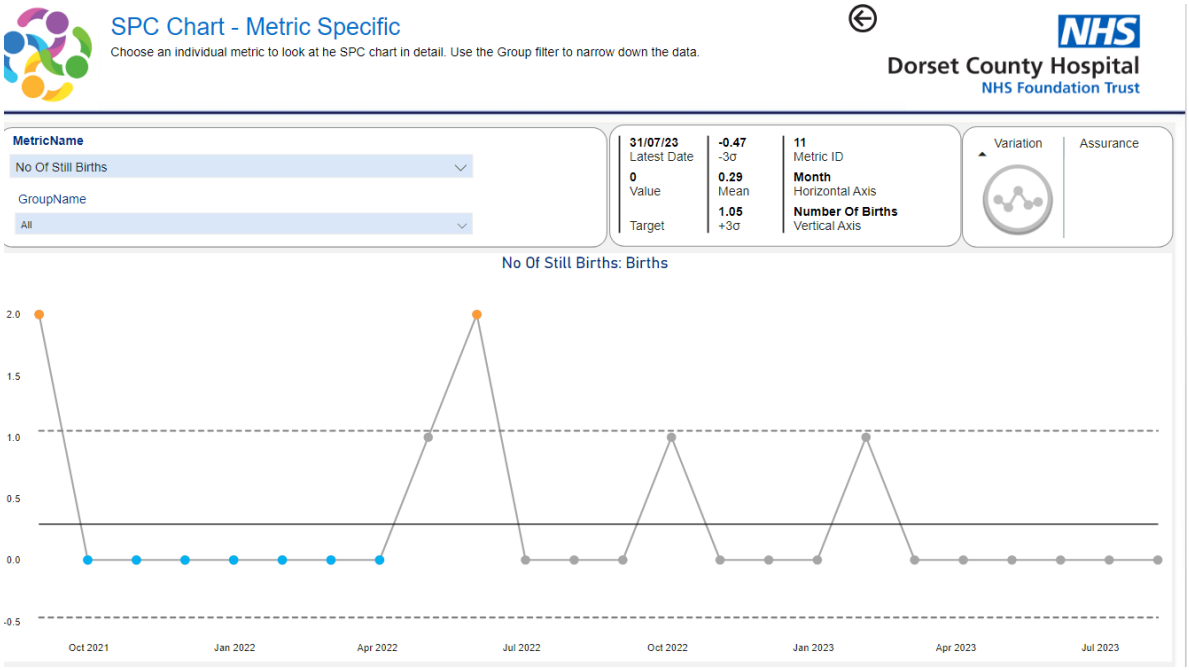
Transformation model

- Utilising BadgerNet functionality
- Culture & leadership Quadrumvirate, Ward to Board
- **MIS**
- Working with MNVP
- CCFv2
- SBLCBv3
- Working in collaboration
- Shared learning

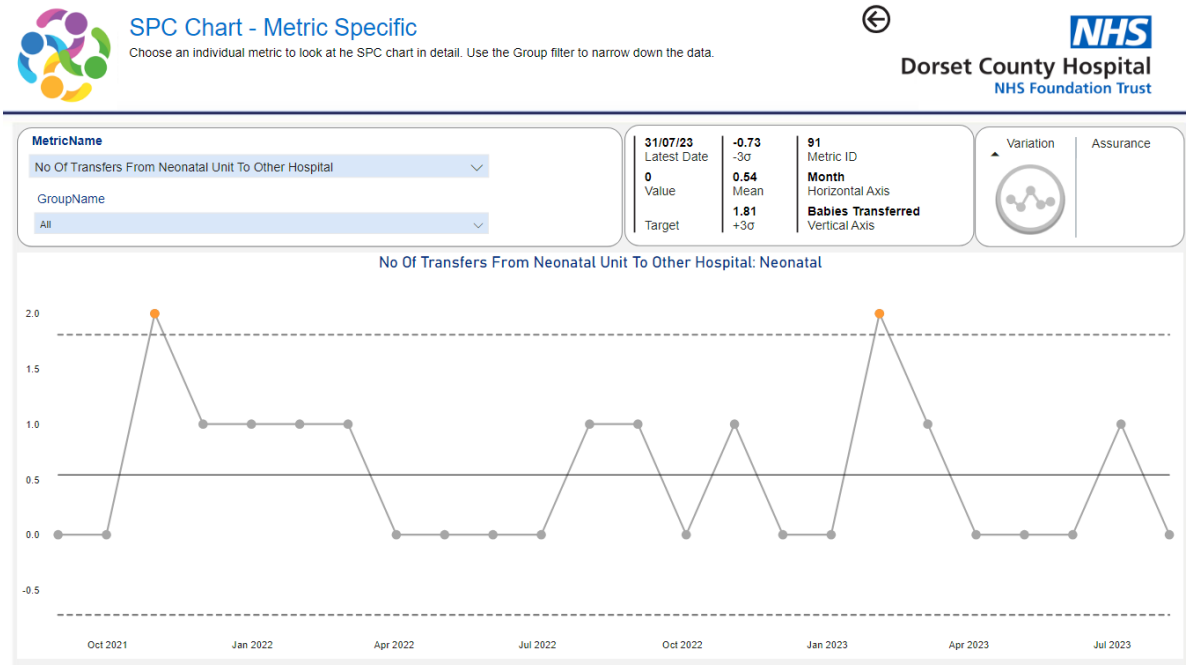
Inspiring confidence, highlighting opportunities, harnessing system support, learning from events, and showcasing best pra

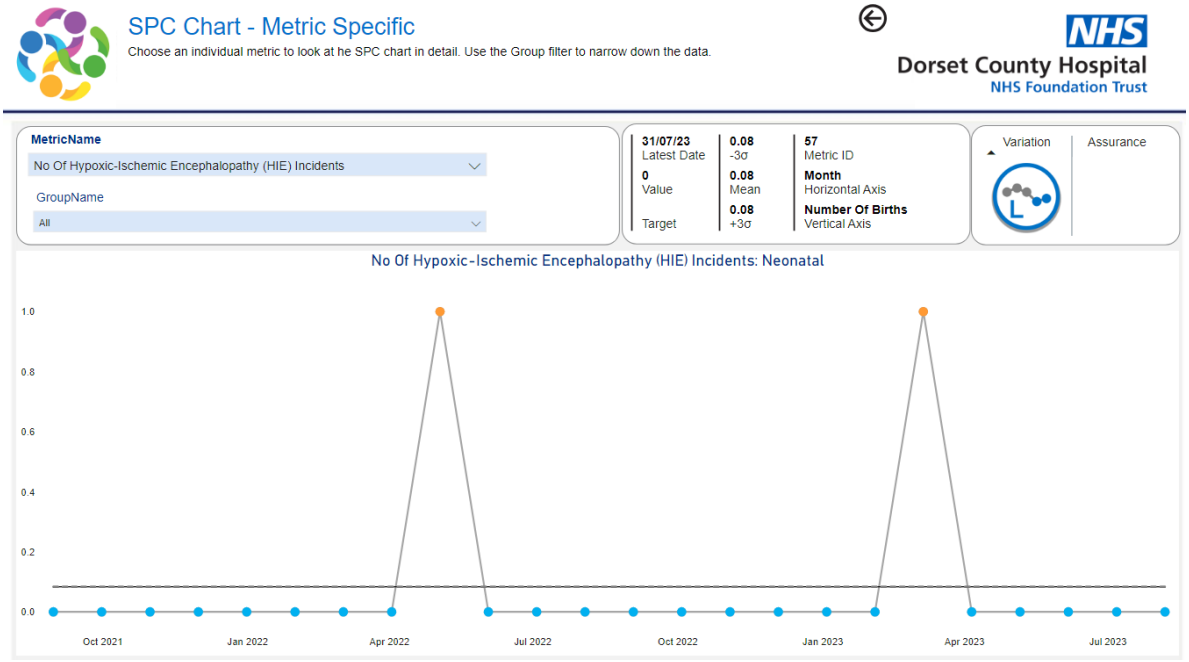
Activity

Below are a selection of SPC charts relating to specific metrics that are national KPIs or to an ongoing risk or outlier status. Ongoing work with the BI Team will see production of a Maternity Report specifically for Quality Committee and Board. Prior to that, data will be presented in this format.


SPC Chart - Metric Specific
Choose an individual metric to look at he SPC chart in detail. Use the Group filter to narrow down the data.
NHS
Dorset County Hospital
NHS Foundation Trust
MetricName
No Of Still Births
GroupName
All
31/07/23
Latest Date
0
Value
Target
-0.47
-3σ
0.29
Mean
1.05
+3σ
11
Metric ID
Month
Horizontal Axis
Number Of Births
Vertical Axis
Variation
Assurance
No Of Still Births: Births
2.0
1.5
1.0
0.5
0.0
-0.5
Oct 2021
Jan 2022
Apr 2022
Jul 2022
Oct 2022
Jan 2023
Apr 2023
Jul 2023


SPC Chart - Metric Specific
Choose an individual metric to look at he SPC chart in detail. Use the Group filter to narrow down the data.
NHS
Dorset County Hospital
NHS Foundation Trust
MetricName
No Of Neonatal Deaths < 28 Days
GroupName
All
31/07/23
Latest Date
1
Value
Target
0.17
-3σ
0.17
Mean
0.17
+3σ
13
Metric ID
Month
Horizontal Axis
Number Of Births
Vertical Axis
Variation
Assurance
H
No Of Neonatal Deaths < 28 Days: Births
1.0
0.8
0.6
0.4
0.2
0.0
Oct 2021
Jan 2022
Apr 2022
Jul 2022
Oct 2022
Jan 2023
Apr 2023
Jul 2023


SPC Chart - Metric Specific
Choose an individual metric to look at he SPC chart in detail. Use the Group filter to narrow down the data.
Dorset County Hospital
NHS Foundation Trust
MetricName
No Of Transfers From Neonatal Unit To Other Hospital
GroupName
All
31/07/23
Latest Date
0
Value
Target
-0.73
-3σ
0.54
Mean
1.81
+3σ
91
Metric ID
Month
Horizontal Axis
Babies Transferred
Vertical Axis
Variation
Assurance
No Of Transfers From Neonatal Unit To Other Hospital: Neonatal
2.0
1.5
1.0
0.5
0.0
-0.5
Oct 2021
Jan 2022
Apr 2022
Jul 2022
Oct 2022
Jan 2023
Apr 2023
Jul 2023


SPC Chart - Metric Specific
Choose an individual metric to look at he SPC chart in detail. Use the Group filter to narrow down the data.
Dorset County Hospital
NHS Foundation Trust
MetricName
No Of Hypoxic-Ischemic Encephalopathy (HIE) Incidents
GroupName
All
31/07/23
Latest Date
0
Value
Target
0.08
-3σ
0.08
Mean
0.08
+3σ
57
Metric ID
Month
Horizontal Axis
Number Of Births
Vertical Axis
Variation
Assurance
L
No Of Hypoxic-Ischemic Encephalopathy (HIE) Incidents: Neonatal
1.0
0.8
0.6
0.4
0.2
0.0
Oct 2021
Jan 2022
Apr 2022
Jul 2022
Oct 2022
Jan 2023
Apr 2023
Jul 2023

SPC Chart - Metric Specific

Choose an individual metric to look at he SPC chart in detail. Use the Group filter to narrow down the data.

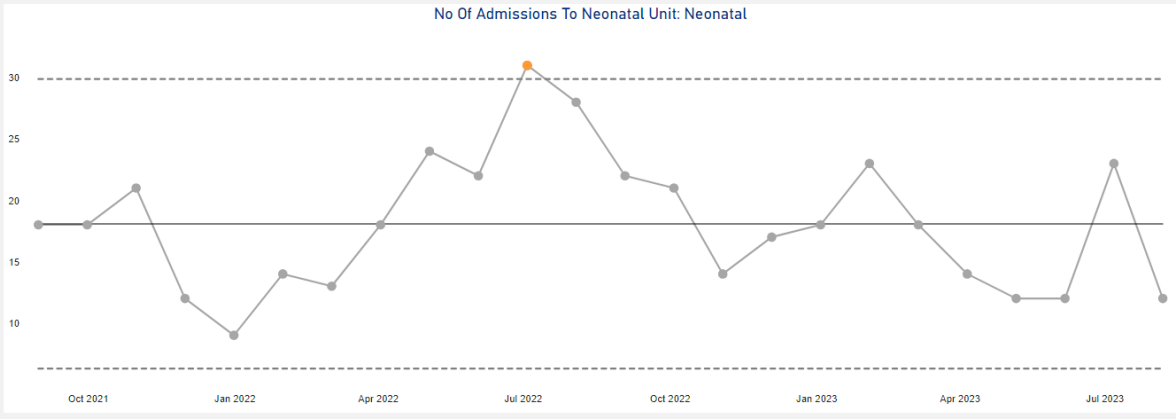
Dorset County Hospital
NHS Foundation Trust

MetricName: No Of Admissions To Neonatal Unit

GroupName: All

31/07/23 Latest Date	6.29 -3σ	90 Metric ID
12 Value	18.08 Mean	Month Horizontal Axis
Target	29.88 +3σ	Babies Admitted Vertical Axis

Variation | Assurance



SPC Chart - Metric Specific

Choose an individual metric to look at he SPC chart in detail. Use the Group filter to narrow down the data.

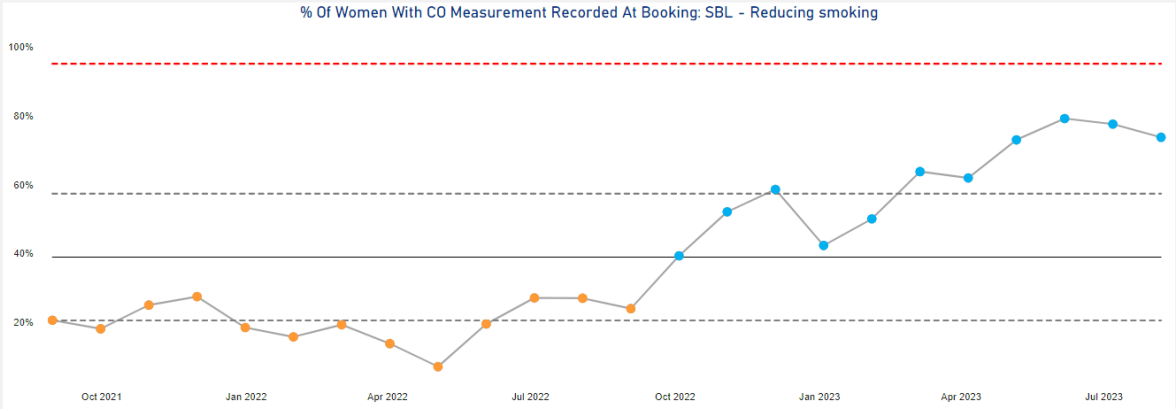
Dorset County Hospital
NHS Foundation Trust

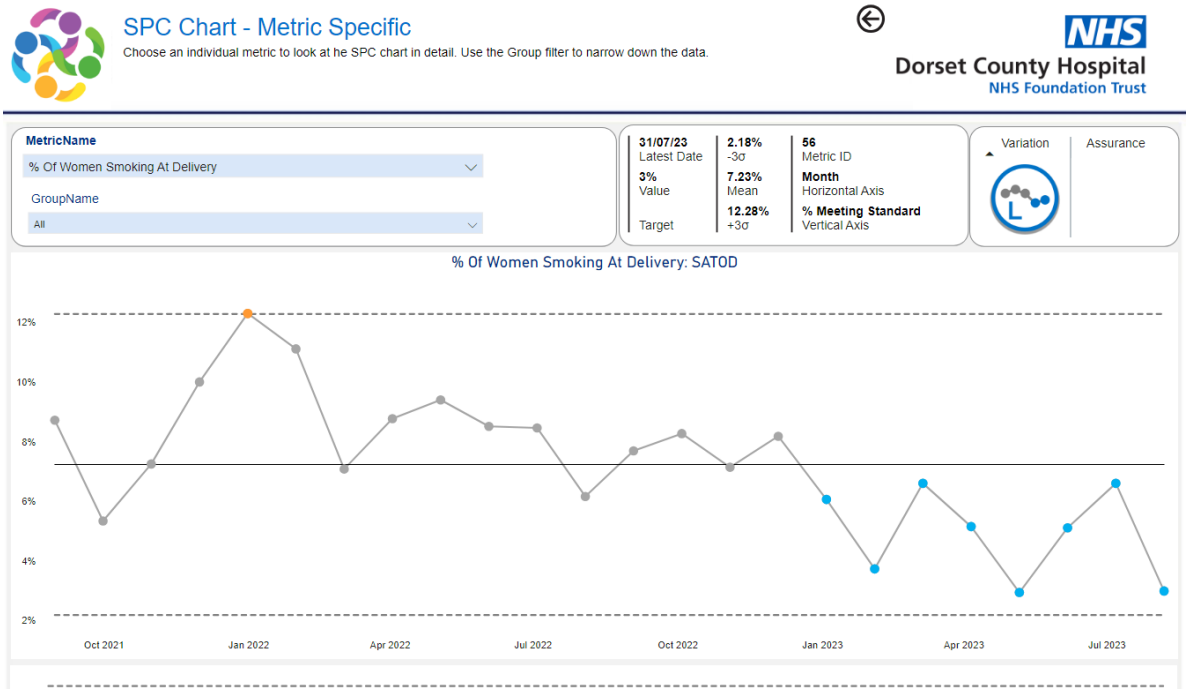
MetricName: % Of Women With CO Measurement Recorded At Booking

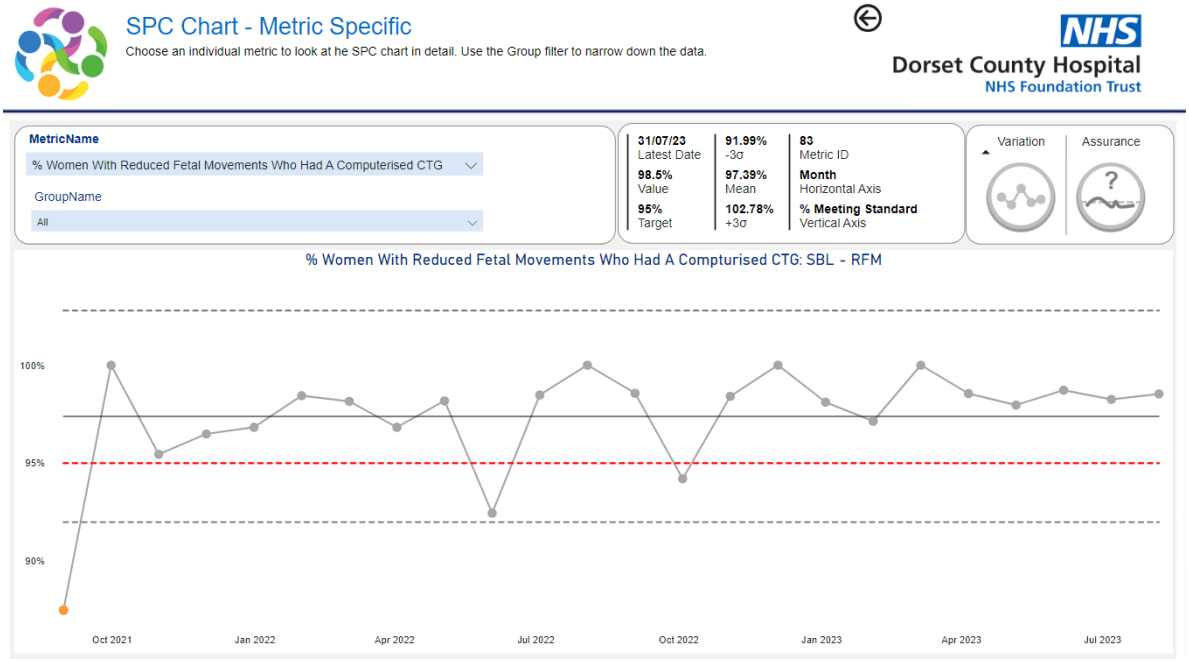
GroupName: All

31/07/23 Latest Date	20.53% -3σ	75 Metric ID
73.7% Value	38.93% Mean	Month Horizontal Axis
95% Target	57.32% +3σ	% Meeting Standard Vertical Axis

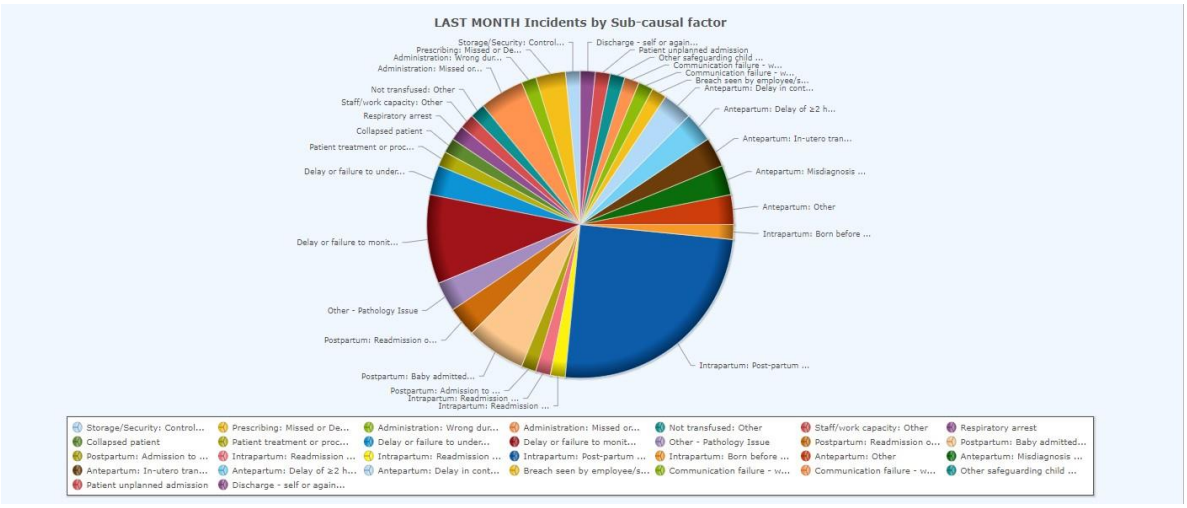
Variation: H | Assurance: F

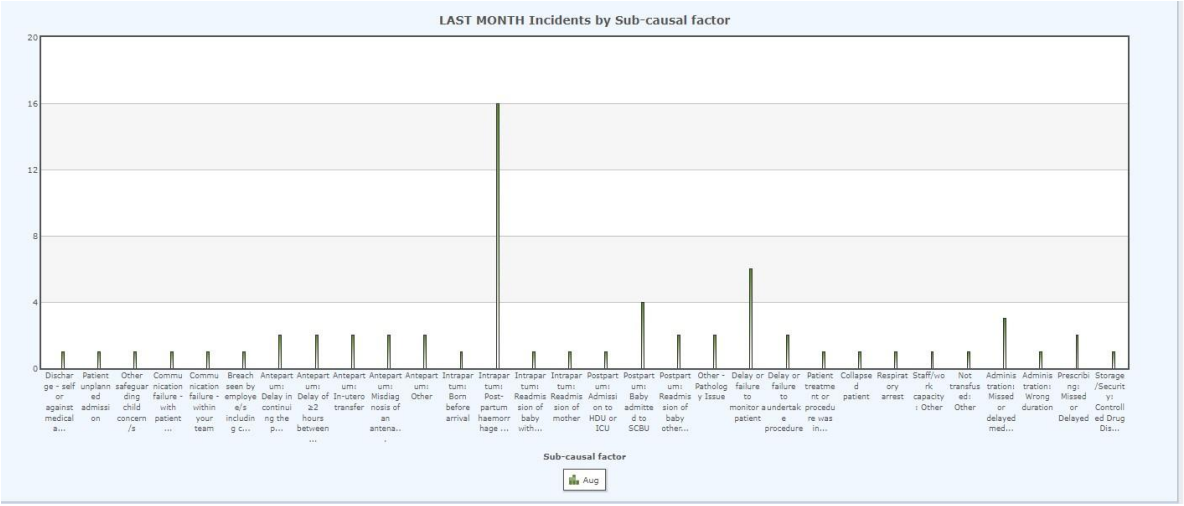



SPC Chart - Metric Specific
Choose an individual metric to look at he SPC chart in detail. Use the Group filter to narrow down the data.
Dorset County Hospital
NHS Foundation Trust
MetricName
% Of Women Smoking At Delivery
GroupName
All
31/07/23 Latest Date
3% Value
Target
2.18% -3σ
7.23% Mean
12.28% +3σ
56 Metric ID
Month Horizontal Axis
% Meeting Standard Vertical Axis
Variation
Assurance
% Of Women Smoking At Delivery: SATOD
12%
10%
8%
6%
4%
2%
Oct 2021
Jan 2022
Apr 2022
Jul 2022
Oct 2022
Jan 2023
Apr 2023
Jul 2023


SPC Chart - Metric Specific
Choose an individual metric to look at he SPC chart in detail. Use the Group filter to narrow down the data.
Dorset County Hospital
NHS Foundation Trust
MetricName
% Women With Reduced Fetal Movements Who Had A Computerised CTG
GroupName
All
31/07/23 Latest Date
98.5% Value
95% Target
91.99% -3σ
97.39% Mean
102.78% +3σ
83 Metric ID
Month Horizontal Axis
% Meeting Standard Vertical Axis
Variation
Assurance
% Women With Reduced Fetal Movements Who Had A Compturised CTG: SBL - RFM
100%
95%
90%
Oct 2021
Jan 2022
Apr 2022
Jul 2022
Oct 2022
Jan 2023
Apr 2023
Jul 2023

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 September 2022 to August 2023

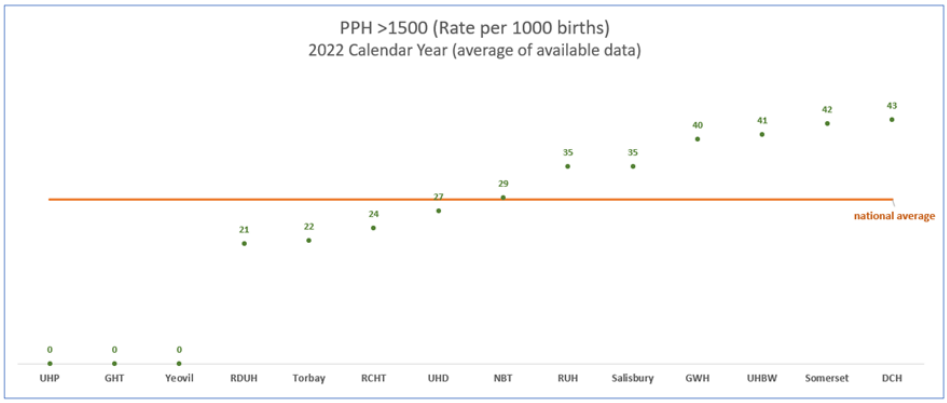
Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	June	July	Aug
63	74	62	60	34	44	38	37	77	101	100	63
Number of incidents overdue: 26 .			Primarily relates to neonatal incidents and those requiring input from other specialties and/or agencies Neonatal governance lead to be appointed shortly and neonatal matron joining DCH Oct 2nd								

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

Red flag	Descriptor	Incidents for August
RF1	Escalation to divert of maternity services & poor staffing numbers, including medical staffing and SCBU	1 for SCBU 1 for maternity
RF2	Missed medication	0
RF3	Delay in providing or reviewing an epidural in labour	0
RF5	Full examination not carried out when presenting in labour	0
RF6	Delay of ≥2 hours between admission for induction of labour & starting process	2
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

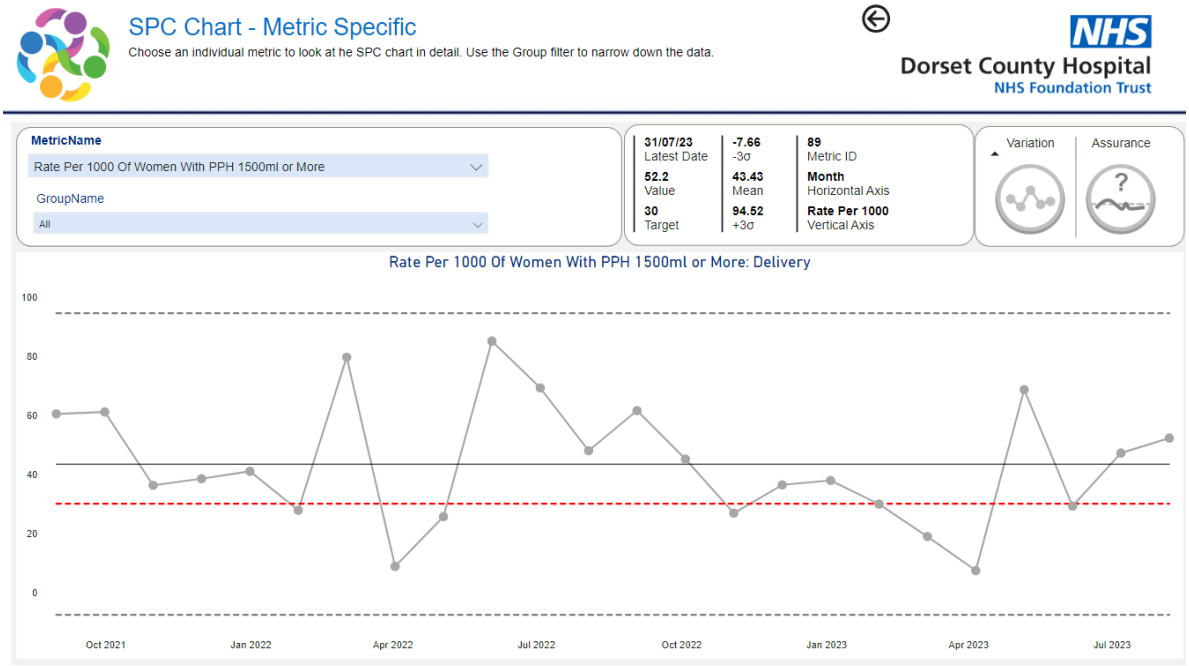
Focus on postpartum haemorrhage >1500mls

According to data that is submitted via the Maternity Services Data Set, DCH is an outlier for postpartum haemorhages over 1500mls. This data is currently being verified and our initial questions are outlined below. The Safety Team are considering how to respond to this – currently planning to review all cases of a signficant PPH as an audit.



SW Regional Team Questions:

- Are systems satisfied that MSDS trust level PPH data are accurate?
- Are trusts using a risk assessment tool? If yes, which tool is being used?
- What method for quantifying PPH is being used?
- Where the rate is greater than the national average is there an action plan in place to address this?
- Are there any PPH initiatives / examples of good practice that can be shared?



Improvement : Reducing post-partum haemorrhage (PPH) cases with blood loss ≥1500mls
Project team: Lindsey Burningham, Linda Deadman, Liz Passells, Jane Hall, Mamdouh Shoukrey, Katherine Barr, Vanessa Bartholomew, Frances Dubey, Sarah Dominey, Nicky Trent

Dorset County Hospital NHS Foundation Trust

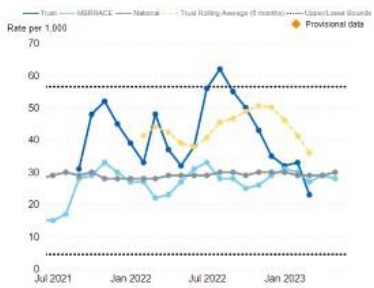
Problem statement : DCH has been identified as an outlier for PPH 1500mls and above since September 2021. PPH is a common obstetric emergency where prompt recognition and appropriate management can help reduce associated maternal morbidity and potential mor tality. The definition of PPH is the loss of 500 ml or more of blood within 24 hours of the birth of a baby. PPH can be minor (500 –1000 ml) or major (more than 1000 ml). Major could be divided to moderate (1000 –2000 ml) or severe (more than 2000 ml).

SMART aim:
To decrease the incidence of PPH cases ≥1500mls to ≤ the national average by September 2024 to improve outcomes for women

Measures to track improvement:
- Incidence rate of PPH cases ≥1500mls
- Timeliness of PPH detection and intervention
- Compliance with clinical guidelines
- Training and education completion rates
- Data accuracy and completeness

Target:
Trust rolling average (6 months) rate per 1000 births to be ≤ national rate per 1000 births by September 2024

Current state and baseline measurements for the targets :



Programmes of work/Key drivers:

1. **Early detection and assessment**
   - Timely identification of high -risk women
   - Effective monitoring of blood loss at delivery
2. **Clinical pathways and guidelines**
   - Use evidence -based guidelines for managing PPH
   - Ensure standardised processes for PPH prevention and treatment
3. **Staff training and education**
   - Continuous training for management of PPH
   - Promote awareness of best practice and updated guidance
4. **Risk factors assessment**
   - Identify and address individuals specific risk factors for PPH
   - Develop personalised care plans for high -risk women
5. **Communication and teamwork**
   - Improve multidisciplinary communication
   - Enhance teamwork and co -ordination during labour and delivery
6. **Service user engagement and involvement**
   - Facilitate involvement in decision making regarding care and debrief following PPH
   - MNVP involvement in staff training
7. **Data collection and analysis**
   - Use SPC charts for data collection
   - Regularly analyse data to assess accuracy and identify trends and areas for improvement
8. **Feedback and continuous improvement**
   - Collect feedback from staff and service users
   - Use feedback to make iterative improvements in PPH management processes

Work underway and planned work:

- Clinical audit of all 2022 cases ≥1500mls – utilise findings to inform drivers and change ideas
- New PPH governance process with categorisation and associated pathways for review and reporting to commence October 2023
- External scrutiny from LMNS and UHD representative to identify themes – planned for November monthly review
- Data cleansing and quality assurance ongoing with digital midwife and BI team

Specific risks of interest - postpartum haemorrhages >1500mls

Reference date	Incident	comments

DCH84930	First baby, induction of labour, pregnancy induced hypertension. Previous obstetric haemorrhage 3litre Quick labour - PPH 2000ml In anticipation of PPH, IV access early in IOL process and 40iu oxytocin infusion prepared to give following birth. This was commenced immediately when cord clamped and cut. Placenta birthed by controlled cord traction Emergency bell called and PPH box brought to room. MSW scribing. Blood loss measured. Placenta checked. Tranexamic acid (TXA) given. IV commenced, Misoprostol and Haemobate given. Sutured by registrar. Observations as per protocol. Indwelling catheter. Consultant obstetrician & anaesthetist informed.	**Response from Safety Team midwife** Risk factors in this case include; BMI 40, previous 3L MOH, Induction of labour including Prostaglandins and Oxytocin infusion. Due to risk factors, PPH was anticipated and a venflon was inserted early in the induction process with 40iu oxytocin prepared prior to birth. Coordinator present at birth with PPH box and IV fluids. Emergency bell used once PPH was confirmed, weighing of blood loss commenced. Registrar sutured the perineum and blood loss was controlled with the removal of blood clots from the vagina. The woman recovered well without the need for a transfusion and was discharged the following day. This case was managed well. However, the management of obstetric emergencies requires the input of the wider multidisciplinary team. The consultant and anaesthetist were called but as per hospital guidance, 2222 emergency call must be made to alert members of the multidisciplinary team not present on the ward, especially following the recognition of an ongoing PPH (i.e. theatre team and the anaesthetist).
DCH85643	Ventouse birth with episiotomy. spontaneous low risk labour. PPH 1758mls from episiotomy	**Response by Safety Lead midwife** Risks of PPH include delay in 1st stage of labour and augmentation with oxytocin. Ventouse birth with episiotomy, recognition of PPH by team during delivery, correct procedure followed by calling emergency bell and 2222 call put out. Haemostasis achieved with use of uterotonics, suturing, txa, Haemobate. IV fluids given, plan for full blood count and discussion regarding removal of epidural catheter post event. Haemoglobin 6 hours post birth was 91g/l.
DCH85553	PPH 1563mls. Caused by tone and trauma-vessel bleeding on tear. 2 doses of Syntometrine,1 x TXA, 2 cannulas, Plasmalyte. Oxytocin 30 units increased to 166ml then 40 units oxytocin commenced. Placenta delivered and checked - complete Suturing by Registrar	**Response by Safety Lead Midwife** Risk factors for PPH include induction of labour with Prostaglandins and oxytocin infusion, BMI of 33. This woman, a multip, received one Prostin tablet and an ARM was performed the following morning when her Cervix was 2cm dilated. Following the administration of IV Oxytocin, the woman progressed very rapidly and birthed her baby two hours later. Third stage was managed with Syntometrine (administered

		one minute following birth). Bleeding was noted within a few minutes and the emergency bell was used to summon help. Bleeding from a tear and atony was identified, fluids were administered alongside TXA and IV Oxytocin. A 2nd cannula was sited and suturing was commenced promptly. Haemostasis was achieved and all bleeding settled following completion of this. As is best practice for management of obstetric emergencies, the full multidisciplinary team, including the anaesthetist were present to manage this PPH. All care appropriate to clinical situation and this PPH appears to have been well managed. The woman was discharged home the following day with an Hb of 108g/l without the need for oral/IV Iron or a blood transfusion. She is recovering well at home.
DCH85500	Primary PPH following spontaneous vaginal birth. Complicated perineal trauma. Suturing, catheterised, cannulated. Fluids and oxytocin administered	**Response by Safety Team Midwife and Anaesthetist:** Normal birth followed by an obvious trickle of blood the emergency bell was activated and staff attended promptly including the Anaesthetist. Management of the PPH was achieved with suturing, which was complicated by friable tissue and difficult visualisation. TXA was administered, IV access was achieved with IV fluids commenced. A 2222 call was not made which would have meant theatre staff were also present in case transfer was required. Once the PPH was over 1.5L the Obstetric and Anaesthetic Consultant should have been informed to attend. **Learning identified:** when a PPH is identified a 2222 call should be made to ensure the full team is present to manage the PPH. when a PPH is ongoing at 1500mls there should be escalation to the Obstetric and Anaesthetic Consultant. This will be fedback via PROMPT sessions.
DCH85548	Vaginal birth, followed by PPH of 1.9L and retained placenta	**Still under review** Lengthy discussion has now taken place with the midwife caring for this woman, some communication/human factors identified, awaiting her response in writing. Midwife and coordinator asked to review notes regarding active management of 3rd stage. However, syntometrine documented as being given 6 minutes following birth. Unable to see what medications were given to manage PPH, also no blood loss

		recorded. To recheck when added to record. Risk factors for PPH include BMI 55, Induction of labour with Prostaglandins and Oxytocin. Of note, the woman bled again the following day, accumulated blood loss from birth and PN room is 1989mls
DCH85184	PPH of 1728mls. Baby born by Cat 3 LSCS for prolonged spontaneous ruptured membranes (SROM), declined SROM augmentation. Suspected estimated fetal weight (EFW) >97th centile. Planned homebirth, had been counselled of risk of PPH and shoulder dystocia at 36+2. Known ovarian cyst, already planned for removal of this if LSCS. Cannulated prior to spinal as standard. In dwelling urinary catheter inserted prior to birth as standard TXA and Haemabate given. Cell salvage not used as cystectomy performed intraoperatively and cyst fluid contaminated blood in suction bottle. Transferred to postnatal ward, 1-1 care and MEOWS observations commenced. Warmed IV plasmalyte (second bag) commenced slowly	**Response by maternity safety team** Majority of pregnancy care with UHD, transferred to DCH at 33 weeks. scans in place for growth in view of maternal BMI. Scan at 36 weeks demonstrated estimated fetal weight raised (EFW) review on DAU with appropriate counselling, to revisit following 38 week scan 38 weeks scan increased EFW-counselled and decided to continue with home birth. 38+4 SRM. 38+5 reviewed on DAU, observations normal VE demonstrated not in labour, decided for caesarean. Proceeded in a timely manner. Risk factors for PPH were raised BMI, prolonged SRM PPH announced during operation by Obstetric Consultant. Managed with medications. PN plans followed expected pathway. PN haemoglobin 82, discharged home on day 1 with no concerns identified during the PN period at home.
DCH85217	Post partum haemorrhage of 1600mls. PPH followed vaginal birth, IOL via ARM and oxytocin. Emergency bell called. Additional cannula inserted. Oxygen given, Oxytocin infusion, syntometrine, ergometrine and tranxeamic acid all given. 4L IV fluids given over course of labour (suspected sepsis also earlier therefore earlier fluids given). Perineum sutured, bleeding then settled	**Ongoing review.** Noted that 4 litres of fluid is significant amount.

Specific risks of interest

Reference	Incident	comments
DCH84905	There has been a serious problem with temperature control in the maternity operation theatre. Had to perform an emergency caesarean and the temperature in the theatre was 28 degrees. It felt suffocating for the staff and baby came out with temperature of 38 c. The high temperature created difficulties for the whole team as well as the patient and her baby.	**Response from anaesthetic consultant** There have been further issues with temperature regulation in maternity theatre. The temperature this morning was 28.5C (and has been 30C on another occasion) with extremely high humidity

	I expedited the delivery as it was an emergency and completed the operation within 20 minutes to help everyone to get out of the theatre. It was very difficult to perform in that high temperature. The manager JH was informed in the morning. The anaesthetic consultant KB was involved in this matter to escalate as the temperature in the maternity theatre, this morning was still high to be used safely.	despite being flagged yesterday I believe. They did an emergency procedure overnight and several staff felt unwell. It had been too low at 19C the day before. Someone in Estates has sorted the issue this morning and it has cooled down relatively quickly. I have spoken to Estates this morning who has explained that there have been hiccups with upgraded systems but that it should all be settling down in the next few weeks. In the meantime he has kindly agreed that a member of the Estates team will check the maternity theatre temperature each morning at 8am to check it isn't way off what we would expect (23-24C). I'm not sure what the humidity is supposed to be and even if our display in theatre is accurate. We would have had to use another theatre in an emergency. Linked to Risk Register - 1656 - Temperature Issues in Theatres

Babyloss statistics for August		
Intrauterine death	Neonatal death	Late neonatal death
There were three losses in August. One loss meets the criteria for PMRT	nil	nil

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

Serious incidents and HSIB
DCH77894
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 be 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
Immediate actions Parents informed and reassured All same LOT number tubes 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. A very positive meeting. The RCA will be shared with them as well, once completed **August update** Report completed and submitted to Risk Dept for inclusion in LIP. Parents informed of progress following email from them to consultant paediatrician with further questions
DCH79901
July update The SI was heard at LIP on the 13/6/23. The patient has a follow up appointment with consultant obstetrician on the 11/7/23 – follow up letter to be used as DOC. No harm was caused by our care and baby is well. **August update** Incident now closed by Risk Department. All documents completed
DCH79898
Update: 72 hour report completed and submitted. Joint PMRT review meeting with UHD on 30/03/23. The care was graded as C which indicates different care may have made a difference to the outcome. This relates to the management of a sub-chorionic haematoma identified during routine scanning. The panel concluded there should be a documented requirement for an early referral to the fetal medicine specialist at 24 weeks when a sub-chorionic haematoma is identified. Wording and updating of the relevent guideline is being discussed and agreed. **July update:** scheduled for LIP 21/07 **August update** Heard at LIP in August. Actions discussed and added from PMRT. Awaiting ICS closure
DCH79954
July update: DoM and Paediatric Consultant met with parents recently to discuss what happened and ensure their questions are included in the RCA. Time line provided and many questions answered. **August update** RCA almost ready for submission
DCH80360 HSIB
Update: HSIB have contacted staff. Currently parents reluctant to engage further with HSIB. Accepted by NHS Resolutions Early Notification (EN) scheme. NHSR reference number for this matter is M22CT236/014. Once we are in receipt of a finalised copy of the HSIB report we will need to provide this to NHSR via DTS. **June update**: New lead HSIB investigator who has identified two more members of staff to interview. Informal discussion between DoM and HSIB lead for the South West suggested the family have raised concerns about an earlier request for a caesarean. **August update:** report being checked for factual acuracy. No safety actions identified

Risk Register

ID	Title	Risk Statement	Open	Risk	responsibility

1721	abnormal placentation pathway for delivery	Abnormal placentation is graded depending on level of invasion. These are high risk pregnancies and delivery needs to be in a unit with 24 hour intervention radiology, obstetric consultants who specialists and urologists. Wessex region does not have a funded, agreed referral pathway as none of the units have the capability to provide this service. As caesarean section rates increase the risk of abnormal placentation will also increase. The risks are massive haemorrhage, bladder damage if the placenta has invaded through to the bladder, premature delivery and hysterectomy.	05/09/23023	moderate	division
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. **August** No update. Situation remains the same	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 **August update** Screening results returned within expected time frame – now low risk	06/06/2023 Managed risk	low	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. **August 2023** the appointment of a ninth consultant will alleviate pressure and provide time to increase antenatal clinics for women at risk of premature birth. However, currently women are seen as required	06/06/2023 Quarterly review	moderate	Care group
1623	Obstetric team handover in the evenings	National requirement to have a face-to-face handover with incoming and outgoing consultant obstetricians present in the morning and at the beginning of the night shift. Currently DCH has f2f handover in the morning, lunchtime and 5.30pm. Consultants not present at the 9opm handover (registrar and SHO present, consultant available remotely) **August 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 **August 2023** Roll out of BSOTS in ANDAU Sept 2023. SoP for BSOTS completed. next step is to train all midwives working on labour ward to use BSOTS whern ANDAU closed (overnight). Significant training implications and possibly more staff required to ensure triage parameters met >95%	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 **August 2023** Room still not in use as further structural concerns identified. CEO and MD aware following visit to service	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 is not be fit for purpose **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 **August 2023** Estates attending Maternity to review location of new call bells.		high	divisional

1456	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 **August 2023** Recent incident of no capacity for level 3 NICU. Possibility of very premature baby being born at DCH. Therefore risk remains moderate	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. **August 2023** significant improvement in in measurement of CO at booking and smoking at time of delivery rates. The CO monitoring at booking is now at >70%. SATOD is currently below the national target of 6%. Current data is being interrogated to identify why approx 30% women did not have a CO taken at booking. This may be due to data entered incorrectly on EPR or lack of face-to-face bookings or individual practice. recruitment for more midwives has been approved. This will improve the opportunity to provide face-to-face bookings. One community team has introduced a clinic for CO screening and screening bloods, prior to booking with the midwife, that has successfully addressed the problem of telephone bookings. This model being considered for other community areas.	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	24/12/2019	High	Division

		midwives do in a more traditional midwifery setting, so staff exposure is not on a daily basis and none of the night core work full time and tend to swap and change which area they work in from one night to the next. **August 2023** Improvement work on rooms 25&27 starting in September			
876	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 **August 2023** Whilst datix submissions have reduced this month. Workforce data shows the significant number of shifts understaffed. Recent recruitment for band 6 midwives saw 26 applicants with 22 from overseas. Four candidates invited to interview but vacancies remain	20/07/2021 Quarterly review	moderate	division

Complaints

Total informal and formal

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

C23508 This complaint concerns the care during induction of labour, the lack of midwifery continuity and poor care after the birth, including staff not supporting the woman with	Currently, the case is being reviewed and a response written by the DoM

caring for her baby, pain relief not provided on time and the lack of a single room	
C23089 This complaint concerns issues around care during labour and aferwards	**August update** Letter sent to patient learning points are as follows: • Clarify our policy around eating during labour and ensure women are correctly advised • Remind midwives and doctors about the importance of providing care that is responsive, woman centred and takes into account the challenges the woman and her partner are managing. This is particularly important when a mother and baby are separated because of a neonatal admission • Ensure all staff understand that ward rounds must be kept to a minimum and that permission must be given by the woman or her partner before entering the room. • When waking a woman during the night, midwives must be gentle, patient and ensure they carefully explain what is happening and why • Remind staff of the importance of prescribed medication being given on time
C23142 This complex complaint concerns issues around the postnatal care of baby and a possible delay in identifying deterioration.	Currently, this is being reviewed by an MDT, including full review of labour and birth and CTG monitoring.

Quadrumvirate meeting August

Present: Jo Hartley, Director of Midwifery
Clare Hollingsworth, Consultant Paediatrician
James Male, Service Manager
Beena Dandawate, Consultant Obstetrician

Minutes of previous meetings

- The new Neonatal Matron is starting at the beginning of October. The lack of leadership was acknowledged and the challenges this had brought to the staff
- DS is making good progress on establishing the Transitional care service effectively
- Interviews for the neonatal governance role will take place in September – 2 good candidates. The post holder will work under the Governance lead
- Planned cover for ANNP is 9-9. James awaiting confirmation of funding and agreed JD and PS
- We discussed the value of experience for the Neonatal Lead Consultant and the ANNP, in spending 1-2 weeks a year at a level 3 Neonatal Unit. Claire is going to

ask a colleague at UHS. JM could you consider from a job plan perspective please. **No update**

- Discussion around the impact of doctors strikes including the possibility of consultants striking. **Update: consultant IA now planned**

- Discussion around the necessity to expand the consultant led service for women at risk of premature birth. Currently not enough clinic capacity although there is LMNS funding to increase the role by 0.5PA once clinic space has been identified. **Update: this will be addressed when a ninth obstetric consultant is appointed**

- A further discussion about diabetic capacity and the need to increase clinic appointments. This is being discussed by the MDT diabetic - significant enthusiasm for an expanded service but again, capacity is a challenge **Update: discussions continue but no progress**

Matters arising

JoH outlined the focus of this meeting. To consider safety and quality issues, staffing, the training needs analysis, staff feedback and national guidance, documents and KPIs

The use of locums at night on the maternity ward was discussed. Whilst the finding has now been agreed to employ three new SHOs, the majority of the shifts are still being covered by locum nest.

The importance of job planning for paediatrics was explored and the obstacles preventing completion. JM and BD have completed this for obstetrics successfully and is very keen to do so for paediatrics

JoH conformed the NED safety Champion would be invited to this meeting quarterly

Discussion around the best time for this meeting. Tuesday week 3 in the morning

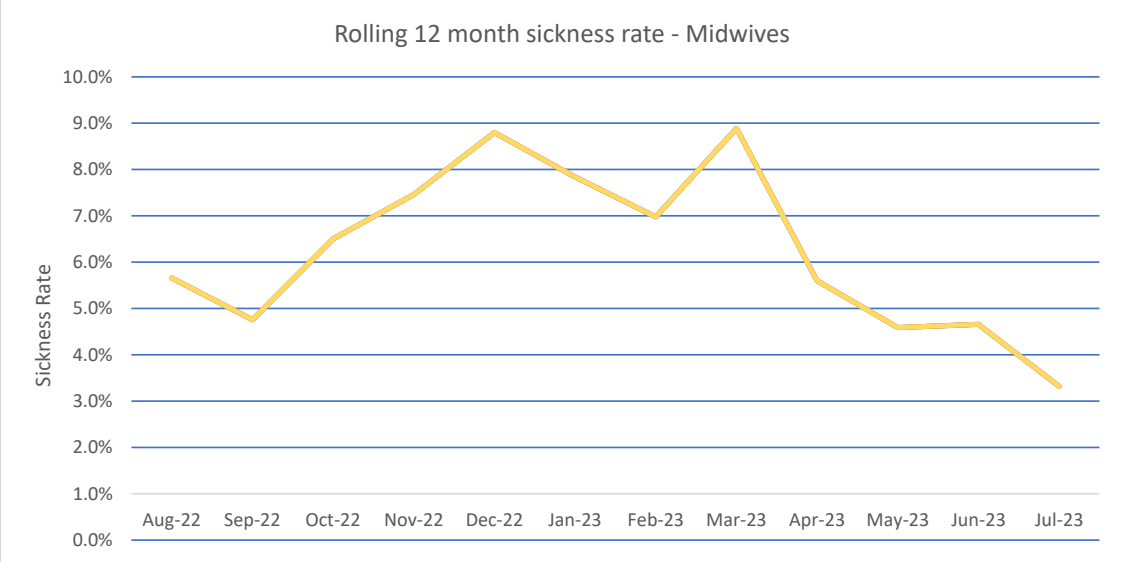
ToR to be circulated with the minutes

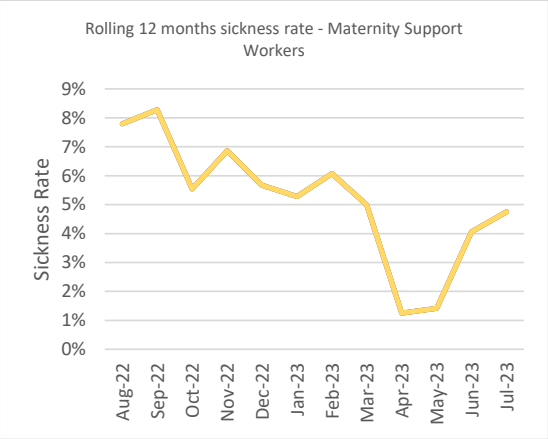
The outlier status for the maternity service in relation to PPHs over 1500mls discussed. Agreement this needs to be a focus for governance and QI. An audit has started on all incidents from 2022 with a monthly focus going forward

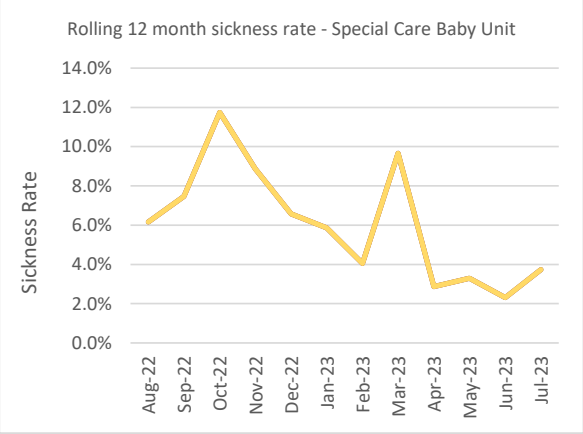
Discussed non-registrants giving medication to babies on SCBU. Agreed this can only happen if the medication is checked by two registrants, then added to a baby's milk feed. The feed can then be given by the non-registrant. Practice Educator currently writing competency assessments for HCAs and nurses.

All babies transferred out from SCBU to another neonatal unit must be added to datix and reported on monthly, via the Maternity Safety and Quality Report. ANNP will kindly provide this

Workforce update



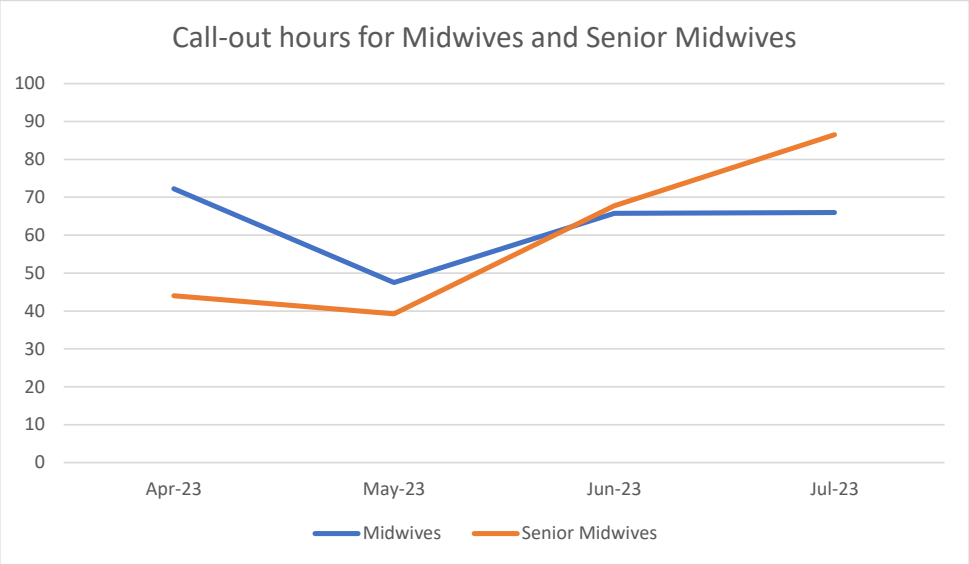




Overall sickness rates from 1st August 2022 – 31st July 2023
Midwives – 6.32%
Maternity Support Workers – 5.18%
Special Care Bay Unit – 7.01%

July Call-Out Hours

Midwife call-out for the unit – **66 hours**
Senior Midwives call-out – **86.5 hours**



Bank and Excess hours

	Maternity Unit/ DAU	Community	Band 2 MSW's	SCBU Band 5/6	SCBU Band 2
Bank	367.5 hrs / 67.5 hrs	230.75 hrs	232.5 hrs	180.5 hrs	0 hrs
Excess	200.5 hrs (unit) 29.25 (DAU)		47.5 hrs	124 hrs	11 hrs
Incentives	9		3	0	0

Shifts not covered by substantive or bank staff

Community	
Chesil	15.47%
Dorchester	16.9 %
Cranberries	34.9 %
Moonfleet	21.7 % (60.8 % staffed by bank)
Maternity Unit	
Day Shift	26.4 %
Night Shift	19.35 %
Total	24 %
ANDAU	4 shifts not covered 5.47%

Maternity Support Workers	
Inc. PM Shifts	42.4 %
Exc. PM Shifts	33.3 %

92 out of 217 shifts were not covered – 27.2 % of those covered were by bank/excess hours.
Band 3 – AN
13 shifts not covered.
Band 3 – PN
12 shifts not covered.

Special Care Baby Unit	
Band 5/6	0.9 %
Band 2	7.46 %

MSW turnover rate is 0.
Rolling 12- month Midwife turnover rate is currently 3.85%

Safety Champions Action Tracker

Awaiting minutes from recent meeting

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 language to align with region and aid collaboration with DHC	LB	End April	LMNS partnership meeting updated regarding review and possible revision	
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	KB		QI project being led by a senior midwife to improve pathway for elective LSCS Elective activity continuing during strike action	

		-consider separate staffing -consider second theatre				
		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 -Compile a paper for Trust Board with SBAR format – National recommendation , GAP analysis, Mitigation, Risks and a plan	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 in the interim	
Neonatal	BAPM	**Neonatal Hypoglycaemia** Local guideline currently not aligned with BAPM guidance resulting in neonates undergoing unnecessary invasive blood testing procedures	CH	End May	New guideline ratified in line with BAPM and regional guidance	

		-Revised guideline to align with BAPM				
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 Datix Investigations	**Informed Consent** 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	JoH		Ongoing Service user voice 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	N
Maternity	Ockenden	**Doctors evening handover** Align Consultant and other grade	James Male/ JoH		Ninth consultant soon to be recruited allowing for the introduction	N

		Doctors handover times (currently 30-minute differential) to a unified 17:30			of face-to-face handover at 9pm	
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. local programme management with Trustwide oversight and department actions	Y

Maternity Incentive Scheme current compliance August 2023

Safety Action	Current compliance	Expected compliance – brief overview and comments
1.Perinatal Mortality Review Tool (PMRT)		Full compliance verification after 7th Dec reporting period deadline – current cases verified as compliant. Quarterly PMRT reports to board commenced in August 2023. No cases in Q1. No risks identified to remaining fully compliant.
2. Maternity Services Data Set (MSDS)		Preliminary data check demonstrates full compliance. Power BI team report CQUIMS and metrics being on target. Further to this the BadgerNet audit tool confirms this. Official verification via NHS digital in October 2023 once July data validated. Currently no risks identified to preventing being fully compliant.
3. Transitional Care (TC) & Avoiding Term Admissions into		New TC guideline compiled to incorporate 34-week babies in line with BAPM guidance. The guideline outlines bespoke staffing model and audit schedule which will provide evidence of compliance. New pathway set for launch on 1st November 2023. ATAIN group meeting

Neonatal unit (ATAIN)		monthly. New reporting schedule incorporates quarterly reporting into maternity governance, quality committee, Trust Board and LMNS safety meeting. Current expectation is this safety action will be compliant in year 5 validation period.
4. Clinical workforce planning		Relevant bodies and Royal Colleges' standards mapped for compliance for each discipline and gaps identified utilising recommended tools and frameworks. Anaesthetic and Obstetric workforce no risk areas identified. Current risk of non-compliance for neonatal medical workforce due to reliance on GP trainees for neonatal cover instead of paediatric trainees
5. Midwifery workforce planning		Inaugural workforce oversight report submitted to Trust Board in August 2023 this key document and minutes from Trust Board evidencing discussion and sign off will satisfy multiple criteria and provide evidence of compliance. Acuity tool currently in development, safer staffing fellow supporting this work.
6. Saving Babies' Lives Care Bundle version Three (SBLCBv3)		SBLv3 implementation tool made available on 7/8/23 (significantly delayed from release date in July). Webinar to explain how to use tool - technical issue preventing attendance by Governance Lead and currently no response from NHSE with a recording. Element leads working through V3 criteria to identify gaps and risks of compliance. Implementation of 70% of interventions across all 6 elements overall, with at least 50% of interventions in each individual element likely by MIS target date (Q4). Quarterly meetings scheduled with LMNS for oversight and QIP development. First meeting scheduled for October 2023. ***SBL implementation tool utilised for evidence collation and will be submitted as a separate document.***
7. Maternity & Neonatal Voices Partnership (MNVP)		MNVP representative employed by the ICS, linking closely with the Trust. Specific workstreams need to be finalised within the ICS/LMNS in relation to outstanding MIS actions. Increased availability is required to ensure embedded coproduction in relation to the TNA and service provision and development. MNVP rep undertook site visit in September and linked with several ongoing workstream leads at DCH including education and training team implementing CCFv2 (below – SA8). See below for update.
8. MDT training		TNA and plan underway to implement all six core modules of the Core Competency Framework version 2 (CCFv2) over a 3-year period, starting from MIS year 4 in August 2021 up to July 2024. The plan needs agreement by the quadrumvirate then sign off by Trust Board. CCFv2 requirements do not require 90% compliance by 1st December 2023, only CCFv1 must achieve this in MIS Year 5 reporting timeframe. Areas of risk include requirement to have resuscitation council (RC) registered instructors teaching newborn basic life support. Currently only 3 in Trust – mitigation, MIS allows a year to plan for this standard and will accept in date NLS trained staff to deliver in the interim period – target date July 2024. Financial risk due to requirement to provide a third mandatory training day (currently 2) to incorporate additional requirements of CCFv2. Challenges around 90% compliance in smallest cohorts of staff e.g., Consultant Obstetricians where 1 person out of 8 being out of date results in 87.5% compliance overall. Ongoing strikes affecting training capability due to Consultants covering clinical work, this affects their training stats, ability to deliver training and also essential MDT mix on the study day. Training now incorporating service users via MNVP rep attending SIMS and undertaking the role of patient as well as a real family being involved with the baby abduction SIM in August. This satisfies CCFv2 criteria for service user involvement.

9. Perinatal Quality Surveillance Model (PQSM) – Board assurance		NED and ED Board level maternity safety champions appointed. Due to significant activity within the service during July, an element of this action has not achieved its target date, 17 July. *Evidence that the Trust's claims scorecard has been reviewed alongside incident and complaint data and discussed by the maternity, neonatal and Trust Board level safety champions at a Trust level (Board or directorate) quality meeting.* Triangulation report provided by Trust risk lead which details claims alongside complaints and themes
10. Healthcare Safety Investigation Branch (HSIB)		1 open HSIB case ongoing, draft report received and checked for factual accuracy – awaiting final report. full compliance against required standards expected to be met. No risks identified to remaining fully compliant.

Neonatal transfer out data for July

gestation	birthweight	Discharged to hospital name	Booked place of birth	commentary
		Within region	DCH	Transferred for escalation of care

ATAIN data for July

6 babies in total admitted to SCBU at >37 weeks gestation. This gives an ATAIN percentage of 5.8%

Key themes identified
4 for respiratory distress One for infection One for hypoglycaemia 3 admitted from postnatal ward 2 from labour ward 1 from ED 4 spontaneous births 1emergency caesarean 1 elective caesarean

Friends and family feedback

Feedback
1: All the midwifes and drs were amazing, especially Gemma for supporting me afterwards.
1: The sonographer we saw was so lovely
1: My midwife has made all the difference- Ceci. Very attentive, caring & genuinely willing to help. I feel extremely comfortable and lucky to be in her care.

1: Eliza Crabb is my midwife and she is an absolute dream. She is so kind and attentive and makes me and my partner feel safe and comfortable.	
1: Lovely staff. Friendly helpful sonographers. Kind thorough midwives. No issues with appointments. BadgerNet is easy to use and navigate.	
1: Jess and Allie, absolutely amazing midwives.	
1: Everyone on the delivery suite were so nice and helpful during and after birth. Rachel and Claire were amazing can't thank them enough for delivering my baby into the world safely, Claire especially for after getting us moved over to SCBU quickly and settled, being 3 hours from home it was nice to get settled and everyone made it a more pleasant experience considering the circumstances	
1: Grace and StM Chloe and the whole maternity team are amazing throughout my care	
1: No nothing could be done to improve I had the best care on the labour ward the midwives I had through my labour were absolutely amazing	
Everyone was very helpful and understanding!! Lilly Crosby-Davis Lauren Radburn Both midwives were amazing	
1: All the staff were absolutely fantastic, can't fault any of our experience with the birth of our baby girl, thank you everyone	
1: Midwifes communication with me during labour was really good I felt listened to and supported during my labour	
2: Was well looked after, meant to score very good. Special mention to abby the student midwife and the midwife working with her (sorry can't remember the name) as they were both very caring and reassuring.	
1: My maternity team was amazing throughout my pregnancy and postnatally. As it was a surrogacy pregnancy, Jacqui from the cygnet team went above and beyond to ensure I was well cared for and the intended parents were also involved and included in the care plan. I received extra visits in the postnatal period to check on my mental welfare, the whole experience was positive and I couldn't thank the team enough!	
1: They respected my wishes, they kept me informed but without pressuring me.	
1: The staff were all lovely and understanding and really looked after me after a traumatic birth and a week long stay. The SCBU were also incredible	
1: I had exemplary postnatal care from my midwife and the whole cygnet team. I had as many visits as I needed, support with feeding, including phone call advice and support, and when my baby needed a tongue tie release, I was fully informed and supported through that. Special mention to my midwife Sonia, to student midwife Zelle and Cygnet midwives Karen, Gemma, Ceci and Sarah who all supported me throughout my whole journey	
I didn't really go on the ward just went back for a check up on my son and the midwife I had was again amazing. The home care I have has been diabolical	**Unfortunately, without knowing more about this woman, it is impossible to respond to her concerns about community care. As she describes coming back to the ward for a postnatal check, it is possible she is from out of area**

Had to stay a few days and was well looked after. Only felt that sometimes we had to keep asking what was going on/what the plan was going forward. Special mention to Amanda for the thorough discussion and reassurance pre discharge home and also on the night shift was looked after by a wonderful lady however sadly cannot remember her name as it was quite brief. She changed my bed for me, was super friendly/chatty and made sure we were topped up with water.	
Lack of care. First time mum, left in a sideroom, no one checked on me or baby or took any clinical observation at any point during my stay considering I had to stay overnight as i had lost too much blood during labour. Me and baby were just left to it and I had no idea what I was doing. No drinks offered. I didn't see a midwife unless on the drug round. I would've liked guidance on how to care for my baby i.e when to feed her/how often. I felt forgotten about.	**It is so disappointing to read of this experience. Postnatal care continues to be the most challenging area of maternity care. This relates primarily to it being the area that manages with reduced staffing numbers in order to staff higher risk areas such as Labour Ward. It is not unusual for only one midwife and one maternity support worker to manage all postnatal women and babies if staffing is poor or acuity high. This feedback has been shared with the postnatal lead midwife and her team**

Training compliance until end of July 2023

TRAINING	STAFF GRADE	PERCENTAGE OF ATTENDANCE	NUMBER OF NON-COMPLIANCE	COMMENTS
PROMPT (Practical Obstetric Emergency Procedure Training)	Obstetric Anaesthetist (covering Obstetrics)	83%	4	Dr industrial action July PROMPT New anaesthetists could not attend
	Consultant Obstetrician	75%	2	Dr industrial action July PROMPT 1 Consultant taken off faculty and 1 taken off training to cover. 1 just out of date. **Action:** 1 consultant allocated to Sept course. 1 requested to attend Sept/Oct
	Registrars	100%	0	
	ST1/F2	67%	1	1 cancelled due to industrial action **Action:** New F2 requested to attend Oct
	GP Trainees	100%	0	
	Midwives	92%	13	2 Midwives taken off June PROMPT to cover labour ward = 1.5%
	MSW	90%	3	

BASIC LIFE SUPPORT	Obstetric Anaesthetist	79%	5	
	Consultant Obstetrician	75%	2	1 booked
	Obstetric Registrars	86%	1	
	ST1/F2	100%	0	
	GP trainee	75%	1	
	Midwives	96%	6	**Action:** Staff booked on course in next couple of months
	MSW	78%	7	**Action:** Staff emailed or booked on course in next couple of months
NLS Yearly	Midwives	89.5%	13	2 have received sim training =1.6%
NLS 4 Yearly	Senior Midwives and Homebirth Midwives	96.5%	1	Booked August
K2 CTG	Consultants	100%		
	Registrars	100%		
	Midwives	85%	13	Reminders sent

Dorset County Hospital NHS Foundation Trust

Dorset HealthCare University NHS Foundation Trust

Implementation of the new Fit & Proper Person Test Framework

Trust Board Meeting

Executive Lead(s):	Nicola Plumb, Chief People Officer Julie Dawes, Interim Director of Corporate Affairs (DHC)
Accountable Officer(s):	David Clayton-Smith, Joint Chair Matthew Bryant, Joint Chief Executive
Author(s)	Tim Bossenger/Katie Noke/Julie Dawes/Hilary Harrold
Date of Meeting:	26 September 2023
Purpose of Report	1. The purpose of the paper is to advise Board members of the new Fit and Proper Person Test (FPPT) Framework which was published by NHS England (NHSE) early last month. The Framework aims to help strengthen and reinforce the individual accountability of Board members, and the transparency around this. 2. The paper also aims to provide assurance that arrangements are being established to ensure effective implementation of the new Framework, including by describing the specific actions we need to take and the support that will be provided by NHSE.

Executive Summary

NHS England (NHSE) published a new Fit and Proper Person Test (FPPT) Framework on 2 August 2023 alongside guidance for chairs and staff on implementation. A directory of board level learning and development opportunities was published at the same time. NHSE expect elements of the Framework to be used from 30 September 2023 with full implementation by 31 March 2024.

This briefing paper sets out the key elements of what is required by the Framework, gives an overview of its contents and highlights the changes to current arrangements for Dorset County Hospital board members. NHS provider trust chairs are accountable for ensuring this Framework is implemented effectively and nominated senior individuals responsible for taking actions set out in the Framework. Priority actions are proposed to support local implementation of the new requirements.

Recommendations	The Trust Board is asked: a) to **NOTE** the report, and that further updates will be presented in due course leading up to full implementation of the new Framework by 31 March 2024. b) to NOTE that a series of additional data fields will be being added to the Electronic Staff Record (ESR),to support the Trust's implementation of the FPPT Framework and to standardise recording of checks across the NHS of

	information about Board member qualifications and career history. c) To confirm its *SUPPORT* for the proposed priority areas identified for local implementation of the new Framework d) to **RATIFY** the decision by the DCH/DHC Joint Executive Team that from the point of appointment, deputies should be included within the scope of the Fit and Proper Person Test Framework e) to **NOTE** that it is proposed that new DBS checks be undertaken for all existing board directors who have not had a DBS check in the previous 12 months. f) To **NOTE** the proposed ongoing assurance arrangements

Implementation of the new Fit & Proper Person Test Framework

Background and Context

1. The licence under which DCH operates as an NHS provider of services requires that the Trust "*must not appoint, or have in place, a person as a Director who is not fit and proper*".

2. 'Fit and proper' has been broadly defined in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 5 as being an individual:

   - of good character
   - with the qualifications, competence, skills and experience which are necessary for the relevant office or position or the work for which they are employed
   - who are able by reason of their health (after reasonable adjustments are made) of properly performing tasks which are intrinsic to the office or position for which they are appointed or to the work for which they are employed
   - who has not been responsible for, been privy to, contributed to or facilitated any serious misconduct or mismanagement (whether unlawful or not) in the course of carrying on a regulated activity or providing a service elsewhere which, if provided in England, would be a regulated activity

3. Examples of 'unfitness' are also defined in the legislation:

   - the person is an undischarged bankrupt or a person whose estate has had sequestration awarded in respect of it and who has not been discharged
   - the person is the subject of a bankruptcy restrictions order or an interim bankruptcy restrictions order or an order to like effect made in Scotland or Northern Ireland
   - the person is a person to whom a moratorium period under a debt relief order applies under Part VIIA (debt relief orders) of the Insolvency Act 1986
   - the person has made a composition or arrangement with, or granted a trust deed for, creditors and not been discharged in respect of it
   - the person is included in the children's barred list or the adults' barred list maintained under section 2 of the Safeguarding Vulnerable Groups Act 2006, or in any corresponding list maintained under an equivalent enactment in force in Scotland or Northern Ireland
   - the person is prohibited from holding the relevant office or position, or in the case of an individual from carrying on the regulated activity, by or under any enactment.

4. In 2018 Tom Kark QC and Jane Russell (Barrister) were commissioned by the Government to review the FPPT, with a widely held perception that the test under Regulation 5 was not working. The final report, issued in 2019, and having examined the failings at a number of NHS bodies, made seven recommendations. The recommendations covered a broad range of areas including: the competency of Board members, the recording of Board member information (e.g. qualifications and history), mandatory reference requirements for Directors, and powers to disbar Directors for serious misconduct.

5. Formal acceptance of the recommendations was delayed due to the desire to consult widely, and then the subsequent outbreak of the pandemic. When considered, five of the seven recommendations made were formally accepted, with the recommendations not accepted covering the power to disbar Directors and Senior

Managers for serious misconduct[1] and an examination of how FPPT works in social care.

6. On 2 August 2023, NHS England published its new FPPT Framework in response to the five recommendations that were accepted from the Kark review. The purpose of the Framework is to strengthen/reinforce individual accountability and transparency for board members, thereby enhancing the quality of leadership within the NHS.

7. The new Framework applies to all Board members–executive/non-executive/permanent/interim - and is designed to assess the appropriateness of an individual to discharge their duties effectively in their capacity as a Board member. The Framework also aims to help Board members build a portfolio to support and provide assurance that they are fit and proper, whilst preventing demonstrably unfit board members from moving between NHS organisations.

8. NHS Trust Chairs are now ultimately responsible and accountable for taking all reasonable steps to ensure that the new Framework is implemented effectively in their organisation, but there are also specific key roles for Chief Executives, Chief People Officers, and Company Secretaries.

9. NHSE regional directors are responsible for ensuring chairs of provider trusts/FTs and ICBs meet the requirements. The Framework (section 3.6) outlines the responsibilities of the chair. Chairs will be subject to the same FPPT requirement.

The New Fit and Proper Test Framework

10. The new Framework is effective from 30 September 2023 and NHS organisations are expected to use it for all new board level appointments or promotions and for annual assessments for all board members going forward from that date. In practice, NHSE expects that certain elements of the Framework should be used from 30 September 2023, with full implementation then required by 31 March 2024.

11. The new Framework, and supporting documentation, can be found at:

    https://www.england.nhs.uk/publication/nhs-england-fit-and-proper-person-test-framework-for-board-members/

12. The purpose of the new Framework is to strengthen individual accountability and transparency for board members, thereby enhancing the quality of leadership within the NHS.

13. Whilst the FPPT has was first introduced by the Care Quality Commission (CQC) in 2014, the Framework introduces new and more comprehensive requirements around Board appointments and annual review, going beyond what both DCH and other NHS organisations have been doing previously.

14. It is important to note that the Framework does not require any retrospective action and specifies that it is for all new board appointments or promotions and for future annual assessments.

15. The key changes are:

    - a new *standardised board member reference template* for references for all new appointments, with additional questions (relevant to FPPT). For board members who leave their position, organisations must complete and retain

[1] Recommendation 5 related to the establishment of a new independent body, with its powers including investigation, judgement and sanction. This recommendation is "not being progressed at this time"

locally the new member reference, whether or not the reference has been requested by the prospective employer.

- Updates in the NHS *Electronic Staff Record* (ESR) will be made in order store relevant information related to FPPT checks and references, providing a standardised approach to recording, testing and enabling internal compliance reporting

- An *NHS Leadership Competency Framework* will provide guidance for the competence categories against which a board member should be appointed, developed, and appraised

- a *full FPPT review* will be undertaken, against the core elements of the new Framework, whenever new Board appointments are made (including if a Board member moves to a new role in their current organisation, and annually thereafter

- The *annual assessment* needs to be in line with the FPPT checklist, which is set out at appendix 7 of the Framework, so all NHS organisations are required to ensure that they are fully familiar with this document.

- *annual self-attestations* by Board members to confirm adherence to the regulations will continue.

- for *joint appointments*, checks will be undertaken by the host/employing organisation and confirmed to the other contracting organisations (for Board roles filled by two individual - in essence, job shares – both individuals will need to be assessed).

- The duty to *store information* relevant to the annual assessment (as set out in the checklist) will apply to existing directors (as they will have to comply with the assessment each year) and not only new appointees/promotions.

16. Section 3.1 of the Framework contains three flowcharts on suggested approaches to the assessment, including the board member reference process. The flowchart that illustrates the main process is shown below in Annex 1.

Scope

17. The Framework applies to executive and non-executive directors of integrated care boards (ICBs), NHS Trust and Foundation trusts, NHS England and the CQC, interim as well as permanent appointments where greater then six weeks and those who are called “directors” within Regulation 5. This is irrespective of voting rights on the Board or contractual terms.

18. There is flexibility within the Framework for Trusts to extend its scope to cover other senior managerial positions for example, to those who regularly attend board meetings or otherwise have significant influence on board decisions.

19. Deputies are specifically included within the scope of the Framework if they act up to cover a board members role for a period of six weeks or more. Following recent discussion, the Joint Executive Team have determined that for the avoidance of doubt, that it would be prudent for both DCH and DHC to include deputies (from the point of appointment) within the scope of managing the implementation of the Framework.

20. The annual submission requirement is however limited to board members only.

Local implementation of the new FPPT Framework

21. The immediate steps for implementation of the new approach include:

- To inform Board members – by virtue of this paper – that new data points are being added to the Electronic Staff Record system, which will record the testing of relevant information about Board member qualifications and career history. Board members are asked to highlight any specific concerns in relation to this, noting that the data will be managed and controlled in the same way as the existing data that has been collected.

- From 30 September 2023, appointment processes for board members will be in line with the Framework to ensure that potential appointees have demonstrated they have met the FPPT requirements. The Chief People Officer and Director of Corporate Governance will review and revise current arrangements

- From 30 September 2023, apply the new standardised Board member reference template in relation to taking up references for all new Board appointments

- From 30 September 2023, complete and retain locally the new standardised board member reference for any board member who leaves their position for whatever reason and record whether or not a reference has been requested. This is regardless of whether they are moving immediately to another NHS role. This responsibility will sit with the Trust.

- New data fields in ESR will be used to store information related to FPPT checks and references, in line with the criteria detailed in the Framework. This will provide a standard way to record and report compliance internally. The Associate Director of Corporate Governance will hold responsibility for collating the information in an accurate, complete, and timely manner for updating on ESR on behalf of the Trust Chair. Appropriate system testing for readiness will be carried out. The retrospective population of data is not however being proposed.

22. The identified ongoing work towards ensuring full compliance with all remaining aspects of the Framework by 31 March 2024, include:

- The development of an FPPT project implementation plan outlining the actions to be taken and the associated timescales in order to provide a coordinated approach between the Chief People Officer and Director of Corporate Governance across both DCH and DHC organisations.

- A new standardised Fit and Proper Person Policy and/or Standing Operating Procedure (SOP), incorporating the recommendations from this paper is also currently being developed to ensure each Trust has robust processes in place to adequately perform FPPT assessments, and to adhere to the requirements of Regulation 5. This document will be presented in due course to the respective DCH/DCH Trust Boards for formal approval.

- The establishment of a time limited, joint task and finish group to ensure the required pace and oversight for the implementation of the Framework. This group will be accountable to the DCH/DHC Joint Executive Team with periodic assurance provided to the respective Audit Committees.

- Ensuring that the related principles and values that underpin the Framework and provide additional context to understand the aims are incorporated into our existing Board Development programme, and cover: the NHS Constitution, the seven NHS guiding principles, the core NHS values and the Nolan Principles of Standards in Public Life.

Support to be Provided by NHS England

23. NHSE has committed to providing a range of support for organisations to help effectively implement and embed the new approach, including:

    - Provision of a suite of supporting documentation, covering FPPT checklist, guidance for Chairs, guidance on completing the Board member references, annual self-attestation template, letter of confirmation, annual submission reporting template (available now).

    - A new suite of Board level learning and development opportunities (available now)

    - A new NHS Leadership Competency Framework (LCF) for Board level roles (originally expected to be published before the end of September 2023)

    - A new Board appraisal framework which will be used for the appraisal of all Board Directors for 2023/24 (March 2024)

Link to the Verdict in the Trial of Lucy Letby

24. Although the actions required in response to the verdict in the trial of Lucy Letby are broad – covering, for example, culture and Freedom to Speak-Up, NHSE in their letter of 18 August 2023 took the opportunity to remind all NHS organisations of their obligations under the Fit and Proper Person requirements "*not to appoint any individual as a Board director unless they fully satisfy all FPPT requirements – including that they have not been responsible for, been privy to, contributed to, or facilitated any serious misconduct or mismanagement (whether lawful or not)*".

Governance and Assurance

25. The following governance arrangements have been adopted to date in order to raise the awareness and understanding of the Framework requirements:

Meeting/Committee	Trust	Date of meeting
Joint Executive meeting	Joint	18th September
People & Culture Committee	DCH	18th September
Board Meeting	DCH	27th September
Board Meeting	DHC	4th October
Council of Governors meeting	DHC	31st October
Council of Governors meeting	DCH	13 November

26. Whilst we are still in the process of working out some of the finer operational processes and procedures that will be included in the proposed Fit and Propre Person Test Policy and/or SOP, we are in the spirit of openness and transparency in a position to confirm at this stage that the following robust assurance arrangements will be put in place:

- an annual report of FPPT compliance is presented to the Trust Board and Council of Governors, and that these reports will be diarised in the relevant Committee workplans
- that following presentation at the Trust Board and Council of Governors, the high-level outcomes of the FPPT assessments will be included in the annual report and on the Publications page of the Trust website.
- that the FPPT processes, controls and compliance supporting the FPPT assessments are subject to review by internal audit every three years
- that the specification for any future commissioned well-led or board effectiveness review should include the FPPT process and testing.

Conclusion

27. The new Framework introduces a means of retaining information relating to testing the requirements of the FPPT for individual Directors, a set of standard competencies for all Board directors, and a new way of completing references with additional content whenever a Director leaves an NHS Board.

28. Aside from a number of specific requirements to be implemented from 30 September 2023 onwards, there will be some detailed work for the Trust to undertake in order to ensure full implementation and compliance. This is likely to require some new or revised processes.

Recommendations

29. The Trust Board is asked:

g) to **NOTE** the report, and that further updates will be presented in due course leading up to full implementation of the new Framework by 31 March 2024.

h) to **NOTE** that a series of additional data fields will be being added to the Electronic Staff Record (ESR),to support the Trust's implementation of the FPPT Framework and to standardise recording of checks across the NHS of information about Board member qualifications and career history.

i) To confirm its **SUPPORT** for the proposed priority areas identified for local implementation of the new Framework

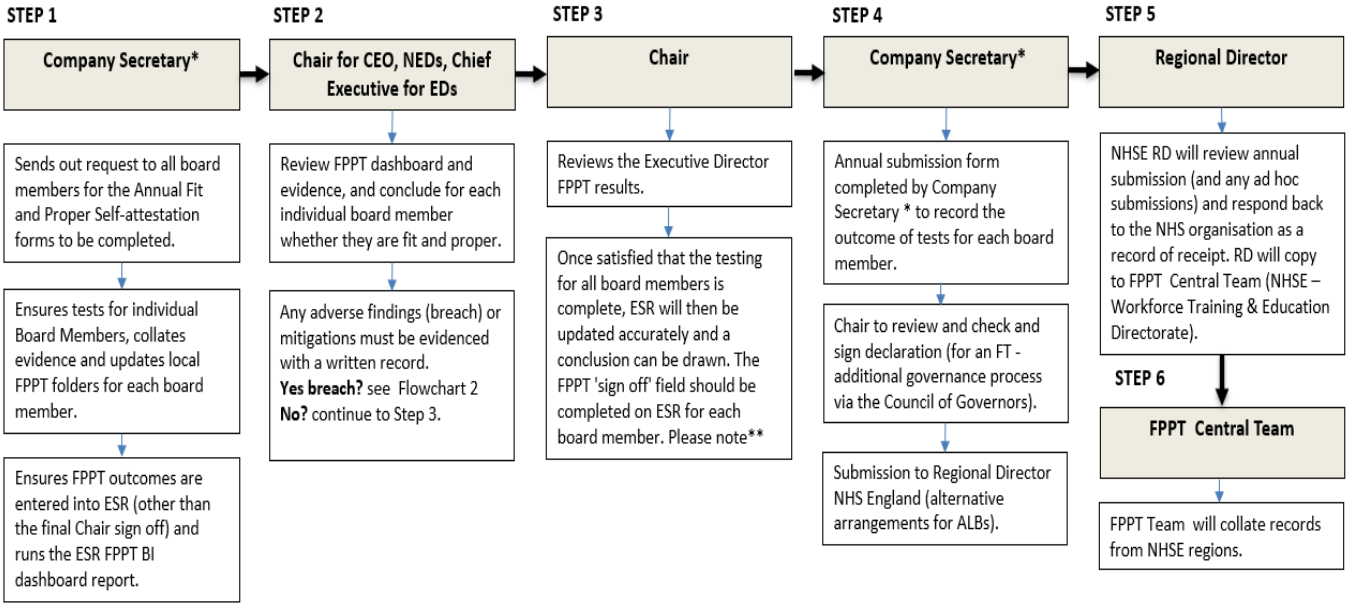
j) to **RATIFY** the decision by the DCH/DHC Joint Executive Team that from the point of appointment, deputies should be included within the scope of the Fit and Proper Person Test Framework

k) to **NOTE** that it is proposed that new DBS checks be undertaken for all existing board directors who have not had a DBS check in the previous 12 months.

l) To **NOTE** the proposed ongoing assurance arrangements.

Appendix 1

Fit and Proper Person Test – Implementation Flow Chart



*Or senior member of staff nominated by and behalf of, the Chair, eg HRD
** SID/Deputy Chair to carry out FPPT on the Chair and 'sign off'
SID = Senior Independent Director
ESR= Electronic Staff Record

Learning from Deaths Report Q1 2023/24

1. Report Details			
Meeting Title:	Board of Directors, Part 1		
Date of Meeting:	27 September 2023		
Document Title:	Learning from Deaths Q1 2023/24		
Responsible Director:	Prof Alastair Hutchison	Date of Executive Approval	
Author:	Prof Alastair Hutchison		
Confidentiality:	No		
Publishable under FOI?	Yes		
Predetermined Report Format?	No. However formatted in line with SW Regional guidance. Breadth of data presented is recognised as an exemplar within SW Region.		

2. Prior Discussion		
Job Title or Meeting Title	**Date**	**Recommendations/Comments**
Hospital Mortality Group	16th August 2023	Accepted
Quality Committee	18th August 2023	

3. Purpose of the Paper	To inform the Quality Committee of the learning occurring from deaths being reported, investigated and appropriate findings disseminated throughout the Trust. To also outline additional measures put in place to assure the Trust that unnecessary deaths are not occurring at DCH despite the elevated SHMI. Presentation of the Learning from Deaths report at Quality Committee and Trust Board is a mandatory obligation for all Trusts.							
	Note (✓)		*Discuss (✓)*		*Recommend*		*Approve (✓)*	
4. Key Issues	The latest published SHMI data (5 months in arrears) for DCH was within the 'Expected Range' for the rolling 12 months to January and February 2023, but fractionally above the range for March 2023 (1.1355 vs 1.1328; page 7). No other local or national indicators suggest excess unexpected deaths are occurring at DCH, but SW Region acting through Dorset ICS, are seeking additional assurance from an external audit of Structured Judgment Reviews (SJRs). SJRs are used to examine the care of a significant sample of people who died whilst in-patients (around 20% vs national standard of 10%), and to learn from any good practice or lapses in care identified. Industrial action has caused delays to these processes. The independent DCH Medical Examiners review every death, speak to immediate relatives and highlight any obvious causes for concern. Prof Hutchison commenced an internal SJR audit during June 2023, of 50 consecutive deaths occurring in September 2022 to look for unexpected events, and report to the quality Committee separately as soon as this is complete. This will be independently reviewed by Dr. Sean Weaver under the auspices of SW Region & Dorset ICB.							
5. Action recommended	The Quality Committee is recommended to: 1. **DISCUSS and NOTE** the findings of the report 2. **DISCUSS** the additional scrutiny occurring 3. **APPROVE** the report and escalate to Trust Board							

6. Governance and Compliance Obligations			
Legal / Regulatory Link	**Yes**		Learning from the care provided to patients who die is a key part of clinical governance and quality improvement work (CQC 2016). Publication on a quarterly basis is a regulatory requirement.
Impact on CQC Standards	**Yes**		An elevated SHMI will raise concerns with NHS E&I and the CQC. The previous reduction in SHMI and improvements in coding are acknowledged, and the overall trend in DCH's SHMI is favourable.
Risk Link	**Yes**		• Reputational risk due to higher than expected SHMI

				• Poor data quality can result in poor engagement from clinicians, impairing the Trust's ability to undertake quality improvement • Clinical coding data quality is improving, but previously adversely affected the Trust's ability to assess quality of care • Clinical safety issues may be under-reported or unnoticed if data quality is poor Other mortality data sources (primarily from national audits) are regularly checked for any evidence of unexpected deaths.
Impact on Social Value			**No**	If yes, please summarise how your report contributes to the Trust's Social Value Pledge
Trust Strategy Link		**How does this report link to the Trust's Strategic Objectives?**		
Strategic Objectives	People	N/A		
	Place	Health inequalities related to 'Place' are well known to impact life expectancy and will be referenced in future reports.		
	Partnership	N/A		
Dorset Integrated Care System (ICS) goals		**Which Dorset ICS goal does this report link to / support?** Understanding and reducing health inequalities		
Improving population health and healthcare			**No**	
Tackling unequal outcomes and access		**Yes**		Health inequalities related to 'Place' are well known to impact life expectancy and will be referenced in future reports.
Enhancing productivity and value for money			**No**	
Helping the NHS to support broader social and economic development			**No**	
Assessments		**Have these assessments been completed?** *If yes, please include the assessment in the appendix to the report..* *If no, please state the reason in the comment box below.* *(Please delete as appropriate)*		
Equality Impact Assessment (EIA)			**No**	Not applicable
Quality Impact Assessment (QIA)			**No**	Not applicable

CONTENTS

1.0 DIVISIONAL LEARNING FROM DEATHS REPORTS

Each Division is asked to submit a quarterly report outlining the number of in-patient deaths, the number subjected to SJR, and the outcomes in terms of assessment and learning.

1.1 Family Services and Surgical Division Report - Quarter 1 2022/23 Report

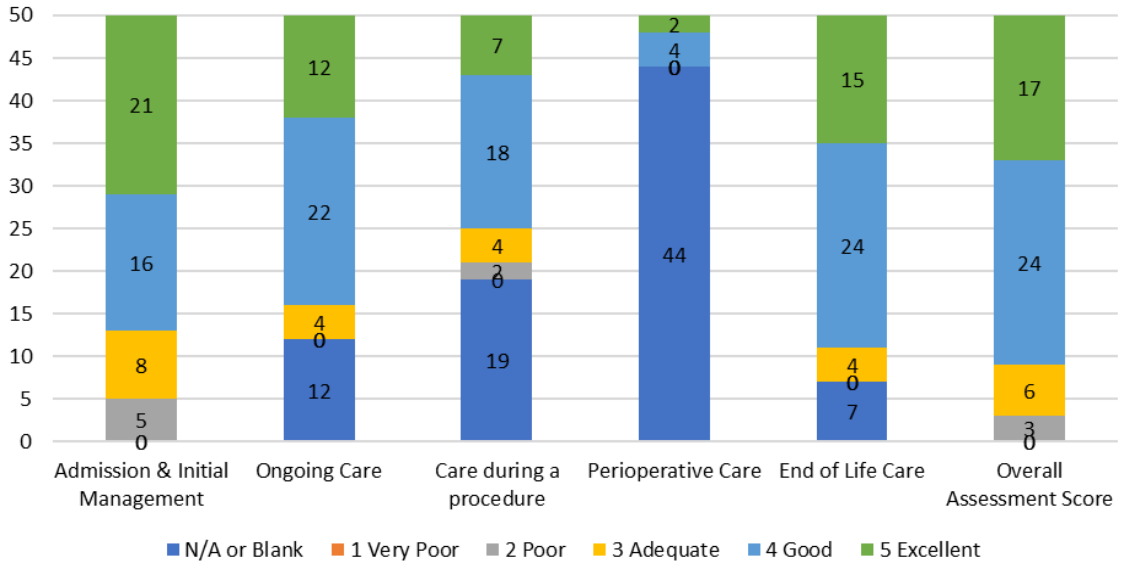
Structured Judgement Review Results: The Family Services & Division had 37 deaths in quarter 1, of which 35 that require SJR's to be completed. Of these 21 have had a SJR completed. Within quarter 1 an additional 29 SJR's have also been completed from previous months.

Outstanding SJR's: The Division have completed a number of SJR's from previous quarters. The backlog of outstanding SJR's (over 2 months) for the Division as at 25/07/2023 is 15:

October	December	February 23	March	April	May
2	1	1	7	3	1

Feedback from SJR's Completed in Quarter 1:

Phase Score	Admission & Initial Management	Ongoing Care	Care during a procedure	Perioperative Care	End of Life Care	Overall Assessment Score
N/A or Blank	0	12	19	44	7	0
1 Very Poor	0	0	0	0	0	0
2 Poor	5	0	2	0	0	3
3 Adequate	8	4	4	0	4	6
4 Good	16	22	18	4	24	24
5 Excellent	21	12	7	2	15	17



Overall Quality of Patient Record:

Blank	Score 1 Very poor	Score 2 Poor	Score 3 Adequate	Score 4 Good	Score 5 Excellent
2	0	3	5	27	13

- Documentation re: cancer diagnosis not absolutely clear in the notes (although pt was apparently aware.) Otherwise good documentation.
- Missing ED notes.
- ED printed notes very difficult to follow (34 pages).
- Full ERCP report – well written.
- Excellent documentation throughout admission to palliation.
- Unsure whether there are notes missing. Nothing available for review pre-ICU referral.
- No Consultant documentation or written that they were involved in any decision making until next morning – discuss at Clinical Governance Meeting.
- Overall good documentation of daily patient condition/assessment and plan of care. A little difficult to establish exact time line of first and second intubations, ? wrong date written on one piece of documentation making it slightly difficult to follow.
- Record was good but notes loose and in wrong order. Writing sometimes difficult to read.

Avoidability of Death Judgement Score:

Score 1 Definitely avoidable	**Score 2** Strong evidence of avoidability	**Score 3** Probably avoidable (more than 50:50)	**Score 4** Possibly avoidable but not very likely (less than 50:50)	**Score 5** Slight evidence of avoidability	**Score 6** Definitely not avoidable
0	1*	0	2	8	39

*This case resulted from a known complication of a necessary gastroscopy in a frail elderly patient. The case and SJR findings have been referred to the Coroner for an Inquest.

Emerging Themes:

1. Poor surgical clerkings which seem to be deteriorating rather than improving – referred to Mr Ng, General Surgery & Colorectal Clinical Governance & M&M Lead, for surgical review.
2. Delay in decision making on admission to ICU regarding TEP – for discussion at Clinical Governance Meeting (CGM).
3. Delay in obtaining central venous access – for discussion at CGM.
4. Failed attempts for invasive lines and procedures should be documented – for discussion at CGM and Newsletter inclusion.
5. Unclear ICU referrals and timings – for discussion at CGM.

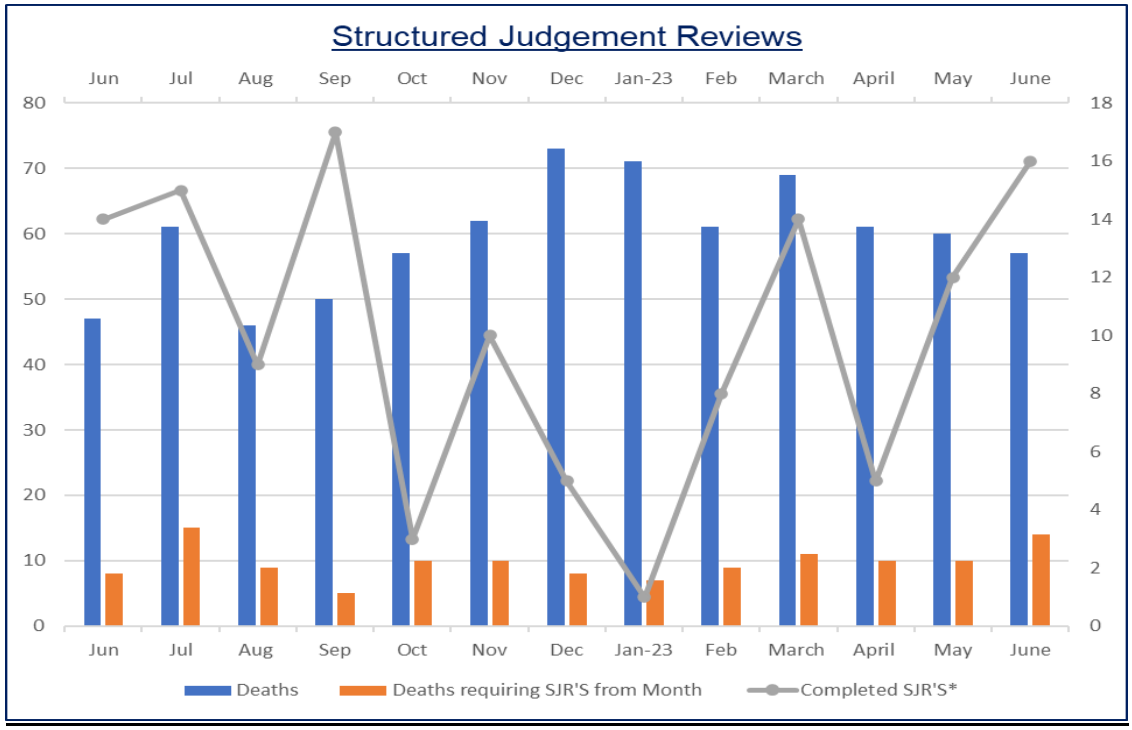
Report completed by: Richard Jee – Divisional Mortality Lead
Laura Symes – Quality Manager

1.2 Division of Urgent & Integrated Care – Quarter 1 Report

Structured Judgement Reviews: In quarter 1 there were 178 deaths, 34 SJR's requested from these deaths and 33 SJR's were completed in total (completed SJR's not necessarily from this quarter).

	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan-23	Feb	March	April	May	June	Total YTD
Deaths	47	61	46	50	57	62	73	71	61	69	61	60	57	178
Deaths requiring SJR'S from Month	8	15	9	5	10	10	8	7	9	11	10	10	14	34
Completed SJR'S*	14	15	9	17	3	10	5	1	8	14	5	12	16	33

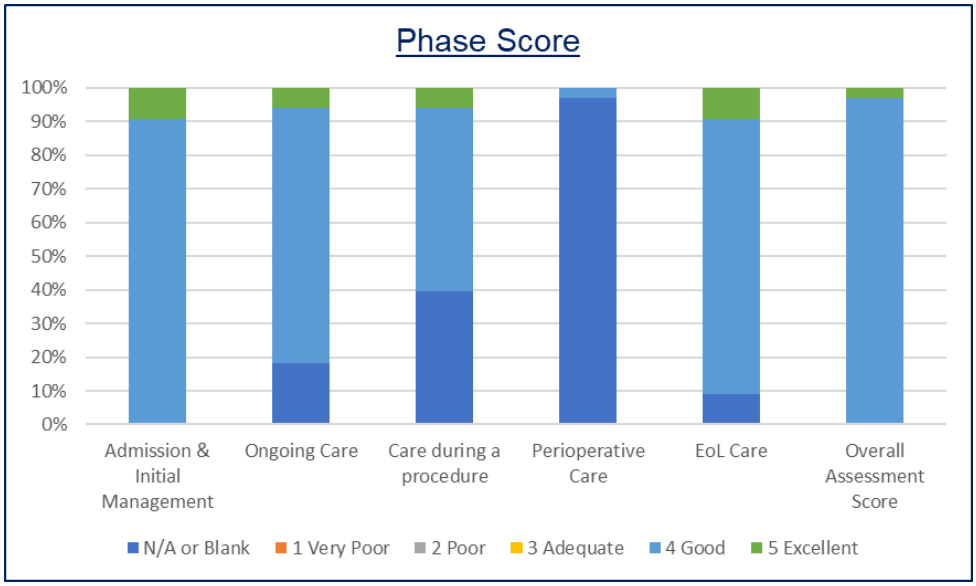
Total outstanding SJR's (not including allocated) = **40**
Outstanding SJR's >2 months = **13**



Nosocomial SJR Requests: 18 Nosocomial deaths (17/10/2021 – 30/04/2022), 8 reviewed by James Metcalf, 10 to review with Emma Hoyle **– Meeting in July cancelled – To be re-scheduled**

Phase score from 24 completed SJR's in Quarter 1:

Phase Score	Admission & Initial Management	Ongoing Care	Care during a procedure	Perioperative Care	EoL Care	Overall Assessment Score
N/A or Blank	0	6	13	32	3	0
1 Very Poor	0	0	0	0	0	0
2 Poor	0	0	0	0	0	0
3 Adequate	0	0	0	0	0	0
4 Good	30	25	18	1	27	32
5 Excellent	3	2	2	0	3	1



Overall quality of patient record

Blank	Score 1 Very Poor	Score 2 Poor	Score 3 Adequate	Score 4 Good	Score 5 Excellent
0	0	0	0	31	2

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

Avoidability of Death Judgement Score

Score 1 Definitely avoidable	Score 2 Strong evidence of avoidability	Score 3 Probably avoidable (> 50:50)	Score 4 Possibly avoidable but not very likely (<50:50)	Score 5 Slight evidence of avoidability	Score 6 Definitely not avoidable
0	0	0	0	1	32

Morbidity and Mortality Meeting Actions/Feedback Highlights

Good Practice

Elderly Care & Stroke:
- Prompt senior review
- Good MDT input
- Good involvement of patient's family with decision making
- Good involvement of Palliative Care Team

Cardiology:
- Good documentation
- Good family discussion and EOLCP put in place
- Early specialty review
- Excellent cardiology care regarding HF, AF and pericardial effusion management
- Timely and appropriate relevant referrals and work up were arranged

Diabetes:
- Good communication with patient and family
- Palliative care involved early and supported fast-track discharge planning
- Regular reviews by MDT

Respiratory:
- Good documentation, prompt medical reviews and appropriate second opinions sought

Actions/Areas for Improvement/Learning from review at M+M:

Elderly Care & Stroke:

- Haloperidol should not be continued after discharge from hospital, unless directed and closely monitored by the Community Mental Health Team (CMHT).
    - Haloperidol can cause significant sedation. Highlight this with Pharmacy – should have been recognised at discharge.

Cardiology (No actions identified in Minutes):

- Documentation from on-call team could be clearer
- Not discussed with on call cons/RBH re ST elevation but likely too unwell to transfer
- Should have clearer documentation as to why ECHO not requested/done (had one 1 week prior to admission)
- Was patient appropriate for specialised cardiac ward or would she have been managed better/discharge planning been implemented sooner on a ward that deals with complex discharges more?

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

2.0 NATIONAL MORTALITY METRICS AND CODING ISSUES

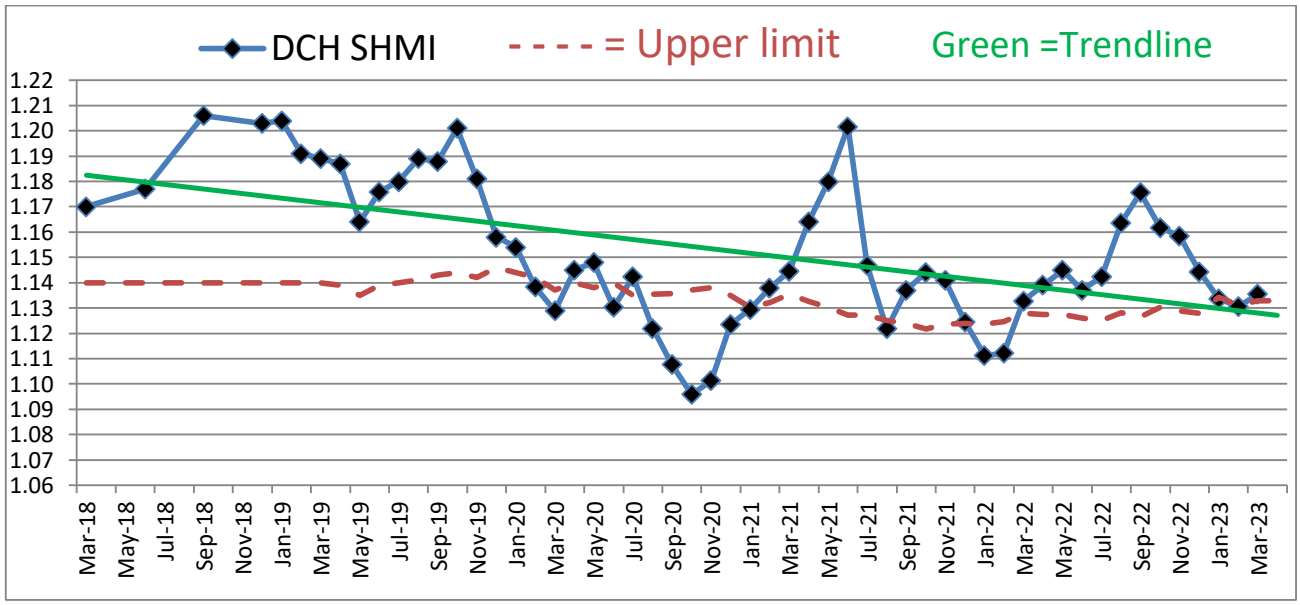
2.1 Summary Hospital-level Mortality Indicator (SHMI)

SHMI is published by NHS Digital for a 12 month rolling period, and 5 months in arrears. It takes into account all diagnostic groups, in-hospital deaths, and deaths occurring within 30 days of discharge.

The most recently published data for the rolling 12 months to January and February was within the 'expected range', with March 2023 rising to just outside the range. We are aware that our data continues to be adversely influenced by short staffing/difficulty recruiting to two posts in the Coding Department, and a possible under-reporting of 'sepsis' in the written medical record.

Victoria Stevens (Clinical Coding Dept. Manager) reports that the Clinical Coding Department cleared the coding backlog prior to the final deadline for annual HES data submission, but the IT company responsible for uploading the submission failed to meet the deadline for data from DCH and 26 other Trusts. This is likely to continue to adversely influence the accuracy of DCH's SHMI data, until it is incorporated into the publication from November onwards. Once the qualified and trainee coders are integrated and fully contributing to the work of the Clinical Coding team, DCH will have a robust team that provides a timely service of high quality.

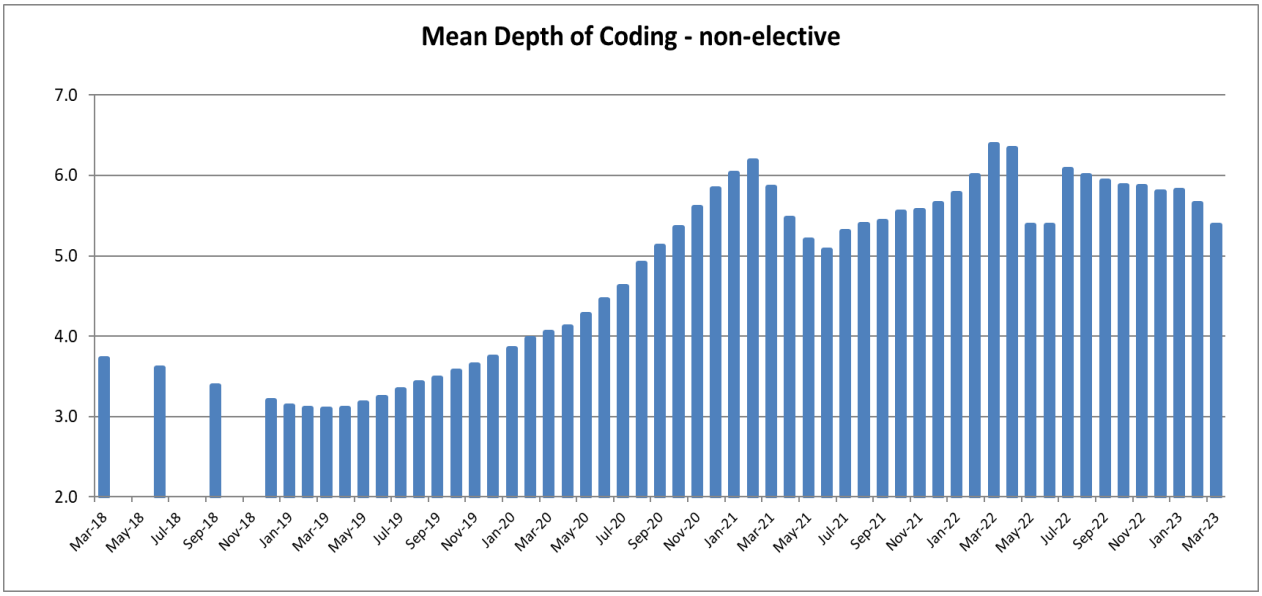
The latest published SHMI (rolling year to March 2023) is shown below:



SHMI is calculated by comparing the number of observed (actual) deaths in a rolling 12 month period to the expected deaths (predicted from coding of all admissions). From October 2019 onwards there had been a steady trend of improvement in DCH's SHMI associated with focus on SJRs, M&M meetings and a full Medical Examiner service, plus investment in the coding department which will result in more accurate coding returns to NHS Digital.

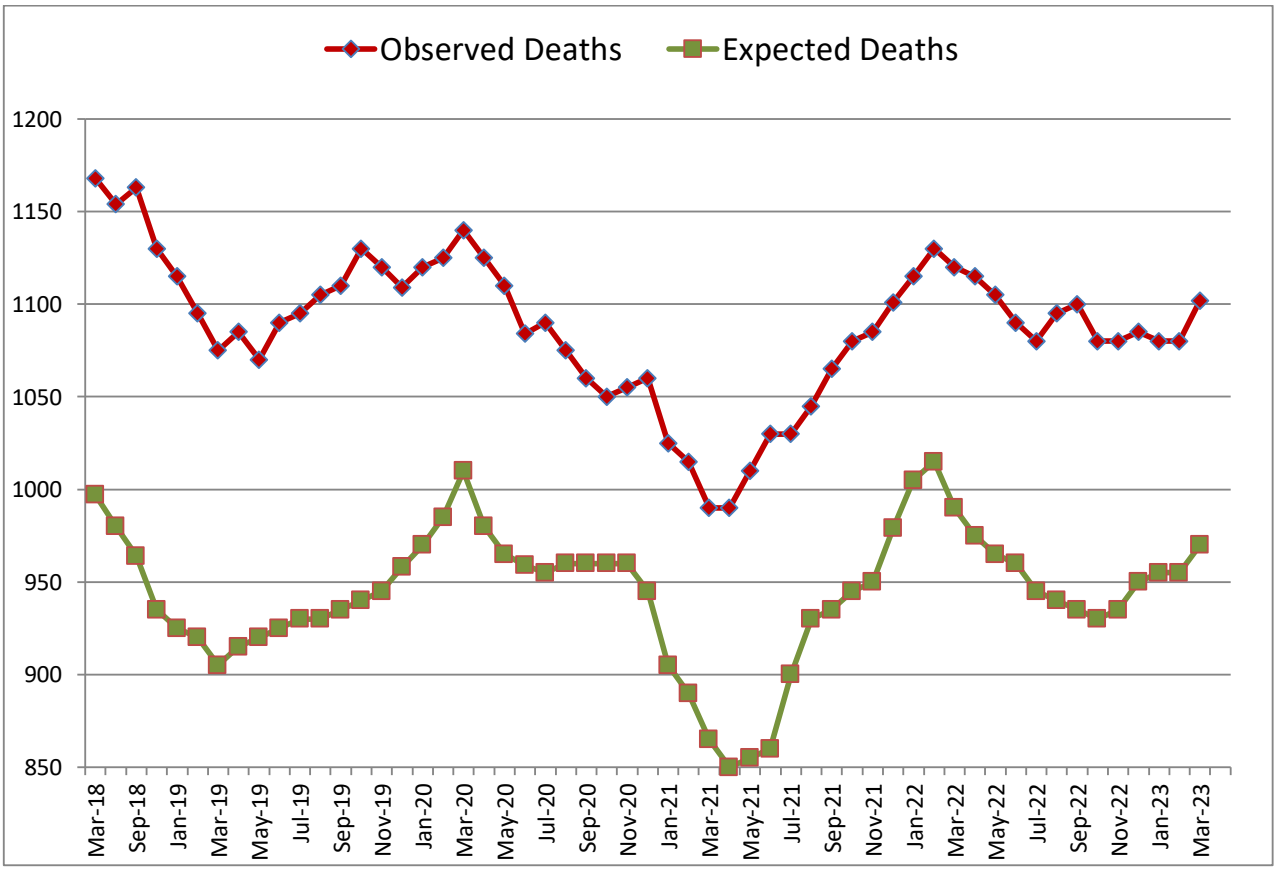
2.2 Depth of coding: NHS Digital states "*As well as information on the main condition the patient is in hospital for (the primary diagnosis), the SHMI data contain up to 19 secondary diagnosis codes for other conditions the patient is suffering from. This information is used to calculate the expected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

DCH's depth of coding had been improving steadily up to March 2022 (see graph below), but the most recently reported months show a tendency to decrease. This may partially explain the recent reduction in 'Expected Deaths' and consequent rise in SHMI. All data points represent 12 months of data.



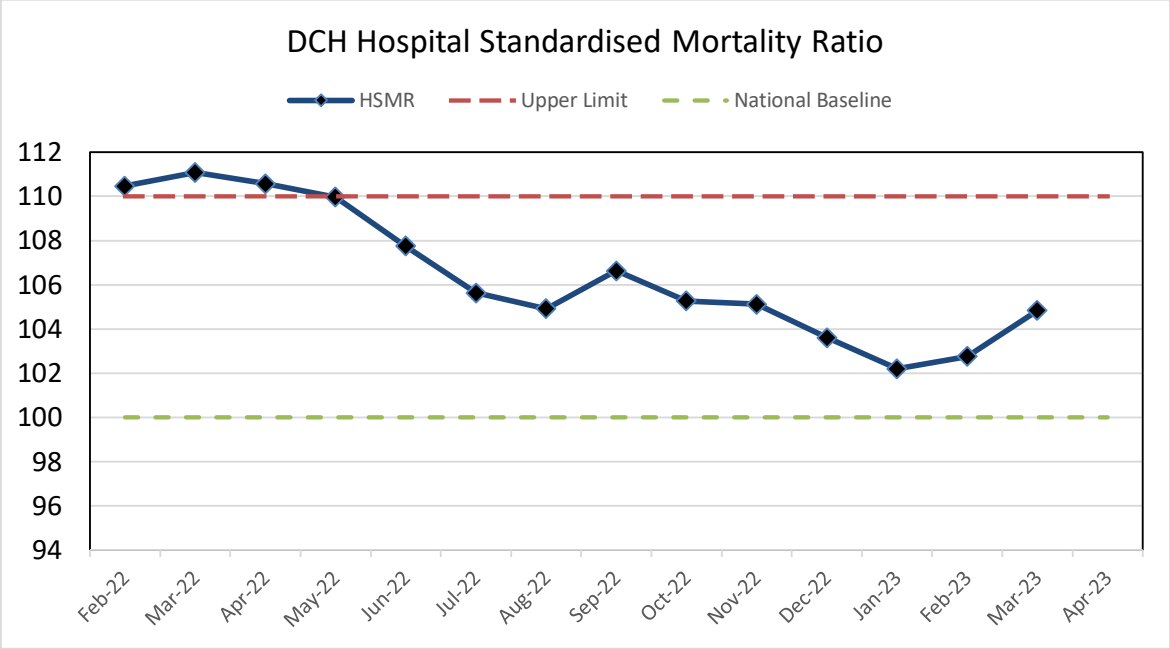
2.3 Expected Deaths (based on diagnoses across all admissions (except covid) per rolling 12 months):

The chart below shows observed (actual) and expected (calculated by NHS Digital) deaths over the past 4+ years (rolling years from March 18 to March 23), the numbers of which are directly influenced by the number of in-patients, particularly during and immediately after the covid-19 pandemic. Whilst both observed and expected deaths tended to decrease over the 7 months to October 22 (as the total number of in-patients has tended to decrease), the expected deaths have recently increased back to their average of around 950 per 12 months.

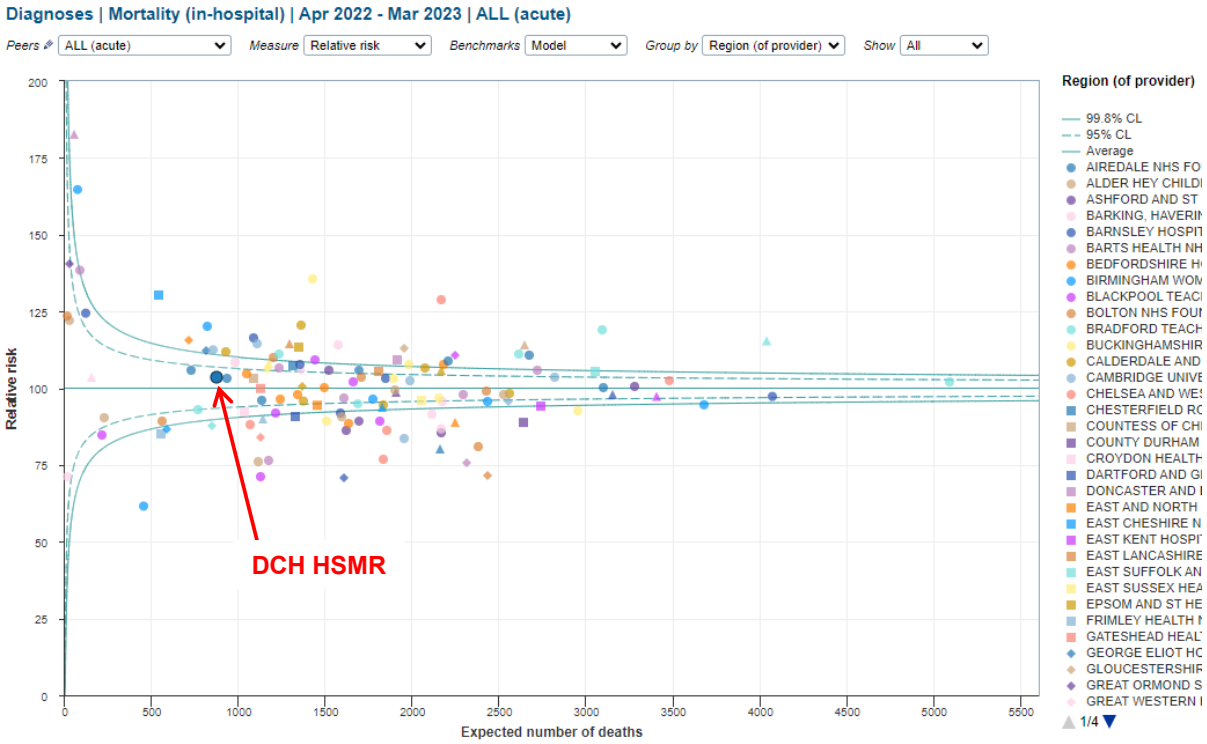


2.4 Hospital Standardised Mortality Ratio (HSMR): After discussions with Dr. Alyson O'Donnell (ICS Deputy CMO) and Dr. Sean Weaver (UHD Mortality lead) it was suggested that this report should include the latest HSMR figures. HSMR is a similar metric to, and was the forerunner of, SHMI. It differs in that it only includes the 56 most common in-patient diagnoses and does not include any deaths occurring after discharge from hospital. It is

calculated by a private provider – Telstra Healthcare. The upper limit of the 'expected range' for HSMR varies but for this retrospective data is approximately 110.0 and therefore DCH's HSMR is well within the expected range. Correlation between SHMI and HSMR is poor – so for example Somerset NHS FT's SHMI is excellent at 0.988 but HSMR is very high at 121.6 which has resulted in questions about its general validity.



The currently available 'all acute NHS Trusts' comparative HSMR data is for the rolling year to March 2023, shown below. 43 Trusts have higher HSMRs than DCH.



3.0 OTHER NATIONAL AUDITS/INDICATORS OF CARE

The DCH Learning from Deaths Mortality Group continues to meet on a monthly basis to examine any other data which might indicate changes in standards of care. The following sections report data available from various national

bodies which report on Trusts' individual performance. However much of this data was interrupted by covid-19 and is gradually catching up again.

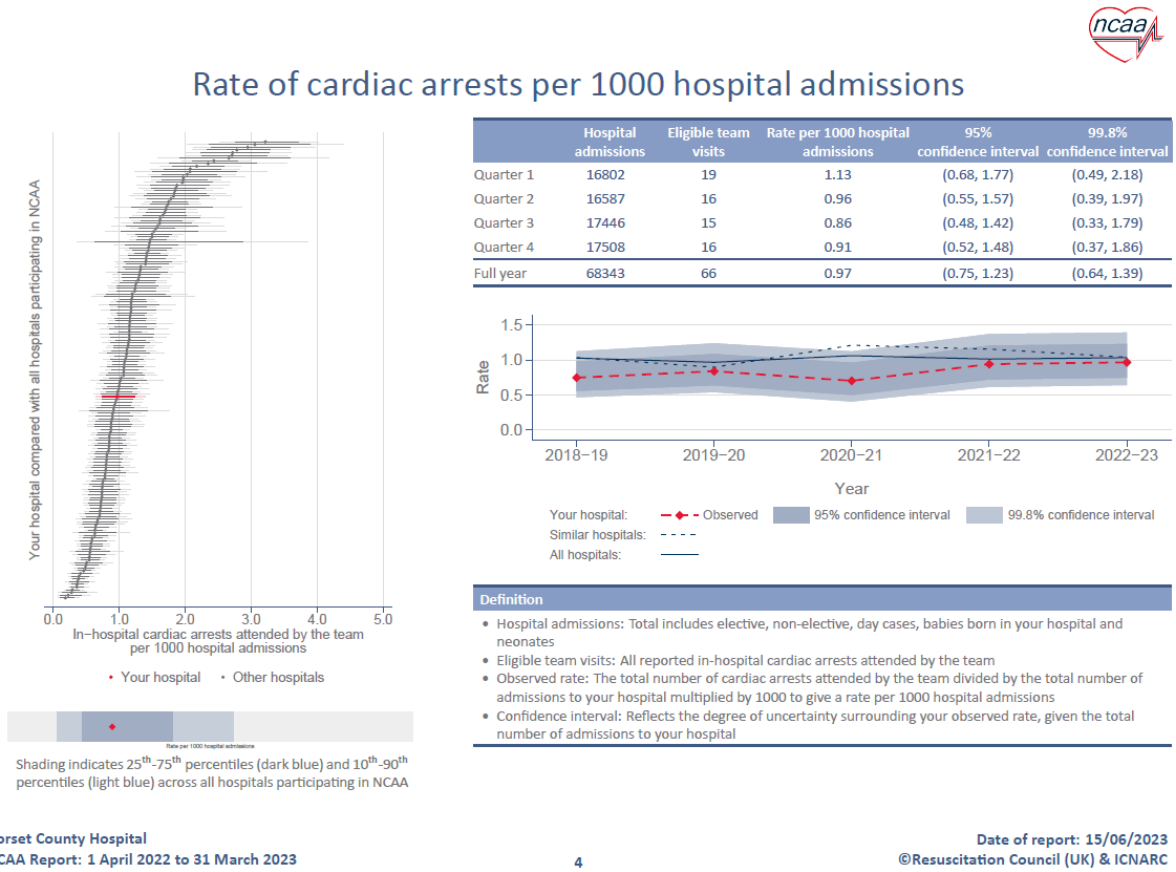
For other metrics of care including complaints responses, sepsis data, AKI, patient deterioration and DNACPR data and VTE assessment data please see the Quality Report presented on a monthly basis to Quality Committee by the Chief Nursing Officer.

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

3.1 NCAA Cardiac Arrest data

The national Cardiac Arrest audit for DCH including data from April 2022 to March 2023 (quarters 1, 2, 3 and 4) was published on 15/06/2023. Frequent cardiac arrest calls suggest unanticipated deteriorations in a patient's condition, whereas fewer calls suggest higher standards of ward care, although this is unproven. A total of 66 cardiac arrest calls were recorded for this 12 month period, but not all were definite cardiac events since the cardiac arrest call is also used for any serious or unexpected patient event.

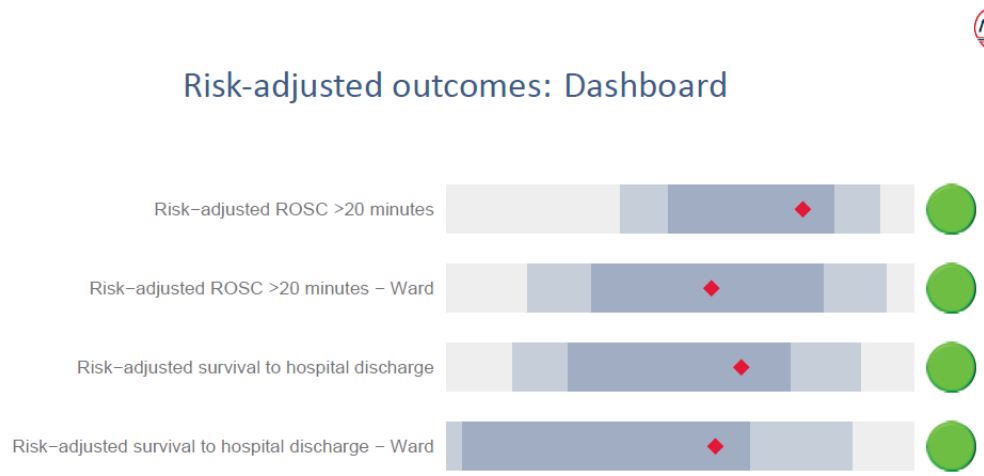
The graph below (left) represents the number of in-hospital cardiac arrest calls attended by the team per 1,000 admissions for all adult, acute care hospitals in the NCA Audit. DCH is indicated in red, and lower on the chart is better. The table to the right gives more detail by quarter year, and the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



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

a) Time to 'Return of Spontaneous Circulation' (a measure of resuscitation effectiveness) and
b) Survival to Discharge.

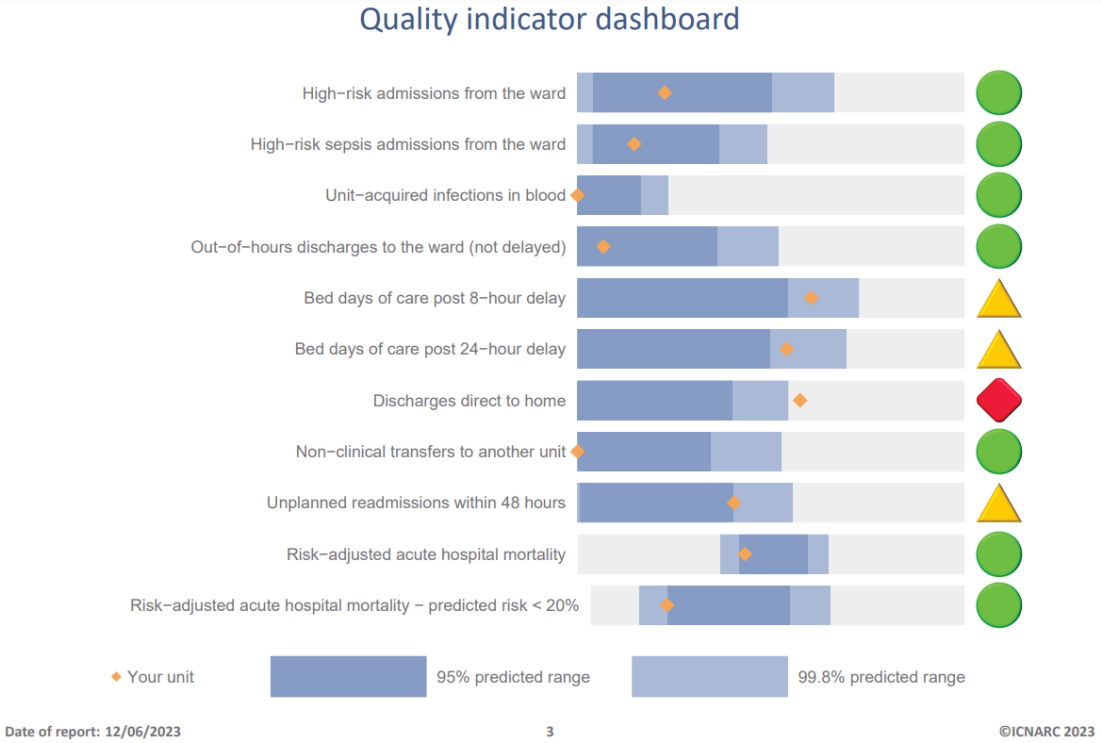
These and all other measures in the report get a 'green' indicator for the most recently reported Quarters 1 - 4 (2022/23). The good rate of survival to discharge is notable.



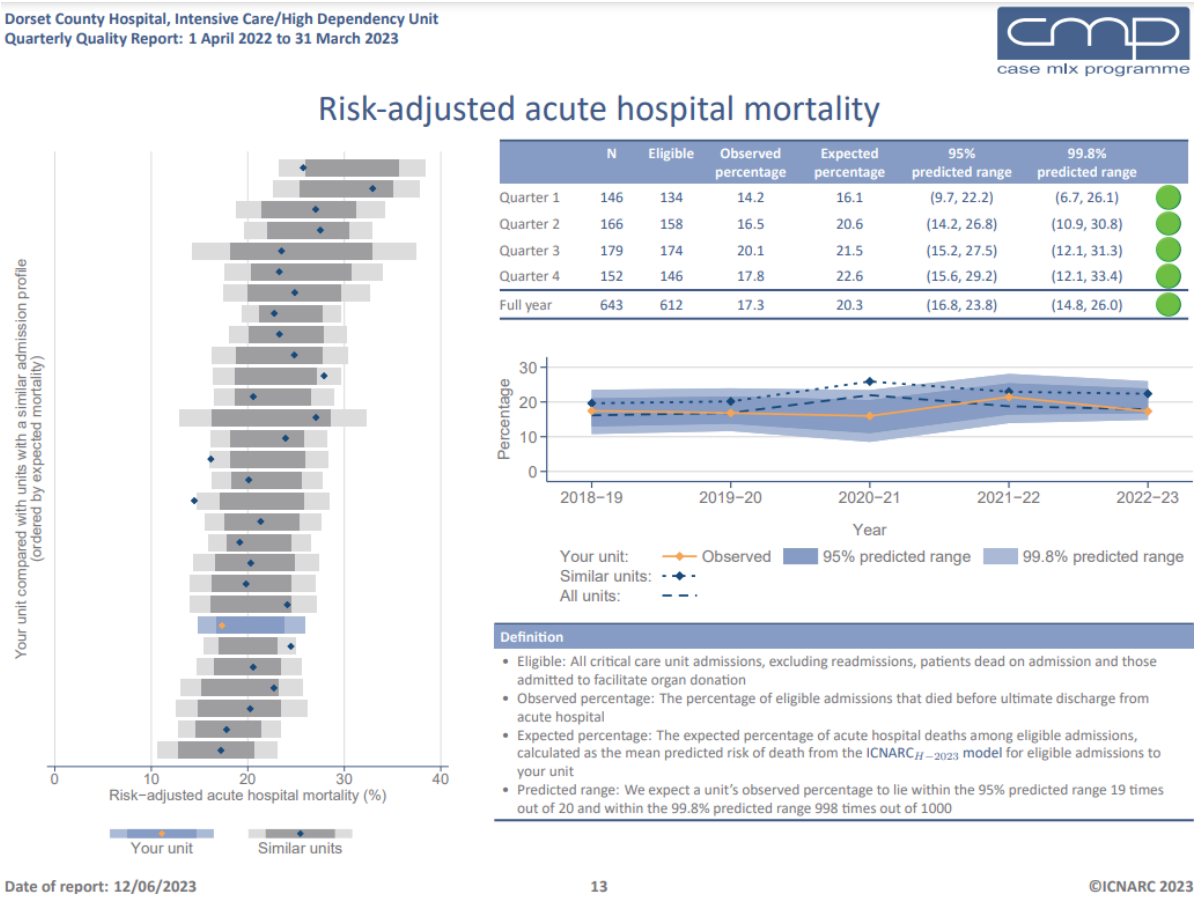
3.2 National Adult Community Acquired Pneumonia Audit latest data – last published Nov 2019 (see below), and not undertaken for either 2019/20 or 2020/21. Data collection restarted in Spring 2022 for publication in Summer this year.

3.3 ICNARC Intensive Care survival data for financial year 2022/23; published 12/06/2023; n = 612 patients.

The amber and red indicators in the chart below indicate delays in being able to discharge patients from ICU, with some delays being long enough that the patient was discharged direct to home (red indicator). This is an indication of DCH bed pressures. Unplanned readmissions for the year were just above the expected range.



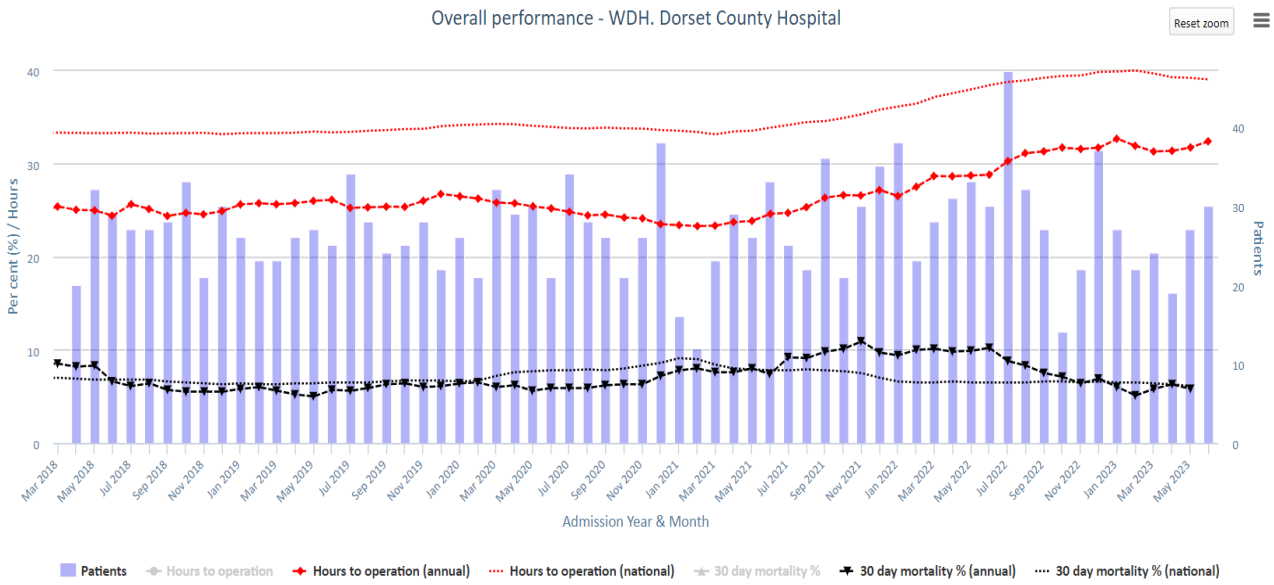
The charts below show the "risk-adjusted acute hospital mortality" following admission to the DCH Critical Care Unit in Q1 – Q4 2022/23. They compare observed and expected death rates in a similar fashion to SHMI, with expected deaths of 124 but actual deaths of only 106.



These results are well within the expected range.

3.5 National Hip Fracture database to April 2021

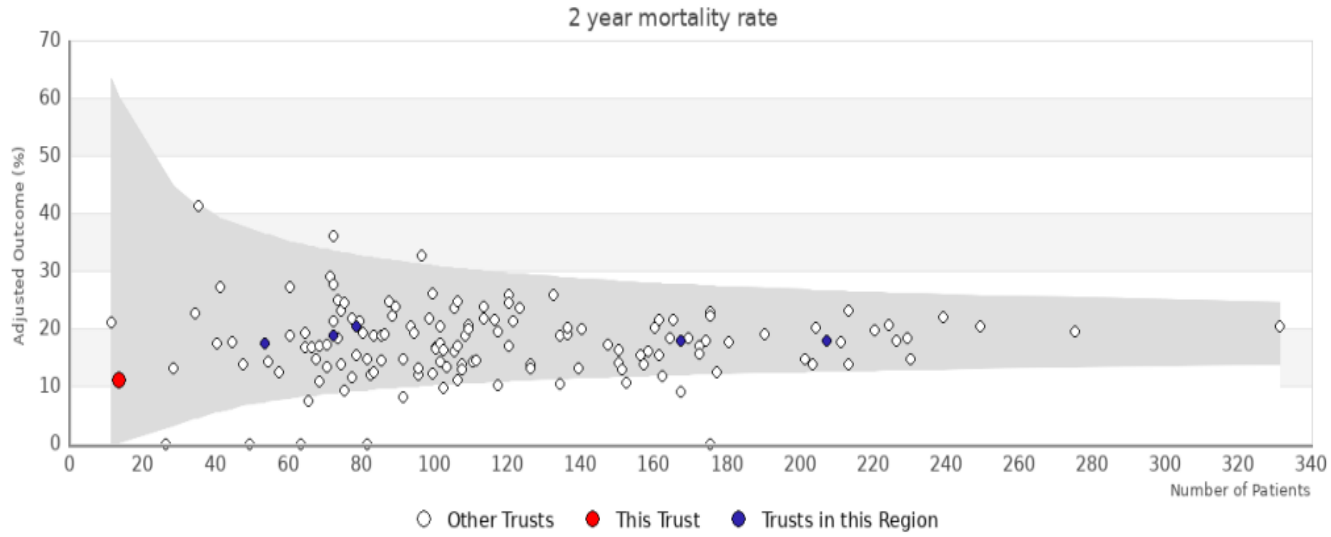
30 day mortality rose in 2021/22 but has been below the national average for 5 consecutive months.



'Hours to operation' remains significantly better than the national average (31.7 vs 39.2 hours) and, after a post-covid rise from around 23 hours, is tending to decrease again.

3.6 National Bowel Cancer Annual audit

Data for 2 year survival after bowel cancer surgery for patients in England and Wales diagnosed with bowel cancer 1 April 2020 – 31 March 2021 was published earlier this year. The graph below shows the latest available 2 year survival data for these patients compared to all other NHS Trusts, with other Wessex Trusts in dark blue. The numbers are very small reflecting the effect of the covid pandemic on admissions, however 2-year survival data for DCH is good with an expected death rate of 10.9% versus an actual rate of 7.8%. This percentage difference probably reflects a difference of a single patient's survival.



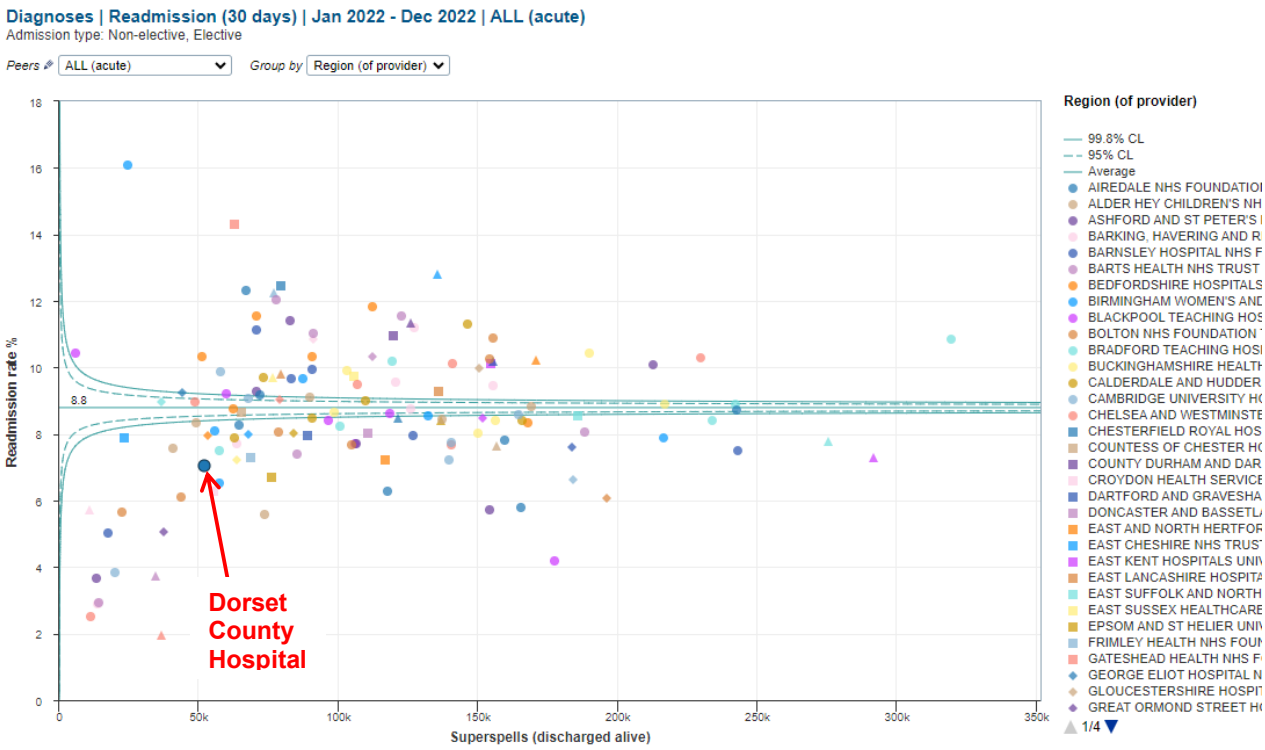
3.7 Getting it Right First Time; reviews in Qtr 1

GIRFT are now responsible for, and primarily focusing on, recovery of waiting lists in 6 High Volume, Low Complexity (HVLC) specialties – ophthalmology, ENT, gynaecology, general surgery, urology and orthopaedics. However, this has no direct bearing on Learning from Deaths. None of these services have been individually reviewed during Q1.

3.8 Trauma Audit and Research Network

DCH is a designated Major Trauma Unit (TU) providing care for most injured patients, and has an active, effective trauma Quality Improvement programme. It submits data on a regular basis to TARN which then enables comparison with other TUs. No new data has been published since that reported in the previous Q2 Learning from Deaths report. The data is therefore unchanged and reports up to December 2021 only. The TARN website states that a data update will be available by 31st May 2023, but currently the website is unavailable.

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



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

4.0 QUALITY IMPROVEMENT ARISING FROM SJRs

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

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

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

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

5.0 MORBIDITY and MORTALITY MEETINGS

Morbidity and mortality meetings are continuing across the Trust, with minutes collated by Divisional Quality Managers. Dates of these meetings are reported to and reviewed by the Divisional Clinical Governance meetings. Dr. Richard Jee is producing a revised protocol for required actions arising from SJRs which identify possible poor outcomes, near misses or any other aspects that require further

investigation. This will take into account the change from RCA investigations to the more recent PSIRF approach.

6.0 LEARNING FROM CORONER'S INQUESTS Q1

DCH has been notified of 15 new Coroner's inquests being opened in the period 01 April 2023 – 30 June 2023.

13 inquests were held during Quarter 1. Five inquests were heard as Documentary hearings, not requiring DCH attendance. Five required the clinician to attend Court in person. Two required attendance remotely from the DCH 'virtual courtroom' (in THQ) using Microsoft Teams. One inquest was a hybrid – some clinicians attending in person and some joining remotely. One pre-Inquest Review hearing was held.

We also received a request from Swindon Coroner Service for records of a patient seen at DCH, we are awaiting the outcome of that hearing.

We currently have 38 open Inquests. The Coroner has reviewed all outstanding cases to decide whether any can be heard as documentary hearings. No new pre-inquest reviews were listed during this period.

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

7.0 LEARNING FROM CLAIMS Q1

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

Claims pattern Quarter 1 FY 23/24.

New potential claims	18
Disclosed patient records	27 (15 claims, 12 disclosures to the coroner)
Formal claims	4 clinical negligence, 1 employee claim
Settled claims	2 clinical negligence, 0 employee claims
Closed - no damages	1 clinical negligence, 0 employee claims

8.0 SUMMARY

SHMI improved as predicted in the rolling years to January and February 2023 and then rose slightly outside the expected range for the year to March 2023. All mortality data requires on-going scrutiny and an audit of approximately 50 deaths is in process to look for any evidence of 'avoidability' or poor care, as well as closer examination of diagnostic groups that are indicating higher observed than expected deaths. It has been delayed significantly by on-going industrial action and internal DCH/DHC issues and events. Additional external oversight has been arranged through the ICS and a link has been established with Dr Sean Weaver, mortality lead at UHD.

The coding department continues to attempt to recruit to establishment and is also in the process of recruiting three apprentice coders.

No other metrics of in-patient care suggest that excess mortality is occurring at DCH and much of the national data suggests better than average mortality, although National Hip Fracture mortality was less good during covid-19 but is currently better than the national average again. Nevertheless the Hospital Mortality Group remains vigilant and will continue to scrutinise and interrogate all available data to confirm

or refute this statement on a month by month basis. At the same time internal processes around the completion and recording of SJRs, M&M meetings and Learning from Deaths are now well embedded and working effectively within the Divisional and Care Group Teams.

Report Front Sheet

1. Report Details			
Meeting Title:	Board of Directors, Part 1		
Date of Meeting:	27 September 2023		
Document Title:	**GMC Survey Action Plan Update**		
Responsible Director:	Nicola Plumb - Chief People Officer	Date of Executive Approval	12 September (EH)
Author:	Dr Paul Murray, Director of Medical Education		
Confidentiality:	N/A		
Publishable under FOI?	Yes		
Predetermined Report Format?	No		

2. Prior Discussion		
Job Title or Meeting Title	**Date**	**Recommendations/Comments**
OEG	11 September	NA
People and Culture Committee	18 September	Noted

3. Purpose of the Paper	The purpose of this update is to provide the People and Culture committee with an overview of the most recent GMC National Training Survey results and the changes and developments within medical education.							
	Note (✓)	✓	*Discuss (✓)*	✓	*Recommend (✓)*		*Approve (✓)*	
4. Executive Summary	The GMC National Training Survey is undertaken in March to May each year. This report outlines the areas of excellence and those areas that were low outliers. Action plans are in place in Orthopaedics and O&G. The report also summarises the recent developments and changing landscape of medical education and the next steps for DCH.							
5. Action recommended	The Board is asked to note the action plan update.							

6. Governance and Compliance Obligations				
Legal / Regulatory Link			**No**	
Impact on CQC Standards		**Yes**		Well lead domain
Risk Link		**Yes**		Areas of under-performance are highlighted which, if not effectively addressed, could present a risk to the alignment to the NHS People Plan, the provision of high-quality patient services and/or to the Trust's financial position.
Impact on Social Value		**No**		
Trust Strategy Link		**How does this report link to the Trust's Strategic Objectives?** *Please summarise how your report will impact one (or multiple) of the Trust's Strategic Objectives (positive or negative impact). Please include a summary of key measurable benefits or key performance indicators (KPIs) which demonstrate the impact.*		
Strategic Objectives	People	The Trust aspires to provide high quality educational opportunities to all trainees. In the case of medical trainees, they are an important factor in both current and future workforce plans.		
	Place			
	Partnership			

Dorset Integrated Care System (ICS) Objectives	**Which Dorset ICS Objective does this report link to / support?** *Please summarise how your report contributes to the Dorset ICS key objectives.* *(Please delete as appropriate)*		
Improving population health and healthcare	**Yes**		High quality training will help to produce a sustainable workforce supply.
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)		**No**	
Quality Impact Assessment (QIA)		**No**	

INTEGRITY | RESPECT | TEAMWORK | EXCELLENCE

NHS
Dorset County Hospital
NHS Foundation Trust

Director of Medical Education Overview and GMC NTS 2023

September 2023

Dr Paul Murray

Director of Medical Education

Outstanding care for people in ways which matter to them

• 2023 GMC Survey of doctors in training - results, updates and actions

•Future developments in Education

Our doctors

- A mix of consultants, doctors in training (almost exclusively from Wessex Deanery), and Locally Employed Doctors (LEDs: Staff Grades, Specialty Doctors (SAS grades), Trust Doctors, ‘F3s’, Associate Specialists, Fellows); and now Medical Support Workers

- Deanery trainees are here for between 6 months and 2 years

- Rotas are designed around a certain number of doctors but lower levels of doctors training in some specialties around the nation plus increased numbers of LTFT (less than full time) working mean rotas are not filled

- Rotas are increasingly dependent on the recruitment of Locally Employed Doctors in addition to deanery posts

The GMC National Training Survey (NTS)

- Annually, March-May
- Doctors in formal Postgraduate training ONLY, at present
- No longer compulsory (may explain lower response rates)
- 18 sets of questions relating to work in and out of hours
- Results can be broken down by Specialty (eg for all doctors at all grades in Surgery) or by Programme (eg only the higher Specialty Trainees in Paediatrics)
- Results are measured against a national mean score and flagged accordingly: Green = national ‘above’ outlier, Red = national ‘below’, light green = tending above, pink = tending below

Overall Results for DCHFT – 65% response rate

Indicator	2019	2021	2022	2023
Overall Satisfaction	80.36	78.29	73.31	78.45
Clinical Supervision	88.08	89.98	88.30	89.24
Clinical Supervision out of hours	84.23	86.24	83.42	84.99
Reporting Systems	76.73	77.10	71.38	75.14
Workload	50.70	58.16	47.14	48.87
Teamwork	76.91	75.00	75.31	74.76
Handover	68.94	69.13	65.56	72.45
Supportive Environment	74.34	72.81	75.56	77.47
Induction	78.34	78.92	74.75	81.74
Adequate Experience	80.23	79.28	71.25	76.58
Curriculum Coverage	78.19	76.04		
Educational Governance	74.41	76.26	69.58	72.51
Educational Supervision	87.22	89.38	83.28	84.91
Feedback	75.89	76.39	64.96	70.66
Local Teaching	71.81	63.87	63.24	67.30
Regional Teaching	65.27	67.45	65.55	61.34
Study Leave	65.17	61.67	55.78	60.11
Rota Design	55.25	61.10	47.40	58.28
Facilities		72.64	75.06	75.31

Excellence! (Green Outliers)

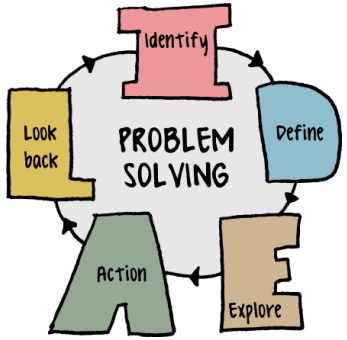
- **General surgery** - handover
- Facilities, supervision and workload in **Gastroenterology**
- Educational Governance in **Internal Medicine Stage 1**
- Supportive environment in **Medicine F1**
- Induction in **Paediatrics** posts
- Supportive environment in **O+G** Specialty posts
- Supportive environment in **Core Anaesthetics**
- Local Teaching for **GP ED Posts**
- Reporting systems in **Cardiology**

- **Facilities across all DCHFT posts (2nd year running)**

Low Outliers (Red scores)

- Educational Governance in **ICM posts**
- Handover, adequate experience, overall satisfaction and local teaching across **O+G posts**
- Clinical supervision out of hours in **T+O posts**
- Study leave in **Paediatrics GP posts**

- The O+G and T+O issues have been highlighted by the GMC survey team
- Actions plans requested



Trauma and Orthopaedics

Post Specialty	Indicator	2019	2021	2022	2023
Trauma and orthopaedic surgery	Overall Satisfaction	69.18	95.00	69.38	67.00
Trauma and orthopaedic surgery	Clinical Supervision	78.00	97.00	83.44	73.25
Trauma and orthopaedic surgery	Clinical Supervision out of hours	78.98	94.17	78.91	73.75
Trauma and orthopaedic surgery	Reporting Systems	74.55	80.00	67.50	70.00
Trauma and orthopaedic surgery	Work Load	39.77	51.67	38.28	28.75
Trauma and orthopaedic surgery	Teamwork	75.76	78.33	78.13	65.00
Trauma and orthopaedic surgery	Handover	60.94	81.25	68.75	65.63
Trauma and orthopaedic surgery	Supportive Environment	66.36	83.00	71.88	66.00
Trauma and orthopaedic surgery	Induction	75.45	87.00	68.75	77.00
Trauma and orthopaedic surgery	Adequate Experience	77.50	85.00	64.06	65.00
Trauma and orthopaedic surgery	Curriculum Coverage	73.48	93.33		
Trauma and orthopaedic surgery	Educational Governance	63.64	86.67	60.42	50.00
Trauma and orthopaedic surgery	Educational Supervision	77.65	97.50	85.94	83.75
Trauma and orthopaedic surgery	Feedback	65.10	92.71	58.33	45.84
Trauma and orthopaedic surgery	Local Teaching	72.22	71.33	72.92	
Trauma and orthopaedic surgery	Regional Teaching	83.33	85.00	70.84	
Trauma and orthopaedic surgery	Study Leave	63.39	75.00	43.45	38.54
Trauma and orthopaedic surgery	Rota Design	48.30	77.50	41.41	30.00
Trauma and orthopaedic surgery	Facilities		70.00	69.29	73.33

Action plan – T+O

- New rota design, included Doctors in Training input – started August 2023

Additional

- SHO rota'd 8-6 Saturday and Sunday to cover wards with FY1

- twilight SHO shift 4pm - midnight Monday to Friday.

These measures mean that FY1s should not be working unsupervised and will always have SHO support. The on call SHO will have support from the twilight SHO until midnight (8-12 the busiest time for the Hospital at Night surgical SHO).

- HEE have not requested a formal action plan, stating that the “majority of responses were positive”

O+G – All posts

Post Specialty	Indicator	2019	2021	2022	2023
O+G	Overall Satisfaction	86.80	59.29	49.38	58.33
O+G	Clinical Supervision	94.00	88.33	84.38	85.00
O+G	Clinical Supervision out of hours	92.50	80.36	84.38	87.50
O+G	Reporting Systems	77.00	74.11	77.86	68.00
O+G	Work Load	68.75	49.11	64.58	48.61
O+G	Teamwork	85.00	65.48	82.29	68.06
O+G	Handover	70.00	59.82	54.17	57.29
O+G	Supportive Environment	74.00	60.71	75.63	71.67
O+G	Induction	78.00	69.29	70.63	80.00
O+G	Adequate Experience	82.00	73.21	50.00	56.25
O+G	Curriculum Coverage	80.00	69.05		
O+G	Educational Governance	81.67	64.29	68.75	58.33
O+G	Educational Supervision	93.75	86.61	71.09	72.92
O+G	Feedback	73.33	84.37	43.33	63.54
O+G	Local Teaching	59.17	16.95	48.75	32.33
O+G	Regional Teaching	78.89	61.81	66.67	65.83
O+G	Study Leave	85.83	46.43	58.33	63.33
O+G	Rota Design	80.00	31.25	37.50	37.50
O+G	Facilities		68.33	79.00	67.50

Action plan – Obs and Gynae

1. A full day of consultant led induction on the first Thursday of the placement.

2. Teaching programme has been taken over by senior trainee (under consultant supervision) who has coordinated all teaching activities into a monthly email. Electronic feedback has been taken for the last 3 months and has shown a significant improvement in trainee satisfaction with local teaching. Also plan for a monthly teaching afternoon when the majority of junior doctors are available.

3. **Due to rota gaps**, a long-term locum doctor and another trust grade doctor employed to work on Labour Ward to release trainees for theatre, outpatient hysteroscopy and clinic.

4. Consultant led handover at 08:30, 13:00 and 17:00.

5. Work to ensure LTFT trainees do appropriate pro-rata number of on calls, thereby improving overall experience

INTEGRITY | RESPECT | TEAMWORK | EXCELLENCE

NHS
Dorset County Hospital
NHS Foundation Trust

Action Plans for Red Outliers

- General Surgery, F1 medicine, GP medicine, O+G, Cardiology, ED GP posts
- Results shared and action plans requested
- To report back to Medical Education Group
- Escalation to departmental and divisional management if progress not made
- In year feedback from doctors in training via Junior Doctor Forum, Exception Reports and End of Placement surveys
- HEE have requested formal plan for O+G
- Next GMC Survey will be in May 2024

Trainer Survey

- Response rate of 40% in 2023 (same as 2021)
- High levels of Trainer satisfaction with Professional Development (green outlier)
- Ongoing work to compare ESR with HEE approved supervisor lists to target recruitment of new supervisors/trainers
- Real time access to HEE supervisor records to support local timely educational revalidation

Recent Developments

- Pressures of Industrial Action
- DCH to be part of Radiology training Academy, first trainees started August 2023
- Expansion of Specialty training in Cardiology, Respiratory, Gastro and Diabetes posts, discussions regarding geriatrics
- Now appointed 4th F3 Medical Education Fellow to support Undergraduate and postgraduate training. Plans for 2nd, concurrent post for 2024
- Ongoing expansion of LED workforce, supported by Associate LED Tutors
- Ongoing high numbers of trainees PAs, ANPs, Specialist nurses plus UHS medical students – pressure on supervision, competing training concerns
- Involvement of junior doctors in management decisions – rota design, induction planning, redeployment, Junior Doctor Forum
- Continued focus on Exception Reporting
- Supported Return to Training (SuppoRTT) scheme; established lead for SuppoRTT and LTFT training, increased opportunities for LTFT training at all levels of training

What is ahead?

- Expansion of Medical Student and Junior Doctor numbers – Foundation to expand again 2024, meaning an increased requirement for Supervision, appraisal, space and accommodation, further medical students
- Action plans in areas of concern; areas of good practice asked to share the learning
- "Recovery" funding – wellbeing, simulation projects
- Continued investment in Junior Doctor Forum
- Ongoing support to LEDs and overall workforce strategy – recruit, retain and develop
- Ongoing focus on Wellbeing and support – average med student debt now estimated £106k. BMA campaign for pay restoration

Thank you

For your ongoing commitment to teaching, training and supervising

Report Front Sheet

1. Report Details			
Meeting Title:	Trust Board of Directors		
Date of Meeting:	27 Sept 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	19/09/2023
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	19/09/2023	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 (19 Sept 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.

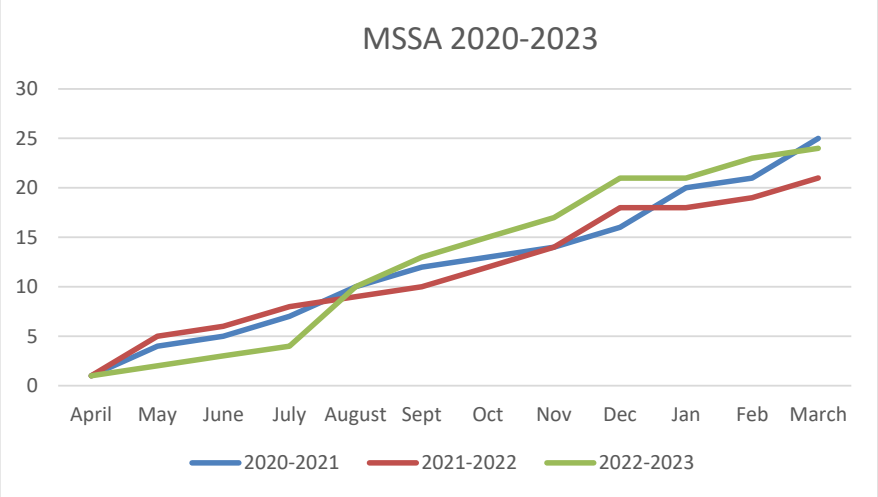
For the purposes of agreed trajectories HOHA and COHA are now combined in reporting.

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

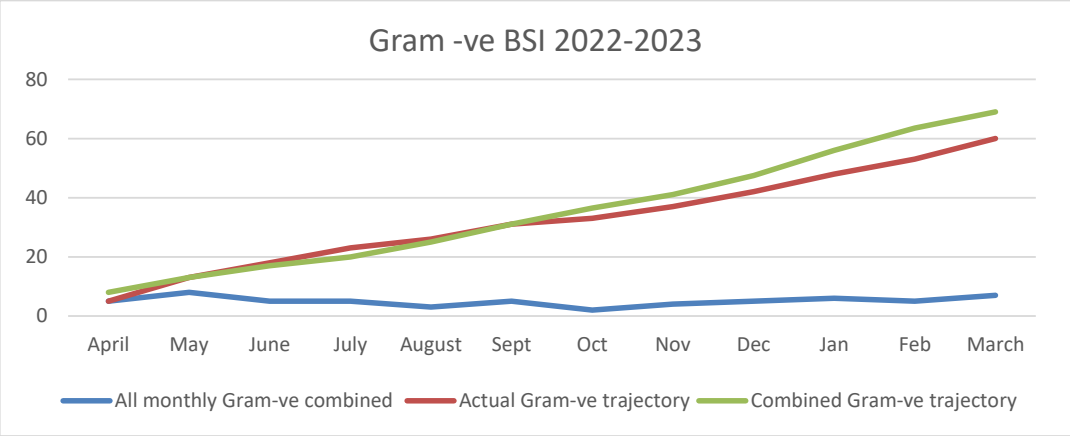
Gram-negative blood stream infections (BSIs) are a healthcare safety issue. From April 2017 there has been NHS ambition to halve the numbers of healthcare associated Gram –negative BSIs by 25% March 2021 (PHE 2017) and 50% March 2024 (PHE 2019). February 2019 it was announced that the date for achieving 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.

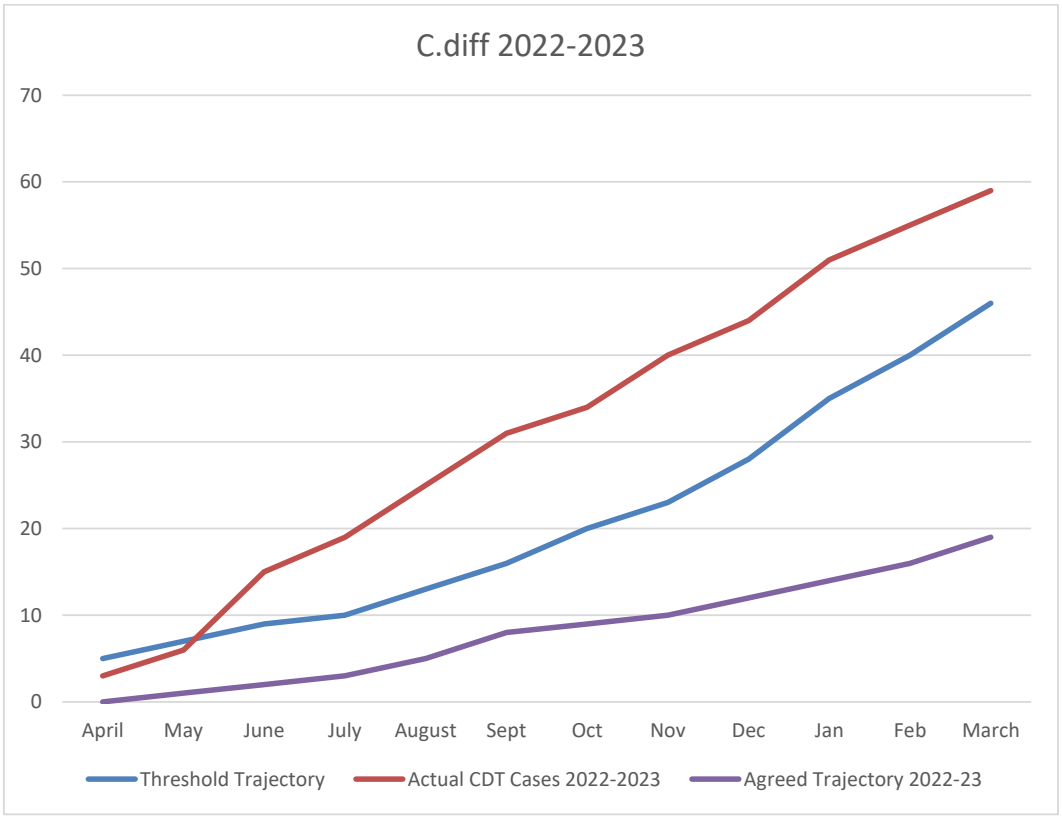
In 2022-2023 there were a total of 11 positive BSI samples for Klebsiella, which were attributed to the Trust – HOHA & COHA. All cases of Klebsiella sps. that occur >48hrs after admission are reviewed by the Infection Prevention & Control Team. A full data collection process is carried out in accordance 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.

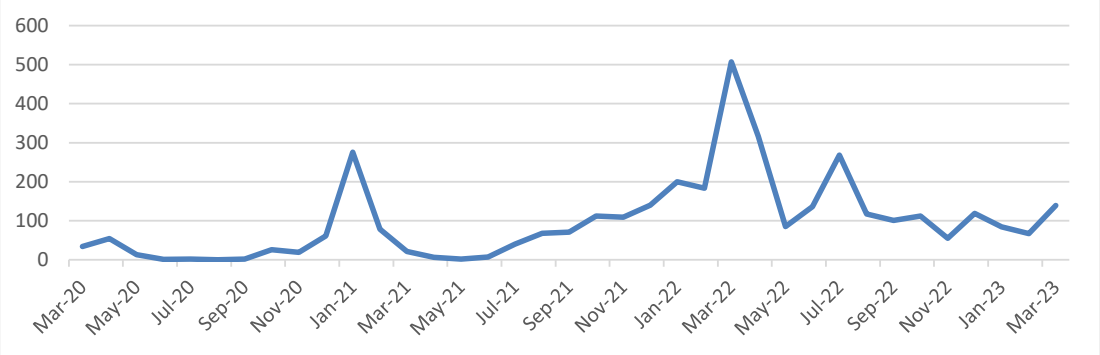
The hospital environment has been adapted to suit the needs for this new ongoing virus and the complexities that it creates. Over the past 3 years the IPCT have continued to support the trust throughout the pandemic with updates to guidance in line with Public Health England/UKHSA and expert response 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.

ESTATES REPORT (Terry May – Deputy Head of Estates & Facilities)

WATER QUALITY

The Estates Team are responsible for maintaining the Trust's water systems, across the main hospital site and satellite properties, and reporting status to the Water Quality Management Group (WQMG) and Infection Prevention and Control Group. Provisions for water safety are independently audited by experts from the Water Hygiene Centre, who provide the Trusts third party Authorised Expert for water safety.

Policy & Governance
New appointments required by the Water Safety Policy have been made following changes in key personnel.

Estates on behalf of the Trust has undertaken via a specialised consultant, Water Safety Risk Assessments (RA's) of the Hospitals water systems. We have received two of three reports and expecting the third by the end of August. The recommendations are as we expected and not as favourable as we would have liked, however, this informs us of important actions we need to take to ensure we are managing Water Safety effectively and efficiently within the Trust.

Those most of concern are within the table below: -

Imminent Danger Table			
Building	**Unit**	**Survey Element**	**Imminent Danger and Recommendation**
		Inspection of the Written Scheme	There is no log book system in place.
			Create a log book system to hold all monitoring and maintenance records. No records produced during the risk assessment being carried out.
		Inspection of the Written Scheme	There is no suitable written scheme in place.
			Create a written scheme based on the requirements of ACoP L8, paragraphs 60-64. No Written Scheme was produced during the risk assessment being carried out.
		Cold Water (South Wing BTCW)	There is biofilm evident in the cold water tank(s).
			Short term - Clean and disinfect the tank. Investigate and eliminate the cause of the biofilm. Long term - remove units which accommodate highly susceptible ie immunocompromised patients, from this system. Supply them with direct mains fed water. It was seen evidence of some biofilm contamination was identified in form of black spotting inside cold water storage tank 72TA01.

We are aware that there is not an all-encompassing logbook for Water Safety within Estates, rather a collection of Excel Spreadsheets, which is not ideal and was meant to be an interim measure whilst MiCad was further developed, this is now being moved forward with improvements to MiCad being made.

1. It was always the intention to develop a full 'Written Scheme' being a revised and updated Water Safety Plan, following the adoption of the Water Safety Policy and the results of the Water Safety RA's, which also provide updated schematic drawings of the water systems. Staffing with Estates has been stretched and, in some areas, covered by agency staff, however, we have recently recruited an Estates Mechanical Officer, who will be leading the Operational Water Group in developing the Water Plan.
2. This work has been actioned, completed and the said CWS tank is being monitored.

The recommendations from the RA's and the Draft Water Safety Policy were both to be discussed at the Water Quality Management Group on the 10th August, however, this was postponed due to an unexpected major Generator and Power issue. A revised meeting is being set for September 2023, whereby, the Water Safety Policy can be ratified and the WQMG updated on progress of the analysis of the Water Safety RA's and development of the Water safety Plan.

Regular sample testing has been maintained in high-risk areas throughout the Trust, by Estates Operatives and supported Contractors. This is being reviewed as it is clear we require dedicated Operatives to undertake this work, which is being investigated as part of a wider Estates structure review with our partner DHC.

In summary, the Trust is working towards best practice for managing Water Safety across the Hospital, and in undertaking Water Safety RA's it is in a better place to be able to prioritise, develop and implement a well-informed Water Safety Plan to achieve this aim.

Risks

HCWS (Hot and Cold-Water Systems) are managed within capability and availability and, in general, the main site systems need investment to mitigate age related and maintenance issues.

There have been 696 reactive calls to leaks in the period 01/04/22 – 31/03/2023 of various descriptions, with (approx. 46% or 323) High Priority: 143: being emergency or urgent with the potential to cause significant damage,42: were out of hours, 30 were due to roof leaks, 78 leaks through ceilings, 16 leaks affecting theatres, 14 were air conditioning condensation water leaks, a further (54% or 373) were of various descriptions with a lesser significance.

New Properties

The acquisition of additional properties and capital projects have presented some challenges. Measures to mitigate the various problems have been identified and are being implemented.

Sampling

The table below shows the number routine samples and raised counts.

OUTLETS	SAMPLES TAKEN	RAISED COUNTS

Legionella	405	69
Pseudomonas A	433	23

REPLACEMENT FLOOR COVERINGS (Floor Works)

223 flooring jobs in the past 12 months have completed. Included in this, was the re-laying of the main staircase to South Wing, which has significantly improved the area and provides a very good impression for those entering the Trust by the South Wing entrance.

Where possible Estates have standardised floor covering by using Tarket IQ Granit, with nonslip areas, Tarket Altro Walkway 20 or Altro Aquarius is used. To improve aesthetics and cleaning the wooden skirting where possible has been removed and a cap and cove finish has installed. This is a more expensive exercise, however, improves the hygiene element and looks so much better in clinical areas, makes mopping and cleaning so much easier.

Estates use contractors, Future Flooring and Carpets 2000, for this specialised work, with both companies working very well with Estates and the departments, supported by very positive feedback on their cooperation and work ethics. Both are local smaller companies that works well, Estates have tried to use some of the bigger contractors, and they are not really interested, and the standards are poor, (Charlton Down being a fine example). Estates have considered bringing flooring works within the in-house Estates Maintenance Team; however, it appears to not be viable at this time.

DECORATION AND ENVIRONMENT (Painting)

371 painting jobs have been completed in within this financial year.
One completed 98% of these being the only painter. We have employed an additional Painter this financial year to improve output and catch-up on backlog.
Dulux Sterishield is used in all clinical areas, with Blosan used in Theatres.
Dulux Scuffshield has proven very efficient in the corridors.
Standard matt is used in ward corridors and some streets.
Gardenia is the standard colour, although moving forward we are introducing a palate of muted colours, to aid patients and visitors with the general feel of the building.

VENTILATION

The Estates team continue to carry out routine inspection and maintenance on all ventilation systems and formal validations on all Theatres and Critical Areas in compliance with HTM 03-01 Part B carrying out remedial works as required. In the past 12 months we have replaced the AHUs feeding UCV Theatre no1 and UCV Theatre no 2 and X-Ray CT1.

Estates are currently approving ventilation drawings for AHUs for South Walks House, Ridgeway ward and the new Hospital Build ED and CCU.

The AP(V) works under the auspices of an AE(V) maintaining the Permit to Work system and ensure all statutory and regulatory records are validated. Following changes to the HTM 03-01 all ventilation issues are discussed at the Ventilation Safety Group.

WARD ADUITS

In association with IPC and Hotel Services, Estates continue to support weekly environmental audits, with any identified Estates related works being duly raised within the Repairs System and undertaken on merit of priority.

Capital Works

Projects 2022/23	Description of works
POW Refurb	Alterations to the Prince of Wales Annex to form a number of single rooms and makes changes to the surrounding areas to enable this end of the ward to run more efficiently and make better use of the space
Fire Alarm Replacement	Replace fire alarm system site-wide to address corporate risk due to age of current system and non-compliance
Access Control	Replace existing 20 year old cotag system with new due to current system going in to obsolescence and reliability becoming an increasing issue
Chemo Unit Refurbishment	Improvement for patient enhancements to be carried out. Scopes of works has increased from original concept. Works to commence late 2023/24
Chemo Unit Decant Arrangement	Decant of Chemo therapy unit during works. Works to commence late 2023/24
Renal Pod	To make the building safe for clinical use and building compliance as risks identified. Works to be agreed 2023/24
Respiratory Medicine Labs	Full refurbishment of department
Xray Angiogram	Reviewing proposed works for 2023/24 as contract already been procured without Estates input
Xray Room 5	Proceeded without Estates input - works now complete - managed by Radiology
Kingfisher De-escalation	Mental Health Welfare room. Creating ligature light suite and bathroom
Pathway Home Hub	To reduce pressures on ED but creation of space for discharge lounge, frailty SDEC, pharmacy etc. Works likely to take place 2023/24
Helipad Works	Closure of helipad and relocation of service
Offsite Therapies Centre - Roof Replacement	Lifecycle replacement of roof and guttering. Works to take place 2023/24
South Wing Repointing	Water penetrating roof and department through brick work
Aseptic Works	Remove sink, extend benching and add IPS outside of suite. Works taking place 2023/24
Modular Discharge Lounge	New modular building funding from NHS England to be used for Discharge Lounge combined with Discharge Lounge +
Fire Compartmentation	Survey of fire compartmentation; review of existing, changing if required and including if not existing already - Operations Project
Mortuary	Install new body store, replace Paed store, replace all existing rollers

Nurse Call	Stroke POW Maternity - Not suitable for stand-a-lone unit, so will need a full upgrade Further scoping in progress to identify other priority wards Works to take place 2023/24
Roof Replacement	Site wide roof replacement programme
Site Wayfinding	Comms team have progressed some updated wayfinding
Ridgeway Orthopaedic 24 ring fenced beds	Alteration to ward layout to support ringfencing if bed spaces for Orthopaedic recovery
Asbestos Management Policy	In progress with Ion
Water Safety Management Remedials and Monitoring	This is to combat legionella and reduce backlog maintenance on water safety.
Gutter Cleaning	Clearance carried out to prevent the build-up of flora and fauna to maintain roof weather protection and integrity also to reduce infestation risk.
Kingfisher Balcony	Replacement floor, new storage areas and column padding - works to commence in 2023/24
PoW Side room Alterations	Further alterations to PoW Side rooms previously refurbed as part of project 4.13 Renal PoW alterations. Aiming to address stakeholder concerns with room size. Options appraisal to be sent across for further works to take place 2023/24
Maternity Day Assessment Unit	Creation of new larger DAU to help with increased demand on service
Orthodontics and Women's Health	Utilising an unused corridor to provide an additional Ultrasound room for WH and a staff rest area for Orthodontics
Vespasian - Decant for SWH Outpatient services	Replace floor so suitable for clinical services, secure blind ligature risks and film treatment room windows and doors
Medical Gas upgrade	Upgrade Medical Gas throughout North Wing
Hospedia Removals	Remove Hospedia units in North Wing, tied in with Med Gas upgrade works
ENT & Orthodontics	Installation of ventilation to each treatment room

DECONTAMINATION SERVICES REPORT (Joe Lythe – Service Manager: Theatres, Anaesthetics, CRCU and Decontamination)

STERILE SERVICES DEPARTMENT

Quality Management System - Accreditation

The department continues to maintain a full Quality Management System and maintain certification to BS EN ISO 13485:2016. The department is also registered with the Medicines and Healthcare products Regulatory Agency (MHRA).

As a result of Brexit there are some ongoing changes in regulatory requirements. The Medical Device Directive has transferred to the Medical Device Regulation UK MDR 2002 (as amended) our Notified Body that was based in Sweden as an EU Representative has been transferred successfully after a transitional audit to a UK based competent authority.

The Accreditation held by the service continues to give quality assurance on the products produced and allows the department to provide services for external customers.

External Customers

The department provides a service to various external customers including dental practices in East and West Dorset, a local GP practice and the Dorset & Somerset Air Ambulance. Undertaking work for external customers is only possible due to the accreditation achieved by the service. We are looking to increase our external customers for the service to other local GP Practice & Dentists.

Environmental Monitoring

The Clean Room Validation is completed by an accredited external laboratory on a quarterly basis. This consists of:

- Settle Plates
- Contact Plates
- Active Air Samples
- Particle Count
- Water – Total Viable counts (TVC)
- Detergent testing

The laboratory also tests:

- Product bio burden on five washed but unsterile items – Quarterly
- Water Endotoxin - Annual

Latest testing of all areas occurred in May 2023 and the pack room was given a Class 8 clean room status, which is appropriate for the service.

All results are trended, and corrective actions are undertaken for any areas or items found to be outside of acceptable limits. There are no areas of particular concern currently.

For compliance with HTM 01-01 ProReveal testing is undertaken on a quarterly basis; this involves 50 instruments per washer (200 in total) being tested to detect any residual protein on the instrument surface, after being released from the washer-disinfector but prior to sterilisation. Results have been in excess of 99% for each test; this gives assurance that the detergent used in each validated washer-disinfector is effective.

Tracking and Traceability

Patient registration by clinical users against sterile items at the point of operation is undertaken in one Theatre and one Outpatient Department at the moment.
Best practice would see this system being used in all patient treatment areas and this has been recommended through the Decontamination Group Meeting; currently there is insufficient funding for the purchase of the necessary scanners and software licences. Patient tracking at the time of use significantly reduces the risk of expired items or used instruments being inadvertently used on a patient.

Shelf-Life Testing

Products that had been packed and sterilised for greater than 365 days (our maximum shelf life) are sent for sterility testing on an annual basis or when a new wrap is introduced. Previous testing still showed 100% sterility which gives assurance that the decontamination process is effective.

A new double-bonded wrap was introduced in 2020 and sets wrapped in this will be sent for testing once they have expired their 365-day shelf life.

Staff Training

All Managers and Supervisors have achieved qualifications relevant to their role. This gives assurance that they have a full understanding of the Decontamination process and can effectively manage SSD on a day-to-day basis.

All members of staff receive training appropriate to the area of production they are working in and are observation assessed following initial training. Refresher training is repeated for all staff after 3 years of service followed by further observation assessment by a supervisor. No member of staff will work independently without having been assessed as being competent to undertake the role.

Joe Lythe Service Manager is the Trust's Decontamination Lead.

ENDOSCOPY DECONTAMINATION UNIT

Quality Management System - Accreditation

The department continues to maintain a full Quality Management System and maintain certification to BS EN 13485:2016 as an extension to scope of the existing certification in the Sterile Services Department.

This service is not registered with the MHRA, as the unit does not have a controlled environment product release area, therefore full registration cannot be achieved; this means that an endoscope reprocessing service cannot be offered to external customers.

Environmental Monitoring

Validation is completed by an accredited external laboratory on a quarterly basis. This consists of:

- Settle Plates
- Contact Plates
- Active Air Samples
- Particle Count
- Water – Total Viable counts (TVC)
- Detergent testing

The laboratory also tests:

- Product bio burden on cleaned endoscopes at point of release from the washer and at 3 hours following release which is the maximum usage period following release – Yearly.
- Product bio burden on surrogate scopes stored in a drying cabinet for 7 days and at 3 hours following release - Annually.

Latest testing of all areas occurred in May 2023

Tracking and Traceability

Patient registration by clinical users at point of use is undertaken in all 3 treatment rooms in Endoscopy and more recently in the outpatient Urology Suite. This provides accurate traceability of all endoscopes used and significantly reduces the risk of endoscopes that have expired the 3 hour window being used on a patient.

TRUST WIDE AUDITS

Audit #4936 Compliance with Decontamination Procedure for Invasive Devices (Guideline 1341)

It is a required standard of HTM (Hospital Technical Memorandum) 01-01:2016 that full traceability of reusable items can be evidenced. In relation to invasive probes, used in the Outpatient or Theatre setting, this requires the completion of the Tristel Wipe audit book and the insertion of the Tristel Wipe decontamination sticker being placed in the patient's health care record.

The only exception was in Ultrasound; the Radiology Patient System is audited for the same information as patient's health care records are not accessed during this diagnostic process.

This annual audit is carried out by the audit team member for each area with results then reviewed by the Audit Lead and any non-conformances discussed at the Decontamination Group meeting.

The audit results for 2022/23 are not yet finalised.

Audit #5010 Decontamination and Single Use Instruments

This annual audit is used to measure compliance with requirements for the management of sterile instruments and single use instruments as per HTM 01-01:2016 and the sample involves each department that is supplied by Decontamination Services and also uses single use surgical instruments.

This observation audit is carried out by the audit team member for each area with results then reviewed by the Audit Lead and any non-conformances discussed at the Decontamination Group meeting.

The outcome of the 2022/23 audit has not yet been finalised. This will be followed up and submitted once return is received.

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.

Antimicrobials: Summary report for financial year 2022/23.

Rhian Pearce (Antimicrobial pharmacist), Amy Bond (Consultant microbiologist)

Overview

Antimicrobial resistance (AMR) is an emergent crisis threatening health outcomes across all healthcare settings.

The hospital's Antimicrobial Stewardship Programme (ASP) aims to optimise the use of antimicrobial agents to improve clinical outcomes whilst limiting the emergence of AMR and *C. difficile (C-diff)*. It is our primary defence against the threat of AMR. ASPs require investment and adequate resources to operate effectively.

Antimicrobial Stewardship (AMS) is a prominent feature on the government's healthcare agenda, with numerous publications and directives issued to promote stewardship across all healthcare settings.

This report highlights the programme's performance over the last year, including progress against targets, improvement work, and challenges.

2.1 Achievements 2022/23	
Antimicrobial Stewardship Committee	• The Antimicrobial Stewardship Committee (ASC) has struggled to convene over the last year. Re-invigorating the ASC will be a priority for the coming year.
Surveillance • Effective surveillance of antibiotic prescribing, resistance patterns, HCAIs and infection-related outcomes is the foundation of any stewardship program but requires continued investment in informatics and IT solutions. This continues to be an area of focus for the Antimicrobial Stewardship Team.	**Antibiotics Consumption:** • EPMA reporting capacity has continued to improve. Several reports have been developed to support various stewardship activities, improve data capture and allow more targeted intervention. • We also utilised our REFINE/DEFINE database, dramatically improving our ability to monitor antibiotic prescribing trends across the Trust. **Resistance monitoring:** • We looked at Enterobacteriaceae resistance trends locally and compared them with other hospitals. **Patient outcomes for infection syndromes:** • We interrogated a recently launched AMR database to gather data on mortality, length of stay and readmission rates for various infections.

	These metrics provide critical intelligence, supporting monitoring, decision-making, evaluation, and local interventions. Harnessing digital technologies is a priority for AMS. We have secured additional resource to continue progress in this area.
Trust Policies (includes guidelines, PGDs, PSDs, clinical pathways)	**Antimicrobial prescribing guidelines:** Poor guideline accessibility, leading to poor guideline compliance and serious error, has emerged as a recurring theme from RCAs, AMS ward rounds and clinician feedback. We continue to work on updating guidelines to include robust diagnostic criteria as well as streamlining information into an easy-to-use format. Administrative support has been secured to develop our microguide platform to improve guideline accessibility.
RCAs/C-diff	• Continued participation in *C-diff* RCA and PII meetings where we provide a formal review of antibiotic prescribing, feeding back to clinical teams directly. This also allows us to capture themes related to antimicrobial prescribing and *C-diff* trends. • We formally reviewed themes relating to antibiotic prescribing as part of a 'c-diff deep dive'. Some poorly performing clinical specialities were highlighted as part of this review. We continue to collaborate with these areas to improve antibiotic prescribing. • We updated our hospital-acquired pneumonia guideline, replacing co-amoxiclav with doxycycline or co-trimoxazole, in an effort to reduce exposure to 'c-*diff* provoking' antibiotics.
Education	**Mandatory training** • Implemented a three-yearly mandatory training programme, delivered via e-learning, for all prescribers on AMS, using the ARK toolkit. Anticipated roll-out in the coming months to coincide with our EPMA upgrade, which has new functionality to support the ARK tool.
	Face-face teaching sessions: • Gentamicin/Teicoplanin/Vancomycin prescribing (F1s) • AMS and Introduction to the Antibiotic review toolkit with case studies. (F1s) • UTI CQUIN and stewardship principles – elderly care junior Drs

Audits/QI projects	We performed a number of audits and QI work this year, highlights include: establishing baseline data on antibiotic durations and penicillin allergy; a review of vancomycin prescribing on the renal unit and subsequent development of a vancomycin protocol in haemodialysis; audit and QI work to raise awareness of doxycycline- polyvalent cation interactions.
AMS ward rounds	We instated regular AMS rounds looking at 10-20 patients per round covering 3 months (Sept–Dec 2022), performed by the antimicrobial pharmacist and microbiology registrar. We used this time to gather intelligence on antimicrobial prescribing, target patients for intervention, and educate prescribers. Specific clinical areas and AMS metrics were reviewed, including IV/PO switch, broad-spectrum agents, and antibiotics exceeding 5 days. The intelligence gathered during this period suggests prescribing is generally satisfactory, and no concerning themes were identified. We have temporarily paused this activity due to resource constraints but plan to re-introduce regular ward rounds following the appointment of an additional microbiologist (planned start date; August 2023)

NATIONAL TARGETS

AMS CQUIN schemes 2022/23

Locally agreed performance metrics and data submission:

DCH adopted the UTI CQUIN scheme for 2022/23, which mandated a data collection requirement of 100 cases per quarter, regardless of trust size. Given the AMS team's resource constraints, we agreed to a reduced sample size with our CCG partners. This involved collecting baseline data in Q1 (20 patients), quality improvement interventions in Q2 and Q3, and a repeat measurement in Q4 to demonstrate improvement. This approach allowed us to prioritise quality improvement interventions over data collection.

Performance against the CQUIN target and QI interventions

We achieved 50% compliance in Q1, exceeding the minimum payment threshold of 40% but falling short of the maximum payment threshold of 60%. This improved significantly in Q4, achieving 95% compliance overall, which meant we met the full payment for our combined performance for the year. Our performance compares favourably to the national mean (Fig. 1). A breakdown of compliance against individual CQUIN indicators is provided below (Fig. 2)

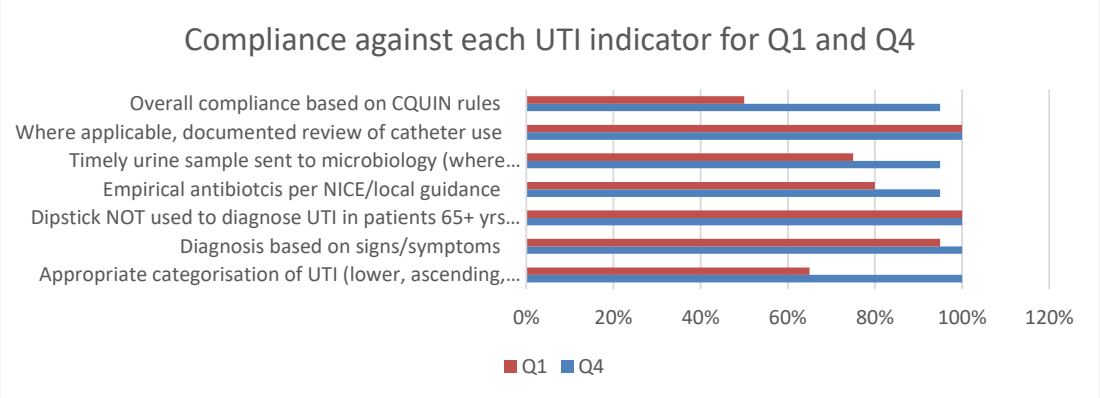
Our quality improvement interventions included: promoting nitrofurantoin over trimethoprim for the empirical management of lower UTI, which we achieved by creating an EPMA alert; incorporating specific learning points into the Junior doctor

induction; collaborating with a clinical lead in specialities of interest to champion improvement; using our AMS rounds to target UTI specifically allowing us to engage with prescribers in real-time and gather intelligence on drivers of non-compliance; delivering an education session to the elderly care junior doctors. Importantly, our QI interventions were highly targeted to the areas of non-compliance identified in the first quarter and tailored to the feedback received from clinicians.

Fig. 1.

CCG2: Appropriate antibiotic prescribing for UTI - DCH performance vs England average		
	England	**DCH**
2022/23 Q1	51%	50%
2022/23 Q2	55%	-
2022/23 Q3	56%	-
2022/23 Q4	58%	95%

Fig. 2.



NHS standard contract for the financial year 2022/23

As part of the NHS standard contract for the financial year (2022/23), NHS trusts were required to reduce 'watch-reserve*' antibiotics by 4.5% compared to their 2018 calendar year baseline.

**Based on the AWARE antibiotic classification system, antibiotics are classified into three groups; Access, Watch and Reserve. Access antibiotics tend to be narrower spectrum and should be used first line, whereas watch and reserve antibiotics are generally broader spectrum with activity against more resistant organisms, and their use should be limited.*

DCH performance against the standard contract target

Fig. 3: In-region comparison of growth for watch-reserve antibiotics; figures from the financial year 2022/23 compared with the 2018 calendar year

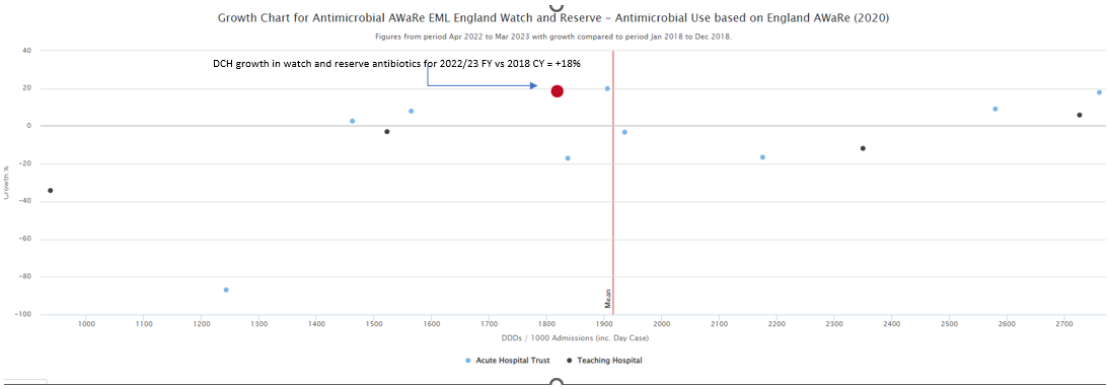
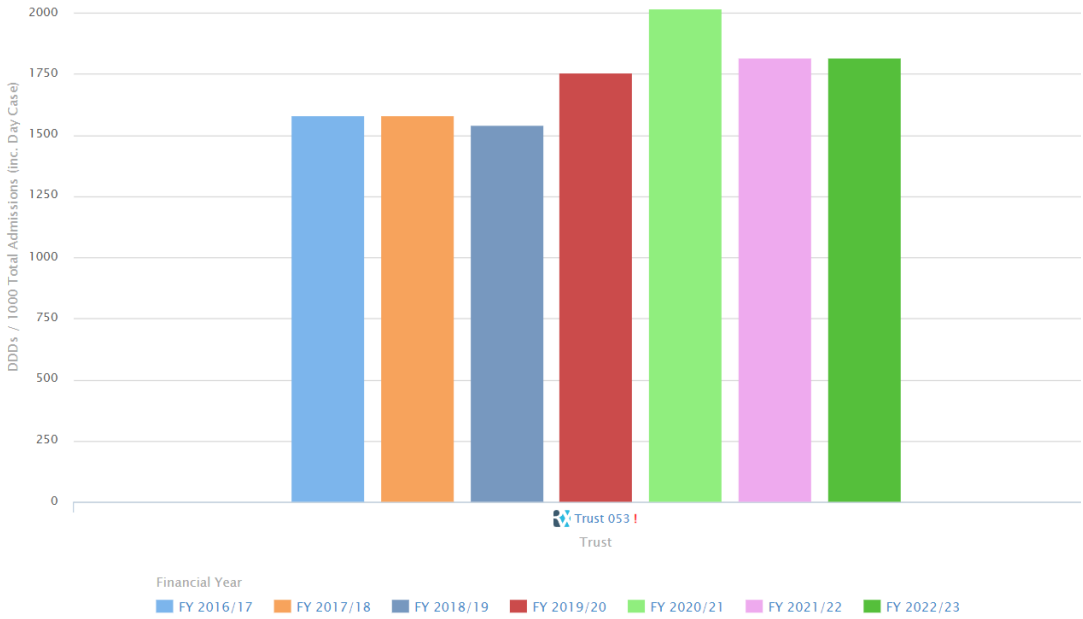


Fig. 4: DCH trend in watch and reserve antibiotic consumption by FY (2016/17 – 2022/23)



DCH did not meet the standard contract target for 2022/23. Watch and reserve (WaRe) antibiotic consumption for the financial year 2022/23, measured as total DDDs adjusted for admissions, is up 18% on our 2018 calendar year (Fig. 3). Compared with other trusts in the South-West, DCH has seen a comparatively larger increase in growth over this period. Despite this growth, DCH prescribing rates of WaRe antibiotics remain below the regional mean, and overall consumption in WaRe antibiotics is comparable to the previous FY (Fig. 4)

There are some important limitations to acknowledge:-

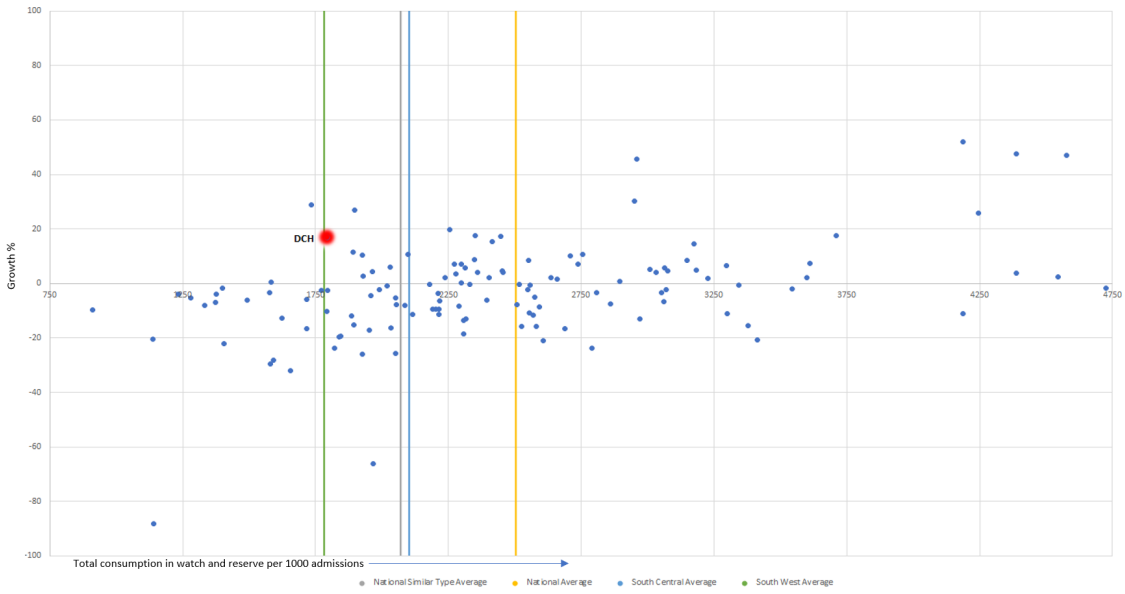
Data are unadjusted for case mix, age and sex. As such, direct comparison between DCHFT and the regional picture is limited. In addition, there is significant variation in hospital and regional antibiotic prescribing across England, so it is unclear who we should benchmark our consumption data against.

We, therefore, performed further analysis to better understand this variance and produce more meaningful benchmarking standards for DCH. We compared our WaRe prescribing rates against the South West, South Central, national aggregate,

similar type/size hospitals and looked at the national spread of data. Results are shown below (Fig 5).

Fig 5.

Scatter plot of acute trusts in England, illustrating DCH growth (compared to 2018 baseline) and total consumption in watch and reserve abx per 1000adm vs national, regional and peer hospital average.



This work provides assurance that DCH has low rates of WaRe antibiotic prescribing overall, appearing in the lower quartile nationally and comparing favourably against a range of benchmarks.

The standard contract target for DCH remains an important driver for stewardship efforts locally, but we need to be cautious of driving WaRe antibiotic use too low because it may negatively affect patient outcomes.

Patient outcome data and resistance trends are not routinely monitored alongside consumption data, which raises serious concerns over the potential unintended consequences of targeting antibiotic consumption in isolation; top-line consumption figures are only part of the picture. This has been a significant area of development for us, and we are therefore pleased to be able to present resistance and outcome data for the very first time (see section 4)

Reasons for observed growth:

The exact drivers for this observed increase in watch and reserve antibiotic use are undetermined. It is likely multifactorial. To date, we have not identified a convincing correlation with inappropriate antibiotic prescribing (based on ward-rounds, *C. diff* RCA findings and audit activity)

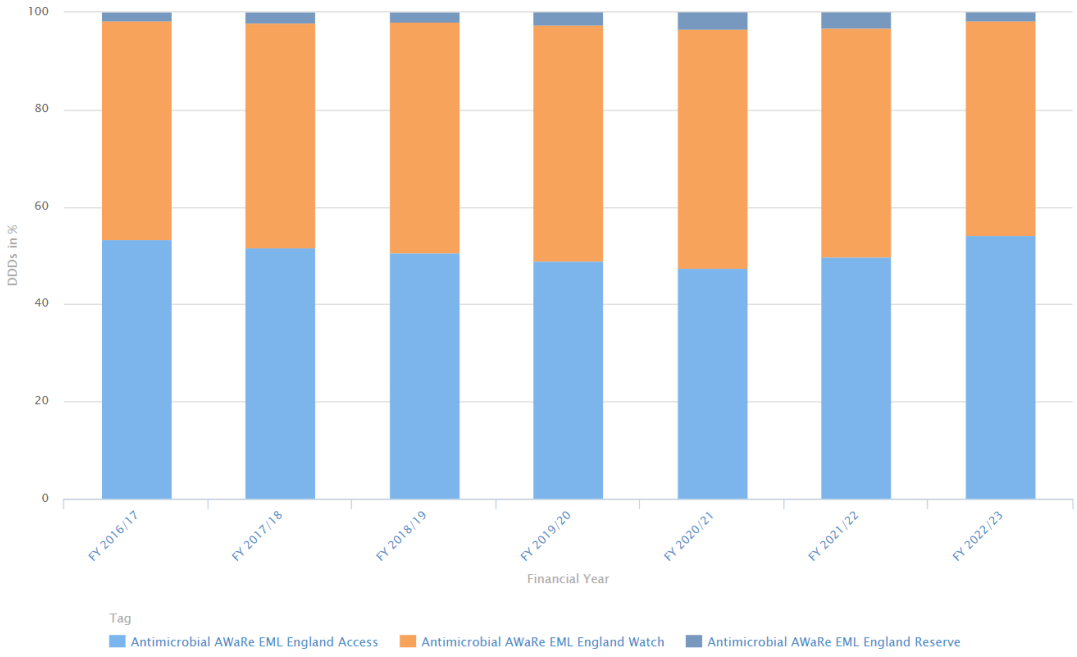
Potential explanations include;

- change in case mix/patient complexity
- lower threshold for initiating antibiotics due to sepsis campaign
- trend towards more aggressive antibiotic dosing regimens
- changes to local empirical antibiotic regimens (e.g. NICE guidance recommending broader spectrum antibiotics than we used historically)

- Increasing resistance rates
- a significant increase in ED activity

The relative proportions of Access, Watch and Reserve antibiotics for this financial year are comparable to our historical baseline, indicating that we are prescribing more antibiotics in general across all categories (Fig .6).

Fig. 6: Watch, reserve and access antibiotics as a proportion of total antibiotics



Consumption trends within DCH and clinical specialities of interest.

Co-amoxiclav accounts for the greatest proportion of WaRe antibiotics at DCH, representing 36% of total WaRe consumption for FY 2022/23 and 16% of total antibiotics prescribed (see Fig. 7).

We analysed antibiotic consumption trends across DCH which showed that ED disproportionately contributes to watch and reserve consumption, primarily due to their high use of oral co-amoxiclav (Fig. 8). ED prescribing of WaRe antibiotics has almost doubled since 2017 (Fig. 9). We are currently collaborating with our ED colleagues to better understand this growth. Of note, consumption data is currently adjusted for admissions and does not include ED attendances, which may explain the increase in ED's antibiotic use. We plan to work with business intelligence to improve our denominator figures to more accurately reflect changes in activity that influence antibiotic consumption.

Fig. 7

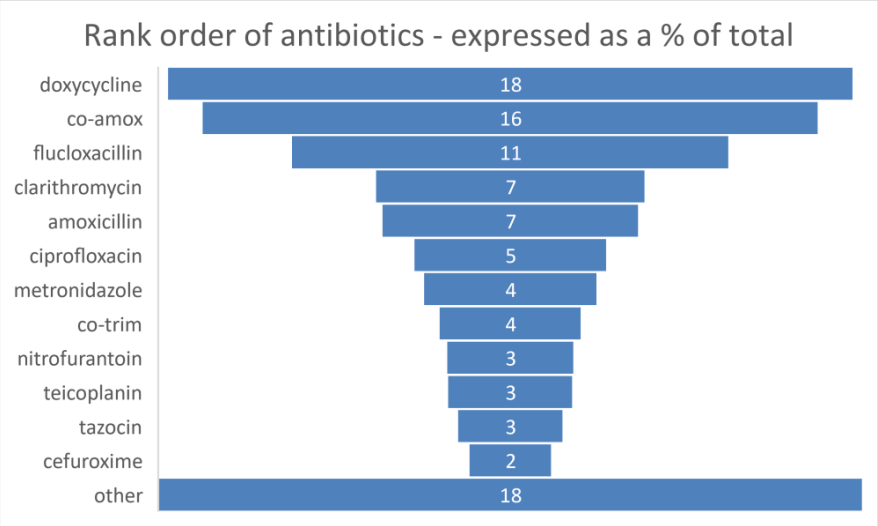


Fig. 8

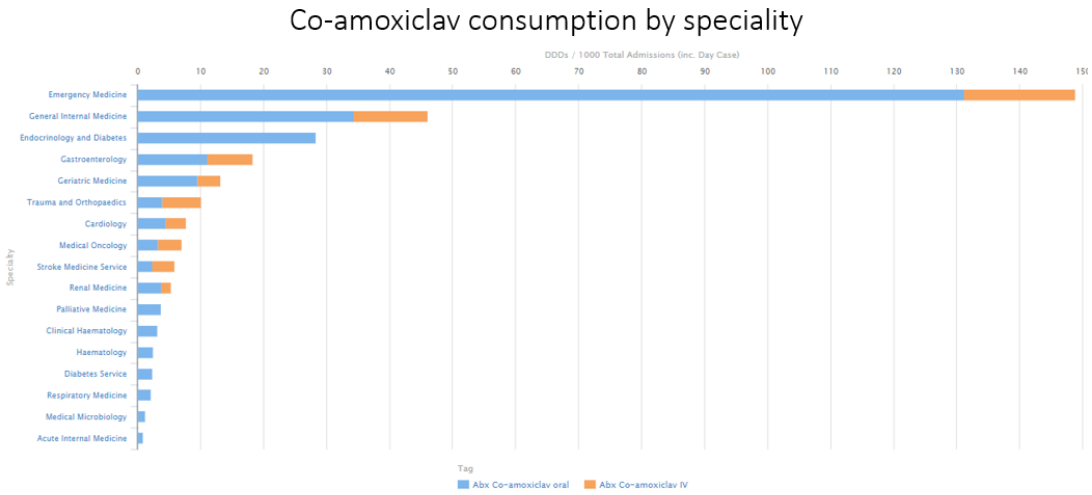
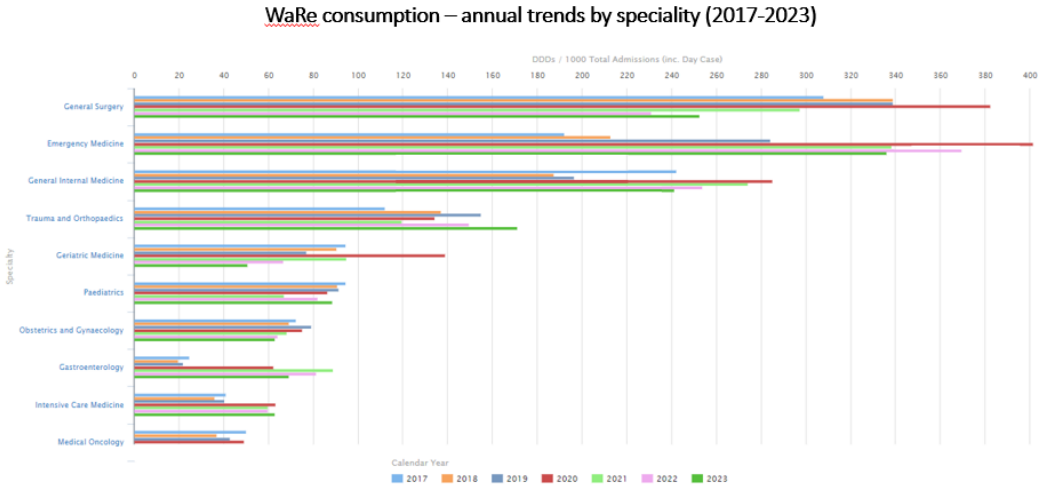


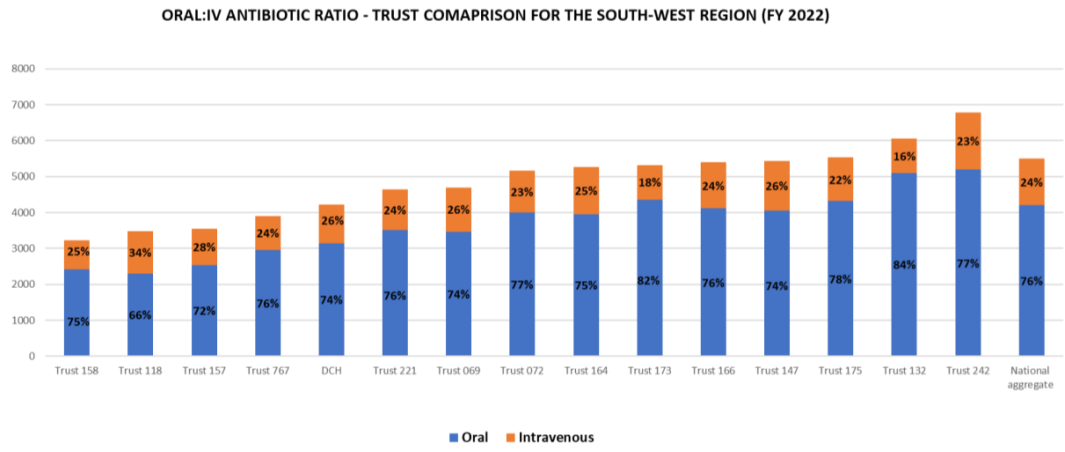
Fig 9.



3. Intravenous antibiotic prescribing.

DCH are required to report on intravenous antibiotic prescribing as part of our contractual obligations. There is also a CQUIN for the coming financial year (2023/24) to drive improvements in IV/PO antibiotic switch. DCH's PO:IV ratio is consistent with other trusts in the region and comparable to the national aggregate (Fig. 10). We will continue to monitor progress in this area.

Fig 10.



Antimicrobial resistance surveillance

Resistant rates for Enterobacteriaceae in blood cultures

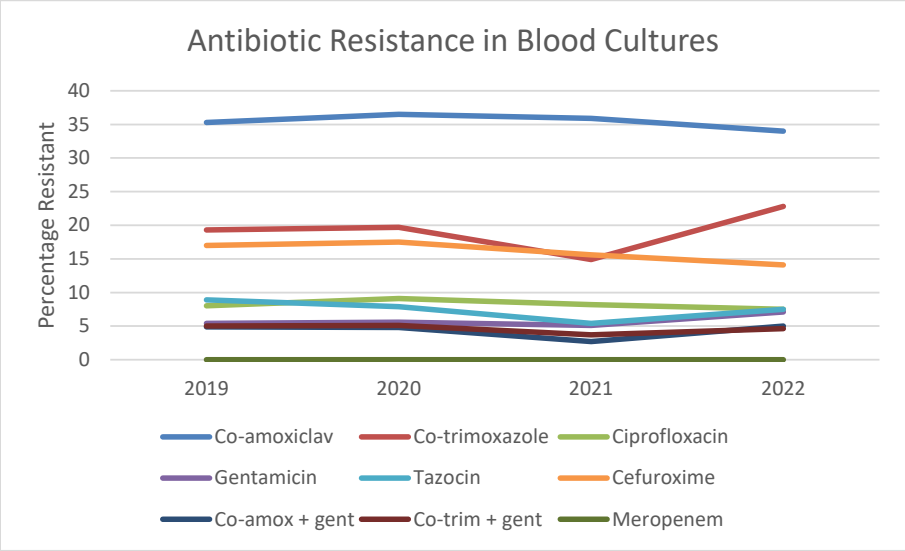
Source: local laboratory antimicrobial susceptibility results.

Table 1 shows percentage antimicrobial resistance rates and trend over time for all Enterobacteriaceae in blood cultures; Figure 1 is a graphical representation of the same data. This is annual data from 1 January to 31 December.

Table 1

	2019	2020	2021	2022
Co-amoxiclav	35.3	36.5	35.9	34
Co-trimoxazole	19.3	19.7	14.9	22.8
Ciprofloxacin	8	9.1	8.2	7.5
Gentamicin	5.4	5.6	5.1	7.1
Tazocin	8.9	7.9	5.4	7.5
Cefuroxime	17	17.5	15.6	14.1
Co-amox + gent	4.9	4.8	2.7	5
Co-trim + gent	5	5.1	3.7	4.6
Trimethoprim	27.7	28	23.6	
Meropenem	0	0	0	0

Figure 1



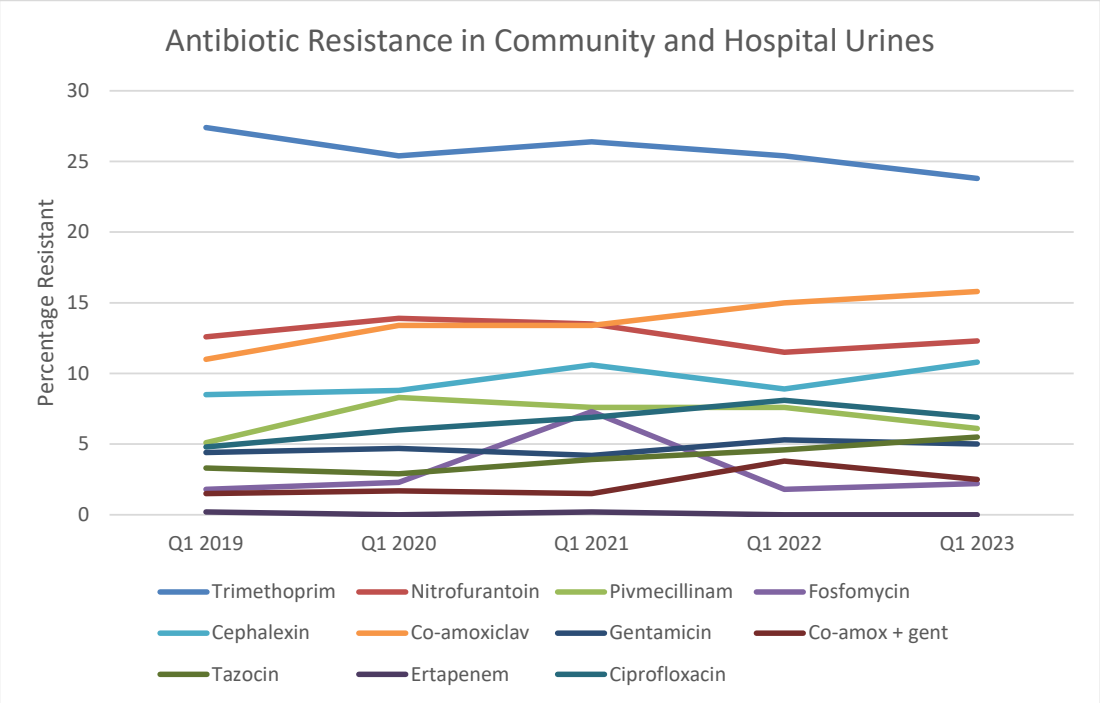
Resistance rates for Enterobacteriaceae in urine samples

Source: local laboratory antimicrobial susceptibility results.

Table 2 shows percentage antimicrobial resistance rates and trend over time for all Enterobacteriaceae in community and hospital (combined) urines; Figure 2 is a graphical representation of the same data. This is Quarter 1 data for each year.

Table 2	**Q1 2019**	**Q1 2020**	**Q1 2021**	**Q1 2022**	**Q1 2023**
Trimethoprim	27.4	25.4	26.4	25.4	23.8
Nitrofurantoin	12.6	13.9	13.5	11.5	12.3
Pivmecillinam	5.1	8.3	7.6	7.6	6.1
Fosfomycin	1.8	2.3	7.3	1.8	2.2
Cephalexin	8.5	8.8	10.6	8.9	10.8
Co-amoxiclav	11	13.4	13.4	15	15.8
Gentamicin	4.4	4.7	4.2	5.3	5
Co-amox + gent	1.5	1.7	1.5	3.8	2.5
Tazocin	3.3	2.9	3.9	4.6	5.5
Ertapenem	0.2	0	0.2	0	0
Ciprofloxacin	4.8	6	6.9	8.1	6.9

Figure 2



Benchmarking for antimicrobial resistance in E coli isolated from Blood Cultures

Source: UKHSA Fingertips.

Table 3 shows quarterly average percentage of antibiotic-resistant E coli in Blood Cultures, for DCH compared with other local hospitals and England. This is data for 2022 Quarter 3.

Table 3

	England	DCH	UHD	UHS	Salisbury	Yeovil	RD&E
Tazocin	10.5	8.0	3.0	No data	7.0	4.0	7.0
Gentamicin	9.6	10.0	10.0	6.0	13.0	12.0	9.0
Ciprofloxacin	18.6	8.0	15.0	19.0	18.0	16.0	13.0
3rd-gen cephalosporins	14.3	10.0	10.0	13.0	19.0	10.0	10.0

Summary

There are no immediate areas of concern with our resistance rates in blood cultures. There have been small increases in resistance to Tazocin and gentamicin – no immediate action is required but we will continue to monitor. Co-trimoxazole resistance in blood cultures is at 22.8%, however we do not often use this agent empirically in systemically septic patients. We have considered using co-trimoxazole in the Acute Abdomen guidelines, but at present it is probably not suitable for use as a sole Gram negative agent; we will continue to monitor.

Resistance rates in urine samples have remained fairly stable, with the exception of a 5% rise in co-amoxiclav resistance over the last 4 years. However, the combination of

co-amoxiclav and gentamicin has only 2.5% resistance and therefore remains suitable for empirical treatment of ascending UTI and pyelonephritis.

Overall, DCH resistance rates for E coli in blood cultures compare favourably to the England averages and are similar or better than our neighbouring Trusts. The exception is Tazocin, for which we are seeing higher rates of resistance than the other local Trusts – this requires close monitoring. As a first step, we should consider looking at how much of our current usage is outside the existing Antimicrobial Prescribing Guidelines.

Monitoring and benchmarking of outcomes

Source: NHSE Foundry

The following tables show outcome data for infection, as percentages, for DCH compared with England and UHD and UHS. This is financial year data (the data for Readmission rates is not yet available beyond January 2022).

Mortality

	All-cause sepsis	Bacterial infection or bacterial sepsis	Pneumonia	Cellulitis	UTI
2021-2022					
England	15.2	13.7	13.7	1.6	2.8
DCH	21.0	4.9	14.0	1.1	2.9
UHD	17.3	6.2	15.3	1.7	4.2
UHS	10.6	4.0	12.5	1.2	2.6
2022-2023					
England	16.8	13.9	13.9	1.7	3.1
DCH	21.5	5.4	14.9	0.5	2.7
UHD	17.1	5.9	15.1	1.9	3.8
UHS	10.6	3.5	10.5	0.6	1.4

Average length of stay

	All-cause sepsis	Bacterial infection or bacterial sepsis	Pneumonia	Cellulitis	UTI
2021-2022					
England	9.8	6.1	9.2	5.7	7.3
DCH	9.9	6.3	9.2	6.3	7.8
UHD	12.4	6.9	10.3	7.1	9.0
UHS	10.7	6.1	9.5	4.6	6.6
2022-2023					
England	10.2	6.3	9.5	6.0	8.0
DCH	8.7	7.2	9.4	7.2	11.1
UHD	12.6	7.3	10.8	8.2	10.4
UHS	10.6	5.9	8.7	5.0	6.2

Readmission rate

	All-cause sepsis	Bacterial infection or bacterial sepsis	Pneumonia	Cellulitis	UTI
Jan 2022					
England					
DCH	6.3	8.3	3.7	0	5.4
UHD	1.3	10.5	6.5	8.3	8.5
UHS	1.5	8.0	3.5	3.8	5.7

Summary

NSHE Foundry is new and we have only recently accessed this data, therefore there is still work to be done in understanding how it is derived and how we can use it.

There are no immediate areas of concern except for the all-cause sepsis mortality and readmission rates (highlighted). However, the outcomes for specific infections, i.e. cellulitis, pneumonia and UTI do not show the same level of discrepancy, therefore it is possible that this is a data anomaly resulting from differences in coding. Further investigation into this is ongoing.

It is noted that UHS have lower mortality than DCH for pneumonia and UTI. This may be influenced by the different populations, but it is an opportunity for us to compare our prescribing guidelines and clinical practice with UHS.

Summary of future work

We plan to continue work on developing a set of metrics for monitoring stewardship activity, focusing on process and outcome measures. We are also in the process of agreeing a work-plan for AMS, to better illustrate the need for future investment, improve resource allocation, and prioritise the limited resource we already have. One of the overarching aims will be to co-ordinate efforts regionally by strengthening collaborative relationships with the ICB, peer hospitals and our ICPT partners.

Closing statement

Despite the significant challenges ahead, we are committed to our vision for AMS at DCH – an ambitious and forward-thinking approach which is closely aligned with the Trust's priorities and goals. Importantly, there is a central focus on delivering meaningful change rather than 'ticking boxes' to give the illusion of assurance.

The AMS team will continue to develop and refine the programme workplan to deliver this vision. This will, of course, take time and need continual revision. We ask for patience and understanding from the trust board whilst this activity is undertaken.

A final word, the key to successfully implementing our vision is strong leadership and an unwavering commitment from senior management. This will be necessary to ensure adequate resource allocation, provide influence over workflows, and help us integrate the programme's objectives into the organisational framework and culture.

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: o based on the measures as prioritised in the hierarchy of controls. o applied in order and include elimination; substitution, engineering, administration and PPE/RPE**.** o communicated to staff. o 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: o patient isolation rooms o cohort areas o 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, Part 1		
Date of Meeting:	27 September 2023		
Document Title:	**Quarterly Guardian Report of Safe Working report: Doctors in Training (Apr 23 – June 23)**		
Responsible Director:	Alastair Hutchinson, Chief Medical Officer	Date of Executive Approval	17/08/23
Author:	Kyle Mitchell, Guardian of Safe Working		
Confidentiality:	No		
Publishable under FOI?	Yes		
Predetermined Report Format?	Yes		

2. Prior Discussion		
Job Title or Meeting Title	**Date**	**Recommendations/Comments**
People and Culture Committee	August 2023	Circulated to members by email

3. Purpose of the Paper	The production of a quarterly Guardian of Safe Working (GoSW) report to the Board is a requirement of the 2016 Junior Doctor Contract. The report is also shared with the Local Negotiating Committee for Medical and Dental staff.							
	Note (✓)	✓	*Discuss (✓)*		*Recommend (✓)*		*Approve (✓)*	✓
4. Executive Summary	A summary of key issues relating to safe working hours and rota gaps for Junior Doctors in training for quarter 1 (2023/2024)							
5. Action recommended	The Board is asked to: 1. **NOTE and APPROVE** the GoSW paper.							

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

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

Title of Meeting	**People and Culture Committee**
Date of Meeting	**21/08/2023**
Report Title	**Quarterly Guardian Report of Safe Working report: Doctors in Training (Apr 2023 – June 2023)**
Author	**Mr Kyle Mitchell, Guardian of Safe Working (GoSW)**

1. Executive summary

- Junior Doctors, Educational Supervisors and Trust managers continue to engage with the process of delivering an effective Exception Reporting mechanism.
- In keeping with the normal annual trend of competency progression and increasing operational effectiveness of junior doctors in rotational posts, relatively few Exception Reports were submitted in this quarter.
- No areas have been highlighted as being outliers in terms of Exception Report submission rates.
- The areas where Exception Report submission has been highest are Trauma and Orthopaedics, Renal Medicine, and ENT surgery.

2. Introduction

All eligible doctors in training at the Trust between October and December 2022 were working under the terms of the 2016 Junior Doctors Contract with 2019 updates; all have the opportunity to submit Exception Reports; and all work schedules complied with contractual commitments under the 2016 Contract. The provision of quarterly report from the Guardian of Safe Working is a contractual requirement outline in the T&CS of the 2016 Contract.

3. High level data

Number of training post (total):	190
Number of doctors in training post (total):	165.8
Annual average vacancy rate among this staff group:	16.7

Exception reports in order of number raised

Exception reports by department				
Specialty	No. exceptions carried over from last report	**No. exceptions raised**	No. exceptions closed	No. exceptions outstanding (13/08/23)
Acute Medicine	0	**3**	3	0
Diabetes and Endo.	0	**1**	1	0
ENT	0	**8**	8	0
General Surgery	0	**3**	3	0
Geriatric Medicine	1	**4**	5	0
Medical Oncology	0	**3**	3	0
Obstetrics & Gynaecology	0	**7**	7	0
Paediatrics	1	**0**	1	0
Renal	0	**10**	10	0
Respiratory Medicine	4	**2**	6	0
Trauma & Orthopaedics	0	**11**	11	0
Total	6	**52**	58	0

Exception reports by grade				
Grade	No. exceptions carried over from last report	No. exceptions raised	No. exceptions closed	No. exceptions outstanding
FY1	6	21	27	0
FY2	0	8	8	0
CT1	0	14	14	0
CT2	0	1	1	0
ST1	0	8	8	0
Total	6	52	58	0

4. Work schedule reviews

Upon the submission of an Exception Report that suggests a mismatch between a junior doctor's work schedule and the actual clinical demands required in that post, it is the responsibility of that doctor's educational supervisor to trigger a *Level 1 (Work Schedule) Review*. Example outcomes of such a review include no requirement for change, a prospective requirement to adjust existing work schedules, or even institutional change. The Exception Report is closed at Level 1 if the junior doctor and educational supervisor agree an outcome or escalated to *Level 2 Review* (with involvement of Guardian/DME and service management) if

the junior doctor is not in agreement with the outcome. *Level 3 Review* constitutes a formal grievance hearing with HR representation.

Exception Reports taken to Level 1 Work Schedule Review

Specialty	Grade	Number	Rota
Acute Medicine	F1	1	2022 F1 Surgical 05/04/2023 - 01/08/2023
Geriatric Medicine	F1	1	2022 F1 Medical 05/04/23-01/08/23
Renal Medicine	CT1	1	2022 IMT 1/2 MED 05/04/23-01/08/23

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

5. Immediate Safety Concerns.

Two Exception Reports were highlighted as being of Immediate Safety Concern (ISC), submitted within Trauma and Orthopaedics. Both were promptly escalated and scrutinized, and there was active involvement of clinical supervisor and service manager.

6. Vacancies

Appendix 1 will be updated to include all vacancies among the medical training grades during the previous quarter reported for each month, split by specialty and grade.

7. Fines

There were no fines levied during this period.

8. Other issues arising

Well attended Junior Doctors Forums continue to meet on a scheduled basis in line with contractual requirements.

Ongoing Industrial Action represents a significant challenge for doctors of all grades and for the hospital management structures. The Guardian has worked with the Medical Director and Junior Doctor representatives locally to reiterate that this is a national issue and does not relate to any local employment arrangements.

A significant amount of work is provided to the Trust by Junior Doctors working extra-contractual (locum) shifts. The Junior Doctor's contract specifies overall limits to the amount of work, contracted and paid extra-contractual, that a Junior Doctor can work. The Guardian has discussed this issue with Junior Doctors, local rota coordinators, the Head of People Services and the Medical Director, and with the BMA's local Industrial Relations Officer. The Trust remains committed to

compliance with all aspects of the Junior Doctors contract including the issue of ensuring a safe limit to extracontractual working. The Guardian has offered to review and advise should exceptional circumstances necessitate deviation from normally sanctioned working patterns.

9. Summary

A well-attended and lively Junior Doctors Forum helps maintain communication between Junior Doctors and the Trust; the Exception Report system continues to function; significant improvements have been made in areas previously identified as being outliers; clinical demand continues to mean that sometimes, Junior Doctors must work over and above their contracted hours.

10. Recommendation

The Guardian asks the committee to note this report and to consider it to provide an assurance of compliance with the safeguarding aspects of the 2016 Junior Doctors Contract.

APPENDICES

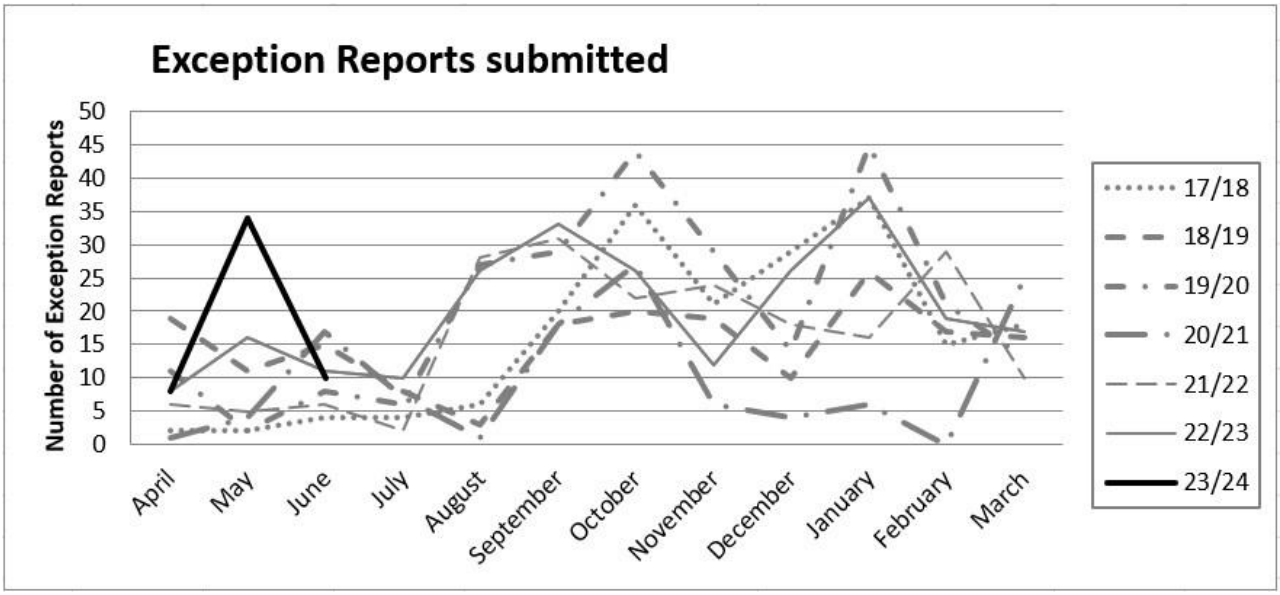
QUARTERLY GUARDIAN REPORT ON SAFE WORKING HOURS: DOCTORS IN TRAINING

APRIL 23 – JUNE 23

Appendix 1 – Trainee Vacancies within the Trust

Department	Grade	Rotation Dates	Apr 23	May 23	June 23	Average Q3
Paediatrics	ST3	Sept	0	0	0	0
Paediatrics	ST4+	Sept	1	1	1	1
O&G	ST1	Oct	0	0	0	0
O&G	ST3+	Oct	0.6	0.6	0.6	0.6
ED	ST3+	Sept and Feb	1.2	1.2	1.2	1.2
Surgery	CT1	Aug	0	0	0	0
Surgery	CT2	Aug	0	0	0	0
Surgery	ST3+	Oct	1	1	1	1
Orthopaedics	ST3+	Sept	1	1	1	1
Anaesthetics	CT1/2	Aug	0	0	0	0
Anaesthetics	ST3+	Aug and Feb	1	1	1	1
Medicine	CT1/2	Aug	3.8	3.8	4.8	4.1
Medicine COE	ST3+	March	0	0	0	0
Medicine Diab/Endo	ST3+	Aug	0	0	0	0
Medicine Gastro	ST3+	Sept	0	0	0	0
Medicine Resp	ST3+	Aug	0	0	0	0
Medicine Cardio	ST3+	Feb	1	1	1	1
Medicine Renal	ST3+	Aug	0	0	0	0
Haematology	ST3+	Sept	0	0	0	0
Med/Surg	FY1	Aug	0	0	0	0
Med/Surg	FY2	Aug	1	1	1	1
GPVTS	ST1	Aug & Feb	2	2	2	2
GPVTS	ST2	Aug & Feb	1.6	1.6	1.6	1.6
GPVTS	ST3	Aug & Feb	1.2	1.2	1.2	1.2
Orthodontics	ST3+	March	0	0	0	0
Total			16.4	16.4	17.4	16.7

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



Minutes of the meeting of the Part 1 Public ICB (ICB) Board of NHS Dorset
Thursday 6 July 2023 at 10am
Board Room at Vespasian House, Barrack Road, Dorchester, DT1 1TS
and via MS Team

Members Present:		
	Jenni Douglas-Todd (JDT)	ICB Chair
	Rhiannon Beaumont-Wood (RBW)	ICB Non-Executive Member
	John Beswick (JB) (virtual) (part)	ICB Non-Executive Member
	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) (virtual)	ICB Non-Executive Member
	Siobhan Harrington (SH)	Chief Executive University Hospitals Dorset NHS Foundation Trust and ICB NHS Provider Trust Partner Member
	Leesa Harwood (LH)	Interim Non-Executive Member
	Paul Johnson (PJ) (virtual)	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
Invited Participants Present:		
	Neil Bacon (NB)	ICB Chief Strategy and Transformation Officer
	Louise Bate (LBa) (virtual)	Manager, Dorset Healthwatch
	Cecilia Bufton (CB) (virtual)	Integrated Care Partnership Chair
	Dawn Harvey (DH)	ICB Chief People Officer
	Jon Sloper (JS)	Chief Executive, Help and Kindness
	Stephen Slough (SS)	ICB Chief Digital Information Officer
	Dean Spencer (DSp) (virtual) (part)	ICB Chief Operating Officer
	Manish Tayal (MT)	Associate Non-Executive Member
In attendance:		
	Liz Beardsall (LBe) (minutes)	ICB Head of Corporate Governance
	Kate Calvert (KC) (for David Freeman)	ICB Deputy Chief Commissioning Officer
	Jane Ellis (JE)	ICB Chief of Staff
	Jonathan James (JJ) (for Andrew Rosser)	Deputy Chief Finance Officer, South Western Ambulance Service Foundation Trust
	Emma Lee (EL) (for Karen Loftus)	Partnerships Manager, Community Action Network
	Ben Sharland (BS) (for Forbes Watson)	GP Alliance Deputy Chair
	Dan Steadman (for item ICBB23/112) (DSt)	Chief Operating Officer, Agincare Group
	Natalie Violet (for items ICBB23/119 and 120) (NV) (virtual)	ICB Head of Planning and Oversight

Public:		
	1 member of the public and 1 member of ICB staff observing were present in the room.	
Apologies:		
	Sam Crowe (SC)	Director of Public Health Dorset (participant)
	Graham Farrant (GF)	Chief Executive, Bournemouth, Christchurch and Poole Council (participant)
	Spencer Flower (SF)	Leader Dorset Council and ICB Local Authority Partner Member (West) (member)
	David Freeman (DF)	ICB Chief Commissioning Officer (participant)
	Karen Loftus (KL)	Chief Executive, Community Action Network (participant)
	Matt Prosser (MP)	Chief Executive, Dorset Council (participant)
	Andrew Rosser (AR)	Chief Finance Officer, South Western Ambulance Service Foundation Trust (participant)
	Forbes Watson (FW)	GP Alliance Chair, Primary Care Partner Member (member)
	Dan Worsley (DW)	ICB Non-Executive Member (member)

ICBB23/108 Welcome, apologies and quorum

The Chair declared the meeting open and quorate. There were apologies from: Sam Crowe, Graham Farrant, Spencer Flower, David Freeman, Karen Loftus, Matt Prosser, Andrew Rosser, Forbes Watson and Dan Worsley.

The Chair welcomed Rhiannon Beaumount-Wood, ICB Non-Executive Member, to her first formal ICB Board meeting.

ICBB23/109 Conflicts of Interest

There were no conflicts of interest declared in the business to be transacted on the agenda.

ICBB23/110 Minutes of the Part One Meeting held on 4 May 2023

The minutes of the Part One meeting held on 4 May 2023 were agreed as a true and accurate record.

Resolved: the minutes of the meeting held on 4 May 2023 were approved.

ICBB23/111 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.

ICBB23/112 Staff Story: Housing

The ICB Chief People Officer introduced the Staff Story video which highlighted affordable accommodation as a key to attracting and retaining the health and social care workforce in Dorset. The story focused on the story of Joju Thomas and the work of Agincare in supporting their staff with housing requirements. The Board was joined by Dan Steadman, Chief Operating Officer from Agincare, who also featured in the film.

Joju Thomas told his story of moving from India to England to work as a nurse, and the challenge he faced around housing and understanding local culture. He used this experience to build a framework for Agincare to support staff arriving from overseas. Agincare now guarantee supported accommodation for six months from arrival for their staff. Dan Steadman encouraged the Dorset system to break down the barriers to supporting people with key worker housing, for both relocating UK staff and staff arriving from overseas.

The Chair reiterated that the Board was engaged with the issue of housing and a housing round-table was being led by Matt Prosser, Dorset Council.

The Board discussed the cultural and pastoral aspects of supporting staff from overseas, noting that the system's positive work in this area had previously been discussed by the ICB Board.

The Board agreed it would like to respond with a collective message to the Dorset Council Housing Strategy consultation, and in future wished to move to codesigning housing strategies with local authority partners.

The need to understand affordability and volume was discussed. It was noted that work had already been undertaken on what was affordable in relation to housing and the percentage of the health and care workforce who were struggling with housing costs was also know. However it was not understood how many houses this would relate to, and this would form part of the work of the housing round-table.

The Chief Executive offered to bring a briefing paper back to the Board regarding housing including details of the Dorset Council Housing Strategy Consultation.

ACTION: PM

The Chair thanked the team, and especially Joju Thomas and Dan Steadman, for the Staff Story.

ICBB23/113 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 Government response to the Hewitt Review
- NHS England (NHSE) has formally stood down the COVID-19 incident
- Publication of the Government mandate to the NHS
- Planned industrial action by junior doctors and consultants in July
- Publication of the NHS Long Term Workforce Plan
- Publication of the NHS Dorset Joint Forward Plan
- An update on the work regarding Place development
- Official opening of the Weymouth Research Unit
- The formation of a coalition at Bournemouth, Christchurch and Poole Council
- CQC inspections at Dorset County Hospital and University Hospitals Dorset
- Updates from partners, which were welcomed by the Board.

With regard to the NHS 75th Birthday, the CEO recognised the unique position of the NHS and the fantastic work it had done and continued to do, and the role that partners played in allowing the NHS to flourish. The future now needed a different approach: responding to those who are unwell but also focusing on prevention and heath promotion. The Board

reflected that sadly much of the media coverage of the NHS's birthday had not focused on the positive work of the NHS.

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

Items for Decision

There were no items for decision

Items for Noting/Assurance/Discussion

ICBB23/114 Committee Escalation Reports

The Board Committee Chairs presented the Committee Escalation Reports from the June meetings. All issues discussed were included in the previously circulated reports and key issues included:

- Clinical Commissioning Committee – recommended the Self Management Contract and 999 Lead Commissioning Agreement (to be discussed in the Part Two Board meeting), and scrutinised the diabetes workplan
- Finance and Performance Committee – approved the urgent ambulance service contract extension and undertook a deep dive into Personal Healthcare Commissioning, as this was an area of significant challenge
- People and Culture Committee – approved the NHS Dorset People Plan and approved a change to the committee membership to better reflect the work of the committee
- Primary Care Commissioning Committee – reviewed the process for requests for changes to Primary Care Networks, noted the excellent work around the pharmacy, optometry and dental services delegation, and discussed the Creating Sustainable General Practice in Dorset report from the GP Alliance
- Quality and Safety Committee – received the Quality Report, approved the Dorset LeDeR (Learning Disabilities Mortality Review) Annual Report 2022/23 for publication, and received the Dorset Local Maternity and Neonatal System (LMNS) Quality Report
- Risk and Audit Committee – approved the Annual Report and Accounts (19 June), and, at the meeting of 22 June, considered the plans for revision of the Board Assurance Framework, and discussed the proposed new finance ledger. The Committee Chair thanked Manish Tayal for his work on the committee.

Resolved: the Board noted the Committee Escalation Reports.

ICBB23/115 Quality Report

The ICB Chief Nursing Officer introduced the previously circulated Quality Report which had been previously scrutinised by the Quality Committee. Highlights included:

- Pathway to Home, noting the positive outcome measures and patient experiences
- Targeted visits undertaken to mental health wards and upcoming Multi Agency Discharge Events
- Positive safeguarding visit from NHSE England (letter included as an appendix)
- Annual Patient Safety Audit and the Patient Safety Incident Response Framework (PSIRF)
- The work of the Shared Learning Panel
- Quality Assurance visit to Community Health and Eye Care (CHEC).

The Board discussed the mechanisms for receiving assurance that the system was on plan, complaints and proactive feedback collection in primary care, and the need for baseline data and average mean data from previous years for comparison where this was available.

The deterioration in performance in relation to dementia diagnosis was noted. The Dementia Working Group (DWG) action plan was being monitored by the Clinical and Professional Reference Group (CPRG), who believed the plan to be robust. The ICB CEO and Joint CEO Dorset County Hospital and Dorset HealthCare agreed to continue the discussion outside the meeting, and the ICB Chief Medical Officer would update the Board after the CPRG received an update from the DWG in the autumn.

ACTION: PM/MB
ACTION: PJ

Resolved: the Board noted the Quality Report.

ICBB23/116 Finance Report

The ICB Chief Finance Officer introduced the previously circulated Finance Report covering the financial position of the ICB and ICS NHS providers as at May 2023 (month 2). The report now included information on voluntary and community sector (VCS) finances.

The system was reporting a year to date deficit of £4.3m against breakeven plans submitted to NHS England. Key financial pressures related to the impact of industrial action, inflation and agency spend. It was noted that work was underway to review the operational groups to better understand where assurance and responsibility for delivery sat.

The Board discussed the potential impact of industrial action on the financial position and noted that no national support had yet been offered in relation to this. Energy costs were discussed and it was noted that each organisation would be working on its own energy expenditure.

Resolved: the Board noted the Finance Report.

ICBB23/117 Portland Barge Update

The ICB Chief Medical Officer (CMO) introduced the previously circulated update on progress towards supporting the healthcare needs of the asylum seekers to be housed on a barge at Portland Port.

Since the paper was circulated, the initial funding offer had been increased and the team were working on how to maximise this funding to provide the fullest primary care offer to the barge residents. The go-live date was still planned for July, building to full capacity by the autumn. The ICB CMO was undertaking a series of media interviews in the afternoon, regarding mitigating the impact of the barge on the local population. The ICB CMO thanked the team for managing this complex work.

The joint priorities remained ensuring provision of services to Portland residents whilst safeguarding the residents of the barge as much as possible. The positive multi-agency work regarding this issue was noted. The Board discussed the need for access to specialised translation services and the plans that were in place regarding this.

The Chair thanked the ICB team and partners for their work.

Resolved: the Board noted the Portland Barge Update.

ICBB23/118 Performance Report

The ICB Chief Operating Officer introduced the previously circulated Performance Report, which provided a summary of performance at end of 2022/23, an overview of current performance against national operational targets for 2023/24 and an update on the developmental work underway for performance reporting in 2023/24.

The current key challenges were flow through the urgent and emergency care pathway resulting in an increase in patients with No Criteria to Reside (NCTR), the upcoming risk of industrial action, the potential for an increase in 78 week waiters, diagnostic challenges in audiology and echocardiograms, out of area placements for mental health, and perinatal mental health services.

The positive performance for cancer, four hour Emergency Department (ED) standard and ambulance response times was noted. It was noted that the figure for ED performance should be 69.5% rather than 54.8% as stated in the report (2.17) for University Hospitals Dorset (UHD). UHD were also in the process of having a new ED IT system installed, which was an added complexity currently.

The Joint CEO Dorset County Hospital and Dorset HealthCare reported that his key concerns regarding mental health service provision were out of area placements, children and young people, and dementia diagnosis. There had been a commitment to achieve the perinatal mental health standard in quarter two and it was anticipated this would be met. It was requested that a section on mental health be added into the Performance Report commentary.

ACTION: DSp

It was noted that population screening data was currently included in the primary care reporting, which would be included in the Quality Report in future.

Resolved: the Board noted the Performance Report.

ICBB23/119 Operational Planning 2023/24 Closedown

The ICB Chief Operating Officer introduced the previously circulated Operational Planning 2023/24 Closedown, which included the letter from NHS England, which was a positive response to the plan.

It was noted that the plan had been produced on the assumption, in line with guidance from NHS England, that there would be no industrial action.

The Chair thanked the team for their work on the production of the Operational Plan.

Resolved: the Board noted the Operational Planning 2023/24 Closedown.

ICBB23/120 ICB Annual Assessment

The ICB Chief Operating Officer introduced the previously circulated ICB Annual Assessment final report which had been circulated along with the data from the feedback interview conducted by Healthwatch Dorset.

The findings of the interviews were largely positive especially around leadership, and the ICB's focus on health inequalities and integration. Three areas for Board development had been identified: reducing NHS focus, understanding the ICB's new responsibilities and maximising use of resources.

The Board discussed the transition from a GP led membership organisation to an ICB, noting that this had largely gone well, but there was work to be done on developing the

relationship between the ICB and the GP Alliance and supporting GPs' understanding of the ICB's role.

The Board noted the summary outlined in the report and agreed the proposed areas of development for inclusion in the Board Development programme for 2023/24.

ACTION: LB

Resolved: the Board noted the summary outlined in the report and agreed the proposed areas of development for inclusion in the Board Development programme for 2023/24.

Items for Consent

The following items were taken without discussion.

ICBB23/121 Learning Disabilities Mortality Review Annual Report

Resolved: the Board noted the Learning Disabilities Mortality Review Annual Report.

ICBB23/122 Personal Health Commissioning Annual Report

Resolved: the Board noted the Personal Health Commissioning Annual Report.

ICBB23/123 Special Educational Needs and Disabilities (SEND) Annual Report

Resolved: the Board noted the Special Educational Needs and Disabilities (SEND) Annual Report.

ICBB23/124 Questions from the Public

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

In Weymouth and Portland we once had four hospitals with wards full of beds. Now we have one with beds. We had eight GP surgeries, now we have six. Two of them hanging on by a thread with not enough doctors. Portland MIU is repeatedly closed. The board could ask that the Home Office fully fund an urgent restoration of the local NHS before sending the barge. To fully reopen Portland Hospital beds. To permanently reopen the MIU. To fail in these risks harming community cohesion. This will need to be agency staff at premium rates to begin with. Will the integrated care board take urgent action to restore all the cuts to Weymouth and Portland NHS provision before the arrival of the barge?

The Chair provided the following response:

The Integrated Care Board is currently working with system partners and the Home Office in relation to how we can best support asylum seekers who will come to Portland. From a health perspective, our primary focus is to ensure that we can provide care for this vulnerable group of people in such a way that mitigates the impact on local services, which we know are stretched.

Additionally, before the barge was announced, we have initiated the 'Portland Together' project, following a meeting with the local community earlier this year, where some of the challenges you mention were also raised. This project is at the initial discovery phase, which includes conversations with local residents and those who work on the island to identify what really matters to them, information gathering and sharing as we better understand the services provided and identifying any opportunities for change that we can immediately take action on.

This project will enable us to plan together with local communities across the whole of Dorset on how we can improve the health and well-being of our population.

ICBB23/125 Any Other Business

Review of the meeting:

- Papers were sharper and the number of pages had reduced
- There was a good level of questioning and challenge, noting that this questioning was a reflection of the Board's greater understanding of the issues under discussion
- Noting it was a year since the transition to the ICB, the Board was now talking in a more holistic way and was focusing more on strategic issues
- There remained a need to ensure that Board conversations reflected the system infrastructure
- There was a need to ensure local authority colleagues were in attendance, noting that it had been unavoidable that they were absent today
- There was a need to develop a greater focus on prevention in Board meetings, with consideration being given to how the Board agendas could be driven by the Board Assurance Framework and the four core ICS purposes.

ACTION: LB

The Chair noted that it was Manish Tayal's final meeting after a full year in post, as he was moving abroad. The Chair thanked Manish for being part of the ICB's initial journey and praised him for his skills in blending cultures and exemplifying the values of the NHS. His commitment, constructive challenge and passion for engagement with wider voices would be missed.

ICBB23/126 Key Messages from the Meeting

The Chair summarised the key messages from the meeting as:

- The Board reiterated its commitment to focusing on housing as a key determinant of health with the ambition of codesigning future housing strategies with local authority partners
- The positive messages relating to the NHS 75th Birthday, the role of partners in supporting the NHS to flourish and the move to a prevention and healthy communities focus
- The risks and challenges posed by planned industrial action by junior doctors and consultants in July
- The positive annual assessment feedback, especially relating to the ICB's leadership and focus on integration and tackling health inequalities.

ICBB23/127 Date and Time of Next Meeting

The next meeting of the ICB Board would be held on Thursday 7 September 2023 at 10am, in the Boardroom, Vespasian House, Barrack Road, Dorchester, Dorset DT1 1TS.

ICBB23/128 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: