Ref: DCS/TH

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

You are invited to attend a **public (Part 1) meeting of the Board of Directors** to be held on **31st January 2024** at **8.30 am to 11.30am** 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.	**Staff Story**	Presentation	Vicki Hyde, Occupational Therapist Carol Thorne, Clinical Practice Educator Juliet Sturgess Associate Director of Allied Health Professions	Note	8.30-08.55
2.	**FORMALITIES** to declare the meeting open.	Verbal	David Clayton-Smith Trust Chair	Note	08.55-9.00
	a) Apologies for Absence: Trevor Hughes	Verbal	David Clayton-Smith	Note	
	b) Conflicts of Interests	Verbal	David Clayton-Smith	Note	
	c) Minutes of the Meeting dated 29th November 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 • Ambulance Handover Escalation Protocol	Enclosure	Anita Thomas Executives	Note Approve	9.25-9.40
6.	**Finance Report**	Enclosure	Chris Hearn	Note	9.40-9.55
Coffee Break 9.55-10.10					
7.	**Maternity Update** • Maternity Incentive Scheme (Jan QC)	Enclosure	Jo Hartley Lindsey Burningham	Note Approve	10.10-10.30
8.	**Board Assurance Framework** (Dec RAC)	Enclosure	Phil Davis	Approve	10.30-10.45
9.	**Equality Diversity and Inclusion Annual Report**	Enclosure	Nicola Plumb	Note	10.45-11.00

	(Jan PCC)				
10.	**Board Sub-Committee Escalation Reports** (Dec 2023 and Jan 2024) a) Quality Committee b) Finance and Performance Committee c) People and Culture Committee d) Risk and Audit Committee e) Charitable Funds Committee f) Working Together Committee in Common	Enclosures	Committee Chairs and Executive Leads	Note	11.00-11.15
11.	**Questions from the Public**	Verbal	David Clayton-Smith	Note	11.15-11.20
	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 11.20-11.25
	The following items are to be taken without discussion unless any Board Member requests prior to the meeting that any be removed from the consent section for further discussion.				
12.	**ICB Part 1 Board Minutes**	Enclosure		Note	-
13.	**Any Other Business** Nil notified	Verbal	David Clayton-Smith	Note	-
14.	**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 March 2024** in the **Board Room, Trust Headquarters, Dorset County Hospital, Dorchester** and via **MS Teams.**				

Part 2 items

- Chair's Update
- CEO's Update
- Fortuneswell Pharmacy Cost Update
- Corporate Risk Register
- Risk Maturity Audit and Action Plan
- Working Together Programme Update
- Working Together Programme Options Appraisal
- Board Sub-Committee Review

Consent Items:

- Dorset Council Reablement Facility
- Contracts for approval
- Cyber Security Update

Minutes of a public meeting of the Board of Directors of Dorset County NHS Foundation Trust held at 8.30am on 29th November 2023 at Board Room, Trust Headquarters, Dorset County Hospital and via MS Teams videoconferencing.

Present:		
David Clayton-Smith	DCS	Trust Chair
Matthew Bryant	MBr	Chief Executive
Chris Hearn	CH	Chief Finance Officer
Jo Howarth	JH	Chief Nursing Officer
Alastair Hutchison	AH	Chief Medical Officer
Eiri Jones	EJ	Non-Executive Director (Deputy Chair)
Claire Lehman	CL	Non- Executive Director
Stuart Parsons	SP	Non- Executive Director
Nicola Plumb	NP	Chief People Officer
Anita Thomas	AT	Chief Operating Officer
David Underwood	DU	Non-Executive Director
In Attendance:		
Dawn Dawson	DD	Chief Nurse, Dorset Healthcare
Trevor Hughes	TH	Head of Corporate Governance (Minutes)
Jo Hartley	JHa	Head of Midwifery (via videoconference)
Molly Mitchem	MM	Young Person (Patient Story)
Kate Parish	KP	Transition Youth Worker (Patient Story)
Lynne Patterson	LP	Freedom to Speak Up Guardian
Simon Pearson	SPe	Head og DCH Charity
Jess Phillips	JP	Young Person (Patient Story)
Hannah Robinson	HR	Staff Member (Patient Story)
Sally Shead	SS	Member of staff - observing
Candi Sidey	CS	Acute Health Facilitator (Patient Story)
Charlotte Tuckett	CT	Transition Nurse Specialist (Patient Story)
Eden Yates	EY	Young Person (Patient Story)
Members of the Public (attending via videoconference):		
Kathryn Harrison	KH	Lead Governor
David Taylor	DT	Governor
Lynne Taylor	LT	Governor
Apologies:		
Margaret Blankson	MB	Non-Executive Director
Nick Johnson	NJ	Deputy Chief Executive and Director of Strategy, Transformation and Partnership
Stephen Tilton	ST	Non-Executive Director

BoD23/088	**Patient Story**	
	JH introduced the three young people that had supported the 15 steps challenge initiative that aimed to consider initial impressions when people visited services for the first time. MM, JP and EY were active young volunteers with the trust and had prepared a short presentation of their impressions of the various services that they had visited. Positive impressions included: • Wards bright, clean and airy.	

- Staff were friendly and patients had privacy.
- There were dedicated children's areas.

Areas for improvement included:

- A lift was not working making access and navigation difficult.
- Improved wheelchair access was needed in some areas.
- Signage was confusing.
- No hoist available
- Poor Wi-Fi in some areas of the hospital.
- Some areas were busy and cramped.
- Notice boards were cluttered making it difficult to identify important public messaging.
- Occasional strange and unpleasant smells.

Recommendations included:

- Improved disabled access to toilets.
- Change colour schemes to brighten and uplift some areas.
- Provide accessible equipment.
- Charitable funds could be accessed to make changes and provide improved entertainment facilities for young people.

The young people thanked the board for the opportunity to be heard and to help make improvements within the hospital.

The Board acknowledged the importance of hearing the views of all hospital users and visitors, including those of young people and provided the following responses to the points raised:

- On improving disability access and facilities, particularly within the Children's Centre, the challenge was identifying suitable space, which often had technical and engineering complications, and funding. the trust was continuing to make improvements where possible, and the Health Inequalities Group was actively discussing these issues.
- 'Grab boxes' were being sourced to provide headphones and noise dampening equipment to better support people less able to tolerate noisy environments.
- The Children's Room had been upgraded and sensory equipment was being introduced. Plans to use the facility outside school hours were also in development.
- The trust had been shortlisted following a bid for greener community funds to develop a sensory garden. The outline business case was being submitted and an outside space had been identified.
- The Active Hospital Programme focussed on increasing activity throughout the hospital for all patient groups and the Health Inequalities Group would bring a report on their activities to the Board at a future point.

The Board sought the young peoples' view on digital / technological enhancements that the trust could make to improve access to information and communications, noting systems in other trusts making patient access to medical records and appointment booking simpler. Recent upgrades to the Wi-Fi within the trust had also been completed.

	The Board thanked the young people for their fresh insight into their experiences of the hospital and noted in particular, the increased anxiety caused for wheelchair users navigating their way through the hospital when essential access equipment was out of order. The Board enquired whether the volunteering experience had peeked interest in pursuing future employment in healthcare and heard that the young people were considering available apprenticeship opportunities. The Chair thanked the young people for the positive discussion, their hard work in developing the feedback and helping to make improvements to patients' experiences of the hospital. The Board requested that the group return to the Board in six months' time to review actions taken and again in 12 months' time to review other parts of the hospital. Discussion followed about the benefits of establishing a young people's reference group within the trust and further consideration would be given to developing this aspect within the engagement strategy and working with DHC to build on their Youth Board arrangements.	
	Resolved that: the Patient Story be heard and noted.	
BoD23/089	**Formalities**	
	The Chair declared the meeting open and quorate and welcomed governors to the meeting. Apologies for absence were received from Margaret Blankson, Nick Johnson and Stephen Tilton.	
BoD23/090	**Conflicts of Interest**	
	There were no conflicts of interest declared in the business to be transacted on the agenda.	
BoD23/091	**Minutes of the Meeting held on the 27th September 2023**	
	The Minutes of the meeting dated 27th September 2023 were approved as an accurate reflection of the meeting, noting a minor typographical error on page 7 that would be corrected.	
	Resolved: that the minutes of the meeting held on 27th September 2023 were approved.	
BoD23/092	**Matters Arising: Action Log**	
	The action log was considered, updates received in the meeting were recorded within the log, and approval was 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.	
BoD23/093	**Chair's Comments**	
	The Chair advised the Board that a joint governor workshop with DHC was to be held the following day focussing on the governor role within the wider system and considering how to better connect with the membership across both trusts.	

	The Chair reported that: • Regular discussion with lead governors continued to support the developing relationships with NEDs and consideration was being given to governors joining the 15 steps site visits with executive and non-executive colleagues. • Discussions with UHD continued to build relationships and a joint Board meeting in February 2024 between UHD, DCH and DHC boards was in planning. A provisional date was being held in diaries across the three trusts. • The DCH and DHC Annual General and Annual Members meetings had been held recently and had been successful and well attended. • EJ and FW had been appointed a Deputy Chairs of DCH and DHC respectively and were meeting regularly. • The regular programme of DHC and DCH visits and discussion with the Leagues of Friends continued. • His recent talk at a local University of the 3rd age, (more normally referred to as 'U3a') had been very well attended. • He and MBr had met with BCP council recently to build relationships across the county. • Regular chair to chair meetings continued with UHD and the ICB to discuss system working.	
	Resolved: that the Chair's Comments be noted.	
BoD23/094	**CEO Update**	
	MBr highlighted the following: • The importance of actively seeking the views of quieter voices in service development and redesign. • Some national progress in negotiations relating to consultant industrial action although the junior doctor position remained unresolved. • Board reflections on the Letby case • The Board welcomed the new Secretary of State for Health and Social Care. • The system priorities were outlined in the report and needed to be reviewed in planning process context. • Participation in the system CQC inspection pilot would not be formally rated although feedback would be provided. • Good progress on Working Together Programme initiatives continued. • The trust had signed up to the Sexual Safety Charter. • The trust had recently hosted a visit by the Regional Director, NHS England and Michael Marsh that had discussed strategy and site developments. The visitors had been very impressed with changes made to the site and were congratulating of the leadership and delivery of the changes. • Full planning permission for planned developments had been received and further discussion of the New Hospitlas Programme was scheduled in part 2 of the meeting. • The Board had considered the CQC maternity report thoroughly. Whilst disappointed in the outcome of the report, the trust accepted the report in full and acknowledged the levels of confidence and value articulated by service users. Actions taken in response to the warning notice had been submitted the previous day. The board was reminded	

	that the inspection had been undertaken as part of the national programme and that a majority of trusts required improvement. • The outcome of the CQC report had been covered by the Dorset Echo and comments posted about the article had been generally supportive of the service. Morale within the service remained high. Community feedback had also been positive. • Congratulations were extended to Midwife Rachel McWilliams who had won the Southwest regional UK MUM Award 2023. • Congratulations also extended to Zoey Fry, Interim Paediatric Matron who had been awarded a Queen's Nurse Award. • It was clarified that circa 40% of the local population still needed vaccination against winter illnesses.	
	Resolved that the CEO Update be noted.	
BoD23/095	**Balanced Scorecard**	
	The Board recognised that further development of explanatory narrative within the report was underway. The following key performance points were highlighted: • Ambulance handover performance had deteriorated slightly and had been impacted by high numbers of patients remaining in hospital with No Reason to Reside. • Diagnostic performance had improved slightly. • 52 and 65 week wait trajectories were not being met due to increased demand (6%) and reduced activity due to the impact of industrial action. • There was a small number of cases that had not met the 62 day diagnosis target and interventions had been implemented to restore the position. • The performance data had been reviewed by the Finance and Performance committee the previous week. **People metrics** NP summarised that: • Turnover and vacancy rates were reducing. • Sickness levels were expected to increase over the winter months. A deep dive recently presented to the People and culture Committee had identified that most absence was not related to the workplace. • The underlying vacancy still needed to reduce. • The recruitment and resourcing action plan focussed on continuing to strengthen current processes and engagement with clinical teams. • Seven Healthcare Assistant posts had been offered following a recent recruitment event and vacancies were being supported through additional housekeeping and other supporting roles. • The trust had been nominated as 'Apprenticeship organisation of the year'. • Agency costs were reducing, and bank fill rates were increasing. • The staff survey had closed the previous week with a 41% return rate which was slightly below the national average.	

	• Staff flu and covid vaccination uptake stood at circa 40% and further promotion of the programme was in place. **Quality** • There had been a significant increase in medication related incidents resulting in no harm. Recording of these incidents had recently undergone recategorization and staff were being actively encouraged to report of missed doses, thorough discussion had taken place at Quality Committee. • The timely completion of Electronic Discharge Summaries remained an issue due to technical difficulties and the need to further improve processes and approve summaries within the same working day. **Finance** CH highlighted following key areas: • Agency spend was reducing but remained above trajectories. • Delivery efficiencies was intrinsically linked to other indicators - £431k had been delivered against the ambitious £900ktarget. • The year end cash position remained at risk and updates would be included in report going forward. Progress had been made via international recruitment and training of cardiology technician staff un addressing the cardiology diagnostics backlog and there was a national programme to promote employment opportunities. The cardiology waiting list was kept under constant review to identify any increased urgency for those waiting. Performance was improving but still was not meeting the required standard. The Board recalled previous discussion of financial plan and review of productivity against 2019 performance activity with concerns identified escalated to appropriate committees. DM01 activity had been discussed in relation to potential harms by the Quality Committee and the Board heard that Dorset was leading in respect of performance across the southwest. The Board acknowledged the development of the dashboard report and noted that several indicators suggested the need for process redesign and the need to better understand the actions being taken. Improvements to the report or appropriate committee dashboard reports, including performance against the strategic ambitions, would be in place for 2024/25 when the planning guidance had been received.	
	Resolved that: the Balanced Scorecard and System Performance Update be received and noted.	
BoD23/096	**Finance Report**	
	CH outlined the Month 7 position: • There had been an in-month deficit of £1.7m bringing the total to £8.5m year to date. • Drivers of this position included continuation of the industrial action impact and high levels of agency spend. There was a £2.9m overspend against the target due to 23 escalation beds being	

open and high patient acuity, inflationary pressures on utility contracts and drugs.

- The efficiency ambition had set a £10.9m target and the Value Delivery Board process was gaining traction on the identification and delivery of this target. Focus remained on delivery although this had been impacted by operational capacity.
- Regular meetings with operational areas were taking place to support and review trajectories.
- Elective activity was underperforming by £2.1m although there had been a national reduction in the target.
- The forecast risk to achievement of a breakeven position was £14.4m. The implementation of stretch targets reduced this to £10m and this was being fed into the system position.
- The risk to the cash position amounted to circa £12m. Mitigations were being implemented and a further report would be returned to the Board.

CH reported that the revised Operating Plan had been submitted following board approval and had identified a deficit position for the remainder of the year. Regional and national meetings would be held the following day where the submission would be challenged. There was significant potential that there would be increased scrutiny of investments and workforce movements, and a review of productivity would likely also be undertaken.

Essential to reducing agency expenditure was the need to reduce the number of vacancies and keep sickness absence levels down. The development of alternative support roles was also being progressed and incentive schemes across the system were being aligned. The use of off framework agencies had dramatically reduced, and clinical leaders were actively challenging decisions at the point of contact.

The Board emphasised the need to understand the system bed number requirement to better support the use of escalation beds and set plans for future years. CH reminded that the medium-term financial plan included the use of temporary staffing and noted the interdependencies with workforce plans and service plans.

The Board acknowledged the considerable increase in the number of internationally recruited nurses to address vacancies over the previous 12 months and also noted the additional costs associated with pastoral care and accommodation.

The 2024/25 planning round was due to commence, and system-wide discussion was supporting the setting of consistent and realistic targets.

MBr noted the significant challenge and emphasised the need for board members to understand and be able to articulate:

- the risk issues and drivers of the financial position.
- Robust assurances on the mitigating actions being taken. The Finance and Performance Committee would continue to scrutinise the position and the executive team was reviewing previous investments to provide a report to the Board going forward.

	• Importantly, the need to clearly articulate assurances regarding agency staffing was noted. A report would be provided to the Finance and Performance Committee providing assurances on the delivery of the agency spend targets so avoiding an adverse impact on the financial forecast. • The system position and ability to influence this. There would be further actions arising from discussions with the national team the following day.	**CH / NP / JH**
	Resolved: that the Finance Report be received and noted.	
BoD23/097	**Maternity Update**	
	JHa attended for this item. The report was taken as read although JH highlighted the following: • The number of Co2 measurements taken at booking were increasing. • The incidents of post partum haemorrhage greater than 1500mls was decreasing. • No new incidents had been reported to Healthcare Safety Investigation Branch (HSIB). • 1 HSIB ongoing case had been closed with no safety actions. • 10% of incidents related to staffing levels. • Venous thrombo-embolism risk assessments were being reviewed. • No perinatal mortality reports had been made. • The availability of a surgical assistant risk was being mitigated. • No complaints had been received. • Staffing challenges in respect to vacancies. The service was forecasting that it would not be fully compliant with the additional year 4 requirements of the Maternity Incentive Scheme (MIS). Risks to compliance included: • The level of GP trainees, • midwifery workforce planning. JHa reported the need to achieve 70% compliance with the Saving Babies Lives Care Bundle standards. Performance was currently at 30% although there was confidence that the target would be achieved. JHa further reported that: • Training remained a challenge due to small size of the service. • 1 premature baby had been transferred to a specialist unit. • ATTAIN figures were below the 5% target. • Service user feedback continued to be positive. • Positive feedback about the staff and positive culture within the service had been received following a recent visit by regional colleagues. • The further support and development of consultant leadership was a focus of the trust.	

	The Board were reminded of prior approval for the recruitment of an additional 5.4 FTE midwives and to substantivise the maternity governance post. A workforce review was underway and would inform planning for the coming year. Mitigations in place for workforce risks. EJ noted strenuous discussion by the Quality Committee, reflecting on what was working well, the CQC report and action plan in place and advised that many metrics were improving. Positive Maternity Voices feedback was noted alongside training and support for Obstetricians. Several documents had been presented to the Quality Committee the previous week that had assured the committee. The Board was assured that the training needs analysis had been based on core competencies and had been review by the committee. A plan had also been developed to understand the future reporting requirement to Board. Next year – as part of the work plan to be sighted on MIS and CNST repotting requirements. DD commented on the positive Board discussion and sought clarity on MIS milestones. DD noted the need for continued support for the maternity team also. JHa responded that staff and leaders would ask to speak to the board champions about their concerns and had good access and were well supported. JHa added that staff reported that they felt they were seen and heard as a team. In response to a query, the Board heard that initial actions were in place and that there was a longer-term plan to implement a full call bell system as part of the wider programmes of work within the hospital. MBr commented in the increasingly specialist nature of maternity services and observed that nonclinical Board members may need support to understand what they needed to seek assurance on. He advised that a Board Development session was planned in the new year. The system LMNS lead could perhaps support this session. MBr advised that the Board needed to have clarity and to consider the information presented and to understand the significance and actions arising. The paper would need to respond to these points going forward. The Board noted the ongoing discussions and development of the maternity service dashboard. The report would continue to be refined and to incorporate benchmarked performance going forward.	
	Resolved: that the Maternity Update be received and noted.	
BoD23/098	**Learning From Deaths Report**	
	AH reported that there were no concern arising from the report to escalate to the Board. The SHMI had declined further and had continued a steady downward trend.	

	A review of the nonelective death rate relating to emergency surgery for acute abdomen had demonstrated a death rate of 4% against the 11% national average. AH advised that the coding backlog was starting to increase slightly and that a meeting with the coding lead to resolve was scheduled. Readmission rates to hospital also appeared to be in a positive position indicating very few failed discharges.	
	Resolved: that the Learning from Deaths report be received and noted.	
BoD23/099	**Freedom to Speak Up Update**	
	LP attended for this item and summarised key aspects of the biannual report{ • 100 cases had been reported to the guardian in Q1 and Q2. The significant increase being because of increased visibility and promotion of the role. • No whistleblowing disclosures had been reported in the period. • Impact on worker wellbeing was a theme and the guardian was referring staff to dignity workshops. • No anonymous concerns had been raised. • Greater triangulation of data was taking place through attendance at safety huddles etc. • Monthly reports were being provided to the People and Culture Committee and senior leader meetings. LP outlined that the next steps included increasing visibility further and exploring the impacts of detriment. Plans were in development to further grow network champions, aiming to have one champion in each service and to incorporate training in the ward accreditation scheme. The Board acknowledged the enthusiasm LP brought to the role and noted that 60% of staff had tried to report their concerns via another route, demonstrating an increasingly open culture. Where concerns raised were about managers, staff were supported by HR managers and provided with further training and coaching. The Board noted the level of incivility in complaints and advised that this was not acceptable. LP responded that managers were often pressurised and that civility was regularly discussed at staff and manager away days Manager training needs were also being addressed and a review of the Management Matters training was underway and the topic of civility would inform further development of the programme. The Board thanked LP for work being undertaken and reiterated that she had open access to members of the Board	
	Resolved: that the Freedom to Speak Up Update be received and noted.	
BoD23/100	**Board Subcommittee Escalation Reports**	

	The following subcommittee Escalation Reports were taken as read. Committee Chairs drew attention to the following key points: **Quality Committee** • Noted prior discussions by the Board. • There was a plan in place to support the additional needs for oncology care. • The update regarding call bells in maternity services had been received by the Board. • The committee noted the improved reporting culture in respect of medication errors. • The use of mixed sex accommodation was being closely monitored. • A presentation from the Ophthalmology service was planned. • A Never Event had been reported and the committee was awaiting the outcome of the investigation. • There had been positive movement in some clinical indicators. **Finance and Performance Committee** • Noted the Board discussion and additional board meeting discussions of the financial position and performance challenges. • The committee noted the compliance with Freedom of Information Act requirements risk due to limited resources and capacity. **People and Culture Committee** • Digital team and clinical coding resourcing. • The committee noted the deep dive on agency expenditure. • An Equality, Diversity and Inclusion (EDI) had been received. The annual report would be presented to the Board in January 2024. The EDI maturity audit had been reviewed and the committee had requested the inclusion of an action striving for continued improvement. **Working Together Committee in Common** • The recent joint Board discussions had identified the need to consider benefits further and commended the progress made over the previous twelve months. The shift in executive appointments to support greater alignment was noted and the plan for the coming year was being finalised. **Charitable Funds Committee** • The Board noted planned discussion of the annual report and accounts following the Board meeting and that the charity business plan for the coming year had been reviewed.	
	Resolved that: Board subcommittee Escalation Reports be received and noted.	
BoD23/101	**Social Value Action Plan and Biannual Progress Report**	
	SPe attending for this item, thanking the Board for the opportunity to present. He drew attention to the following points: • Social value would feed into the joint strategy development.	

	• Energy and decarbonisation were a key focus requiring a new strategy. The trust was working with advisors to develop a plan and to apply for public funding to support decarbonisation. • Procurement metrics included local spend – the amount spent with local suppliers was rising. • Voluntary and community services spend was also on a rising trajectory. • Plans to implement the living wage had moved to the ICB to be considered within the system People Plan. • Local employment opportunities were set out in the report and the positive impact of apprenticeships leading to employment with the trust were noted. • Social value activity was also included in the report. • A system level anchor network maturity report was being developed and would be reported in the new year. Examples of social value work can be found at https://haln.org.uk/case-studies SPe reported that benchmarking data across the NHS was not yet available although DCH continued to take a leading role at system level. Several models from health learning networks and leaders in this work were available and would be circulated. In response to questions promoting sustainability, the Board hear that the trust Sustainability Group was exploring options including increasing local spend and improving clinical waste. Training on supporting Net Zero Carbon was available to staff via the electronic staff record system. The Allied Health Professional (AHP) strategy was not yet published but considered clinical aspects of sustainability and many actions that could be taken going forward via the Sustainability Group to land some of the practical aspects of this work. The newly appointed AHP lead would be taking opportunities forward and consider the best use of outside space to promote wellbeing. The Board noted the staff wellbeing link and the positive procurement approach in delivering the trust's social value pledges and embedding these into daily practice.	
	Resolved that: the Social Value Action Plan and Biannual Progress Report be received and noted.	
BoD23/102	**Strategy Update**	
	PL attended for this item and reminded the Board of the arrangements in place to monitor delivery of the strategy objectives, outlining some of the individual projects. The Board Assurance Framework (BAF) supported delivery and risk mitigation and milestone plans were in development to demonstrate tangible delivery. There was considerable work in train. PL went on to update on the joint strategy development with DHC. He clarified the scope of the joint strategy and development of the strategic objectives. The strategy would be supported by an improvement framework and a review of BAF risks. Active engagement was taking place with a wide range of stakeholders.	

	PL outlined the next steps in the development of the joint strategy noting the risks and the ambition to support transformational changes in working processes to improve patient outcomes. He also noted the need for balance between pace and effective engagement. MBr acknowledged the need to create space for conversation and engagement with colleagues. The joint strategy was a strategy for the two organisations (DCH and DHC) who shared a joint commitment to population health improvement and was not about organisational form. However, the two trusts may want to consider organisational identity. A set of service principles would evolve and would be supported by enabling strategies and process redesign. The Board noted the importance of their role in setting strategy and seeking assurance on co-design and co-development. A proposal for further Board discussion would be developed.	**MBr**
	Resolved: that the Strategy Update be noted.	
BoD23/103	**Questions from the Public**	
	KH fed back comments from the Your Voice meeting regarding accessibility difficulties experienced by wheelchair users using the car park as not everyone used disabled parking spaces. A review of available spaces was currently underway. Navigation around the site was also difficult due to poor signage and KH proposed the development of and App. A wayfinding project was in place to oversee the issue bearing in mind the ongoing developments across the site and temporary nature of signage currently. DT fed back that people he had engaged with had been very supportive of the trust's maternity service and that a recent presentation to the council about the South Walks House development had been incredibly well received by the community.	
	CONSENT SECTION	
	The following items were taken without discussion. No questions had been previously raised by Board members prior to the meeting.	
BoD23/104	**Guardian of Safe Working Quarterly Report**	
	Resolved: that the Guardian of Safe Working Quarterly Report be approved.	
BoD23/105	**Seasonal Surge / Winter Plan**	
	Resolved: that the Seasonal Surge / Winter Plan be approved	
BoD23/106	**Communications Activity Report**	

	Resolved: that the Communications Activity Report be received and noted.	
BoD23/107	**Any Other Business**	
	No other business was raised or notified. The items on the part 2 meeting agenda were summarised to promote openness and transparency.	
BoD23/108	**Date and Time of Next Meeting**	
	The next Part One (public) Board of Directors' meeting of Dorset County Hospital NHS Foundation Trust will take place at **8.30am** on **Wednesday 31st January 2024 in the Board Room, Trust Headquarters, Dorset County Hospital** and via **MS Teams.**	

Action Log – Board of Directors Part 1

Presented on: 31st January 2024

Minute	Item	Action	Owner	Timescale	Outcome	Remove? Y/N
Meeting dated: 29th November 2023						
BoD23/102	**Strategy Update**	A proposal for further consideration to be developed.	**MBr**	January 2024	Board development sessions will include strategy development.	
Meeting Dated: 27th September 2023						
BoD23/071	**Balanced Scorecard**	Further narrative to be included to explain performance or variance and targets to be included with metrics.	**PD**	~~November~~ ~~December~~ January 2024	AT and JW are working closely with Executive Leads to develop narrative to address variation in the dashboard. This narrative is included within the January Balanced Scorecard.	
Meeting Dated: 26th July 2023						
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~~ ~~December~~ January 2024	Agenda item for January's Board	**Yes**

Actions from Committees…(Include Date)						

Actions to Committees…(Include Date)						
BoD23/096 November Board	**Finance Report**	A report to be provided to the Finance and Performance Committee providing assurances on the delivery of the agency	**CH / NP / JH**	December 2023	Added to FPC Action Log	**Yes**

		spend targets so avoiding an adverse impact on the financial forecast.				

Report Front Sheet

1. Report Details			
Meeting Title:	Board of Directors		
Date of Meeting:	Wednesday 31 January 2024		
Document Title:	CEO Report		
Responsible Director:	Matthew Bryant, CEO	Date of Executive Approval	15.01.24
Author:	Jonquil Williams, Corporate Manager		
Confidentiality:			
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

This briefing provides the Board with information on a number of national and local topics of interest.

It is intended to supplement the verbal report from the Chief Executive.

The Board may wish to note, in particular:

National:

- The publication of the NHS vaccine strategy

Dorset Integrated Care System:

- Industrial action update
- Response to financial challenges

Joint working

- An update on progress in the Working Together programme

Dorset County Hospital:

- Ridgeway Ward refurbishment
- Accreditation as a National Joint Registry (NJR) Quality Data Gold Provider

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. Strategic update – national topics of interest

NHS Vaccine strategy

2.1 The NHS published its first vaccine strategy in December 2023 which sets out how the NHS will improve uptake and give more freedom and flexibility to the public. It aims to make it easier for people to get vaccinated in places that are most convenient, increasingly alongside blood pressure tests and other important health checks. This strategy puts vaccines at the heart of prevention alongside other services, to increase population-wide coverage while reducing health inequalities. In taking this approach the NHS aims to stop the spread of infections such as measles and help prevent as many people as possible becoming seriously unwell.

Pharmacy First Launch

2.2 The new Pharmacy First service is set to be launched on Wednesday 31 January 2024. This service will see seven new clinical pathways and the expansion of existing blood pressure and oral contraception services. This service will enable community pharmacists to offer advice to patients and supply NHS medicines, including some prescription-only medicines, where clinically appropriate, to treat common health conditions (sore throat, infected ears, impetigo, shingles, infected insect bites, sinusitis and uncomplicated urinary tract infections in women), without the need for a GP appointment and a prescription.

3. Strategic update – Dorset Integrated Care System

Industrial action

3.1 The New Year started with the longest ever period of industrial action undertaken by the British Medical Association doctors in training, between 3 and 9 January 2024. This followed industrial action carried out from 20-23 December 2023. The management of the industrial action coincided with a highly pressurised time of the year for NHS urgent and emergency care services with increased rates of flu and Covid-19.

3.3 Dorset system partners worked together to plan and prepare to ensure the safe delivery of health care services for the people of Dorset, while supporting staff and the right of colleagues to strike. Industrial action will have ongoing impacts beyond this action as we recover services.

NHS Financial Challenges

3.4 NHS England issued a letter to all ICB and Trust Chief Executives in November 2023 providing clarity on priorities and funding for the rest of this financial year. This included setting out arrangements for the allocation of some additional funding to cover the costs of industrial action.

3.5 After a full review of the financial position, and determining mitigation actions, the Dorset system has submitted a deficit position of £12m for the current year to NHS England.

Dorset's NHS organisations have been working together to implement the steps required while continuing to deliver safe and effective patient care. Actions include:

- a vacancy control process across all organisations in Dorset

- a lock on any proposed investments across the whole Dorset system with any investment over £100k having to be agreed by the ICB
- limiting non-pay expenditure only to essential spend.

Electronic Patient Record (EPR)

3.5 NHS Dorset and provider trusts are now working with NHS Somerset to develop a joint approach to commissioning an EPR for the providers across Dorset. We have agreed joint leadership arrangements to create the outline business case over the next few months.

Dorset Integrated Care System community market place events

3.6 System partners worked together to organise two successful market place events, attended by 150 people, on 28 November in Blandford and 7 December in Poole. A wide variety of partners attended with Covid-19 vaccinations provided, blood pressures taken, information and signposting for the public and opportunities to hear what is important to local people. The system will be holding further market place events in the near future enabling members of the public to access vital health checks alongside receiving latest information and updates.

Community conversations in Portland

3.7 The Our Dorset ICS has completed a pilot of a place-based community approach to planning services needed in local neighbourhoods. As part of the pilot the ICS held an event on Portland on 1 December 2023 to showcase what people are saying and provide the opportunity for additional comments. A co-production event with local people, communities and other stakeholders is being planned for February 2024 and a one year on event is planned with Island Community Action and residents of Portland in April 2024.

4. Joint working

Vaccination programme, Autumn/Winter 2023

4.3 Good progress has been made to vaccinate residents most at risk against both flu and Covid-19, with over 222,000 people vaccinated across Dorset so far this autumn, 66% of those eligible. Vaccination appointments are available through a number of GP practices, pharmacies and vaccination centres across the county. All care home vaccinations have been completed.

4.4 Dorset was placed in the top 3% of the country for successfully vaccinating care home residents as a priority cohort during the first month of the vaccination programme. In addition, more than 6,000 housebound patient vaccinations have been given in people's homes in Dorset, helping the south west to be named the number one region in the country for protecting our most vulnerable patients against the virus.

4.5 The volunteers for the vaccination service have successfully been brought in-house after being previously contracted out to other organisations. We have supported 107 volunteers to give 3225 volunteering hours and help improve patient experience at our clinics.

4.6 Dorset County Hospital staff vaccination coverage is at 49.5% for flu and 44.0% for Covid-19. Dorset HealthCare staff vaccination coverage is at 42.3% for flu and 37.8% for Covid-19.

Working Together programme – Dorset County Hospital and Dorset HealthCare

4.7 Jenny Horrabin has been appointed Joint Executive Director of Corporate Affairs for both our Trust and Dorset County Hospital. Jenny is currently the Associate Director of Corporate Affairs for Coventry and Warwickshire Partnership NHS Trust, having previously been the Deputy Director of Corporate Affairs for NHS Coventry and Rugby CCG. She is an experienced corporate governance professional with a background in accountancy, having worked across providers and commissioners during her career.

4.8 We continue a range of engagement activities to support the development of a joint strategy for the two trusts. This includes opportunities for stakeholders – including staff, patients, partners and the public – to give their views about the priorities for our trusts in the coming years. Engagement is due to be complete by the end of January after which a draft strategy will be developed for further testing and final approval.

5. Trust updates

Dorset County Hospital

Ridgeway Ward Refurbishment

5.1 On 16 November Ridgeway Ward at Dorset County Hospital is being transformed into dedicated space for people having elective orthopaedic surgery to support the reduction in waiting times.

5.2 The ward is being refurbished to provide 24 beds for orthopaedic elective surgery patients. The £1.4million scheme is being funded by NHS England and is the second phase of a wider £14million project that includes the ongoing work at South Walks House in Dorchester to create a permanent Outpatient Assessment Centre. This will free up clinical space on the main hospital site by offering outpatient clinics, diagnostics and day case procedures.

Targeted Lung Health Check Service

5.3 On 14 December 2023 Dorset Targeted Lung Health service marked its first anniversary and has already proved hugely successful in identifying conditions much earlier and improving outcomes for patients. Dorset County Hospital (DCH) is the lead provider for the programme, working with health partners throughout the county.

5.4 The Targeted Lung Health Check is part of a national initiative aimed at diagnosing and treating lung and breathing problems before they become serious. People aged 55 to 74, who are registered with a Dorset GP and are a current or former smoker, are invited to have a Lung Health Check.

The team has screened the population of Royal Manor Health Care on Portland and are well on their way to screening the Kinson Road Surgery in Bournemouth, with more planned this year. They have carried out 902 face-to-face Targeted Lung Health Checks and 440 CT scans, finding six early-stage lung cancers and several other cancers.

In addition, they have diagnosed emphysema, high blood pressure and coronary artery disease and started treatment that will help prevent early deaths from lung and cardiac disease.

Weymouth Research Hub – Photography competition

5.5 Weymouth Research Hub has been brightened up in time for Christmas with help from talented local photographers. Staff at the hub partnered with Weymouth Camera Club to select 12 images of the area, as part of efforts to build links with the local community.

5.6 The images were unveiled at a special ceremony in the hub, based in the renovated Linden Unit in Radipole Lane. First, second and third places were also awarded. Now anyone who comes forward to take part in vital, life-saving health research studies will be able to admire the new wall art. The pictures, printed onto canvas, decorate the main corridors in public areas and every clinic room.

5.7 The winning images were voted for by staff from the two NHS Trusts - Dorset County Hospital and Dorset HealthCare, as well as staff at the National Institute for Health and Care Research (NIHR) Clinical Research Network Wessex, which supports the hub.

National Joint Registry

5.8 On 08 December Dorset County Hospital is celebrating after being named as a National Joint Registry (NJR) Quality Data Gold Provider after successfully completing a national programme of local data audits.

5.9 The NJR monitors the performance of hip, knee, ankle, elbow and shoulder joint replacement procedures to improve clinical outcomes for the benefit of patients, but also to support and give performance feedback to orthopaedic clinicians and industry manufacturers. The registry collects high quality orthopaedic data in order to provide evidence to support patient safety, standards in quality of care, and overall value in joint replacement surgery. The ‘NJR Quality Data Provider’ certificate scheme was introduced to offer hospitals a blueprint for reaching high quality standards relating to patient safety and to reward those who have met registry targets.

5.10 In order to achieve the award, hospitals are required to meet a series of six targets during the audit period 2022/23. One of the targets which hospitals are required to complete is compliance with the NJR’s mandatory national audit aimed at assessing data completeness and quality within the registry.

Celebrating success – New Year Honours

5.11 A huge congratulations to Administrator Julie Fry who was recognised in the New Year Honours for her services to education and health in Kenya. Julie has done incredible work to improve the lives and futures of children in Kenya and is the Co-Founder of the Kenyan Project.

5.12 On 11 December we celebrated our Long service awards, these awards are for our staff who have worked at Dorset County Hospital for 25 years.

Report Front Sheet

1. Report Details			
Meeting Title:	Board of Directors		
Date of Meeting:	Wednesday 31st January 2024		
Document Title:	Dorset County Hospital Balance Score Card		
Responsible Director:	Anita Thomas, Chief Operating Officer	Date of Executive Approval	23.01.23
Author:	Jonquil Williams, Corporate Business Manager		
Confidentiality:	If Confidential please state rationale:		
Publishable under FOI?	Yes		
Predetermined Report Format?	No		

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

3. Purpose of the Paper	What is the paper about? Why is the paper is being presented and what you are asking the Board / committee to do?							
	Note (✓)	x	Discuss (✓)		Recommend (✓)		Approve (✓)	
4. Key Issues	This report addresses the key elements of the Balanced Scorecard, bringing in additional elements from sub-Board Committee papers where useful for a rounded view of the Trust performance in that section. Please note under section 2 Performance there is a summary of the 65 week wait declared position for the end of this financial year which was previously detailed at the January Finance and Performance Committee and provides a response to Board Action **BoD23/101 (part 2)** **Key areas to highlight:** **Quality** • Emergency readmissions within 30 days of discharge have risen to 8.9% year to date. • Electronic Discharge Summary sent within 24h of discharge remains below target at 76%. • SHMI has remained within he expected range and is predicted to fall further **Performance** • Cancer waiting list, backlog and backstop have seen growth but the Trust did meet 31 day standard however did not meet the 62 day standard. • Theatre utilisation was 72.05% slight reduction to November. • Diagnostics – the Trust achieved 84.2% against a target of 99%. • The total waiting list increase by 34 patients, total waiting list size is 1201. • Ambulance handover delays – 53.9% of all handovers in 15mins and improvement of 7.5% and 93% were completed in 30mins and 30 patients were delayed for more than an hour.							

	People • Appraisal rate has increased to 77% • Overall sickness has increased for the fifth month running. • Vacancy rate decreased and is now 5.74%. Lowest rate since June 2022. • Turnover decreased to 10.8%. **Finance** • Adjusted financial plan. • Agency spend effected covering sickness and vacancies. • Capital expenditure is behind plan year to date. • Efficiency delivery – delivered against plan for Corporate, Digital, Covid and Prothesis however Security and high cost agency off plan.
3. Action recommended	The Board of Directors are asked to Note this report.

4. Governance and Compliance Obligations				
Legal / Regulatory Link		**Yes**	**No**	If yes, please summarise the legal/regulatory compliance requirement. (Please delete as appropriate)
Impact on CQC Standards		**Yes**	**No**	If yes, please summarise the impact on CQC standards. (Please delete as appropriate)
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Equality Impact Assessment (EIA)		**Yes**	**No**	
Quality Impact Assessment (QIA)		**Yes**	**No**	

1. Introduction

1.1 19 measures in this reporting period fail to give process assurance within the current scorecard – this may mean the process does not easily lend itself to representation as an SPC chart or that without intervention the process will not deliver the required outcome. Each is addressed below and where appropriate other measures described which give a more rounded perspective on the Trust performance within that section.

2. Quality and safety

2.1 A draft Quality Dashboard will be presented this month to the Quality Committee with the expectation that a broader set of measures will be introduced to the Board Balanced Scorecard. In the interim we continue with the current set of measures:

2.2 Four measures – Never Events, Serious Incidents and the two IPC measures all continue as 0. Work continues to move towards reporting data for assurance and whether SPC is the correct format for reporting infrequent events. This will also align to PSIRF and revised arrangements for reporting and investigation of safety incidents.

2.3 Emergency readmissions within 30 days of discharge have risen from around 6.6% for the full year 2022/23 to 8.9% (year to date) but remain below the national average of 9.7% (DrFoster data). A low readmission rate may suggest a discharge process that is too cautious and therefore the recent rise may not be inappropriate but requires continued monitoring.

2.4 Electronic Discharge Summary sent within 24hrs of discharge remains below target at 76%, however the data behind this figure is known to be inaccurate (under-reporting for patients discharged out of hours and at weekends) and work is on-going to correct this.

2.5 Summary Hospital Mortality Indicator has remained within the expected range for 7 of the past 8 months (all reports are 5 months in arrears) and is predicted to fall further in the coming 4 months.

2.6 Trust remains under trajectory for all healthcare acquired reportable infections. Reporting for the Falls Action Group has shown that the incidents of falls have dropped over the past 6 months and that our incidents of falls are now under the mean value for the Trust. MUST recording has increased since last month – MUST audit is included on the agenda for Nutrition Steering group for the end of January 2024 which will aid ongoing monitoring.

2.7 Patient Safety Incident Response Framework process rolling out with advancements in Falls and Pressure Ulcer reviews. Review of Patient Safety huddle in progress alongside attendance at early adopter trust to gain fuller understanding of process.

2.8 Whilst there is a reduction in hospital acquired pressure damage at Grade 3 and above; ongoing support and development of the prevention agenda needs to be embedded particularly in relation to Grade 2 pressure damage. New TVN Lead Nurse will start at DCHFT in February 2024 and in the interim period DCNO will support TVN to drive forward. One never event reported in December 2023 – incident occurred September 2022.

3. Performance

3.1 Cancer- Cancer performance for December has been challenged, with a growth in the waiting list, backlog, and backstop. The Trust did meet the 31-day standard but did not meet the FDS standard or the 62 day standard, nor was the recovery trajectory achieved. The total waiting list size decreased by 37 patients, the backlog (62-103 days) increased by 7 patients to 69 and the backstop (over 104 days) decreased by 6 patients to 27.

3.2 Performance has been impacted by a growth in demand, which wasn't reflected in the 2023/24 operating plan. A deep drive of this has been completed at FPC in January. Cancer performance at a small DGH is impacted disproportionately over peak holiday period and IA activity took place in December.

3.3 To recover from the demand growth and lost activity, a recovery plan, at speciality level is in development, so the H2 performance trajectories are achieved. This will be completed in time for the February FPC meet and will include modelled trajectories.

3.4 Theatre utilisation- Capped theatre utilisation for December was 72.05%, a slight reduction compared to November which was 72.17%. Recent performance is now much closer to that of the regional performance and while it remains adrift from the target, performance is comparable to that of the region. Theatre utilisation performance is now comparable to that of the baseline year 2019/20. One of the most challenged areas of theatre performance at DCH, was the average number of lists that finished earlier than planned. DCH is now outperforming both regional and national performance for early finishes, putting the trust in the best quartile for this metric.

3.5 The current enhanced performance management arrangements for Theatre utilisation will remain in place until March 2024. For Q4, a new booking model, which will include the introduction of reserve patients and shadow lists will be tested. Theatre productivity is also subject to audit at the moment and the team have recently had a GIRFT visit, although the formal feedback from this is still outstanding.

3.6 Diagnostics- The Trust achieved 84.2% against a target of 99% in December. This is a decrease of 3.4% compared to the previous month. The backlog increased by 173 patients and the total waiting list size increased by 146 patients.

3.7 Cardiology is the driving reason for the changes in performance, with a growth in the waiting list and backlog. The recovery plan is being revised, as activity from insourcing providers has not been as forthcoming as previous months, due to a national workforce shortage. This has been requested by the ICB and will therefore be shared with the FPC committee in February.

3.8 RTT, waiting list size and long waiters- The total waiting list increased by 34 patients compared to the previous month; the total waiting list size is 1201 patients larger than the 2023/24 trajectory. The waiting list growth at DCH is special cause variation. The reasons for this are multifactorial and detailed below:

a) Referral demand is 5.66% up on last year. When the trajectories were written, demand was factored in as remaining flat.
b) Activity levels are below plan. The two driving factors are industrial action and theatre utilisation.

3.9 The FPC committee received a deep drive into the referral rate growth and the 6 specialities most impacted by this. This detail will be shared with the ICB at the end of January, with a request that demand for these 6 specialities is reviewed across the system, to determine if the demand increase at DCH is comparable with the rest of Dorset, or if this drift from other providers because of patient choice.

3.10 The 2022/23 planning guidance requires the Trust to have no patients, waiting over 65 weeks for treatment at the end of 2022/23. The impact of industrial action has meant that DCH has seen a return of patients waiting over 78+ weeks and will be unable to deliver zero, 65+ week waiters at the end of March 2024.

3.11 This is the same across the Region and as part of the recent H2 submission, both the 78 and 65+ week wait trajectories have been revised. These trajectories do not include any impact for future industrial action. At the end of December, DCH met the 78+ week wait and 65+ week wait trajectories, despite the industrial action.

3.12 The impact of industrial action is seen across all specialties, those that will have 65+ week breaches at the end of March 2024 are:

ENT 44
General Surgery 159
Gynaecology 90
Ophthalmology 31
Orthopaedics 176

3.13 To ensure the trajectory is delivered, insourcing for ENT, Ophthalmology and Orthopaedics (LLP) is taking place. 35 orthopaedic patients a month are being transferred to the Winterbourne, under the ICB contract with NHS patients already at the Winterbourne that are not in the at-risk cohort are being displaced to accommodate the DCH long waiters. UHD are reviewing their capacity to determine if they can provide mutual aid for Ophthalmology and orthopaedics (hand procedures). Mutual aid for General Surgery and Gynaecology is not an option due to them both being at risk at UHD and the insourcing budget is fully allocated. This is reflected in the trajectory submitted. Focus on productivity in both an outpatient and theatre session for the at risk specialities continues, ensure all capacity has a high booking utilisation.

3.14 Ambulance Handover delays- Ambulance handover delays are a major contributing factor to the under performance of the ambulance response times. There are three, contractual standards for ambulance handover delays, these are:

- 65% of all ambulance handovers to take place within 15 minutes
- 95% within 30 minutes
- None more than an hour

3.15 In December, DCH achieved 53.9% of all handovers in 15 minutes, an improvement of 7.5% on the previous month. 93% were completed in 30 minutes, up by 6% on the previous month and 30 patients were delayed more than an hour, up from 8 the previous month.

3.16 Ambulance handover performance correlates with the increasing number of patients in beds, with no reason to reside. The UEC Winter incentive includes the following targets for ambulance handover delays:

- Have a type 1, A and E department.
- Achieve an average of 80% all-type A and E 4-hour performance over Q4 of 2023/24
- Complete at least 90% of ambulance handovers within 30 minutes from arrival of the ambulance during Q3 and Q4 of 2023/24 (with 95% or more handovers having a valid handover time)
- Improve performance in the above areas compared to winter 2022/23. (73.6%)

DCH is currently re-validating Q3 performance against the SWAST data but is confident that all targets will have been met and will continue to be met in Q4.

3.17 Performance against the 4-hour standard in December 2023 was 77% (including MIU's); a decrease of 3.3% compared to the previous month, this is 1% better than trajectory. DCH has performed higher than the national performance since November 2022 and maintains that position.18.2%, of the Trusts open adult beds were occupied with patients who were medically fit for discharge. This is 2.08% higher than trajectory however, it should be noted that the number of open beds was 23 higher than plan. The Trust were above plan for the number of occupied adult beds (average) open, in response to this increase and the increase in demand at the front door.

3.18 The proportion of patients with no reason to reside continues to be a focus of system and internal meetings. Whilst we saw a predictable drop over the Christmas period, the majority of December saw patient numbers between the median and beyond the upper limit. This would be expected in the lead up to Christmas given the impact of winter (infections etc) and a consequential

increase inpatient admissions, many of whom will have care needs to enable them to return home, therefore increasing LOS.

3.19 The multi-agency discharge (MADE) event in December is due to be repeated in January. The immediate actions included;

- Commenced discharge team 7 day working to support weekend discharge
- Production of a DCH discharge leaflet for patients, relatives and carers to improve communication and expectations for discharge from hospital. The leaflet will be given to all patients admitted on to a ward.
- Provision of community offer postcards providing patients with an alternative source of community support at or after discharge to help reduce unplanned re-admissions
- Dedicated service for patients presenting at ED who require Social Support rather than admission to the hospital.
- Integration of voluntary organisation staff in the discharge lounge to help plan and address potential barriers to discharge.

4. **People**

4.1 Appraisal rate: increased in Month 9 to 77%. All Divisions reported an increase in their appraisal rate during December. The quality of appraisals remains good; evidenced by feedback via the online survey. Our focus is broadening to our future plans for talent management and appraisals.

4.2 Essential Skills: Overall essential Skills compliance remains at the target of 90%. Compliance is at 80% or more for all individual elements of the essential skills package.

4.3 Sickness: Overall sickness percentage increased for the fifth month running in month 8 (November) by 0.09% to 4.55%. There was an increase in both short and long-term absence. The top reason for absence in Month 8 remained as Anxiety/Stress/Depression. This accounted for 24.7% in month a decrease of 0.6% and accounted for 1204 days lost: a decrease of 46 in month. The second highest reason for absence in month 8 was Cough, Cold, Flu.

4.4 Provision of our Occupational health service has moved from Optima to DHU as of 1 January 2024.

4.5 Vacancy & Turnover: The vacancy rate decreased in Month 9 and is now 5.47%, the lowest rate since June 2022. A successful recruitment event was held in Month 8 which led to 19 offers of employment being made. A program of events is in place for 2024.

4.6 All changes to establishment and expenditure now require system peer review and system level reporting and monitoring. Our existing internal recruitment control process has been adapted to meet these requirements with positive feedback from our external panel member.

4.7 Turnover decreased in November and December and is now 10.8%, the lowest rate since March 2022. The top reason for leaving the Trust is retirement, followed by relocation. It is positive to note that the number of staff leaving due to work life balance is reducing. A key source of data relating to turnover, and retention is the annual staff survey. The survey closed at the end of November and the provisional results have recently been received; full results remain under embargo.

4.8 Bank worker usage: The overall bank trend is increasing, although there was a decline in November and December due to a reduction in availability during the school holiday periods.

4.9 Freedom to Speak Up: The total case numbers increased in Month 9 (42 cases). However, 26 of these concerns were generated via a targeted F2SU event held in one speciality. The targeted event was arranged following the triangulation of data from that area. The event was predominantly positive.

4.10 Staff actively engaged, many detailing responses which they'd clearly taken time to put together. Staff made suggestions for improvement and spoke about situations which could have been managed better, providing plenty of learning opportunities.

4.11 B2/3 HCSW transition: Ongoing collaborative working across the system including negotiating with Trade Unions has led to a final proposal being accepted by unions with one remaining out to local ballot. It is anticipated that the final proposal will be accepted in full and therefore it is the intention that eligible staff will receive their actual and compensatory pay in March.

4.12 ED&I: We welcome to the Trust our new Equality, Diversity, Inclusion and Belonging Lead. This role will play a pivotal part in our ED&I agenda with an additional focus on Belonging, in the context of improved staff experience and retention. The ongoing collaboration with DHC and the development of a joint
strategic approach to Inclusion and Belonging will aid this renewed focus.

5. **Finance**

5.1 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. Efficiency delivery challenge, high agency usage and insourcing levels above plan also contribute to the position.

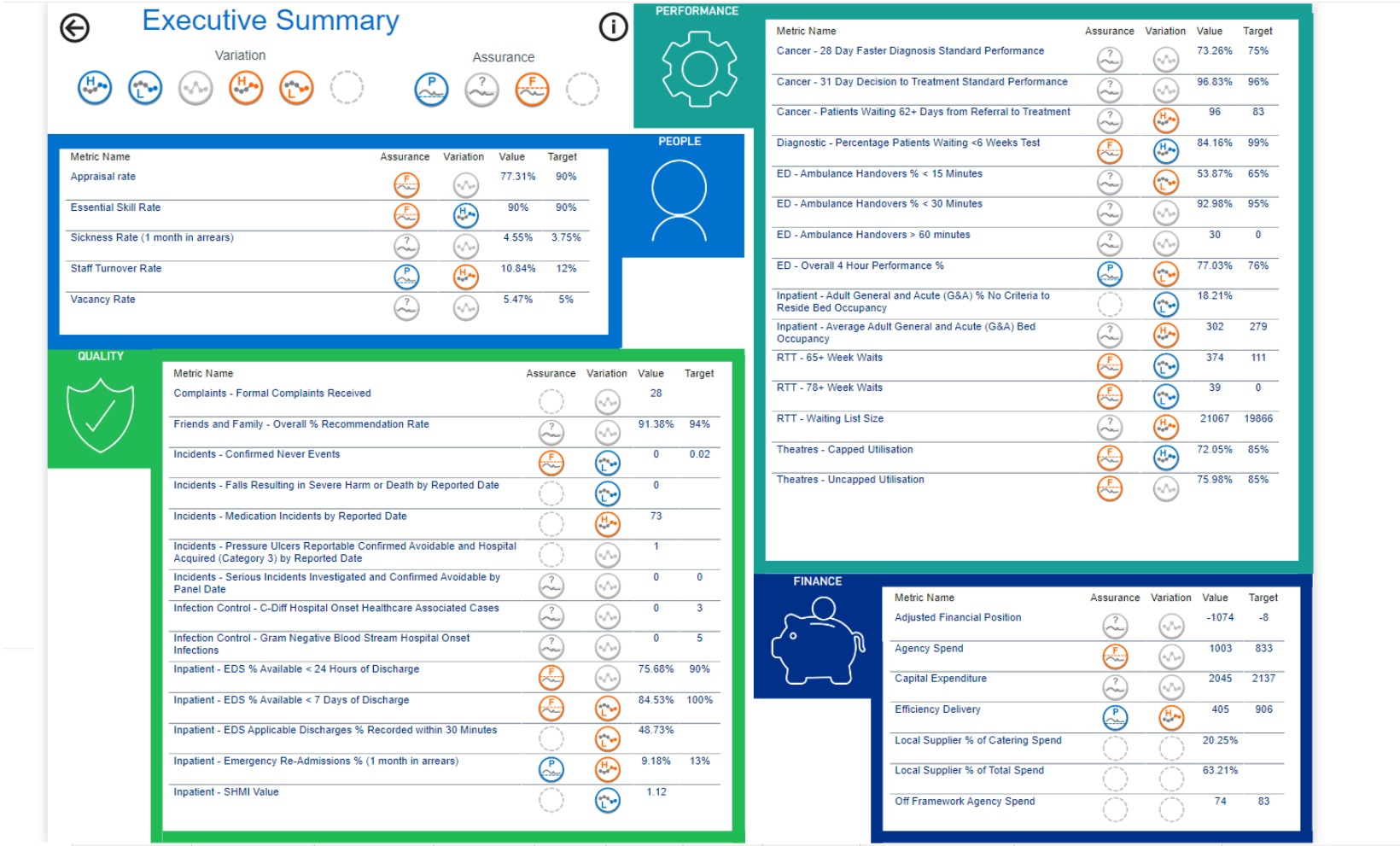
5.2 Agency Spend: As Adjusted Financial Position - higher than planned agency usage covering sickness and vacancies, with allocate on arrival usage and HCA cover by RN agency. Cover during peak industrial action periods has impacted the year to date position as has supporting 23 unfunded beds.

5.3 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.

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

5.5 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.

Appendix 1 – Balance Scorecard



Executive Summary

Variation

Assurance

PERFORMANCE

Metric Name	Assurance	Variation	Value	Target
Cancer - 28 Day Faster Diagnosis Standard Performance			73.26%	75%
Cancer - 31 Day Decision to Treatment Standard Performance			96.83%	96%
Cancer - Patients Waiting 62+ Days from Referral to Treatment			96	83
Diagnostic - Percentage Patients Waiting <6 Weeks Test			84.16%	99%
ED - Ambulance Handovers % < 15 Minutes			53.87%	65%
ED - Ambulance Handovers % < 30 Minutes			92.98%	95%
ED - Ambulance Handovers > 60 minutes			30	0
ED - Overall 4 Hour Performance %			77.03%	76%
Inpatient - Adult General and Acute (G&A) % No Criteria to Reside Bed Occupancy			18.21%	
Inpatient - Average Adult General and Acute (G&A) Bed Occupancy			302	279
RTT - 65+ Week Waits			374	111
RTT - 78+ Week Waits			39	0
RTT - Waiting List Size			21067	19866
Theatres - Capped Utilisation			72.05%	85%
Theatres - Uncapped Utilisation			75.98%	85%

PEOPLE

Metric Name	Assurance	Variation	Value	Target
Appraisal rate			77.31%	90%
Essential Skill Rate			90%	90%
Sickness Rate (1 month in arrears)			4.55%	3.75%
Staff Turnover Rate			10.84%	12%
Vacancy Rate			5.47%	5%

QUALITY

Metric Name	Assurance	Variation	Value	Target
Complaints - Formal Complaints Received			28	
Friends and Family - Overall % Recommendation Rate			91.38%	94%
Incidents - Confirmed Never Events			0	0.02
Incidents - Falls Resulting in Severe Harm or Death by Reported Date			0	
Incidents - Medication Incidents by Reported Date			73	
Incidents - Pressure Ulcers Reportable Confirmed Avoidable and Hospital Acquired (Category 3) by Reported Date			1	
Incidents - Serious Incidents Investigated and Confirmed Avoidable by Panel Date			0	0
Infection Control - C-Diff Hospital Onset Healthcare Associated Cases			0	3
Infection Control - Gram Negative Blood Stream Hospital Onset Infections			0	5
Inpatient - EDS % Available < 24 Hours of Discharge			75.68%	90%
Inpatient - EDS % Available < 7 Days of Discharge			84.53%	100%
Inpatient - EDS Applicable Discharges % Recorded within 30 Minutes			48.73%	
Inpatient - Emergency Re-Admissions % (1 month in arrears)			9.18%	13%
Inpatient - SHMI Value			1.12	

FINANCE

Metric Name	Assurance	Variation	Value	Target
Adjusted Financial Position			-1074	-8
Agency Spend			1003	833
Capital Expenditure			2045	2137
Efficiency Delivery			405	906
Local Supplier % of Catering Spend			20.25%	
Local Supplier % of Total Spend			63.21%	
Off Framework Agency Spend			74	83

Matrix Overview

NHS
Dorset County Hospital
NHS Foundation Trust

Variance \ Assurance	P	?	F		Total
H			3		3
L			3	3	6
		12	4	2	18
H	3	3		1	7
L	1	1	1	1	4
				3	3
Total	4	16	11	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.

QUALITY & SAFETY

Metric Name	Assurance	Variation	Value	Target
Incidents - Medication Incidents by Reported Date		H	73	
Inpatient - EDS % Available < 24 Hours of Discharge	F		75.68%	90%
Inpatient - EDS % Available < 7 Days of Discharge	F	L	84.53%	100%
Inpatient - EDS Applicable Discharges % Recorded within 30 Minutes		L	48.73%	
Inpatient - Emergency Re-Admissions % (1 month in arrears)	P	H	9.18%	13%

Commentary

Receive: Trust remains under trajectory for all healthcare acquired reportable infections. Reporting for the Falls Action Group has shown that the incidents of falls have dropped over the past 6 months and that our incidents of falls are now under the mean value for the Trust. MUST recording has increased since last month – MUST audit is included on the agenda for Nutrition Steering group for the end of January 2024 which will aid ongoing monitoring.

Response: Patient Safety Incident Response Framework process rolling out with advancements in Falls and Pressure Ulcer reviews. Review of Patient Safety huddle in progress alongside attendance at early adopter trust to gain fuller understanding of process.

Review: Whilst there is a reduction in hospital acquired pressure damage at Grade 3 and above; ongoing support and development of the prevention agenda needs to be embedded particularly in relation to Grade 2 pressure damage. New TVN Lead Nurse will start at DCHFT in February 2024 and in the interim period DCNO will support TVN to drive forward. One never event reported in December 2023 – incident occurred September 2022.

PERFORMANCE

Metric Name	Assurance	Variation	Value	Target
Cancer - Patients Waiting 62+ Days from Referral to Treatment	?	H	96	83
Diagnostic - Percentage Patients Waiting <6 Weeks Test	F	H	84.16%	99%
ED - Ambulance Handovers % < 15 Minutes	?	L	53.87%	65%
ED - Overall 4 Hour Performance %	P	L	77.03%	76%
Inpatient - Average Adult General and Acute (G&A) Bed Occupancy	?	H	302	279
RTT - 65+ Week Waits	F	L	374	111
RTT - 78+ Week Waits	F	L	39	0
RTT - Waiting List Size	?	H	21067	19866
Theatres - Capped Utilisation	F	H	72.05%	85%
Theatres - Uncapped Utilisation	F		75.98%	85%

Commentary

Ambulance Handover delays- Ambulance handover delays are a major contributing factor to the under performance of the ambulance response times. In December, DCH achieved 53.9% of all handovers in 15 minutes, an improvement of 7.5% on the previous month. 93% were completed in 30 minutes, up by 6% on the previous month and 30 patients were delayed more than an hour, up from 8 the previous month. Ambulance handover performance correlates with the increasing number of patients in beds, with no reason to reside. DCH is currently re-validating Q3 performance against the SWAST data but is confident that all targets will have been met and will continue to be met in Q4.

Cancer - performance for December has been challenged, with a growth in the waiting list, backlog, and backstop. The Trust did meet the 31-day standard but did not meet the FDS standard or the 62 day standard, nor was the recovery trajectory achieved. The total waiting list size decreased by 37 patients, the backlog (62-103 days) increased by 7 patients to 69 and the backstop (over 104 days) decreased by 6 patients to 27. Performance has been impacted by a growth in demand, which wasn't reflected in the 2023/24 operating plan. A deep drive of this has been completed at FPC in January. Cancer performance at a small DGH is impacted disproportionately over peak holiday period and IA activity took place in December. To recover from the demand growth and lost activity, a recovery plan, at speciality level is in development, so the H2 performance

PEOPLE

Metric Name	Assurance	Variation	Value	Target
Appraisal rate	F		77.31%	90%
Essential Skill Rate	F	H	90%	90%
Staff Turnover Rate	P	H	10.84%	12%

Commentary

Appraisal Rate: the Trust appraisal rate increased in month 9 to 77%, continuing the upward trajectory.

Essential Skills: Essential Skills compliance remains on target (90%).

Sickness: Sickness absence increased in Month 8 to 4.55% with a small increase in both long and short term absence.

Vacancy & Turnover: Both the vacancy rate and turnover decreased in month 9 and sit at the lowest level for over 18 months.

FINANCE

Metric Name	Assurance	Variation	Value	Target
Agency Spend	F		1003	833
Efficiency Delivery	P	H	405	906

Commentary

Efficiency Delivey: 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: As Adjusted Financial Position - higher than planned agency usage covering sickness and vacancies, with allocate on arrival usage and HCA cover by RN agency. 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

Receive: Trust remains under trajectory for all healthcare acquired reportable infections. Reporting for the Falls Action Group has shown that the incidents of falls have dropped over the past 6 months and that our incidents of falls are now under the mean value for the Trust. MUST recording has increased since last month – MUST audit is included on the agenda for Nutrition Steering group for the end of January 2024 which will aid ongoing monitoring.

Response: Patient Safety Incident Response Framework process rolling out with advancements in Falls and Pressure Ulcer reviews. Review of Patient Safety huddle in progress alongside attendance at early adopter trust to gain fuller understanding of process.

Review: Whilst there is a reduction in hospital acquired pressure damage at Grade 3 and above; ongoing support and development of the prevention agenda needs to be embedded particularly in relation to Grade 2 pressure damage. New TVN Lead Nurse will start at DCHFT in February 2024 and in the interim period DCNO will support TVN to drive forward. One never event reported in December 2023 – incident occurred September 2022.

VariationIcon	Pass	Hit or Miss	Fail	Empty	Total
Improvement			1	2	3
Common Cause		4	1	2	7
Concern	1		1	2	4
Neither					
Empty					
Total	1	4	3	6	14

Metric Group	Metric	Group	Latest Month	Value	Target	Variance to Target	Mean	PY - Month Value	YTD Value	Variation	Assurance
Effectiveness	Inpatient - EDS % Available < 24 Hours of Discharge	0 - Total	Dec-23	75.68%	90%	-14.32%	78.16%	80.94%	75.68%		
Effectiveness	Inpatient - EDS % Available < 7 Days of Discharge	0 - Total	Dec-23	84.53%	100%	-15.47%	88.28%	91.16%	84.53%		
Effectiveness	Inpatient - EDS Applicable Discharges % Recorded within 30 Minutes	0 - Total	Dec-23	48.73%			55.58%	52.85%	48.73%		
Effectiveness	Inpatient - Emergency Re-Admissions % (1 month in arrears)	0 - Total	Nov-23	9.18%	13%	-3.82%	8.03%	5.82%	9.18%		
Experience	Complaints - Formal Complaints Received	0 - Total	Dec-23	28			26.72	20	191		
Experience	Friends and Family - Overall % Recommendation Rate	0 - Total	Dec-23	91.38%	94%	-2.62%	91.86%	91%	91.38%		
Safety	Incidents - Confirmed Never Events	0 - Total	Dec-23	0	0.02	-0.02	0.07	0	1		
Safety	Incidents - Falls Resulting in Severe Harm or Death by Reported Date	0 - Total	Dec-23	0			0.21	0	0		
Safety	Incidents - Medication Incidents by Reported Date	0 - Total	Dec-23	73			58.26	59	674		
Safety	Incidents - Pressure Ulcers Reportable Confirmed Avoidable and Hospital A...	0 - Total	Dec-23	1			0.68	0	9		
Safety	Incidents - Serious Incidents Investigated and Confirmed Avoidable by Pan...	0 - Total	Dec-23	0	0	0.00	0.46	0	2		
Safety	Infection Control - C-Diff Hospital Onset Healthcare Associated Cases	0 - Total	Dec-23	0	3	-3.00	2.6	3	26		
Safety	Infection Control - Gram Negative Blood Stream Hospital Onset Infections	0 - Total	Dec-23	0	5	-5.00	3	2	27		
Safety	Inpatient - SHMI Value	0 - Total	Jul-23	1.12			1.14	1.14	1.12		

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

Ambulance Handover delays- Ambulance handover delays are a major contributing factor to the under performance of the ambulance response times. In December, DCH achieved 53.9% of all handovers in 15 minutes, an improvement of 7.5% on the previous month. 93% were completed in 30 minutes, up by 6% on the previous month and 30 patients were delayed more than an hour, up from 8 the previous month. Ambulance handover performance correlates with the increasing number of patients in beds, with no reason to reside. DCH is currently re-validating Q3 performance against the SWAST data but is confident that all targets will have been met and will continue to be met in Q4.

Cancer - performance for December has been challenged, with a growth in the waiting list, backlog, and backstop. The Trust did meet the 31-day standard but did not meet the FDS standard or the 62 day standard, nor was the recovery trajectory achieved. The total waiting list size decreased by 37 patients, the backlog (62-103 days) increased by 7 patients to 69 and the backstop (over 104 days) decreased by 6 patients to 27. Performance has been impacted by a growth in demand, which wasn't reflected in the 2023/24 operating plan. A deep drive of this has been completed at FPC in January. Cancer performance at a small DGH is impacted disproportionately over peak holiday period and IA activity took place in December. To recover from the demand growth and lost activity, a recovery plan, at speciality level is in development, so the H2 performance trajectories are achieved. This will be completed in time for the February FPC meet and will include modelled trajectories.

Diagnostics- The Trust achieved 84.2% against a target of 99% in December. This is a decrease of 3.4% compared to the previous month. The backlog increased by 173

VariationIcon	Pass	Hit or Miss	Fail	Empty	Total
Improvement			4	1	5
Common Cause		4	1		5
Concern	1	4			5
Neither					
Empty					
Total	1	8	5	1	15

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	Dec-23	73.26%	75%	-1.74%	69.51%	77.64%	73.26%		
Cancer	Cancer - 31 Day Decision to Treatment Standard Performance	0 - Total	Dec-23	96.83%	96%	0.83%	96.63%	96.53%	96.83%		
Cancer	Cancer - Patients Waiting 62+ Days from Referral to Treatment	0 - Total	Dec-23	96	83	13.00	79.86	74	816		
Elective	Theatres - Capped Utilisation	0 - Total	Dec-23	72.05%	85%	-12.95%	68.2%	60.37%	72.05%		
Elective	Theatres - Uncapped Utilisation	0 - Total	Dec-23	75.98%	85%	-9.02%	73.37%	64.07%	75.98%		
Outpatient	Diagnostic - Percentage Patients Waiting <6 Weeks Test	0 - Total	Dec-23	84.16%	99%	-14.84%	73.61%	67.87%	84.16%		
Outpatient	RTT - 65+ Week Waits	0 - Total	Dec-23	374	111	263.00	737.34	343	374		
Outpatient	RTT - 78+ Week Waits	0 - Total	Dec-23	39	0	39.00	362.09	99	39		
Outpatient	RTT - Waiting List Size	0 - Total	Dec-23	21067	19866	1,201.00	19000.88	19484	21067		
UEC	ED - Ambulance Handovers % < 15 Minutes	0 - Total	Dec-23	53.87%	65%	-11.13%	72.81%	59.91%	53.87%		
UEC	ED - Ambulance Handovers % < 30 Minutes	0 - Total	Dec-23	92.98%	95%	-2.02%	89.83%	76.49%	92.98%		
UEC	ED - Ambulance Handovers > 60 minutes	0 - Total	Dec-23	30	0	30.00	58.34	173	309		
UEC	ED - Overall 4 Hour Performance %	0 - Total	Dec-23	77.03%	76%	1.03%	82.26%	70.84%	77.03%		
UEC	Inpatient - Adult General and Acute (G&A) % No Criteria to Reside Bed Occup...	0 - Total	Dec-23	18.21%			21.69%	23.38%	18.21%		
UEC	Inpatient - Average Adult General and Acute (G&A) Bed Occupancy	0 - Total	Dec-23	302	279	23.00	295.78	325	302		

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
Appraisal Rate: the Trust appraisal rate increased in month 9 to 77%, continuing the upward trajectory.
Essential Skills: Essential Skills compliance remains on target (90%).
Sickness: Sickness absence increased in Month 8 to 4.55% with a small increase in both long and short term absence.
Vacancy & Turnover: Both the vacancy rate and turnover decreased in month 9 and sit at the lowest level for over 18 months.

VariationIcon	Pass	Hit or Miss	Fail	Empty	Total
Improvement			1		1
Common Cause		2	1		3
Concern	1				1
Neither					
Empty					
Total	1	2	2		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	Dec-23	90%	90%	0.00%	88.89%	90%	90%		
Looking After our People	Appraisal rate	0 - Total	Dec-23	77.31%	90%	-12.69%	75.56%	70.7...	77.31%		
Looking After our People	Sickness Rate (1 month in arrears)	0 - Total	Nov-23	4.55%	3.75%	0.80%	3.99%	4.64%	4.55%		
Looking After our People	Staff Turnover Rate	0 - Total	Dec-23	10.84%	12%	-1.16%	9.72%	11.91%	10.84%		
Looking After our People	Vacancy Rate	0 - Total	Dec-23	5.47%	5%	0.47%	6.64%	8.86%	5.47%		

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

NHS
Dorset County Hospital
NHS Foundation Trust

Commentary
Adjusted Financial Position: Impact of inflationary pressures (gas, electric, catering supplies & maintenance contracts, blood products & drugs) above planned levels along with higher than planned agency usage providing cover during peak industrial action periods, with 23 unfunded beds also contributing to the position. Efficiency delivery challenge, high agency usage and insourcing levels above plan also contribute to the position.
Agency Spend: As Adjusted Financial Position - higher than planned agency usage covering sickness and vacancies, with allocate on arrival usage and HCA cover by RN agency. 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 Delivey: 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				3	3
Total	1	2	1	3	7

Metric Group	Metric	Group	Latest Month	Value	Target	Variance to Target	Mean	PY - Month Value	YTD Value	Variation	Assurance
Capital	Capital Expenditure	0 - Total	Dec-23	2045	2137	-92.00	1936.65	1258	17764		
Revenue	Adjusted Financial Position	0 - Total	Dec-23	-1074	-8	-1,066.00	-350.16	-226	-8863		
Sustainability	Local Supplier % of Catering Spend	0 - Total	Dec-23	20.25%			24.41%		20.25%		
Sustainability	Local Supplier % of Total Spend	0 - Total	Dec-23	63.21%			13%		63.21%		
Value Board	Agency Spend	0 - Total	Dec-23	1003	833	170.00	1198.85	1045	10932		
Value Board	Efficiency Delivery	0 - Total	Dec-23	405	906	-501.00	180.4	1221	3155		
Value Board	Off Framework Agency Spend	0 - Total	Dec-23	74	83	-9.00	142.67		1284		

INTEGRITY | RESPECT | TEAMWORK | EXCELLENCE

NHS
Dorset County Hospital
NHS Foundation Trust

Report Front Sheet

1. Report Details			
Meeting Title:	*Board of Directors*		
Date of Meeting:	*Wednesday 31st January*		
Document Title:	*System Performance Report*		
Responsible Director:	*Matthew Bryant, Chief Executive*	Date of Executive Approval	*15.01.24*
Author:	*Jonquil Williams, Corporate Business Manager*		
Confidentiality:	*If Confidential please state rationale: No*		
Publishable under FOI?	**Yes**		
Predetermined Report Format?	No		

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

3. Purpose of the Paper								
	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 11 January 2024

The following areas are performing as expected at the end of October 2023 when compared to the trajectories supporting the 2023/24 operating plan submission:

- 2-hour urgent community response times.
- Increase in primary care appointments.
- Elective recovery – follow-up activity.
- Reduction in total waiting list.
- Reduction in follow-up outpatients.

Diagnostics – recovery plans in place for audiology at Dorset HealthCare, andechocardiography at Dorset County Hospital.

- Category 2 ambulance response times.
- Bed occupancy.
- 40-minute handover delays.
- Children and young people urgent access to eating disorders.

The following areas are not performing as expected at the end of October 2023 when compared to the trajectories supporting the 2023/24 operating plan submission, however performance was either maintained or improved:

	• Virtual ward utilisation. • Virtual ward capacity. • Elective recovery – day case activity. • Elective recovery – inpatient ordinary activity. • Elective recovery – outpatient first appointment activity. • Patient initiated follow-ups. • Theatre utilisation. • Day case rates. • Faster diagnosis standard. • 62-day backlog. • 4-hour emergency department standard. • Out of area placements. • NHS Talking Therapies. • Dementia diagnosis. • Perinatal mental health access. • Children and young people mental health access. • Children and adolescent mental health service (CAMHS) gateway. The following areas are not performing as expected at the end of October 2023 when compared to the trajectories supporting the 2023/24 operating plan submission and performance deteriorated: • 2-hour urgent community response contacts. • 78-week waiters. • 65-week waiters. • 106% activity (although further validation is required due to an issue with baselines). • Advice and guidance. • No criteria to reside. • Overall access to core community mental health services for adults and older adults with severe mental illness. • Children and young people routine access to eating disorders. An overview of performance can be found in Appendix 1 and Appendix 2 outlining ifthe standard is achieving trajectory, if performance has deteriorated, improved, ormaintained compared to the previous months, the details, and what the statisticalprocess control (SPC) chart demonstrates.
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	11 January 2024
Paper Title	System Performance Report
Responsible Chief Officer	Dean Spencer, Chief Operating Officer
Author	Natalie Violet, Head of Planning and Oversight Rebekah Parrish, Planning and Oversight Officer

Confidentiality	Not confidential
Publishable Under FOI?	Yes

Prior Discussion and Consultation		
Job Title or Meeting Title	**Date**	**Recommendations/Comments**
Performance and Productivity Committee	14 December 2023	Noted
Chief Operating Officer, NHS Dorset	05 December 2023	Approved
Deputy Director of Performance and Planning	05 December 2023	Approved
System Executive Group	29 November 2023	New trajectories noted
Chief Officers across the system as part of the H2 planning submission	November	Paper developed in collaboration
Provider Performance Leads, Chief Operating Officers, and Delivery Group Senior Responsible Officers	October/November	Paper developed in collaboration
Heads of Service and Deputy Directors at the ICB	October/November	Narrative for service areas has been written with the Heads of Service and/or Deputy Directors

Purpose of the Paper	The purpose of this paper is to provide an overview of current system performance against the operating plan.						
	Note:	✓	Discuss:		Recommend:		Approve:
Summary of Key Issues	The following areas are performing as expected at the end of October 2023 when compared to the trajectories supporting the 2023/24 operating plan submission: • 2-hour urgent community response times. • Increase in primary care appointments. • Elective recovery – follow-up activity. • Reduction in total waiting list. • Reduction in follow-up outpatients. • Diagnostics – recovery plans in place for audiology at Dorset HealthCare, and echocardiography at Dorset County Hospital.						

- Category 2 ambulance response times.
- Bed occupancy.
- 40-minute handover delays.
- Children and young people urgent access to eating disorders.

The following areas are not performing as expected at the end of October 2023 when compared to the trajectories supporting the 2023/24 operating plan submission, however performance was either maintained or improved:

- Virtual ward utilisation.
- Virtual ward capacity.
- Elective recovery – day case activity.
- Elective recovery – inpatient ordinary activity.
- Elective recovery – outpatient first appointment activity.
- Patient initiated follow-ups.
- Theatre utilisation.
- Day case rates.
- Faster diagnosis standard.
- 62-day backlog.
- 4-hour emergency department standard.
- Out of area placements.
- NHS Talking Therapies.
- Dementia diagnosis.
- Perinatal mental health access.
- Children and young people mental health access.
- Children and adolescent mental health service (CAMHS) gateway.

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

- 2-hour urgent community response contacts.
- 78-week waiters.
- 65-week waiters.
- 106% activity (although further validation is required due to an issue with baselines).
- Advice and guidance.
- No criteria to reside.
- Overall access to core community mental health services for adults and older adults with severe mental illness.
- Children and young people routine access to eating disorders.

An overview of performance can be found in Appendix 1 and Appendix 2 outlining if the standard is achieving trajectory, if performance has deteriorated, improved, or maintained compared to the previous months, the details, and what the statistical process control (SPC) chart demonstrates.

Action recommended

The Board is recommended to:

- **NOTE** the current performance.

06.

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	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.
Tackling unequal outcomes and access	
Enhancing productivity and value for money	
Helping the NHS to support broader social and economic development	

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.

System 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 South West at the end of April 2023. It is important to note the submission assumed no impact of any industrial action during 2023/24.

1.3. On 08 November 2023, NHS England wrote to ICBs and provider Trusts regarding the impact of industrial action. The letter outlined the priorities for the rest of the financial year. The focus was predominately on achieving financial balance as well as ensuring patient safety and focusing on emergency performance and capacity while safeguarding urgent care, high-priority elective, and cancer care.

1.4. To address the cost of industrial action, the government agreed to allocate £800M nationwide, with £9.3M allocated to the Dorset system. Adjustments were made to the elective activity target with the Dorset system aiming for 104% from November 2023.

1.5. Consequently, ICBs and provider Trusts submitted a return on 22 November 2023. Through the submission the system committed to achieve the following:

- Virtual ward capacity.
- Virtual ward occupancy.
- Elective recovery fund (ERF) – 104% from November.
- Faster diagnosis standard.
- 62-day cancer backlog.
- Patients waiting beyond 78-weeks.
- 4-hour emergency department performance.
- Ambulance handover times.

1.6. The submission confirmed the following would not be achieved:

- Financial balance: the planned submission describes a deficit of £31.7M
- Patient waiting beyond 65-weeks: the planned submission illustrates 1,053 patients waiting beyond 65-weeks.

1.7. To complete this submission, existing operating plan trajectories were reviewed. The revised trajectories are illustrated within this report from November 2023 onwards.

1.8. At the point of writing this report, following a national meeting, further work is underway to reduce the financial deficit forecast with the aim of hitting breakeven at the end of March 2024. The programmes associated may impact performance standards. i.e., reducing insourcing and increasing 65-week waiters. Once this work is complete trajectories will be updated accordingly.

1.9. The purpose of this paper is to provide an overview of current system performance against the operating plan.

2. Additional Metrics

2.1. Following feedback from the Board of the ICB in early November, additional children and young people mental health metrics have been incorporated into this report including

children and adolescent mental health service (CAHMS) gateway access, and urgent and routine eating disorder access. All of which are Long Term Plan metrics. Work is underway with NHS Dorset's Business Intelligence Team to replicate the regional reporting for mental health which will support the Mental Health, Learning Disabilities, and Autism Delivery Group and will be incorporated into future System Performance Reports.

2.2. In addition, additional primary care metrics will be incorporated into future System Performance Reports. Scoping is currently taking place.

3. Performance Overview

3.1. An overview of the performance against the operating plan standards can be found in Appendix 1. This is broken down by provider, where applicable. Performance reports including statistical process control (SPC) charts can be found in Appendix 2.

3.2. **Primary and Community Care**
Virtual ward performance continues to be below trajectory for both utilisation and the number of beds available although a slight improvement in utilisation was seen in October. The introduction of the frailty pathway across the system is expected to see an increase in bed capacity, by 40. This is due to commence in December for the west and January for east. Participation in the NHS England South West accelerated change programme continues along with a conversation with system Chief Executive Officer colleagues to move the virtual ward agenda forward.

Urgent community response times within two-hours continues to meet trajectory, however the number of expected referrals into the service remains significantly below trajectory. As part of the Winter Plan and South Western Ambulance Trust's tier 1 support package, work to increase referrals into the service is underway including a falls prevention workshop and increasing the service hours from 0800 – 0800 to 0800 – 0000.

Primary care saw a large increase in appointments, far exceeding trajectory at the end of September.

3.3. **Planned Care**
Reducing 78-week waits remains challenging, addressed through insourcing and outsourcing. Specific challenges lie with orthopaedic cases at Dorset County Hospital with mutual aid and utilisation of the independent sector being explored. In terms of community paediatrics at University Hospitals Dorset, a Dorset-wide demand and capacity review aims to understand the system-wide issue and identify opportunities.

The impact of industrial action is evident in increasing 65-week waits, with 55 patients expected beyond 78-weeks and 1,049 beyond 65-weeks at the end of October. At the end of November, the system is expecting to have 92 patients waiting beyond 78-weeks, and 1,818 patients waiting beyond 65-weeks. The total waiting list is lower than expected numbers, with large reductions over the past three months in cardiology, gastroenterology, neurology and "other" medical, a drop is starting to be seen in gynaecology and ophthalmology dropped significantly in October.

Performance against the 106% standard is currently below expectations at 101% in August, although there are data issues with Dorset HealthCare which are being addressed. Current conversations with NHS England regarding baselines may see this reduce to 100%.

Elective recovery, except for follow-up outpatients, is below expected levels compared to 2019/20 activity, however outpatients first attendances saw a large increase in September

from previous months. Industrial action contributes to underperformance, and efforts are underway to enhance theatre and outpatient productivity, drawing insights from Getting It Right First Time. The focus on reducing the outpatient waiting list, while clinically appropriate, means the originally planned follow-up numbers will not be achieved.

Advice and guidance performance is currently below the expected standard and will be picked up by the Planned Care Improvement Group. NHS Dorset's Planned Care Team is prioritising referral management including emphasising advice and guidance with expected impact in quarter 4. It should be noted that an increase in demand will require additional workforce capacity which may not be the best use of resources when considering long waiters and cancer. Patient-initiated follow-ups are slightly underperforming, and targeted actions in both acutes are anticipated to bring performance in line with the standard by quarter 4.

Theatre utilisation is currently below the expected trajectory, with theatre improvement programmes in both acutes with ongoing incremental improvements expected for the remainder of the year. University Hospitals Dorset do not expect to meet the 85% standard by the end of March, 80% is anticipated. Day case rates continue to underperform which is attributed to University Hospitals Dorset and focus on this area is included in the organisational theatre improvement programme with an expected 83.2% by March 2024.

3.4. **Diagnostics**

Diagnostic waiting times continue to achieve trajectory being 3.67% above trajectory at the end of October. There are two specific modalities of concern: audiology at Dorset HealthCare and echocardiography at Dorset County Hospital. Recovery plans are in place for both.

3.5. **Cancer**

Performance against both the faster diagnosis standard and 62-day backlog are underperforming against trajectory, however both saw an improvement when comparing October to September. Dorset County Hospital are within 0.5% of the trajectory for the faster diagnosis standard and are meeting the 62-day backlog trajectory. University Hospitals Dorset continue to be challenged in delivering both standards due to increased demand and specific specialty challenges including gynaecology and dermatology. There was improvement however at University Hospitals Dorset in October compared to September due to an increase in additional capacity. Pathway improvements are being explored in colorectal, gynaecology, and dermatology to support these standards. The 62-day backlog is on the agenda for discussion at the UHD Touchpoint meeting on 20 December 2023.

3.6. **Urgent and Emergency Care**

The system fell slightly short of the 4-hour emergency department standard (3.03% below trajectory), but category 2 ambulance response times continue to surpass the standard, with South Western Ambulance realigning their resource to ensure more night ambulances. Efforts focus on non-emergency department pathways and workshops for admission/attendance avoidance. No criteria to reside remains too high with 42 people too many at the end of October. There is a focus on reducing delays in exiting intermediate care to ensure there is capacity to move people from hospital as required. A 7-day discharge pipeline is being created to mitigate weekend discharge impacts. A step change increase in early discharge planning is linked to increased use of discharge ready dates on acute wards and stronger/earlier system escalation processes. Time lost to handover delays exceeded the October target by almost five minutes.

3.7. **Mental Health**

Efforts continue to address the issue of adult mental health patients inappropriately placed out of area, with targeted actions in place. The ambition of zero by March 2024 is still a priority for the system. In the medium to long term, the system is implementing the Mental Health Integrated Community Care (MHICC) programme to enhance adult community mental health services, focusing on early help, and reducing the need for inpatient mental health care.

Activity in NHS Talking Therapies continues to underperform due to reduced referrals with a communication plan in place. Likewise, activity in adults and older adults with a senior mental illness accessing community mental health services continued to underperform however, there is an issue with data flow which is being addressed by Dorset HealthCare. The transformation of mental health services through MHICC is expected to improve services for local communities ensuring they are receiving the right care, at the right time, in the right place. It is expected this programme will support community mental health performance.

Dementia diagnosis rates remain below standard. Dorset HealthCare is exploring options of utilising non-recurrent slippage for outsourcing memory assessments and a System Dementia Diagnosis Rates Improvement Plan is in place.

Perinatal mental health services continue to be below trajectory with a recovery programme in place at Dorset HealthCare.

Children and young people's mental health access is below trajectory, with ongoing discussions about Kooth data. Transformation of children and young people's mental health services based on the THRIVE framework is a medium to long term action and a transformational plan 'Your Mind Your Say' is in place to support children and young people's emotional health in support of the Joint Forward Plan. Public Health Dorset have launched a centralised resource aimed at promoting trusted Mental Health Apps to young people in Dorset. A CAMHS stabilisation plan was supported at the mental health programme board in November which will enable interim non-recurrent funding to be used to maintain the improved progress seen with the CAMHS Gateway <4 weeks target over recent months following a focused effort and increased temporary staffing via agency use. Key improvements include monthly wellbeing check in calls to assess risk, escalate, signpost to other resources and a drop-in clinic to support individuals requiring escalation.

The Eating Disorder service is currently implementing a two-year recovery plan, agreed in October 2023, including recruitment of additional workforce to clear the backlog. Recruitment to date has enabled the urgent access standard to be met over the last few months and reduced the backlog whilst meeting new demand. A significant delay is expected for the improvements to show from the recovery plan due to the way the calculation and criteria for RTT pathway works.

4. Conclusion

- The Board is recommended to **NOTE** the current performance.

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Date: 05 December 2023

06.

APPENDICES	
Appendix 1	**Performance Overview**
Appendix 2	**Performance Reports**

Operational Plan Metric	Metric Definition	Data Frequency	System						Dorset County						University Hospitals Dorset					
			End March 2024 Target	End of Reporting Month Target	Data Source	Performance	Variance from Target	Achieving Trajectory	End March 2024 Target	End of Reporting Month Target	Data Source	Performance	Variance from Target	Achieving Trajectory	End March 2024 Target	End of Reporting Month Target	Data Source	Performance	Variance from Target	Achieving Trajectory
Primary and Community Care																				
80% virtual wards utilisation	Reported virtual ward occupied capacity by the total available virtual ward capacity – the number of patients who can simultaneously managed within a virtual ward service	End of month position	80%	80%	Oct-23	54.00%	-26%		N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Virtual ward capacity	Increase the number of patients the virtual ward can simultaneously manage.	End of month position	360	265	Oct-23	134	-131		N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
2-hour urgent care response (no. of referrals)	A count of 2-hour urgent care response first care contacts delivered	End of month position	800	800	Sep-23	457	-343		N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
2-hour urgent community response times	% of compliant referrals within 2 hours	End of month position	80%	80%	Sep-23	82%	2%		N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
% increase in primary care appointments	Planned total number of appointments	End of month position	450,289	423,211	Sep-23	461,546	38,335		N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Planned Care																				
+78 week waiters	Number of incomplete Referral to Treatment (RTT) pathways (patients yet to start treatment) of 78 weeks or more	End of month position	0	0	Oct-23	55	55		0	0	Oct-23	8	8		0	0	Oct-23	47	47	
+65 week waiters	Number of incomplete Referral to Treatment (RTT) pathways (patients yet to start treatment) of 65 weeks or more	End of month position	0	763	Oct-23	1,812	1,049		0	181	Oct-23	481	300		0	571	Oct-23	1,331	760	
106% activity (reduced to 104% in November)	ERF VWA Calculation - Currently provided by Region	End of month position	104%	106%	Oct-23	103%	-3.0%		N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Elective Recovery - day case	Compared to operating plan submission numbers	Monthly	10,123	10,538	Sep-23	6,978	-3,560		2,306	2,346	Sep-23	1,751	-595		7,120	6,926	Sep-23	3,955	-2971	
Elective Recovery - inpatient ordinary	Compared to operating plan submission numbers	Monthly	1,506	1,468	Sep-23	1,123	-345		300	206	Sep-23	144	-62		1,256	1,100	Sep-23	729	-371	
Elective Recovery - outpatient first attendances	Compared to operating plan submission numbers	Monthly	25,235	25,282	Sep-23	29,915	4,633		4,170	4,240	Sep-23	4,108	-132		18,053	18,616	Sep-23	14,441	-4175	
Elective Recovery - outpatient follow-up attendances	Compared to operating plan submission numbers	Monthly	29,013	28,862	Sep-23	78,497	49,635		8,401	7,992	Sep-23	5,893	-2099		21,818	22,928	Sep-23	16,550	-6378	
% advice and guidance of outpatient attendances	Requests for specialist advice, including advice and guidance (A&G) or equivalent via other triage approaches, that facilitate the seeking and/or provision of specialist advice prior to, or instead of, a referral to secondary care. Where that advice is expected to support a referrer to manage a patient without the need for an unnecessary outpatient appointment.	End of month position	17%	15%	Sep-23	8.3%	-6.71%		N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
% patient initiated follow-ups (PIFU) of discharges	A percentage of the number of outpatient attendances that resulted in a patient being moved or discharged to a formal patient-initiated follow-up pathway.	End of month position	5.7%	5.2%	Sep-23	4.61%	-0.59%		5.7%	5.2%	Sep-23	3.3%	-1.9%		5.7%	5.2%	Sep-23	4.2%	-1.0%	
Theatre utilisation	GIRFT has set a target for Integrated Care Systems and providers to achieve 85% theatre touchtime utilisation by 2024/25	End of month position	85%	85%	Oct-23	71.00%	-14.00%		85%	85%	Oct-23	68.00%	-17.00%		85%	85%	Oct-23	72.00%	-13.00%	
Day case rate	The proportion of all admissions for a Trust that were day cases for all procedures in the British Association of Day Surgery (BADS) Directory	End of month position	85%	85%	Jun-23	80.00%	-5.00%		85%	85%	Jun-23	85%	0%		85%	85%	Jun-23	79%	-6%	
Reduction in total waiting list	Total number of patients on the waiting list	End of month position	97,789	97,534	Oct-23	91,905	-5,629	N/A	19,337	20,038	Oct-23	20,991	953	N/A	76,972	76,017	Oct-23	70,914	-5103	N/A
Reduction in follow up outpatients	Number of patients seen as a follow-up, all outpatient, consultant and non-consultant led ALL specialities	End of month position	29,013	28,862	Aug-23	22,443	-6,419	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Diagnostics																				
Increase the percentage of patients receiving diagnostic test within 6 weeks	The number of diagnostic tests for the specified test group carried out during the month within 6 weeks	Monthly	88.40%	83.63%	Oct-23	87.30%	3.67%		88.40%	83.60%	Oct-23	79.90%	-3.70%		88.40%	83.60%	Oct-23	89.60%	6.00%	
Cancer																				
Cancer Faster Diagnosis Standard	Percentage of patients receiving a communication of diagnosis for cancer or a ruling out of cancer, or a decision to treat if made before a communication of diagnosis within 28 days following: - an urgent referral for suspected cancer - a referral for breast symptoms where cancer was not initially suspected or secondary care professional; or - an urgent referral from an NHS Cancer Screening Service	In period mean	78.87%	74.21%	Sep-23	67.10%	-7.11%		75.94%	71.50%	Sep-23	71.00%	-0.50%		75.85%	75.03%	Sep-23	65.60%	-9%	
62 day cancer backlog	Number of patients waiting beyond 62 days for treatment	In period activity	290	303	Oct-23	382	79		70	83	Oct-23	83	0		220	220	Sep-23	298	78	
Urgent and Emergency Care																				
4-hour ED standard	% patients seen with 4 hours. Type 1, 2, & 3 A&E attendances included	Monthly	76%	70.93%	Oct-23	67.90%	-3%		76%	76.00%	Oct-23	77.90%	1.90%		76%	69%	Oct-23	61.50%	-7.00%	
Cat 2 Response (minutes)	Avg time to respond to Cat 2 calls for SWAST for Dorset	Monthly	21	28	Oct-23	27.1	-0.90		N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Reduction in No Criteria to Reside	No of patients that no longer meet the criteria to response	Monthly	206	225	Oct-23	267	42		45	45	Oct-23	64	19		161	180	Oct-23	203	23	
Bed Occupancy - 92% Ambition	G&A Bed Occupancy only	Monthly	96.71%	96.79%	Oct-23	96.80%	0.01%		92.06%	92.06%	Oct-23	98.00%	5.94%		98.08%	98.20%	Oct-23	96.50%	-1.70%	
40-Minute Handover Delays	Avg handover time for the month	Monthly	40	40	Oct-23	35.4	-4.6		N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Mental Health																				
Reduce mental health adult acute out of area placement	Number of inappropriate OAP bed days for adults by quarter that are either 'internal' or 'external' to the sending provider	Monthly	0	0	Oct-23	335	335		N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Increase number of adults and older people accessing IAPT	Total access to NHS Talking Therapies services	Monthly	1,757	1,683	Oct-23	1,510	-173		N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Overall access to core community mental health services for adults and older adults with severe mental illness	Number of people who receive two or more contacts from NHS commissioned community mental health services for adults and older adults with severe mental illness	12 Month Rolling	9,526	8,240	Aug-23	7,170	-1070		N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
CYP MH service	Number of CYP accessing MH Service	12 Month Rolling	8,137	7,500	Oct-23	5,870	-1630		N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Improve access to perinatal MHS	Number of women accessing specialist community PMH and MMHS services in the reporting period	YTD Cumulative	714	714	Oct-23	601	-113		N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Dementia diagnosis rate	Percentage diagnosis rate for people aged 65 and over, with a diagnosis of dementia recorded in primary care	Monthly	66.70%	63.75%	Oct-23	55.0%	-8.7%		N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

NHS Dorset

System Performance Report

October 2023

Performance Summary (1/3)

NHS Dorset

Standard	Achieving Trajectory	Comparison to previous month	Details	SPC – trend over time
Virtual ward utilisation	No	Improved	Comparing October to September, performance improved by 11%	Insufficient data to determine either special cause or common cause variation
Virtual ward capacity	No	Maintained	Comparing October to September, performance was the same	Insufficient data to determine either special cause or common cause variation
2-hour urgent community response contacts	No	Deteriorated	Comparing September to August, performance deteriorated by 2 contacts	Insufficient data to determine either special cause or common cause variation
2-hour urgent community response times	Yes	Maintained	Comparing September to August, performance deteriorated by 2.3%	Insufficient data to determine either special cause or common cause variation
Increase in primary care appointments	Yes	Improved	Comparing September to August, performance improved by 52,572 appointments	Common cause variation, no significant change
78-Week waiters	No	Deteriorated	Comparing October to September, performance deteriorated by 10 patients	Special cause variation of an increasing nature – DOWN
65-Week waiters	No	Deteriorated	Comparing October to September, performance deteriorated by 177 patients	Special cause variation of an increasing nature – DOWN
106% activity	No	Deteriorated	Comparing August to July, performance deteriorated by 2.3% however no figures are included for Dorset HealthCare	No SPC, taken from Future NHS platform
Elective recovery – Day Case activity	No	Improved	Comparing September to August, activity demonstrated 439 more day cases	No SPC, taken from SUS data
Elective recovery – IP Ordinary Activity	No	Improved	Comparing September to August, activity demonstrated 25 more inpatients	No SPC, taken from SUS data
Elective recovery – OP First Appt. Activity	No	Improved	Comparing September to August, activity demonstrated 7,697 more first outpatients	No SPC, taken from SUS data
Elective recovery – Follow Up Activity	Yes	Improved	Comparing September to August, activity demonstrated 47,291 more follow-up outpatients	No SPC, taken from SUS data

SOF Standards associated with the System Oversight Framework with performance against the operating plan assessed by the regional team on a quarterly basis to decide on the segmentation for each provider and the system. In addition, they could trigger tiering.

Performance Summary (2/3)

NHS Dorset

Standard	Achieving Trajectory	Comparison to previous month	Details	SPC – trend over time
Advice and guidance	No	Deteriorated	Comparing September to August, performance deteriorated by just 0.21% but a change in trajectory caused a 3.21% higher variance	Common cause variation, no significant change
Patient initiated follow-ups	No	Maintained	Comparing September to August, performance improved by 0.18%	Special cause variation of an increasing nature – significant UP
Theatre utilisation	No	Maintained	Comparing October to September, performance deteriorated by 0.85%	No SPC available
Day case rates	No	Maintained	Comparing July to June, performance improved by 1%	No SPC available
Reduction in total waiting list*	Yes	Improved	Comparing October to September, performance improved by 2,900 patients	Special cause variation of an increasing nature - UP
Reduction in follow-up outpatients*	Yes	Improved	Comparing September to August, performance improved by 8,763 fewer appointments	No SPC, taken from the System ERF Dashboard
Diagnostics	Yes	Improved	Comparing October to September, performance improved by 1.7%	Common cause variation, no significant change
Diagnostics Recovery – Audiology	No	Improved	Comparing September to August, performance improved by 5%	Special cause variation of a concerning nature – significant DOWN
Diagnostics Recovery – Echocardiography	No	Improved	Comparing October to September, performance improved by 5.23%	Special cause variation of a concerning nature – significant DOWN
Faster Diagnosis Standard	No SOF	Improved	Comparing September to August, performance improved by 4.5%	Common cause variation, no significant change
62-Day backlog	No SOF	Improved	Comparing October to September, performance improved by 9 patients	Special cause variation of an increasing nature – significant UP
4-hour emergency department standard	No SOF	Maintained	Comparing October to September, performance improved by 0.9%	Common cause variation, no significant change
Category 2 ambulance response times	Yes SOF	Improved	Comparing October to September, performance improved by 3 minutes	Special cause variation of an increasing nature – significant DOWN
No criteria to reside	No	Deteriorated	Comparing October to September, performance deteriorated by 7 patients	Special cause variation of an increasing nature – significant DOWN
Bed occupancy*	Yes	Maintained	Comparing October to September, occupancy increased by 0.3%	Common cause variation, no significant change
40-minute handover delays	Yes	Improved	Comparing October to September, performance improved by 5 minutes, 24 seconds	Special cause variation of an increasing nature – significant DOWN

* within the operating plan submission, the system commits to achieve all standards except three - reduction in total waiting list, 25% reduction in follow-up outpatients, and 92% bed occupancy.

SOF Standards associated with the System Oversight Framework with performance against the operating plan assessed by the regional team on a quarterly basis to decide on the segmentation for each provider and the system. In addition, they could trigger tiering.

Performance Summary (3/3)

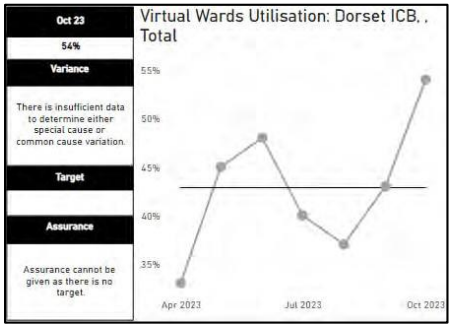
NHS Dorset

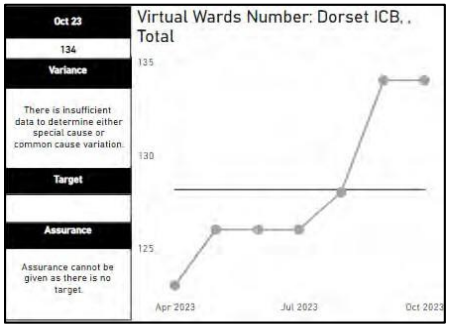
Standard	Achieving Trajectory	Comparison to previous month	Details	SPC – trend over time
Out of area placements	No	Improved	Comparing October to September, performance improved by 180 bed days	Common cause variation, no significant change
Increasing the number of adults and older people accessing psychological therapies (NHS Talking Therapies):	No	Improved	Comparing October to September, performance improved by 110 patients	No SPC available
Overall access to core community mental health services for adults and older adults with severe mental illness	No	Deteriorated	Comparing August to July, performance deteriorated by 20 patients	No SPC, taken from NHS England submission
Dementia diagnosis rates	No	Maintained	Comparing September to August, performance deteriorated by 1%	Common cause variation, no significant change
Perinatal mental health access	No	Improved	Comparing October to September, performance improved by 6 patients	Special cause variation of an increasing nature – significant UP
Children and young people (CYP) mental health access	No	Improved	Comparing October to September, performance improved by 28 patients	Special cause variation of an increasing nature – significant UP
CYP mental health – CAMHS Gateway	No	Maintained	Comparing October to September, performance deteriorated by 3%	Special cause variation of an increasing nature – significant UP
CYP mental health – Routine Access to Eating Disorders	No	Deteriorated	Comparing October to September, performance deteriorated by 15%	Common cause variation, no significant change
CYP mental health – Urgent Access to Eating Disorders	Yes	Improved	Comparing September to August, performance improved by 100%	Common cause variation, no significant change

SOF Standards associated with the System Oversight Framework with performance against the operating plan assessed by the regional team on a quarterly basis to decide on the segmentation for each provider and the system. In addition, they could trigger tiering.

Performance Report

Primary and Community Care: Virtual Wards





Variance against operating plan

80% VW Utilisation	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23		Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
Trajectory	67.23%	70%	73.13%	74.5%	75.22%	79.84%	80%	Original	79.86%	80%	80%	80%	80%
								Revised	54%	60%	65%	70%	80%
Actual	33%	45%	48%	40%	37%	43%	54%						
Variance	-34.23%	-25%	-25.13%	-34.5%	-38.22%	-36.84%	-26%						

Number of VW Beds	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23		Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
Trajectory	119	140	160	200	230	248	265	Original	283	300	320	340	360
								Revised	144	175	236	298	360
Actual	123	126	126	126	128	134	134						
Variance	4	-14	-34	-74	-102	-114	-131						

Latest reporting period: **31 October 2023**
Source: Dorset ICB System Performance Report - Power BI

Data confidence	
Medium	Utilisation information is currently taken from NHS England with a snapshot taken on one day, every two weeks, however a local dashboard is under development. The performance figures do not include remote monitoring data.

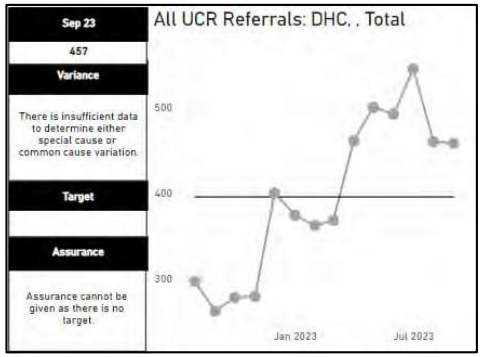
Standard:
- 80% virtual ward utilisation
- Increase the number of patients the virtual ward can simultaneously manage

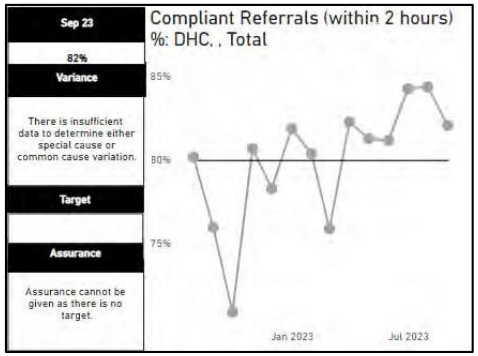
Performance against trajectory:
- Underperforming for both standards:
  - 26% under for utilisation
  - 131 beds under for total number of beds (there are 60 remote monitoring beds which are not in these figures, taking it to 71 under).

Action		Expected impact of action	Delivery date
1	Additional face-to-face beds are expected.	10 additional heart failure beds at UHD 5 additional atrial fibrillation (AF) beds at UHD, 5 additional paediatrics beds at UHD and 20 additional frailty beds across the system.	November December
2	Clinical teams will be encouraged to double the number of face-to-face beds,	Increasing capacity by another 40 in Q4.	Q4
3	A conversation will be held with provider Chief Executive Officers and ICB colleagues to find a way forward which is expected to lead to a clinical conversation to overcome concerns around clinical confidence and increase existing capacity utilisation.	Improve performance in virtual wards.	November
4	Demand review for step-up and step-down provision will take place ensure capacity can flex.	To meet the needs of Dorset residents, keeping individuals outside of the acute setting unless clinically appropriate.	December
5	Maximise on opportunities to utilise the remote monitoring capacity across the system.		Q3/Q4
6	Participation in the NHS England South West accelerated change programme and associated action plan.	To be confirmed once action plan is agreed – follow up workshop planned in November	21/11/2023

Performance Report

Primary and Community Care: Urgent Community Response (UCR)





Variance against operating plan

2-hour UCR no. referrals	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23		Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
Trajectory	720	720	720	800	800	800	800	Original	800	800	800	800	800
								Revised	1300	1300	1300	1300	1300
Actual	460	499	491	544	459	457							
Variance	-260	-221	-229	-256	-341	-343							

2-hour UCR % within 2hrs	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23		Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
Trajectory	80%	80%	80%	80%	80%	80%	80%	Not revised	80%	80%	80%	80%	80%
Actual	82.2%	81.2%	81.1%	84.2%	84.3%	82.0%							
Variance	2.2%	1.2%	1.1%	4.2%	4.3%	2.0%							

Latest reporting period: **30 September 2023**
Source: Dorset ICB System Performance Report - Power BI

Data confidence	
Medium	Data discrepancies exist between local data and the NHS England UCR dashboard: Statistics » 2-hour Urgent Community Response (england.nhs.uk). Work is underway between BI Teams to rectify this. However, regardless of which data set is used, the expected number if contacts is under trajectory.

Standard:

- 2-hour urgent community response contacts (no. of referrals)
- 2-hour urgent community response time (% within 2 hours)

Performance against trajectory:

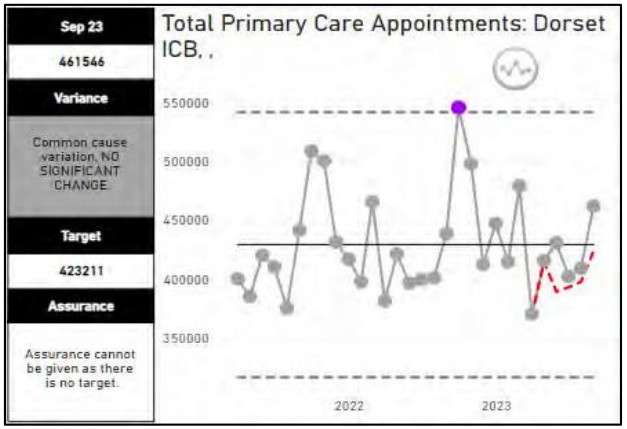
- Underperforming by 343 for number of referrals
- Overperforming by 2% for response time

Action		Expected impact of action	Delivery date
1	Regional priority to increase referrals out of the SWASFT Emergency Operations Centre (EOC) to UCR and system CASs (in order to access other alternative pathways) – NHSE supporting SWASFT as part of their Tier 1 support package. A number factors are being worked through and the way the system is set up is already preventing referrals to SWASFT. A meeting will be set up with DHC and SWASFT colleagues to look at pathway redesign.	Increase referrals into the UCR service, currently unquantified.	December 23
2	Winter planning: UCR service extension from 0800 – 2000 to 0800 – 0000 following a successful trial week in June which saw 86% of 21 patients avoiding a hospital admission. This activity is now being supported by night nursing and intermediate care teams that are already in place as can offer 2 hour urgent response therefore no need to extend UCR hours, training will be completed to align all services to ensure an equitable response to need.	Increase capacity and consequently referrals into the UCR service, currently unquantified	Unknown
3	Falls prevention workshop – awaiting feedback from SWASFT.	Falls prevention workshop took place on 27/09/2023 to look at moving level 1 falls to the VCSE sector, level 2 falls to the UCR service, leaving level 3 to SWAST. Currently unquantified.	Unknown

4	DHC carried out an audit of the wider team rather than by function and found that other service activity, for example by the night nursing team, could be counted towards the UCR standard as they were providing a similar service. Funding will be used to upskill other teams to do more of what the UCR team can do.	The trajectory will not be changed and is now expected to be exceeded.	Unknown

Performance Report

Primary and Community Care: Primary Care Access



Variance against operating plan

Increase in appointments	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
Trajectory	368,609	414,219	389,121	392,794	397,505	423,211	522,267	482,530	403,704	404,328	389,529	450,289
Actual	370,165	415,248	430,978	402,137	408,974	461,546						
Variance	1,556	1,029	41,857	9,343	11,469	38,335						

Latest reporting period: **30 September 2023**
Source: Dorset ICB System Performance Report - Power BI

Data confidence	
Medium	Confidence is high for the total number of appointments however for the 2-week access performance data the 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.

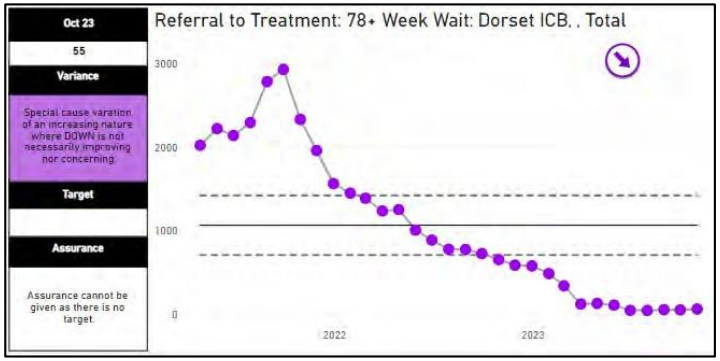
Standard:
- Increase in primary care appointments.

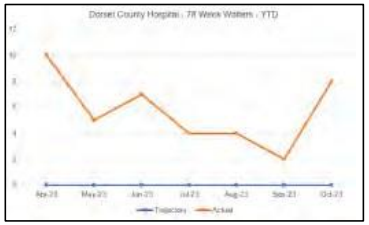
Performance against trajectory:
- Overperforming by 38,335 for increasing the number of primary care appointments

	Action	Expected impact of action	Delivery date
1	Resolve data accuracy issues with NHS Digital General Practice Appointment Data (GPAD) Platform. National issue with NHS England, NHS England South West aware.	The Primary Care Team expects to see a significant improvement in performance once the data accuracy issues have been resolved.	Not expecting this to be resolved during 2023/24
2	Delivery plan for recovering access in Primary Care.	Improve access across primary care, being presented to the Board of the ICB on 02/11/2023.	Throughout 2023/24 and beyond
3	Reviewing the trajectory for 2-week access recognising the data accuracy issues with GPAD.	Reduction in the trajectory to reflect current performance and a reduction in % due to vaccinations for both flu and COVID.	17/11/2023

Performance Report
Planned Care: 78 Week Waiters

NHS Dorset





Variance against operating plan

System Total	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23		Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
Trajectory	0	0	0	0	0	0	0	Original	0	0	0	0	0
								Revised	92	97	74	30	0
Actual	122	102	39	38	47	45	55						
Variance	-122	-102	-39	-38	-47	-45	-55						

Dorset County Hospital	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23		Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
Trajectory	0	0	0	0	0	0	0	Original	0	0	0	0	0
								Revised	27	60	50	30	0
Actual	10	5	7	4	4	2	8						
Variance	-10	-5	-7	-4	-4	-2	-8						

University Hospitals Dorset	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23		Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
Trajectory	0	0	0	0	0	0	0	Original	0	0	0	0	0
								Revised	65	37	24	0	0
Actual	112	97	32	34	43	43	47						
Variance	-112	-97	-32	-34	-43	-43	-47						

Latest reporting period: **31 October 2023**

Source: Dorset ICB System Performance Report - Power BI

Standard:
- Zero 78+ week waiters

Performance against trajectory:

- Underperforming against trajectory by 55 patients.

Data confidence	
High	No concerns

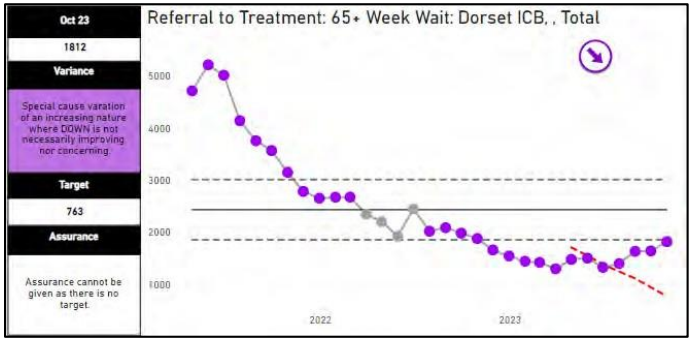
	Action	Expected impact of action	Delivery date
1	Insourcing and outsourcing of patients within the 78-week cohort.	Reduction in 78-week waiters.	Quarter 3 and 4
2	Utilising the independent sector provider contractual envelope with the ICB to transfer patients from the 78-week waiter cohort.	Reduction in 78-week waiters.	Quarter 3 and 4
3	Dorset wide demand and capacity review of community paediatrics.	Clear understanding of system wide issue and identification of potential opportunities.	December 2023

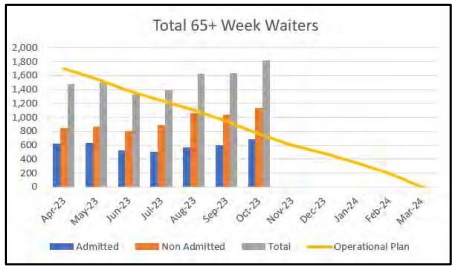
Performance Report

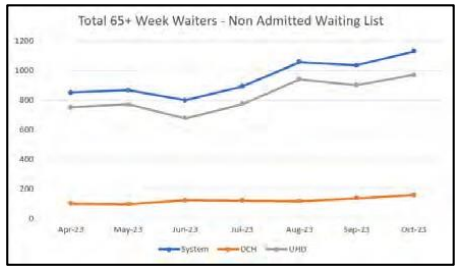
Planned Care: 65 Week Waiters

SOF

NHS Dorset







Variance against operating plan

System Total	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23		Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
Trajectory	1702	1547	1378	1241	1105	940	763	Original	603	483	345	192	0
								Revised	1,818	1,779	1,573	1,490	1,053
Actual	1,474	1,496	1,320	1,393	1,629	1,635	1,812						
Variance	228	51	58	-152	-524	-695	-1,049						

Dorset County Hospital	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23		Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
Trajectory	409	375	335	298	258	221	181	Original	141	111	70	34	0
								Revised	442	509	564	510	500
Actual	225	254	267	271	336	401	481						
Variance	184	121	68	27	-78	-180	-300						

University Hospitals Dorset	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23		Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
Trajectory	1,268	1,149	1,023	925	831	705	571	Original	453	365	270	155	0
								Revised	1376	1270	1009	980	553
Actual	1,249	1,242	1,053	1,122	1,293	1,234	1,331						
Variance	19	-93	-30	-197	-462	-529	-760						

Latest reporting period: **31 October 2023**
Source: Dorset ICB System Performance Report - Power BI

Standard:
- Zero 65+ week waiters

Performance against trajectory:
- Underperforming as a system by 1,049 (DCH 300, UHD 760)

Data confidence	
High	No concerns

Action		Expected impact of action	Delivery date
1	All patients breaching 65-weeks by March 2024 to receive a first outpatient appointment on or before 31 October 2023.	Reduction in 65-week waiters	December 2023
2	Insourcing and outsourcing of patients within the 65-week cohort.	Reduction in 65-week waiters	Quarter 3 and 4
3	Maximising on theatre and outpatient productivity opportunities incorporating the learning from Getting It Right First Time (GIRFT).	To create additional capacity to treat patients within the 65-week waiter cohort.	Quarter 3 and 4

Performance Report

NHS Dorset

Planned Care: 106% Activity

System Total	Apr-23	May-23	Jun-23	Jul-23	Aug-23	YTD
Trajectory	106%	106%	106%	106%	106%	106%
Actual	105.5%	106.1%	99.9%	103.2%	100.9%	103%
Variance	-0.5%	0.1%	-6.1%	-2.8%	-5.1%	-3%

Dorset County Hospital	Apr-23	May-23	Jun-23	Jul-23	Aug-23	YTD
Trajectory	106%	106%	106%	106%	106%	106%
Actual	96.3%	102.6%	93.2%	100.8%	97.4%	97.9%
Variance	-9.7%	-3.4%	-12.8%	-5.2%	-8.6%	-8%

Dorset HealthCare	Apr-23	May-23	Jun-23	Jul-23	Aug-23	YTD
Trajectory	106%	106%	106%	106%	106%	106%
Actual	172.0%	189.5%	176.9%	190%	?	?
Variance	66%	83.5%	70.9%	84%	?	?

University Hospitals Dorset	Apr-23	May-23	Jun-23	Jul-23	Aug-23	YTD
Trajectory	106%	106%	106%	106%	106%	106%
Actual	96.3%	99.6%	92.9%	93.0%	93.1%	94.9%
Variance	-9.7%	-6.4%	-13.1%	-13%	-12.9%	-11%

Latest reporting period: **31 August 2023**
Source: Future NHS

ERF methodology only includes:
- Elective ordinary
- Elective day cases
- Outpatient First attendances (consultant and non-consultant led)
- Outpatient procedures with a published tariff price
- Advice and guidance

Conversations with NHS England regarding baselines are currently underway which may see this reduce to 100%.

Data confidence	
Low	Information based on financial calculations, not activity based. This is the most accurate information available. Further to previous issues, no DHC figures were included in the latest Future NHS report.

Standard:
- Deliver 106% of 2019/20 activity

Performance against trajectory:
- YTD underperforming by 3%, against 106%.
- End of August, underperforming by 5.1%, against 106%

Action		Expected impact of action	Delivery date
1	Actions associated with 78 and 65-week waiters (as per previous slides)	To increase activity numbers.	Quarter 3 and 4
2	Maximising on theatre and outpatient productivity opportunities incorporating the learning from Getting It Right First Time (GIRFT).	To increase activity numbers.	Quarter 3 and 4

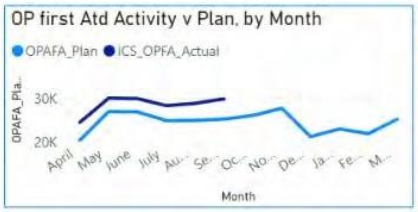
Performance Report

Planned Care: Elective Recovery

NHS Dorset

Elective Activity against Plan

Month	Day Case	IP Ordinary	OP First Atd	OP FUp Atd
April	85.71%	104.03%	119.93%	266.76%
May	80.93%	90.36%	111.29%	286.69%
June	85.79%	68.15%	111.23%	319.34%
July	89.41%	73.07%	113.70%	302.42%
August	80.68%	86.46%	115.52%	295.27%
September	66.22%	76.50%	118.33%	271.97%



NB. Performance affected by industrial action on the following dates:

- 16 April
- 18 June
- 16 / 23 July
- 13 / 20 / 27 August
- 24 September
- 2 / 3 / 4 October

Latest reporting period: **30 September 2023**
Source: Dorset ICB System Performance Report - Power BI

Variance against operating plan

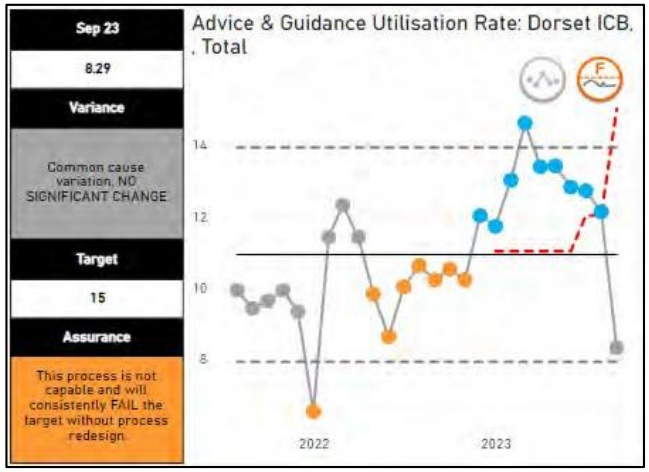
	Plan							Actual							Variance						
	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	YTD Total	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	YTD Total	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	YTD Total
ICS_Day Case	9,253	10,894	10,593	9,536	10,654	10,538	61,468	7,929	8,817	9,084	8,498	6,539	6,978	47,845	-1,324	-2,077	-1,509	-1,038	-4,115	-3,560	-13,623
ICS_IP Ordinary	1,141	1,494	1,978	1,816	1,580	1,468	9,477	1,187	1,349	1,349	1,328	1,098	1,123	7,434	46	-145	-629	-488	-482	-345	-2,043
ICS_OP First Atd	20,458	27,022	26,937	24,939	25,004	25,282	149,642	18,967	23,951	23,642	22,347	22,218	29,915	141,040	-1,491	-3,071	-3,295	-2,592	-2,786	4,633	-8,602
ICS_Op Fup Atd	28,037	28,827	26,034	26,625	28,495	28,862	166,880	27,135	31,350	33,243	30,603	31,206	78,497	232,034	-902	2,523	7,209	3,978	2,711	49,635	65,154

Data confidence	
Medium	Taken from SUS activity data which can experience delays as it is reliant on the 'cashing up' of clinics and admissions.

Action		Expected impact of action	Delivery date
1	Actions associated with 78 and 65-week waiters (as per previous slides)	To increase activity numbers.	Quarter 3 and 4
2	Maximising on theatre and outpatient productivity opportunities incorporating the learning from Getting It Right First Time (GIRFT).	To increase activity numbers.	Quarter 3 and 4

Performance Report

Planned Care: Advice and Guidance



Variance against operating plan

Advice and Guidance	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
Trajectory	11%	11%	11%	12%	12%	15%	15%	15%	15%	17%	17%	17%
Actual	13.4%	13.4%	8.6%	8.8%	8.5%	8.29%						
Variance	2.4%	2.4%	-2.4%	-3.2%	-3.5%	-6.71%						

Latest reporting period: **30 September 2023**
Source: Dorset ICB System Performance Report - Power BI

Data confidence	
High	No concerns

Standard:
- Increase the % of advice and guidance of outpatient attendances

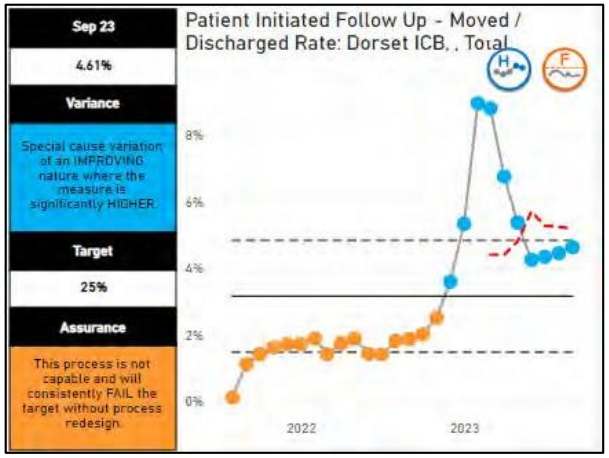
Performance against trajectory:
- Underperforming by 6.71%

	Action	Expected impact of action	Delivery date
1	Advice and guidance (A&G) is being picked up through the Planned Care Improvement Group, recognising an increase in A&G demand will require additional workforce capacity which may not be the best use of resources considering 65 and 78-week waiters and cancer. The introduction of teledermatology and AI within cancer will reduce the demand for A&G requests within that specialty so a reduction may be seen.	To establish what is required to improve performance.	Ongoing
2	The ICB Planned Care Team have prioritised referral management, including the use of advice and guidance (workplan to be signed off and other areas of work paused).	The acutes providing this service are unable to influence demand. However, it is believed those Primary Care Networks (PCNs) who are high referrers will be low users therefore targeted work could improve performance.	Quarter 4

Performance Report

Planned Care: Patient Initiated Follow-Ups

NHS Dorset



Variance against operating plan

System Total	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23		Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
Trajectory	4.4%	4.8%	5.7%	5.3%	5.2%	5.2%	5.3%	Original	4.7%	4.8%	5.7%	5.8%	5.7%
								Revised	4.1%	4.5%	5.1%	5.4%	5%
Actual	6.74%	5.35%	4.23%	4.36%	4.43%	4.61%							
Variance	2.34%	0.55%	-1.47%	-0.94%	-0.77%	-0.59%							

Dorset County Hospital	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23		Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
Trajectory	4.4%	4.8%	5.7%	5.3%	5.2%	5.2%	5.3%	Original	4.7%	4.8%	5.7%	5.8%	5.7%
								Revised	3.5%	3.5%	4%	4.5%	5%
Actual	3.4%	3.1%	3.7%	3%	3.7%	3.27%							
Variance	-1%	-1.7%	-2%	-2.30%	-1.5%	-1.93%							

University Hospitals Dorset	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23		Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
Trajectory	4.4%	4.8%	5.7%	5.3%	5.2%	5.2%	5.3%	Original	4.7%	4.8%	5.7%	5.8%	5.7%
								Revised	4.5%	4.6%	4.7%	4.8%	5%
Actual	8.5%	5.8%	3.7%	3.6%	4%	4.23%							
Variance	4.1%	1%	-2%	-1.7%	-1.2%	-0.97%							

NB. Trajectory target on the graph is incorrect – see table above

Latest reporting period: **30 September 2023**
Source: Dorset ICB System Performance Report - Power BI

Data confidence	
High	No concerns

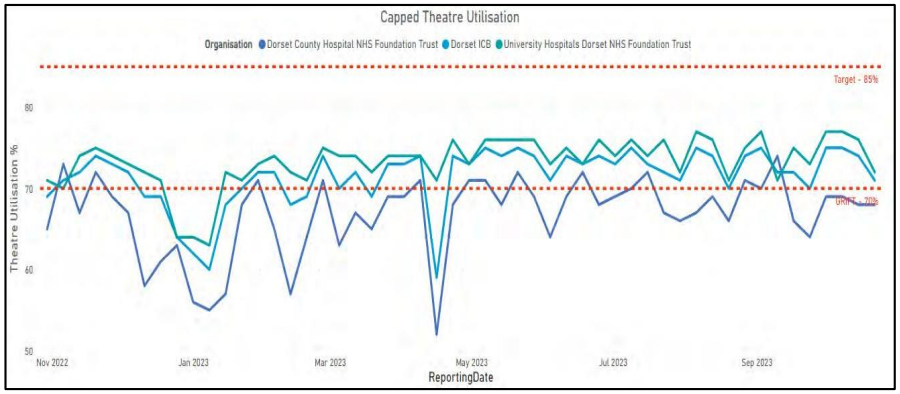
Standard:
- Increase the % of patient-initiated follow-ups of discharges

Performance against trajectory:
- Underperforming by 0.59%

Action		Expected impact of action	Delivery date
1	DCH have reviewed their PIFU delivery programme, increasing resource, and widening the scope.	Expecting performance to recover by March 2024.	Quarter 4
2	UHD have a plan to meet the national target with PIFU as an integral safety net for eliminating 2-year overdue follow ups (patients who meet criteria for PIFU but not discharged will be placed on PIFU following validation). Further rollout of PIFU aligned to the 3 phases of the 2-year follow-up reduction project.	Expecting performance to recover by March 2024.	Quarter 4

Performance Report

Planned Care: Theatre Utilisation



Variance against operating plan

System Total	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23		Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
Trajectory	85%	85%	85%	85%	85%	85%	85%	Original	85%	85%	85%	85%	85%
								Revised	76%	77%	78%	79%	81%
Actual	73%	74%	72%	68%	74%	71.9%	71%						
Variance	-12%	-11%	-13%	-17%	-11%	-13.2%	-14%						

Dorset County Hosptial	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23		Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
Trajectory	85%	85%	85%	85%	85%	85%	85%	Original	85%	85%	85%	85%	85%
								Revised	72%	76%	79%	82%	85%
Actual	71%	69%	68%	65%	73%	62.6%	68%						
Variance	-14%	-16%	-17%	-20%	-12%	-22.4%	-17%						

University Hospitals Dorset	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23		Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
Trajectory	85%	85%	85%	85%	85%	85%	85%	Original	85%	85%	85%	85%	85%
								Revised	77%	77%	77%	78%	80%
Actual	73%	76%	76%	72%	75%	79.7%	72%						
Variance	-12%	-9%	-9%	-13%	-10%	-5.3%	-13%						

Standard:
- 85% theatre utilisation

Performance against trajectory:
- Underperforming by 14%

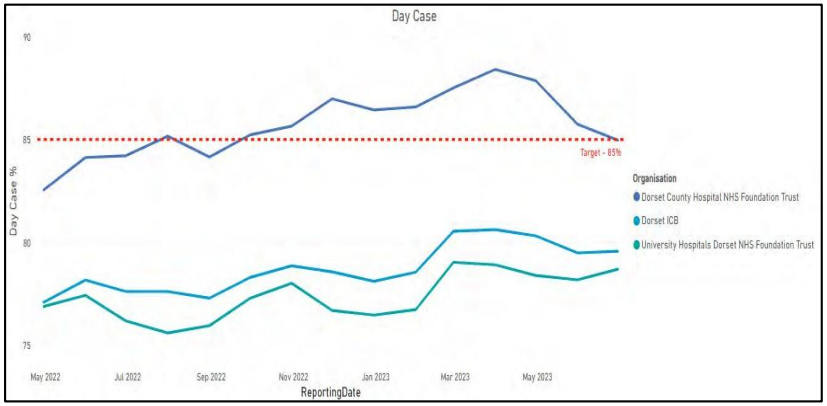
Latest reporting period: **22 October 2023**
Source: Dorset ICB System Performance Report - Power BI

Data confidence	
High	No concerns

Action		Expected impact of action	Delivery date
1	UHD Theatre Improvement Programme in place.	Expecting to meet 80% theatre utilisation by the end of March 2024.	Beyond March 2024
2	DCH Theatre Improvement Programme in place.	Expecting to meet 85% theatre utilisation by the end of March 2024.	March 2024
3	Maximising on theatre productivity opportunities incorporating the learning from Getting It Right First Time (GIRFT) following GIRFT Senior Implementation Manager visit to both UHD and DCH in November.	To increase utilisation.	Quarter 3 and 4

Performance Report

Planned Care: Day Case Rates



Variance against operating plan

System Total	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23		Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
Trajectory	85%	85%	85%	85%	85%	85%	85%	Original	85%	85%	85%	85%	85%
								Revised	83.6%	83.6%	83.7%	83.7%	83.7%
Actual	80%	79%	80%										
Variance	-5%	-6%	-5%										

Dorset County Hosptial	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23		Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
Trajectory	85%	85%	85%	85%	85%	85%	85%	Not revised	85%	85%	85%	85%	85%
Actual	88%	86%	85%										
Variance	3%	1%	0%										

University Hospitals Dorset	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23		Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
Trajectory	85%	85%	85%	85%	85%	85%	85%	Original	85%	85%	85%	85%	85%
								Revised	83%	83%	83.1%	83.2%	83.2%
Actual	78%	78%	79%										
Variance	-7%	-7%	-6%										

Standard:
- 85% day case rate

Performance against trajectory:
- Underperforming by 5%

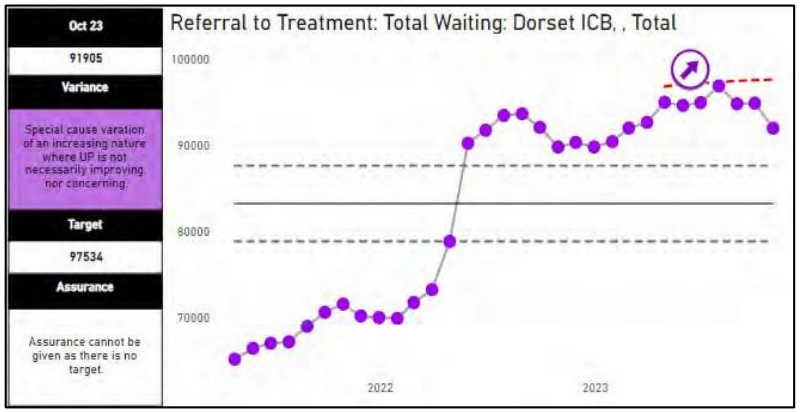
Latest reporting period: **30 June 2023**
Source: Dorset ICB System Performance Report - Power BI

Data confidence	
High	No concerns

Action		Expected impact of action	Delivery date
1	UHD are in the early stages of setting up trust wide project plans supporting right place right procedure initiative. - Overlapping with CANDo lead initiative & LOS workstream. - BADS and GIRFT opportunities identified within Model Hospital forming starting point for review.	Productivity gains expected through freed up capacity within theatres & bed days.	Quarter 3 and 4
2	Theatre improvement actions outlined on previous slide.		

Performance Report

Planned Care: Reduction in Total Waiting List



Variance against operating plan

Reduction in total waiting list	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
Trajectory	96,725	97,032	97,137	97,248	97,371	97,467	97,534	97,604	97,746	97,791	97,784	97,789
Actual	94,547	94,547	94,871	96,788	94,732	94,805	91,905					
Variance	-2,178	-2,485	-2,266	-460	-2,639	-2,662	-5,629					

Latest reporting period: **31 October 2023**
Source: Dorset ICB System Performance Report - Power BI

Data confidence	
High	No concerns

Standard:
- Reduction in total waiting list

Performance against trajectory:
- Overperforming by 5,629 patients

NB. Reduction in total waiting list is one of the three standards the system did not commit to achieve within the operating plan submission. The system still holds trajectories outlining expected performance and the standard continues to be monitored.

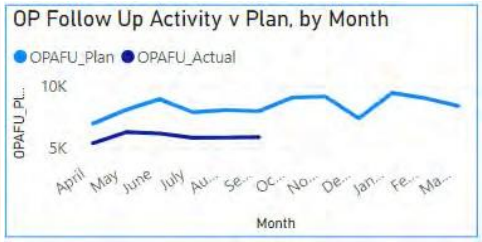
Action		Expected impact of action	Delivery date
1	Validation of waiting list as per national guidance.	Validated waiting list in place.	Ongoing

Performance Report

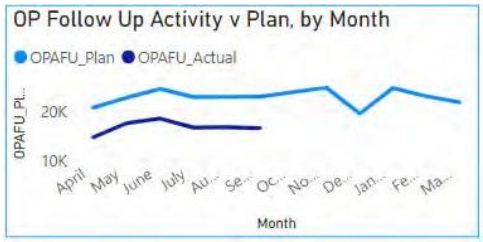
Planned Care: Reduction in Follow-up Outpatients

System

DCH



UHD



Latest reporting period: **30 September 2023**
Source: Dorset ICB System Performance Report – Power BI

Standard:
- Reduction in the number of consultant-led follow up outpatient attendances (Spec acute)

Performance against trajectory:
Overperforming by 6,419 appointments

Variance against operating plan

Reduction in follow up outpatients	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
Trajectory	28,037	28,827	26,034	26,625	28,495	28,862	28,577	32,219	26,588	25,879	25,230	29,013
Actual	27,135	31,350	33,243	30,603	31,206	22,443						
Variance	-902	2,523	7,209	3,978	2,711	-6,419						

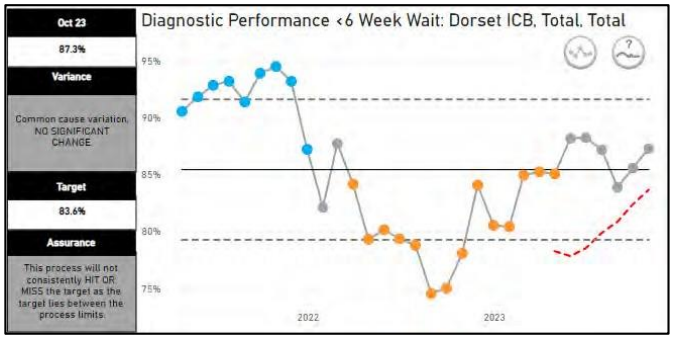
Data confidence	
Medium	The provider charts consider all population (inc. non-Dorset). Whereas the System chart is for Dorset only and includes ISPs.

Follow-up Outpatient Waiting List (patients not on an open RTT clock and past their clinical to be seen date):
- DCH – the follow-up backlog increased by 326 patients in October, with 8,937 patients overdue their target date for a follow-up appointment.
- UHD – the follow-up backlog decreased by 453 patients in October, with 27,493 patients overdue their target date for a follow-up appointment.

NB: 25% reduction in follow-up outpatients is one of the three standards the system did not commit to achieve within the operating plan submission. The system still holds trajectories outlining expected performance and the standard continues to be monitored.

Action		Expected impact of action	Delivery date
1	Moving as many patients as possible to PIFU, as per earlier slide.	Reduction in follow-ups and increase in PIFU performance.	March 2024

Performance Report Planned Care: Diagnostics



Variance against operating plan

Diagnostics	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
Trajectory	78.22%	77.79%	78.51%	79.83%	80.84%	82.36%	83.63%	84.94%	85.89%	86.15%	87.12%	88.40%
Actual	78.2%	88.2%	88.2%	87.2%	83.9%	85.6%	87.3%					
Variance	-0.02%	10.41%	9.69%	7.37%	3.06%	3.24%	3.67%					

Latest reporting period: **31 October 2023**
Source: Dorset ICB System Performance Report - Power BI

Standard:
- Increase % of patients receiving a diagnostic test within 6-weeks

Performance against trajectory:
- Overperforming by 3.67%

Modalities of concern:

DHC
Audiology: 58.4% (latest September data) – see next slide

DCH
Echocardiology: 52.08% – see next slide

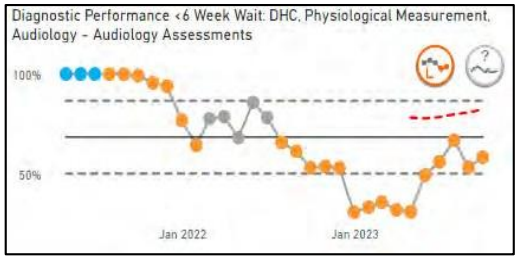
Data confidence	
High	No concerns

Action		Expected impact of action	Delivery date
1	Recovery plan in place for audiology at Dorset HealthCare (see next slide).	To improve performance against this standard.	Ongoing
2	Recovery plan in place for echocardiography at Dorset County Hospital (see next slide).	To improve performance against this standard.	Ongoing

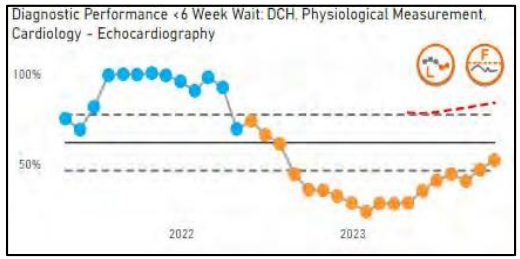
Performance Report

Planned Care: Diagnostics Recovery – Audiology and Echocardiology

NHS Dorset



Latest reporting period: **30 September 2023**
Source: Dorset ICB System Performance Report - Power BI



Latest reporting period: **31 October 2023**
Source: Dorset ICB System Performance Report - Power BI

Variance against recovery plan
Details to follow

Variance against recovery plan

Diagnostics - DCH Echo	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
Plan	33.74%	39.29%	47.83%	61.11%	91.67%	100%	100%	100%	100%	100%	100%
Actual	35.30%	40.90%	44.40%	40.59%	46.85%	52.08%					
Variance	1.56%	1.61%	-3.43%	-20.52%	-44.82%	-47.92%					

Standard:
- Increase % of patients receiving a diagnostic (audiology) test within 6-weeks (at Dorset HealthCare)

Performance against plan:
- To be confirmed (performance was 58.4% at the end of September)

Data confidence	
High	No concerns

Standard:
- Increase % of patients receiving a diagnostic (echocardiology) test within 6-weeks (at Dorset County Hospital)

Performance against plan:
- Underperforming by 47.92%

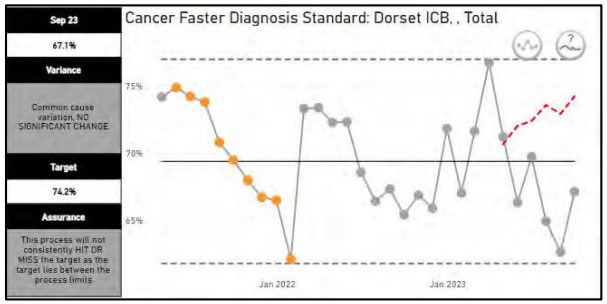
Data confidence	
High	No concerns

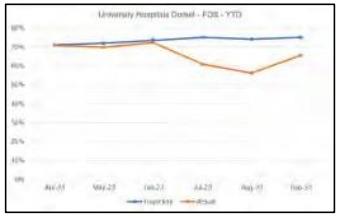
	Action	Expected impact of action	Delivery date
1	Both modalities have recovery plans in place which are being monitored through the Planned Care Improvement Group with escalation to the Planned Care Delivery Group if necessary.	To improve performance against DM01: increase % of patients receiving a diagnostic test within 6-weeks.	March 2024

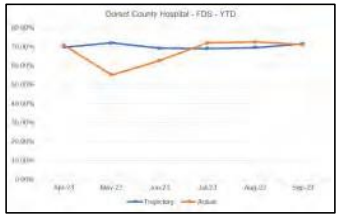
Performance Report

Planned Care: Cancer – Faster Diagnosis Standard SOF

NHS Dorset







Variance against operating plan

System Total	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23		Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
Trajectory	70.64%	72.01%	72.37%	73.55%	72.9%	74.21%	74.18%	Original	74.89%	75.64%	75.53%	75.59%	78.87%
								Revised	69.9%	73.2%	73.2%	74.5%	75.2%
Actual	71.25%	66.3%	69.7%	64.9%	62.6%	67.1%							
Variance	0.61%	-5.71%	-2.67%	-8.65%	-10.30%	-7.11%							

Dorset County Hospital	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23		Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
Trajectory	69.66%	72.02%	69.13%	68.98%	69.44%	71.5%	71.49%	Not revised	74.10%	75.30%	75.64%	75.95%	75.94%
Actual	70.8%	55.1%	62.6%	72%	72.4%	71%							
Variance	1.14%	-16.92%	-6.53%	3.02%	2.96%	-0.5%							

University Hospitals Dorset	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23		Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
Trajectory	71%	72.01%	73.51%	75.03%	74.1%	75.03%	75%	Original	75.16%	75.76%	75.49%	75.46%	75.85%
								Revised	68.5%	72.5%	72.5%	74%	75%
Actual	70.9%	69.8%	72.3%	60.9%	56.1%	65.6%							
Variance	-0.1%	-2.21%	-1.21%	-14.13%	-18%	-9.43%							

Standard:
- 76% of patients diagnosed within 28-days

Performance against trajectory:
- Underperforming by 7%

Latest reporting period: **30 September 2023**
Source: Dorset ICB System Performance Report - Power BI

Data confidence	
High	No concerns

	Action	Expected impact of action	Delivery date
1	Colorectal – decommission the FIT < 10 pathway following NICE publication.	Create additional capacity for fast-track appointments as patients will be managed in primary care. However, there is a significant risk hindering this with coding and identification of patients in primary care which has been escalated nationally. Currently unquantified.	January 2024 (pending resolution of coding issue)
2	Gynaecology – GP direct access pathway for individuals with post-menopausal bleeding taking HRT went live at UHD on 20 November 2023.	Reduce pathway and reduce inappropriate referrals to colposcopy capacity, currently unquantified.	20/11/2023
3	Skin – teledermatology and AI	Phase 1: Community Diagnostic Centre photo hubs (to take images of skin lesions) which will be piloted with one in the east and one in the west of Dorset. Phase 2: introduction of skin analytics to reduce demand on dermatology services.	End of November Mid-January 2024
4	Urology – local template biopsies	Introduction of local template biopsies in October 2023 undertaken by consultants to reduce the pathway with a long-term plan to also do these nurse led to increase capacity and competence.	Unknown – for nurse led

Performance Report

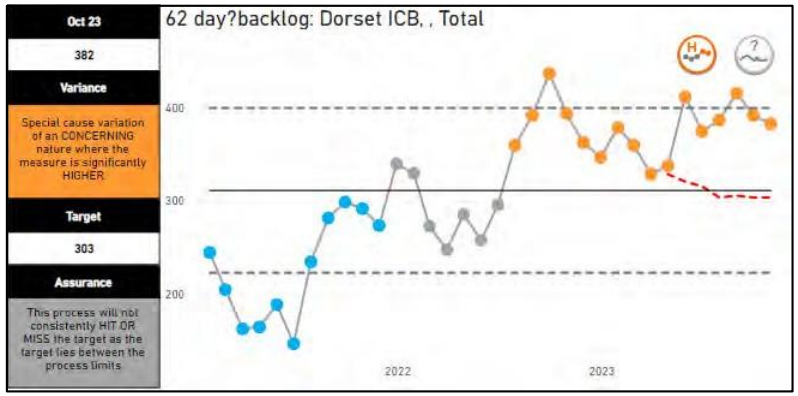
5	Skin – learning from significant increase in demand during the summer.	The learning from this activity will be shared and any inappropriate referrals identified to support conversations with Primary Care.	Unknown

Performance Report

Planned Care: Cancer – 62-Day Backlog

SOF

NHS Dorset



Variance against operating plan

System Total	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23		Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
Trajectory	328	320	315	303	305	303	303	Original	303	303	300	295	290
								Revised	353	333	330	310	290
Actual	337	411	374	386	415	391	382						
Variance	9	91	59	83	110	88	79						

Dorset County Hospital	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23		Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
Trajectory	70	70	75	78	80	83	83	Not revised	83	83	80	75	70
Actual	60	98	89	89	78	78	83						
Variance	-10	28	14	11	-2	-5	0						

University Hospitals Dorset	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23		Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
Trajectory	258	250	240	225	225	220	220	Original	220	220	220	220	220
								Revised	270	250	250	235	220
Actual	279	314	286	298	338	317	298						
Variance	21	64	46	73	113	97	78						

Latest reporting period: **31 October 2023**
Source: Dorset ICB System Performance Report - Power BI

Data confidence	
Medium	Snapshot taken at the end of the month, however, should patients in the backlog be treated and found not to have cancer they will be removed from the backlog numbers.

Standard:

- Reduce the number of patients waiting beyond 62-days for cancer treatment

Performance against trajectory:

- Underperforming by 79 patients (DCH meeting the trajectory but UHD underperforming by 78)

Action		Expected impact of action	Delivery date
1	The cancer backlog will be discussed at the next UHD Touchpoint meeting	Support the reduction of the 62-day backlog.	20 December 2023
2	Faster diagnosis standard actions outlined on previous slide	Support the reduction of the 62-day backlog.	N/A
3	Community Diagnostic Centres	Moving work out of acute trusts to speed up pathways.	Throughout 2023/24 and beyond (some delays experienced)
4	Autumn focus at UHD	An autumn focus on the 62-day backlog with weekly clinical reviews of backlog patients continuing with the aim to reduce numbers in the backlog. Currently unquantified.	Unknown
5	Recruitment and retention initiatives at UHD	Breast locum radiology to support one stop clinics due to workforce vacancies In gynaecology to support the delivery of complex cases.	Ongoing
6	Transformation of MDT meetings at UHD	Release capacity for pathology, radiology and tumour site consultants.	Unknown

Performance Report

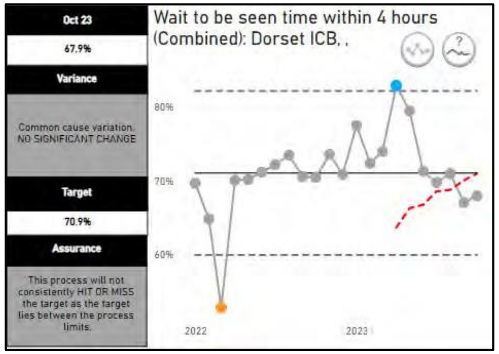
7	Skin – across the system	Insourcing of capacity to support demand.	Ongoing

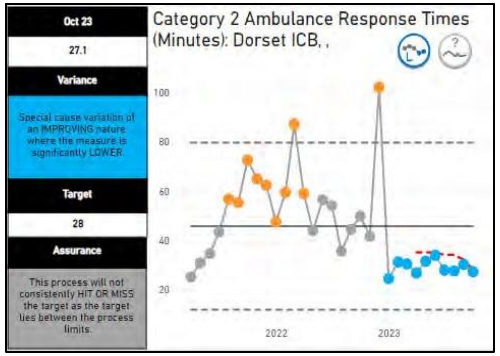
Performance Report

Urgent and Emergency Care: 4-Hour Standard and Category 2 Ambulance Response

SOF

NHS Dorset





Standard:

- 76% of patients waiting less than 4 hours to be seen
- Average time to respond to Category 2 ambulance calls for SWAST for Dorset

Performance against trajectory:

- Underperforming against the 4-hour standard by 3% (DCH overperforming by 2% but UHD underperforming by 5.5%)
- Overperforming by 0.9 minutes for Cat 2 response

Variance against operating plan

4-Hour ED

System Total	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23		Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
Trajectory	63.64%	66.24%	66.68%	68.49%	68.67%	69.96%	70.93%	Original	71.87%	73.02%	73.90%	76%	76%
								Revised	66.4%	67.7%	68.7%	72.4%	76%
Actual	82.8%	79.4%	71.2%	69.7%	70.9%	67%	67.9%						
Variance	19.16%	13.16%	4.52%	1.21%	2.23%	-2.96%	-3.03%						

Dorset County Hospital	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23		Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
Trajectory	71.99%	73.99%	75.01%	76%	76%	76.01%	76%	Not revised	76%	76%	76.01%	76%	76%
Actual	82.8%	79.4%	80.6%	79.3%	79%	78%	77.9%						
Variance	10.81%	5.41%	5.59%	3.30%	3%	1.99%	1.9%						

University Hospitals Dorset	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23		Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
Trajectory	60%	63%	63%	65%	65%	67%	68.5%	Original	70%	71.50%	73%	76%	76%
								Revised	62.5%	64%	66%	71%	76%
Actual	-	-	61.6%	60.1%	62.9%	61.5%	61.5%						
Variance	N/A	N/A	-1.40%	-4.9%	-2.1%	-5.50%	-7%						

Cat 2 Response	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23		Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
Trajectory	35	35	35	34	34	32	28	Not revised	28	28	22	22	21
Actual	26.6	31.4	33.8	27.8	27.4	30.1	27.1						
Variance	-8.4	-3.6	-1.2	-6.2	-6.6	-1.9	-0.9						

Latest reporting period: **31 October 2023**
Source: Dorset ICB System Performance Report - Power BI

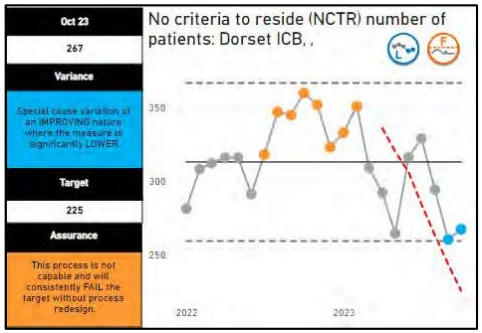
Data confidence	
High	No concerns

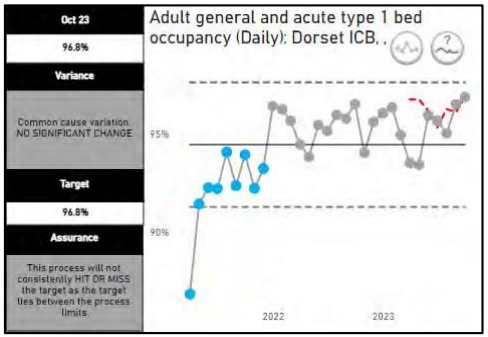
	Action	Expected impact of action	Delivery date
1	SWASFT to realign their resource to have additional ambulances during the night based on the evidence.	• To reduce handover delays in the evening • Improve Cat 2 response	Completed
2	Focus on maximising utilisation of non-ED pathways (acute and community) - UCR, Virtual Wards, UTCs, SDEC etc	• Fewer preventable ED attendances and admissions via ED (Reduced conveyance to ED) • Reduction in the volume of ambulances dispatched to lower acuity patients in the community where clinically safe • Release of ED capacity enabling better flow and increasing ability to meet 4h standard	Ongoing from now (month-on-month improvement)
3	Targeted workshops with focus on Admission and Attendance Avoidance	• Attendance Avoidance – Mapping secondary prevention provision (Reducing exacerbation of LTC or existing Mental Health need). • Assessment of acutely ill patients outside of the acute hospital. • Avoidance of unnecessary admission of patients following assessment and initial diagnosis. • Earlier discharge (prior to full admission) from an acute by enhancing collocated or community based ongoing Clinical, Mental Health and Social Care.	Jan – March 2024

Performance Report

Urgent and Emergency Care: No Criteria to Reside Occupancy

and Bed





Standard:
- Reduce the number of patients with no criteria to reside
- Percentage of general and acute bed occupancy

Performance against trajectory:
- Underperforming for NCTR by 42
- Meeting trajectory for bed occupancy

Variance against operating plan

NCTR												
System Total	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
Trajectory	336	320	306	284	263	243	225	215	206	206	206	206
Actual	292	264	316	329	294	260	267					
Variance	-44	-56	10	45	31	17	42					
Dorset County Hospital	**Apr-23**	**May-23**	**Jun-23**	**Jul-23**	**Aug-23**	**Sep-23**	**Oct-23**	**Nov-23**	**Dec-23**	**Jan-24**	**Feb-24**	**Mar-24**
Trajectory	75	75	75	67	59	51	45	45	45	45	45	45
Actual	56	53	65	66	55	59	64					
Variance	-19	-22	-10	-1	-4	8	19					
University Hospitals Dorset	**Apr-23**	**May-23**	**Jun-23**	**Jul-23**	**Aug-23**	**Sep-23**	**Oct-23**	**Nov-23**	**Dec-23**	**Jan-24**	**Feb-24**	**Mar-24**
Trajectory	261	245	231	217	204	192	180	170	161	161	161	161
Actual	235	211	251	264	240	201	203					
Variance	-26	-34	20	47	36	9	23					
Bed Occupancy												
System Total	**Apr-23**	**May-23**	**Jun-23**	**Jul-23**	**Aug-23**	**Sep-23**	**Oct-23**	**Nov-23**	**Dec-23**	**Jan-24**	**Feb-24**	**Mar-24**
Trajectory	96.70%	96.70%	96.14%	95.29%	96.21%	96.07%	96.79%	96.93%	97.43%	97.14%	97.00%	96.71%
Actual	93.50%	93.40%	95.90%	95.60%	95.00%	96.50%	96.80%					
Variance	-3.20%	-3.30%	-0.24%	0.31%	-1.21%	0.43%	0.01%					

Latest reporting period: **31 October 2023**
Source: Dorset ICB System Performance Report - Power BI

NB. 92% bed occupancy is one of the three standards the system did not commit to achieve within the operating plan submission. The system still holds trajectories outlining expected performance and the standard continues to be monitored.

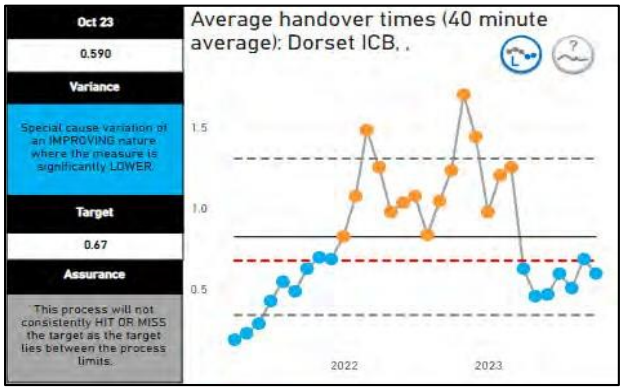
Data confidence	
High	No concerns

	Action	Expected impact of action	Delivery date
1	Increased system focus on reducing delays in exiting intermediate care services to ensure there is capacity to move people from hospital as required.	Reduction in delays in intermediate care (community) capacity will in turn increase outward flow from acute hospitals and reduce NCTR.	Ongoing from now (month-on-month improvement)
2	Creation of a consistent 7 day discharge pipeline across all pathways (including P0) to reduce the impact of low weekend discharges and subsequent weekday surges.	Increase in number of weekend discharges to be equivalent to weekday discharges across all pathways (potentially up 100 extra discharges per week).	Ongoing from now (month-on-month improvement)
3	Step change increase in early discharge planning across all partners linked to increased use of DRDs on acute wards and stronger/earlier system escalation processes.	Reduction in Length of Stay/Delay as a result of earlier discharge planning and reduced risk of missed opportunities.	Ongoing from now (month-on-month improvement)

Performance Report

Urgent and Emergency Care: 40-Minute Handover Delays

NHS Dorset



Variance against operating plan

Av. 40 Minute Handover Delays	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23
Trajectory	40	40	40	40	40	40	40
Actual	48.6	27.0	27.6	35.4	30.0	40.8	35.4
Variance	8.6	-13.0	-12.4	-4.6	-10.0	0.8	-4.6

Latest reporting period: **31 October 2023**
Source: Dorset ICB System Performance Report - Power BI

Data confidence	
High	No concerns

Standard:
- Reduce average time lost to handover delays to below 40 minutes.

Performance against trajectory:
- Overperforming by 4.6 minutes

Action		Expected impact of action	Delivery date
NB: Handover delays are a symptom of lack of flow in the system and/or poor utilisation of alternatives to ED that could have reduced front door demand. Therefore, actions to achieve a reduction in reduction in handover delays are mirrored from other ED action areas.			
1	SWASFT to realign their resource to have additional ambulances during the night based on the evidence.	• To reduce handover delays in the evening • Improve Cat 2 response	Completed
2	Focus on maximising utilisation of non-ED pathways (acute and community) - UCR, Virtual Wards, UTCs, SDEC etc	• Fewer preventable ED attendances and admissions via ED (Reduced conveyance to ED) • Reduction in the volume of ambulances dispatched to lower acuity patients in the community where clinically safe • Release of ED capacity enabling better flow and increasing ability to meet 4h standard	Ongoing from now (month-on-month improvement)

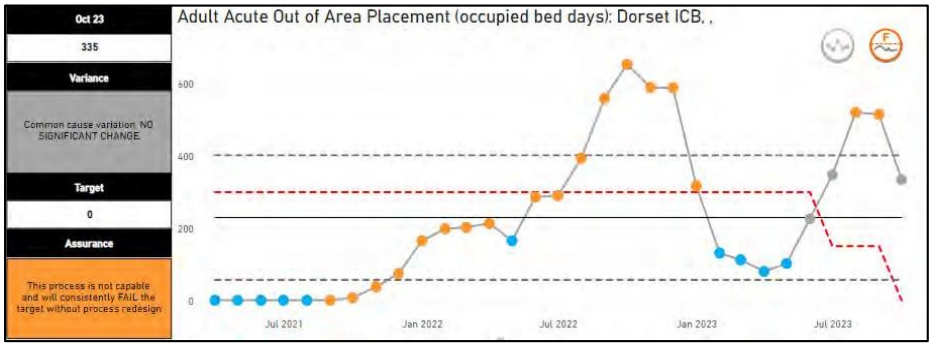
3	Creation of a consistent 7 day discharge pipeline across all pathways (including P0) to reduce the impact of low weekend discharges and subsequent weekday surges	• Increase in number of weekend discharges to be equivalent to weekday discharges across all pathways (potentially up 100 extra discharges per week) • Release of bedded capacity will in turn release ED capacity which will in turn create capacity for timely handover	Ongoing from now (month-on-month improvement)

Performance Report

Mental Health: Out of Area Placements

SOF

NHS Dorset



Variance against operating plan

Out of Area Placements (Bed Days)	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23
Trajectory	300	300	300	150	150	150	0
Actual	80	102	226	340	521	515	335
Variance	-220	-198	-74	190	371	365	335

OOA Placements	End Q1	End Q2		End Q3	End Q4
Trajectory	900	450	Original	0	0
			Revised	900	0
Actual	408	1376			
Variance	-492	926			

Latest reporting period: **31 October 2023**
Source: Dorset ICB System Performance Report - Power BI

Data confidence	
High	DiiS taken from DHC DMG Report and validated against the monthly regional submission.

Standard:
- Reduce the number of adult mental health patients inappropriately placed out of area

Performance against trajectory:
- Underperforming by 335 occupied bed days

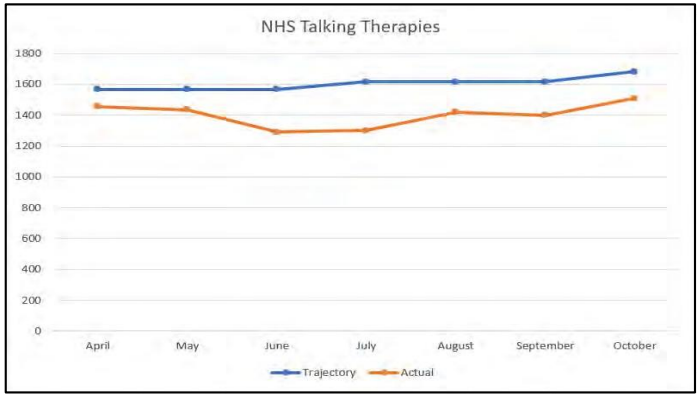
	Action	Expected impact of action	Delivery date
1	Top-priority, targeted work at Dorset HealthCare including: • Review of standard operating procedures. • Auditing of the 'to come in' list. • Clinical Co-Ordinator face-to-face visits. • Weekly updates from out of area placement providers. • Urgent referral process review. • Enhanced flow multi-disciplinary team. • Out of area placement provider assurance. • Multi-agency discharge events (MADEs). • Repatriation prioritisation review. • Daily SITRP and OPEL escalation level reporting.	Reduction in out of area placements.	March 2024
2	The national Getting it Right First Time (GIRFT) have been invited to visit DHC to assess the levels of assurance.	To make sure the organisation is compliant and has sufficient oversight.	Unknown
3	Medium to long-term action: transformation of adult community mental health services.	More emphasis on early help to reduce the need for inpatient mental health care.	2023/24 and beyond

4	Long term action: development of the St Anns site.	Increase Dorset beds by an additional 10.	2025/26

Performance Report

Mental Health: NHS Talking Therapies

NHS Dorset



Variance against operating plan

NHS Talking Therapies	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23
Trajectory	1,567	1,567	1,567	1,617	1,617	1,617	1,683
Actual	1,455	1,435	1,290	1,300	1,420	1,400	1,510
Variance	-112	-132	-277	-317	-197	-217	-173

NHS Talking Therapies	End Q1	End Q2		End Q3	End Q4
Trajectory	4,700	4,850	Original	5,050	5,271
			Revised	4,466	4,466
Actual	4,180	4,120			
Variance	-520	-730			

Latest reporting period: **31 October 2023**
Source: DHC Monthly DMG Report

Data confidence	
High	No concerns

Standard:
- Increase the number of adults and older adults accessing NHS Talking Therapies. Previously known as Improving Access to Psychological Therapies (IAPT)

Performance against trajectory:
- Underperforming against trajectory by 730 at the end of quarter 2.

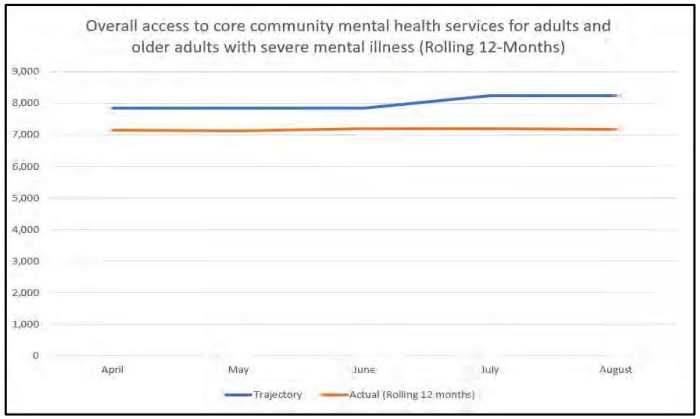
Action		Expected impact of action	Delivery date
1	Communications plan in place due to reduced referrals. DHC note September 2023 – YTD 16,848 referrals down, 0.7% from same period previous year.	To promote the service to local communities.	Ongoing
2	Recruitment drive over autumn.	To ensure that there is sufficient staffing to provide the activity required.	Q3 2023/24
3	Medium to long-term action: transformation of adult community mental health services.	More emphasis on early help.	2023/24 and beyond

4	DHC are supporting two test of concept universal hubs to be launched this financial year (Poole and Weymouth).	To achieve greater visibility and presence to improve referral rates.	End Q4 2023/24

Performance Report

Mental Health: Community Mental Health Services for Adults and Older Adults with Severe Mental Illness

NHS Dorset



Variance against operating plan

CMHS for SMI	Apr-23	May-23	Jun-23	Jul-23	Aug-23
Trajectory	7,850	7,850	7,850	8,240	8,240
Actual	7,145	7,135	7,200	7,190	7,170

CMHS for SMI	End Q1	End Q2		End Q3	End Q4
Trajectory	7,850	8,240	Original	8,765	9,526
			Revised	7,450	8,897
Actual	7,160				
Variance	-690				

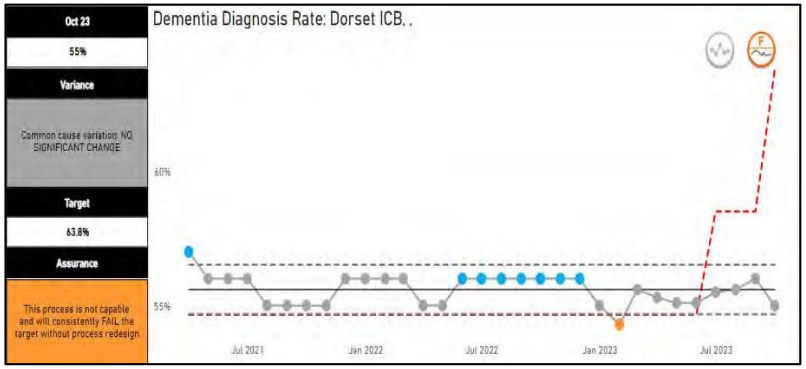
Latest reporting period: **31 August 2023**
Source: Future NHS MH Core Data Pack

Data confidence	
Low	Data review in DHC has identified missing activity – mean of **4545 contacts per month not currently flowing**. This is because this is CMH activity which has no "referral" on the system e.g. open access services. DQ review completed and activity will flow from October for majority of these services (though reporting remains 2 months in arrears so will not show in MHMDS yet). Due to lack of inter-operability across information systems, challenges remain in respect of capturing primary care based Mental Health Additional Reimbursement Roles (ARRS) activity on a consistent basis.

Standard:
- Increase the number of adults and older adults with SMI accessing CMHS (rolling 12-month activity)

Performance against trajectory:
- 690 below trajectory at the end of quarter 1. Deterioration of 20 patients seen in August compared to July (September data not yet available).

	Action	Expected impact of action	Delivery date
1	DHC are supporting two test of concept universal hubs to be launched this financial year (Poole and Weymouth).	To achieve greater visibility and presence	End Q4 2023/24
2	Medium to long-term action: transformation of adult community mental health services via the Mental Health Integrated Community Care (MHICC) programme.	More emphasis on early help.	2023/24 and beyond
3	Further work to unpick the presenting need/reason for referral.	To understand whether there is an underlying increase in prevalent need.	Ongoing
4	Development and implementation of a dedicated complex trauma (personality disorder) pathway including recruitment.		December 2024
5	Open Dialogue is being adopted as the principal way of working within the new model with practitioners across all 3 elements of the model of care due to training before the end of the year.	Open Dialogue is a Systemic Dialogic approach that helps people, and their families feel heard, respected, and validated and is shown to improve outcomes.	March 2024



Variance against operating plan

Dementia Diagnosis Rate	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23
Trajectory	54.66%	54.66%	54.66%	58.5%	58.5%	58.5%	63.75%
Actual	55.3%	55.1%	55.1%	55.5%	55.6%	56%	55%
Variance	0.64%	0.44%	0.44%	-3%	-2.9%	-2.5%	-8.75%

Dementia	End Q1	End Q2		End Q3	End Q4
Trajectory	54.66%	58.5%	Original	63.75%	66.7%
			Revised	55%	56%
Actual	55.5%	56%			
Variance	0.84%	-2.5%			

Latest reporting period: **31 October 2023**
Source: Dorset ICB System Performance Report - Power BI

Data confidence	
Low	No data collected by DHC and only available by GP SMI register. Achievement of target continues to be unlikely due to the CFAS methodology for calculating the target – unlikely that 66.7% is achievable as the population does not exist in Dorset.

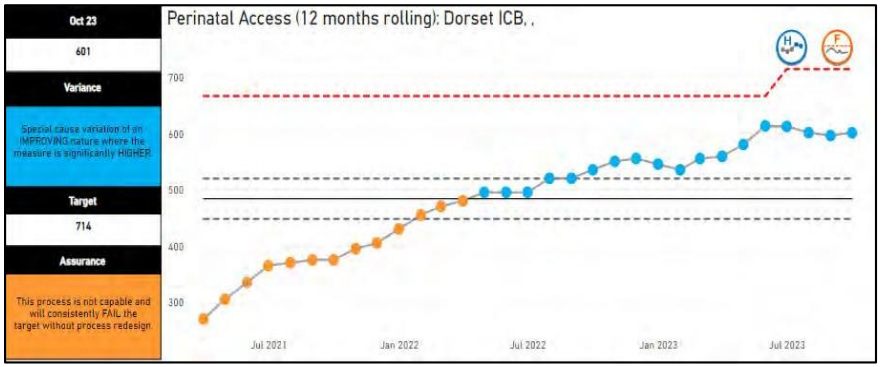
Standard:
- Increase the percentage of people diagnosed with dementia

Performance against trajectory:
- Underperforming by 2.5% at the end of quarter 2.

Action		Expected impact of action	Delivery date
1	DHC reviewing options on feasibility of using £160,000 non recurrent slippage(as agreed) within the financial year including outsourcing options (meetings with three providers have taken place).	To create additional capacity in the memory assessment service	November/ December
2	The System Dementia Diagnosis Rates Improvement Plan for 2023/24 has several objectives including: • Raise awareness of dementia. • Ensuring Health Inequalities are highlighted and addressed. • Work more effectively with the voluntary, community, and social enterprise (VCSE) sector. • Target Primary Care Networks (PCNs) with lower rates. • Improve identification of dementia and raise awareness of dementia within care homes. • Improve data and accuracy of dementia prevalence and incidence recording. • Work more effectively with partner organisations. • Seek to resolve ongoing operational challenges in respect of enabling full implementation of diagnosis by advanced care practitioners as per model outlined within the Dementia Services Review.	Increase diagnosis rates to provide individuals and their families with clarity and understanding of the condition which is crucial for making informed decisions about care, treatment, and planning for the future. Enabling early intervention, supporting personalised care, and providing a roadmap for families, contributing to a more holistic and patient-focused approach to managing dementia.	2023/24

Performance Report

Mental Health: Perinatal Mental Health Access



Variance against operating plan

Perinatal Mental Health Access	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23		Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
Trajectory	666	666	666	714	714	714	714	Original	714	714	714	714	714
								Revised	650	650	714	714	714
Actual	560	580	615	610	600	595	601						
Variance	-106	-86	-51	-104	-114	-119	-113						

Latest reporting period: **31 October 2023**
Source: Dorset ICB System Performance Report - Power BI

Data confidence	
Low	Work undertaken by acute trust employed specialist midwives is currently not captured by MHMDS and therefore there is missing activity towards this indicator.

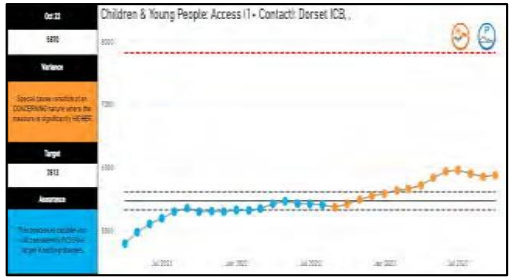
Standard:
- Increase the number of people accessing perinatal mental health services

Performance against trajectory:
- Underperforming by 113

Action		Expected impact of action	Delivery date
1	Ongoing work to maintain relationships between providers is a priority.	To avoid any further concerns following those raised by the Local Maternity Service Board.	Ongoing
2	A Memorandum of Understanding is being developed between DHC and Acute Trusts on the Maternal Mental Health Service.	To ensure there is clarity on the LTP ask and respective roles and responsibilities in meeting this.	Complete
3	Recovery plan in place including targeted education programmes to increase referral rates, reduced screening thresholds, increased capacity, weekly monitoring of assessment uptake, joint research is being undertaken with Bournemouth University entitled "Younger Women's Physical and Mental Health Preparedness for Motherhood". DHC leads are re-looking at the effectiveness of the above actions along with engaging with local maternity system colleagues.	To support improved referral rates.	2023/24 and beyond

Performance Report

Mental Health: Children and Young People (1/2) – Access and CAMHS



NB. Trajectory target on chart incorrect – see tables.

Variance against operating plan

CYP Access	End Q1	End Q2		End Q3	End Q4
Trajectory	6,306	6,975	Original	7,500	8,137
			Revised	7,260	7,515
Actual	5,926	5,844			
Variance	-380	-1,131			

This is a rolling 12-month metric.

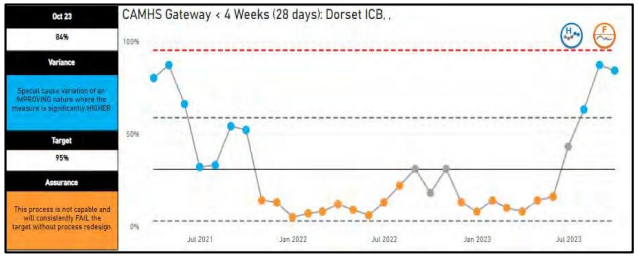
CYP Access	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23
Trajectory	6,306	6,306	6,306	6,975	6,975	6,975	7,500
Actual	5,707	5,821	5,926	5,950	5,893	5,844	5,870

Standard:
- Increase number of people accessing children and young people's mental health services

Performance against trajectory:
- Underperforming by 1,131 at the end of quarter 2.

Latest reporting period: **31 October 2023**

Source: Dorset ICB System Performance Report - Power BI



Variance against operating plan

CAMHS Gateway < 4 weeks (28 days)	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23
Target	95%	95%	95%	95%	95%	95%	95%
Actual	8%	14%	16%	43%	63%	87%	84%
Variance	-87%	-81%	-79%	-52%	-32%	-8%	-11%

Metric measured as part of the NHS Long Term Plan for Children and Young People Mental Health

Standard:
- CAMHS Gateway < 4 weeks (28 days)

Performance against 95% target:
- Underperforming by 11% at the end of October 2023

Data confidence	
Low	Kooth (online mental wellbeing community for children and young people) data is not included. Dialogue with regional and national teams is ongoing in respect of how schools-based activity/intervention is captured within the overall access standard as currently mental health support teams in schools are limited to reporting individual interventions through the MHSDS collection and this is not fully acknowledging the reach and impact of the service offer.

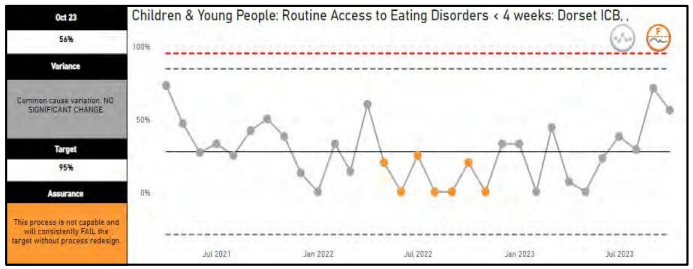
	Action	Expected impact of action	Delivery date
1	Medium to long-term action: transformation of children and young people's mental health services based on the THRIVE framework.	Improved accessibility, support available for those who need it, early help, integrated approach, creating a more supportive and effective system for the children and young people of Dorset.	2023/24 and beyond
2	Transformational plan 'Your Mind Your Say' in place to support children and young people's emotional health.	To support the first pillar of the Joint Forward Plan to: "improve the lives of 100,000 people impacted by poor mental health"	Ongoing
3	Public Health Dorset have launched a centralised resource aimed at promoting trusted Mental Health Apps to young people in Dorset.	The self-care and well-being apps have been carefully selected to support the mental and emotional health of young people.	Ongoing
4	Focused effort on the CAMHS Gateway and increased temporary staffing via agency use.	The < 4 weeks indicator has seen a marked improvement in the last few months.	Ongoing
5	A CAMHS stabilisation plan was supported at the mental health programme board in November.	Enable interim non-recurrent funding to maintain progress.	Ongoing

6	CAMHS key improvements include: • Monthly wellbeing check in calls • Drop-in clinic	To assess risk, escalate, signpost to other resources. To support any individuals requiring escalation.	Ongoing

Performance Report

Mental Health: Children and Young People (2/2) – Eating Disorders

Metrics measured as part of the NHS Long Term Plan for Children and Young People Mental Health:



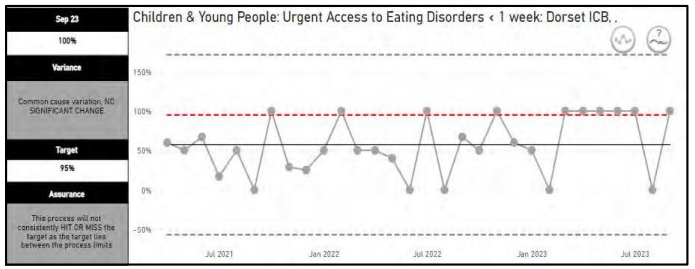
Latest reporting period: **31 October 2023**

Standard:

- Children & Young People: Routine Access to Eating Disorders < 4 weeks

Performance against 95% target:

- Underperforming by 39% at the end of October 2023



Latest reporting period: **30 September 2023**

Standard:

- Children & Young People: Urgent Access to Eating Disorders < 1 week

Performance against 95% target:

- Overperforming by 5% at the end of September 2023 (100%)

Source: Dorset ICB System Performance Report - Power BI

Data confidence	
Low	There will be a significant delay in the improvements showing in the KPIs from the recovery plan due to the way the calculation and criteria for RTT pathway works – until the back log is clear those patients will continually breach the target as will be outside expected times to be seen and the RTT clock does not stop, e.g. for patient choice. If a CYP takes a holiday/leave of absence these will breach as well.

CYP Access to Eating Disorders <4wks	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23
Target	95%	95%	95%	95%	95%	95%	95%
Actual	7%	0%	23%	38%	29%	71%	56%
Variance	-88%	-95%	-72%	-57%	-66%	-24%	-39%

CYP Access to Eating Disorders <1wk	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23
Target	95%	95%	95%	95%	95%	95%
Actual	100%	100%	100%	100%	0%	100%
Variance	5%	5%	5%	5%	-95%	5%

Action		Expected impact of action	Delivery date
1	A 2-year recovery plan business case was agreed in October 2023 – the Eating Disorder service are currently implementing that plan, including recruitment.	Additional workforce to clear the backlog.	Ongoing
2	Recruitment to date (however, there are workforce gaps within the core team due to moving into Tier 4 developments and the remaining recovery plan posts to recruit into that will have an impact on capacity to maintain the current agreed trajectories).	The service have been able to meet the CYP urgent access standard over the last few months and reduce the CYP Waiting List (backlog) whilst meeting new demand.	Ongoing

Report Front Sheet

1. Report Details			
Meeting Title:	Board of Directors, Part 1		
Date of Meeting:	31st January, 2024		
Document Title:	**Ambulance Handover Delay Escalation and Reporting Process**		
Responsible Director:	Anita Thomas, Chief Operating Officer	Date of Executive Approval	22 12 2023
Author:	Sam Hartley, Deputy Divisional Director of Operations, Urgent and Integrated Care		
Confidentiality:	No		
Publishable under FOI?	Yes		
Predetermined Report Format?	No		

2. Prior Discussion		
Job Title or Meeting Title	**Date**	**Recommendations/Comments**
Finance and Performance Committee	22nd January 2024	Recommended to board for approval

3. Purpose of the Paper	To escalate and seek approval for the Trust action card and escalation policy **(Appendix 1)** in response to the letter dated 22/12/2023 from NHS England South West, 'Excessive Ambulance Handover Delays'. **Appendix 2.**							
	Note (✓)	*X*	*Discuss (✓)*		*Recommend (✓)*		*Approve (✓)*	*X*

4. Key Issues

Nationally there has been an increase in ambulance handover delays with the national target for handover being 15 minutes. It is recognised that unassessed patients in the community (those awaiting an ambulance to attend) pose the greatest level of clinical risk in a system. Therefore, handover delays in excess of 15 minutes directly compromise the ambulance service in its ability to respond. As such, every effort must be made to prevent any ambulance handover delays.

In response to the increase, NHS England South West has issued the attached 'Excessive Ambulance Handover Delays' letter

The letter outlines the need for ICS and Trusts to understand:

- The agreed limit for number of ambulances waiting before action is taken.
- The absolute longest wait that you will tolerate after which it is deemed a reportable incident and reported through to your boards
- How you will allocate an executive to oversee the handovers whether due to the volume of ambulances or excessive waits to handover in and out of hours
- What options you have agreed in order to ensure the handover occurs rapidly

	The letter states the following should be considered: • Twice daily executive stocktakes taking a command and control approach to resolve challenges ensuring timely resolution regarding site positions and required actions to maintain performance • Continually developing a rolling plan for 5 ambulance attendances (or set at an appropriate number for your conveyance rate) • 'Zero tolerance' to any waits over an agreed maximum wait time with a solution focus on each handover at risk of breaching Responding to the letter the South West Region has issued guidance through a SOP, 'South West Region Managing Ambulance Handover Delays in Extremis', (Dec 2023). **Appendix 3.** The SOP states that all efforts should be made to ensure SWASFT is in a position to appropriately handover a patient within the nationally mandated 15 minutes; however, where this is not possible, delays should be managed as per the latest SWASFT Ambulance Hospital Handover SOP issued on 9th October 2023 which outlines key roles and responsibilities for the 4 escalation thresholds: ○ **Normal (handovers within 15 minutes)** ○ **Escalated (handovers up to 90 minutes)** ○ **Severe (handovers up to 180 minutes)** ○ **Critical (handovers in excess of 180 minutes)** The Trust has implemented the 'Ambulance Handover Delay Escalation and Reporting Process', Action card 69 on Sharepoint. **Appendix 1.** The process outlines the key actions and timescales and the reporting requirements and has separated responsibility for in and out of hours. **Please note that in line with the expectations of the letter and SOP this only applies to patients being held in the back of ambulances and does not include those placed in the cohort queue.**
5. Action recommended	The Board is recommended to: 1. Review and approve the 'Ambulance Handover delay escalation and Reporting Process', Action Card 69. The requirement of the NHSE letter is that the SOP has Board level approval.

6. Governance and Compliance Obligations			
Legal / Regulatory Link	**Yes**		Requirements are documented in the attached documents and addressed in the action card.
Impact on CQC Standards	**Yes**		

Risk Link		**Yes**		
Impact on Social Value		**Yes**		
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	Gives direction in escalated circumstances		
	Place	Addresses performance and quality risks for the Trust and System		
	Partnership	Outlines good standards for partnership working with ambulance and associated services		
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**		Requirements are documented in the attached documents and addressed in the action card.
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**	

Appendix 1, 2 and 3 below.

Appendix 1

Card Number No	Card Title **Ambulance handover delay escalation and reporting process**	NHS Dorset County Hospital NHS Foundation Trust

The national standard for ambulance hospital handover remains at 15 minutes and all trusts should be working to deliver against this standard.

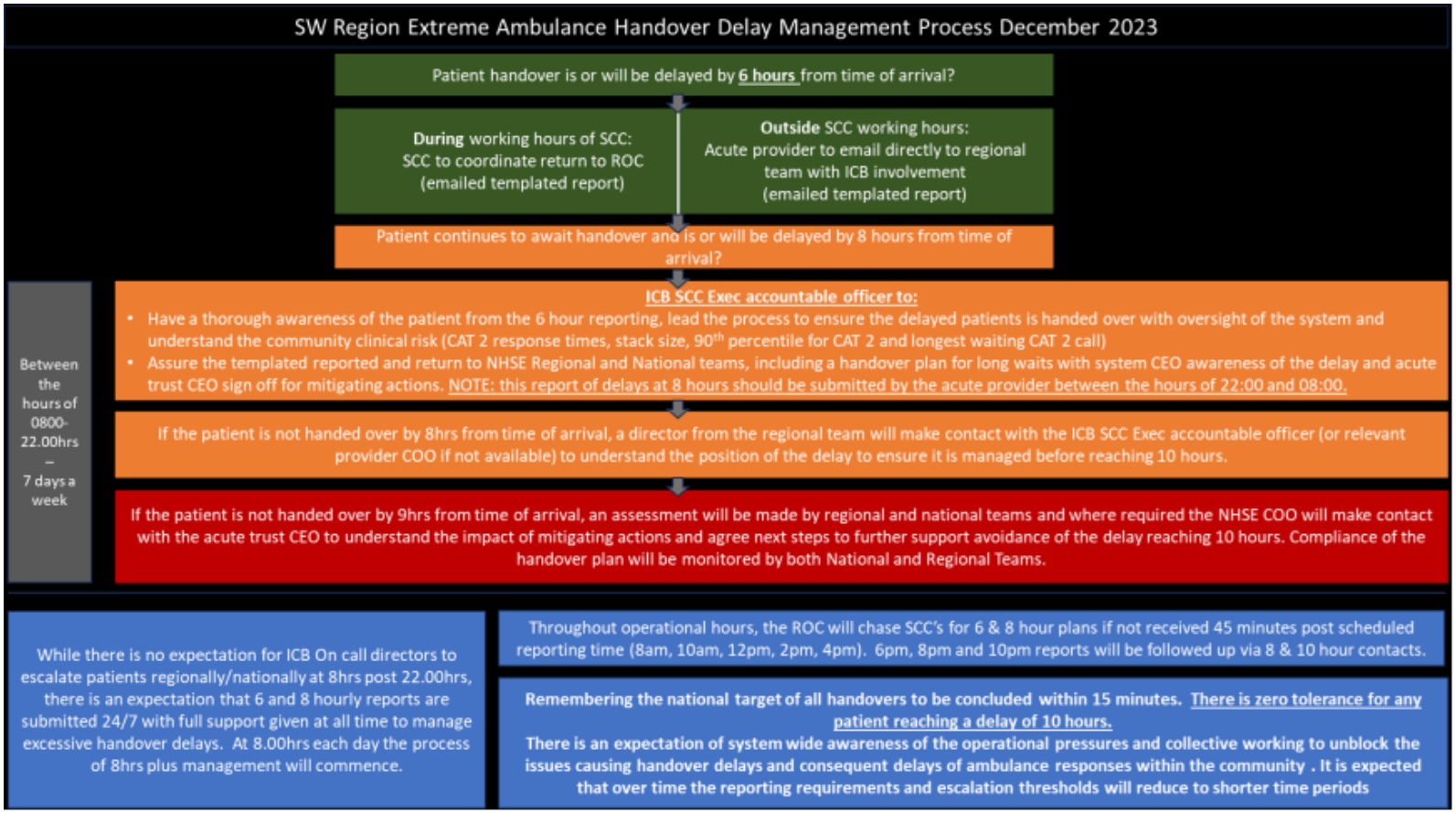
- SCC working with the Acute Trust must report all handover delays for those physically in the back of an ambulance at **6** and **8** hours. (**must be reported 24/7**)
- For all patients with a hospital handover delay of 8 hours there will be contact by the regional team with the SCC accountable officer to discuss plans and mitigations.
- For all patients with a hospital handover delay of 9 hours there will be further review by region and national teams with the potential for contact by the NHSE COO to the acute trust CEO.

Actions	• ED Nurse in charge to inform CSM when patients are physically being held in the back of an ambulance. Reason must be stated no physical place to offload or due to patient not being suitable for offload (e.g. danger to others) • At **60** mins ED to inform CSM and huddle formed in ED with ED NIC, ED Consultant (Middle grade out of hours) to form plan to decompress ED within 60 minutes. • At **120** minutes in hours CSM to inform ED Assistant Service Manager/ Deputy Director of Operations for Urgent care or out of hours on call manager to create plan to decompress ED within 60 minutes. • At **180** minutes in hours Assistant Service Manager/ Deputy Director of Operations for Urgent Care to inform Head of Operations or out of hours on call manager to inform Exec on call to agree plan to decompress ED with agreed timescale. • If risk of patient being held for **240** minutes Deputy Director of Operations for Urgent Care/ Head of Operations to inform COO in hours. • At **240** minutes in hours COO/ Head of Operations to form cross divisional meeting to review actions taken or out of hours Exec and

	on call manager to review actions taken. • At **360** minutes follow reporting requirements below
Reporting requirements	**Reporting 6 hour delays** At 6 hours in hours the Assistant Service Manager/ Deputy Director of Operations for Urgent care will email the SCC or out of hours on call manager will email: • england.swuecteam@nhs.net • england.sw-roc21@nhs.net • TrustIncidentManagers@SWAST.nhs.uk • kevin.johnson@nhs.net • leighton.day3@nhs.net • england.sw-oncall@nhs.net • scc@nhsdorset.nhs.uk with the following information • If the patient has received a medical review and a care plan is in place • If the patient is clinically safe to be cared for in the back of the ambulance • That there is a robust plan and timeframe as to when the patient is going to be off loaded from the ambulance The details of this plan and timeframes should be completed for each patient at waits of 6 hours **Reporting 8 hour delays** When a patient has been waiting 8 hours to complete hospital handover the accountable executive for the system SCC (in hours or on call) must provide an update report to regional and national teams (as outlined in the 8 hour report task card) and assure the agreed actions outlined have been made with sign off from the CEO of the acute trust impacted (or on call Exec if out of hours) and that ICB CEOs have been notified. The report should include for each patient: • Patient Age • Patient NEWS score • Detail of the clinical assessment undertaken by ED practitioner • Evidence of a clear medical plan in place • Evidence of trust executive awareness and key actions

	• Evidence of a clear plan in place to expedite handover • A clear timeframe for actions and a completed handover It should also include the following information on system level risk oversight: • Current average CAT2 response time • 90th centile CAT2 response time • The number of patients currently waiting on the ambulance stack • The current longest wait for a CAT2 response
Created	**December, 2023**

Process Map


SW Region Extreme Ambulance Handover Delay Management Process December 2023
Patient handover is or will be delayed by 6 hours from time of arrival?
During working hours of SCC: SCC to coordinate return to ROC (emailed templated report)
Outside SCC working hours: Acute provider to email directly to regional team with ICB involvement (emailed templated report)
Patient continues to await handover and is or will be delayed by 8 hours from time of arrival?
Between the hours of 0800-22.00hrs – 7 days a week
ICB SCC Exec accountable officer to:
• Have a thorough awareness of the patient from the 6 hour reporting, lead the process to ensure the delayed patients is handed over with oversight of the system and understand the community clinical risk (CAT 2 response times, stack size, 90th percentile for CAT 2 and longest waiting CAT 2 call)
• Assure the templated reported and return to NHSE Regional and National teams, including a handover plan for long waits with system CEO awareness of the delay and acute trust CEO sign off for mitigating actions. NOTE: this report of delays at 8 hours should be submitted by the acute provider between the hours of 22:00 and 08:00.
If the patient is not handed over by 8hrs from time of arrival, a director from the regional team will make contact with the ICB SCC Exec accountable officer (or relevant provider COO if not available) to understand the position of the delay to ensure it is managed before reaching 10 hours.
If the patient is not handed over by 9hrs from time of arrival, an assessment will be made by regional and national teams and where required the NHSE COO will make contact with the acute trust CEO to understand the impact of mitigating actions and agree next steps to further support avoidance of the delay reaching 10 hours. Compliance of the handover plan will be monitored by both National and Regional Teams.
While there is no expectation for ICB On call directors to escalate patients regionally/nationally at 8hrs post 22.00hrs, there is an expectation that 6 and 8 hourly reports are submitted 24/7 with full support given at all time to manage excessive handover delays. At 8.00hrs each day the process of 8hrs plus management will commence.
Throughout operational hours, the ROC will chase SCC's for 6 & 8 hour plans if not received 45 minutes post scheduled reporting time (8am, 10am, 12pm, 2pm, 4pm). 6pm, 8pm and 10pm reports will be followed up via 8 & 10 hour contacts.
Remembering the national target of all handovers to be concluded within 15 minutes. There is zero tolerance for any patient reaching a delay of 10 hours.
There is an expectation of system wide awareness of the operational pressures and collective working to unblock the issues causing handover delays and consequent delays of ambulance responses within the community . It is expected that over time the reporting requirements and escalation thresholds will reduce to shorter time periods

If a patient reaches **6 hours** of waiting in the back of an ambulance for handover, we ask that the system SCC (in hours) or acute trust (outside of SCC working hours) has oversight of the delay with the following detail:

- Assurance that the patient has received a medical review and a care plan is in place from the acute hospital;
- Has confirmed that that patient is clinically safe/appropriate to be cared for in the back of an ambulance;
- That there is a robust plan and associated timeframe as to when that patient is going to be off loaded from the ambulance into the hospital - we ask that this plan and timeframe are shared for each patient.

We ask that the detail above is then emailed to the following:

- england.swuecteam@nhs.net
- england.sw-roc21@nhs.net
- TrustIncidentManagers@SWAST.nhs.uk
- kevin.johnson@nhs.net
- leighton.day3@nhs.net
- england.sw-oncall@nhs.net
- Your ICB on call team

If a patient reaches **8 hours** of waiting in the back of an ambulance for handover, we ask that the **SCC executive accountable officer** (in hours) or the acute trust (out of SCC working hours) has oversight of the delay with the following detail:

- The ICB and Acute Chief Executive are notified of the delay (if in hours) along with one member of the executive tri at ICB and Acute provider (out of hours the on call director) and that there is Acute Chief Executive sign off for mitigating plans.
- Full assurance is obtained that every possible solution for handover and management of clinical risk across the system has been reviewed. This must include awareness of the stack size, CAT 2 response time, 90th centile for CAT2 response and the longest waiting CAT 2 outstanding patients.
- Assurance that the patient awaiting handover has received a medical review and a care plan is in place from the acute hospital
- Has confirmed that that patient is clinically safe/appropriate to be cared for in the back of an ambulance
- That there is a robust plan and associated timeframe as to when that patient is going to be off loaded from the ambulance into the hospital - we ask that this plan and timeframe are shared for each patient.
- We ask that the detail above is then emailed to the following:
- england.swuecteam@nhs.net
- england.sw-roc21@nhs.net
- TrustIncidentManagers@SWAST.nhs.uk
- kevin.johnson@nhs.net
- leighton.day3@nhs.net
- martin.wilkinson1@nhs.net
- lisa.manson@nhs.net
- e.omahony@nhs.net
- england.uec-operations@nhs.net
- england.sw-oncall@nhs.net
- **Your ICB on call team, ICB CEO, ICB COO, Acute CEO and Acute COO**

Classification: Official

Appendix 2

NHS England South West

To:
- ICB Chief Executives

cc.
- Acute Chief Executives
- Ambulance Chief Executives
- ICB & Acute Chief Operating Officers
- ICB & Acute Medical Directors

Martin Wilkinson
Director of Performance and Improvement
(South West)

South West House
Blackbrook Park Avenue
Taunton
TA1 2PX

22 December 2023

Dear Colleagues,

Excessive Ambulance Handover Delays

Firstly, we would like to thank you and your teams on your work to manage the increased pressure in the whole UEC pathway, in particular the impact this is having on the handing over of care of patients between ambulance and acute services.

We know there is shared recognition and a focus across all South West systems to ensure patients are handed over to the emergency departments as soon as possible, balancing the known and unknow risks which sit within the community and the impact this has on patients and ambulance response times.

Over recent weeks there have been numerous instances where patients have had excessive waits to be handed over. We are therefore writing to ask you as ICB Chief Executives to coordinate with your respective acute organisations to ensure that appropriate ambulance escalation protocols are in place. There should be board approval at all acute trusts and the ICB that clearly articulate how you collectively oversee, manage and resolve any excessive waits against your agreed thresholds.

We specifically would like to understand;

- Your thresholds for each of your providers in order to enact your escalation processes for;
    - The agreed limit for the number of ambulances waiting before action is taken
    - The absolute longest wait that you will tolerate after which it is deemed a reportable incident and reported through to your Boards

- How you allocate an executive to oversee the handovers whether due to the volume of ambulances or excessive waits to handover in and out of hours

- What options you have agreed in order to ensure the handover occurs rapidly

Understanding the above will enable a shared view of your approach to risk management, your arrangements for senior ownership in resolving each wait inside the outside of normal working hours and the actions you have agreed to enact.

You may wish to consider the learning from other systems who have made significant rapid improvements in handover waits that include;

- Twice daily executive stocktakes taking a command and control approach to resolve challenges ensuring timely resolution regarding site positions and required actions to maintain performance

- Continually developing a rolling plan for 5 ambulance attendances (this may need to be set at an appropriate number for your conveyance rate)

- 'Zero tolerance' to any waits over an agreed maximum wait time with a solution focus on each handover at risk of breaching

We ask you to co-ordinate the response back to the Region and for copies of the escalation protocols to be sent to the following email address england.sw-roc21@nhs.net by noon 4 January 2024. Follow up discussions will be planned as necessary with system and provider CEOs.

Many thanks for your continued co-operation on this issue.

Yours sincerely,

Martin Wilkinson
Director of Performance and Improvement
NHS England – South West

Dr Michael Marsh
Medical Director
NHS England – South West

Sue Doheny
Chief Nurse
NHS England – South West

Appendix 3

South West Region Managing Ambulance Handover Delays in Extremis

Standard Operating Procedure

Version number: 0.3

First published: December 2023

Next review: June 2024

Prepared by: Ian Chappell & Leighton Day (SW Region UEC Team)

NHS England South West

1. Purpose

Excessive waits in ambulances and delays with patient hospital handover can cause significant harm and distress to patients, their families and carers. The Association of Ambulance Chief Executives (AACE) review of patient safety and impact of hospital handover delays estimates that for every handover delay in excess of 60 minutes there is an increased risk of patient harm, with one in ten patients potentially at risk of severe harm as a result[1].

The national standard for ambulance hospital handover remains at 15 minutes and all trusts should be working to deliver against this standard.

It is nationally recognised that unassessed patients in the community (those awaiting an ambulance to attend) pose the greatest level of clinical risk in a system. Therefore, handover delays in excess of 15 minutes directly compromise the ambulance service in its ability to respond. As such, every effort must be made to prevent any ambulance handover delays.

Hospital handover delays have numerous causes that require the work of providers across a system to resolve and improve. These causes and this work should be understood and supported at a system level, connecting system partners and managing the cause and effect of changes across a footprint. These actions are key to managing delays – but when these delays become severely extended then systems should notify the region, outline key actions, and agree next steps and plans.

This Standard Operating Procedure (SOP) outlines the regional escalation process for ambulance handover delays exceeding **6 hours** in line with regional performance and delivery assurance.

The purpose of this document is to outline the expectations of providers and systems. It also references the key roles and responsibilities of NHSE South West Region, System Co-ordination Centres (SCC), Integrated Care Boards (ICB), South Western Ambulance Service Foundation Trust (SWASFT) and acute hospitals in managing hospital handover delays in extremis.

2. Procedure

2.1 Actions for all ambulance handovers

All acute hospitals and ICBs should have robust processes in place to ensure they are aware of ambulance arrivals and long waits. This can be supported by in-house ambulance arrival software and/or the SWASFT Power BI system (OL334) – for those that require access it can be requested via email to england.swuecteam@nhs.net – or healthcare analytics software and smart system controls, such as SHREWD, which enables real time data access at a system level. The national SCC specification indicates 9 key measures (as part of national OPEL rating) that centres should have system oversight of which includes ambulance performance and delays (System Co-ordination Centre specification (england.nhs.uk)). Awareness of and planning for incoming activity

[1] AACE report published: Hospital handover delays potentially causing significant harm to patients - aace.org.uk

should be business as usual, as should the review of hospital waits in line with local escalation policies.

All efforts should be made to ensure SWASFT is in a position to appropriately handover a patient within the nationally mandated 15 minutes; however, where this is not possible, delays should be managed as per the latest SWASFT Ambulance Hospital Handover SOP issued on 9th October 2023 which outlines key roles and responsibilities for the 4 escalation thresholds:

- **Normal (handovers within 15 minutes)**
- **Escalated (handovers up to 90 minutes)**
- **Severe (handovers up to 180 minutes)**
- **Critical (handovers in excess of 180 minutes)**

It is imperative that the Hospital and Ambulance Liaison Officer (HALO) and or alternative SWASFT designate maintains open dialogue to maintain a co-ordinated approach with the operations teams within Acute Trusts to expedite patient handover.

When all other measure to effectively allow a handover to be undertaken (including utilisation of all capacity, escalation spaces, cohorting spaces and agreed corridor care) are exacerbated and a patient is going to be delays and maintained in an ambulance, it is expected that the Acute Trust ensures the patient receives a full clinical assessment, and any treatment plan is instigated where appropriate to ensure there is no delay in care.

Providers and system partners should work to enact local escalation procedures to mitigate delays and reduce patient safety risk. Local procedures will dictate the degree of local reporting and feedback with system co-ordination centres, but it is expected that extended delays should be managed in partnership with SCCs and that open dialogue on risk management, delivery plans and escalation should be in place with all relevant local stakeholders including SWASFT. Where the SWAST Trust Incident Manager (TIM) or Strategic Commander is not assured that agreed escalation plans are being followed or that risk is being distributed at a system level they should raise this with the system SCC / ICB in collaboration with hospital provider executives.

Appendix 4 outlines key roles and responsibilities that should be considered by relevant stakeholders in managing all hospital handover delays.

Appendix 5 provides a checklist to support management and reduction of hospital handover delays.

2.2 Procedure for ambulance handover delays exceeding 6 hours

Where local escalation procedures and associated actions in the SWASFT Ambulance Hospital Handover SOP have failed to achieve a patient handover within 6 hours, the acute trust is required to report to the Regional Operations Centre (ROC) and Regional UEC Team with clear information and action on these delays with detail as to what the management plan is to off load the patient asap. This information is to be shared in real time and not retrospectively.

Reporting

As part of the management of extended hospital handover delays providers, SCCs and ICBs are expected to provide/support regular reporting. The reporting task cards are outlined in **Appendix 2**

and provide detail on the information required and where this should be shared. It is vital that this information is provided consistently and routinely for every patient with a wait of 6 and 8 hours without exception.

Reporting 6 hour delays

In operational hours of the system SCC, when a patient has been waiting 6 hours to complete hospital handover the **SCC**, having worked with the acute trust in collaboration with the acute trust director on call (or day time equivalent), must report on the patient with the following key information:

- If the patient has received a medical review and a care plan is in place from the acute hospital;
- If the patient is clinically safe/appropriate to be cared for in the back of an ambulance;
- That there is a robust plan and associated timeframe as to when that patient is going to be off loaded from the ambulance into the hospital.

The details of this plan and timeframes should be completed for each patient at waits of 6 hours and shared with the relevant regional stakeholders including the ICB accountable officer. Outside the operational hours of the SCC the acute hospital provider, with ICB involvement, must report this information for all patients waiting 6 hours.

Reporting 8 hour delays

When a patient has been waiting 8 hours to complete hospital handover the accountable executive for the system SCC (in hours or on call) must provide an update report to regional and national teams (as outlined in the 8 hour report task card) and assure the agreed actions outlined have been made with sign off from the CEO of the acute trust impacted (or on call Director if out of hours) and that ICB CEOs have been notified. The report should include for each patient:

- Patient Age
- Patient NEWS score
- Detail of the clinical assessment undertaken by ED practitioner
- Evidence of a clear medical plan in place
- Evidence of trust executive awareness and key actions
- Evidence of a clear plan in place to expedite handover
- A clear timeframe for actions and a completed handover

It should also include the following information on system level risk oversight:

- Current average CAT2 response time
- 90th centile CAT2 response time
- The number of patients currently waiting on the ambulance stack
- The current longest wait for a CAT2 response

A template for this report is provided in **Appendix 3**. The report should be completed for each patient at waits of 8 hours and submitted by the SCC between the hours of 08:00 and 22:00. Outside these hours the acute hospital provider, with ICB involvement, must report this information for all patients waiting 8 hours.

Managing delays in excess of 8 hours

Remembering that the national standard remains at 15 minutes for hospital handover and the expectation to limit delays, there is a **zero tolerance** to delays in excess of 10 hours. Nationally all hospital handover delays in excess of 8 hours will be under regular review and all providers are expected to be able to provide detailed information on individual patients and the plans to enable rapid handover before the 10 hour period.

Between the hours of 08:00 to 22:00 the following will be undertaken to support mitigation of 10 hour handover delay breaches:

8 hour handover delays

It is expected that the SCC executive accountable officer will have thorough awareness of patients approaching 8 hour handover delays based on the 6 hour reporting and that they will lead the process to ensure timely resolution to delays are achieved based on a system understanding of clinical and operational risk.

If a patient has not completed hospital handover at 8 hours of hospital arrival a director from the regional team will contact the SCC executive accountable officer (or relevant hospital provider COO as required) to discuss the delay and to review plans to mitigate a breach of 10 hours.

9 hour handover delays

If a patient has not completed hospital handover at 9 hours of hospital arrival there will be a dynamic assessment by the regional and national teams. As a result the NHS England Chief Operating Officer, where required, will contact the acute trust CEO to directly discuss the situation and agree next steps. Compliance and delivery of the agreed handover plans will be monitored by both National and Regional Teams.

Between the hours of 22:00 and 08:00

SCC and ICB in-hours and out of hours directors should continue to monitor hospital handover delays during this period with their providers and system partners and work on action plans to mitigate all delays. It is expected that 6 and 8 hour reporting will continue to be submitted via acute trusts during this period.

A process map of the expectations for managing hospital handover delays between 6 and 10 hours is outlined in **Appendix 1.**

Appendix 1. Process map of expected management of hospital handover delays >6 hours by providers and systems

NHS England South West

SW Region Extreme Ambulance Handover Delay Management Process December 2023

Patient handover is or will be delayed by **6 hours** from time of arrival?

During working hours of SCC:
SCC to coordinate return to ROC
(emailed templated report)

Outside SCC working hours:
Acute provider to email directly to regional team with ICB involvement
(emailed templated report)

Patient continues to await handover and is or will be delayed by 8 hours from time of arrival?

Between the hours of 0800-22.00hrs – 7 days a week

ICB SCC Exec accountable officer to:

- Have a thorough awareness of the patient from the 6 hour reporting, lead the process to ensure the delayed patients is handed over with oversight of the system and understand the community clinical risk (CAT 2 response times, stack size, 90th percentile for CAT 2 and longest waiting CAT 2 call)
- Assure the templated reported and return to NHSE Regional and National teams, including a handover plan for long waits with system CEO awareness of the delay and acute trust CEO sign off for mitigating actions. NOTE: this report of delays at 8 hours should be submitted by the acute provider between the hours of 22:00 and 08:00.

If the patient is not handed over by 8hrs from time of arrival, a director from the regional team will make contact with the ICB SCC Exec accountable officer (or relevant provider COO if not available) to understand the position of the delay to ensure it is managed before reaching 10 hours.

If the patient is not handed over by 9hrs from time of arrival, an assessment will be made by regional and national teams and where required the NHSE COO will make contact with the acute trust CEO to understand the impact of mitigating actions and agree next steps to further support avoidance of the delay reaching 10 hours. Compliance of the handover plan will be monitored by both National and Regional Teams.

While there is no expectation for ICB On call directors to escalate patients regionally/nationally at 8hrs post 22.00hrs, there is an expectation that 6 and 8 hourly reports are submitted 24/7 with full support given at all time to manage excessive handover delays. At 8.00hrs each day the process of 8hrs plus management will commence.

Throughout operational hours, the ROC will chase SCC's for 6 & 8 hour plans if not received 45 minutes post scheduled reporting time (8am, 10am, 12pm, 2pm, 4pm). 6pm, 8pm and 10pm reports will be followed up via 8 & 10 hour contacts.

Remembering the national target of all handovers to be concluded within 15 minutes. There is zero tolerance for any patient reaching a delay of 10 hours.
There is an expectation of system wide awareness of the operational pressures and collective working to unblock the issues causing handover delays and consequent delays of ambulance responses within the community . It is expected that over time the reporting requirements and escalation thresholds will reduce to shorter time periods

NHS England South West

Appendix 2. Required reporting actions for providers and systems for hospital handovers >6 hours

If a patient reaches **6 hours** of waiting in the back of an ambulance for handover, we ask that the system SCC (in hours) or acute trust (outside of SCC working hours) has oversight of the delay with the following detail:

- Assurance that the patient has received a medical review and a care plan is in place from the acute hospital;
- Has confirmed that that patient is clinically safe/appropriate to be cared for in the back of an ambulance;
- That there is a robust plan and associated timeframe as to when that patient is going to be off loaded from the ambulance into the hospital - we ask that this plan and timeframe are shared for each patient.

We ask that the detail above is then emailed to the following:

- england.swuecteam@nhs.net
- england.sw-roc21@nhs.net
- TrustIncidentManagers@SWAST.nhs.uk
- kevin.johnson@nhs.net
- leighton.day3@nhs.net
- england.sw-oncall@nhs.net
- Your ICB on call team

If a patient reaches **8 hours** of waiting in the back of an ambulance for handover, we ask that the **SCC executive accountable officer** (in hours) or the acute trust (out of SCC working hours) has oversight of the delay with the following detail:

- The ICB and Acute Chief Executive are notified of the delay (if in hours) along with one member of the executive tri at ICB and Acute provider (out of hours the on call director) and that there is Acute Chief Executive sign off for mitigating plans.
- Full assurance is obtained that every possible solution for handover and management of clinical risk across the system has been reviewed. This must include awareness of the stack size, CAT 2 response time, 90th centile for CAT2 response and the longest waiting CAT 2 outstanding patients.
- Assurance that the patient awaiting handover has received a medical review and a care plan is in place from the acute hospital
- Has confirmed that that patient is clinically safe/appropriate to be cared for in the back of an ambulance
- That there is a robust plan and associated timeframe as to when that patient is going to be off loaded from the ambulance into the hospital - we ask that this plan and timeframe are shared for each patient.
- We ask that the detail above is then emailed to the following:
- england.swuecteam@nhs.net
- england.sw-roc21@nhs.net
- TrustIncidentManagers@SWAST.nhs.uk
- kevin.johnson@nhs.net
- leighton.day3@nhs.net
- martin.wilkinson1@nhs.net
- lisa.manson@nhs.net
- e.omahony@nhs.net
- england.uec-operations@nhs.net
- england.sw-oncall@nhs.net
- **Your ICB on call team, ICB CEO, ICB COO, Acute CEO and Acute COO**

Appendix 3: Reporting Template for 8 hour handover delays

Patient 1:

Report Items	Detail
Patient Level Information	
Patient Age	
Patient NEWS Score	
Detail of the clinical assessment undertaken by the ED practitioner	
Supporting evidence that a clear medical plan is in place	
Supporting evidence of trust and ICB executive awareness of key actions and trust CEO sign off for mitigating actions	
Supporting evidence of a clear plan in place to expedite handover	
Supporting evidence of a clear timeframe for actions and a completed handover	
System Risk Oversight	
Current average CAT2 response time	
90th Centile CAT2 response time	
No. of patients currently waiting on the ambulance stack	
The current longest wait for a CAT2 response	

NHS England South West

Appendix 4: Key roles and responsibilities for local management of hospital handover delays <6 hours

Stakeholder	Key roles and responsibilities
Ambulance Crews	- Ensure that clinical review of the patient is maintained and any relevant temporary care is provided as appropriate; - Open dialogue between the hospital ED, HALO and SWAST Operations Delivery Centre is maintained; - Regular review of hospital cohorting arrangements and capacity for transfer; - Constant review of patient safety including escalation where required and documentation and reporting of patient safety incidents when they occur; - Timely and accurate documentation of hospital handover, cohorting, or crew to crew transfer where shift change occurs.
Hospital ED Staff	- Utilise XCAD data on inbound and expected ambulance arrivals to support management and decision making of ED patient flow in collaboration with hospital operations staff; - Ensure timely cleaning and preparation of ED bays, including access to equipment, to reduce delays in access to the department; - Ensure rapid assessment of patients are undertaken and where hospital handover is delayed diagnostic and treatment is started where appropriate; - Rapidly assess patients for suitability for direct admission to another hospital department or alternative care pathway; - Regular review of cohorting capacity including appropriate corridor queuing and pre-ED cohorting and utilisation in line with local escalation policies; - Review of all patients for suitability for fit to sit in the ED waiting area; - Work with the hospital senior executive team to escalate missed opportunities or barriers to flow out of ED; - Work with the SWAST HALO to ensure open dialogue is maintained on actions to reduce hospital handover delays, action plans and timescales, and regular review alongside hospital operations staff of inbound activity to support decision making; - Constant review of patient safety including escalation where required and documentation and reporting of patient safety incidents when they occur; - Timely and accurate documentation of hospital handover and where dual sign off is incomplete or incorrect escalation to the hospital HALO or SWAST Operations Delivery Centre is undertaken.
Hospital Operations Team	- Utilise ambulance activity data for the hospital alongside system wide data flows in collaboration with the SCC/ICB to support data led decision making; - Review the order of ED admitted patients based on overall system risk e.g. understanding risk to CAT2 response times as well as clinical condition of the patient; - Review of key hospital wide flow levers e.g. early discharge decision making, medications review and access for discharge ready patients, NCTR, Virtual Ward utilisation etc. and escalation where hospital agreed standards are not being met; - Review of speciality ready patients from ED to ensure timely review of referrals and action to support flow out of ED; - Oversight of pre and post ED cohorting spaces, including corridor queuing, to ensure timely and appropriate utilisation and review of additional cohorting spaces in line with local escalation policy that will not negatively impact hospital flow; - Work with SCC and hospital executive team to review requirements to and capacity for hospital divert.
Hospital Medical Director	- Review of the impact of timely clinical assessment and decision making on ED flow and support to action appropriate mitigations; - Review of clinical speciality support for ED flow to ensure a balanced hospital approach to bed occupancy and hospital flow; - Review of senior clinical decision making capacity on assessment in ED to ensure timely streaming where appropriate; - Review of patient safety of ambulance patients waiting for hospital handover.
Hospital Executive Team	- Work directly with system SCC to ensure they are fully up to date on hospital handover delays, current hospital performance and key plans to reduce delays as quickly as possible. - Work directly with the system SCC to understand system wide performance and opportunities for managing risk across the system and providers e.g. access to alternative pathways, utilisation of community services, hospital cohorting, hospital diverts etc.

NHS England South West

Stakeholder	Key roles and responsibilities
	- Review key indicators of hospital flow and work with the hospital MD and clinical and operational leads to ensure all relevant actions to improve flow out of ED are being taken. - Review all patients waiting in excess of 4 hours and ensure there are adequate plans in place to manage patient safety and risk and to mitigate further delays.
SWAST HALO	- Act as the key point of contact for review of handover delays, communication with hospital staff and reporting to SWAST TIM/Operational Commander. - Working with the hospital ensure there has been review of patient suitability for alternative hospital pathways to ED and whether there are alternative care options outside the hospital. - Ensure patients have had a timely clinical assessment and that appropriate diagnostic/treatment is being managed whilst queuing. - Ensure regular review of cohorted space utilisation by SWAST and the hospital to ensure all appropriate options have been considered across the hospital footprint according to escalation protocols. - Monitor inbound activity and provide regular reporting of the local position and agreed actions with the SWAST TIM/Operational Delivery Centre to support dynamic operational decision making. - Ensure that hospital handover data recording is accurate and that crews are appropriately recording dual pin handover, cohorting or shift to shift transfer in a timely way.
SWAST Trust Incident Manager (TIM)/SWAST Strategic Commander	- Work with the HALO, hospital operations and executive teams (acute trust director on call or daytime equivalent) to ensure there is an up to date review of hospital handover delays and local actions based on the SWAST/hospital escalation criteria. - Where handovers exceed 4 hours and there is no agreed assurance of an appropriate timescale for admission/discharge with the hospital, the TIM should ensure that the SWASFT Strategic Commander is informed and that there is escalation to the SCC on-call Director to escalate the specific patient(s) with the relevant key information. - Review and implement opportunities for managing activity across systems in order to reduce extended individual hospital handover delays working with the system SCC.
ICB/System on Call Director	- Ensure there is open dialogue on hospital delays with the SCC, providers and system partners and that regular reporting and oversight is in place. - Work with SCCs and providers to agree system level approaches to reduce specific in-day delays. - Ensure that clear action plans are available for long handover delays and that mitigating factors have been discussed at a system level.
SCC	- Review live hospital handover positions and work directly with hospital providers to review, support and manage long delays. - Work with hospital providers to ensure there are updates on all patients delayed in excess of 4 hours and that there are robust plans in place to mitigate further delays in preparation for regional reporting of 6 hour delays. - Review activity in providers across the system and work with them to ensure that there is a balanced approach to risk and where possible activity is spread to manage this risk i.e. dynamic conveyancing etc.
ROC	- Monitor hospital and system level handover delays. - Continue daily operational calls with systems to understand pressures and support operationally at a regional level.
SW Regional Team	- Monitor hospital and system level handover delays. - Continue work on providing support with UEC recovery plan objectives that will directly impact hospital performance and handover delays.

Appendix 5. Checklist to support reduction in hospital handover delays

Pre and post Hospital	Is there any additional capacity for attendance/admission avoidance being implemented? - i.e. Primary Care, virtual ward, ARI Hub.
	Does the Ambulance service have access/authority to contact for advice and refer patients directly to SDEC / specialty services including Medicine, Surgery, Frailty etc.
	Are existing alternative pathways accessible/used to their full capacity?
	Has the DoS been reviewed and updated?
	Is there a clear plan with system partners to support complex discharge pathways with process improvements or additional capacity?
	Is there oversight and management of SLA cover in 111 for call taking and clinical validation lines for ED and 999 dispositions?

ED	Do front door acute services (ED and Assessment units) have easy and regular access to alternative pathways? e.g. UCR, virtual wards, mental health and palliative care etc.
	Is there a designated accepting senior nurse/coordinator who takes handovers, coordinates ambulance crews and has the ability to directly steam patients to other services?
	Is there an ambulance arrival / assessment (RAT) area in place with optimal capacity and senior medic oversight?
	Is the physical process of recording ambulance handovers robust and understood with ambulance and acute staff with a written SOP?
	Are there effective escalation lines in place between SWAST and Acute management?
	Is whole system risk part of the operational decision making in relation to hospital handover delays?
	Is there a process in place to manage ambulance patients away form a cubicle/trolley where the clinical situation applies? e.g. UTC or waiting room
	Has there been a review of demand and capacity from an ED workforce perspective?

In patients settings	Are there robust operational plans in place to deliver at least 33% of discharges ahead of mid-day?
	Do weekend discharges match 80% of weekday discharge numbers?
	Is there full implementation of criteria to reside against national standards?
	Is there daily senior medical and nursing oversight of NCTR patients?
	Has any additional capacity been identified and made operational, be that cohorting or escalation spaces, outside of ED?
	Are internal professional standards actively in place and operational including a pull from ED and standards across in patient care?
	Is there a simple, timely and effective process for referring complex discharge patients early in the acute spell and no need for "medically fit" status in place before assessment?
	Is there an effective full hospital protocol in place that sees risk managed into in patient wards?
	Is weekend in-patient senior medical workforce and support services effective to optimise weekend discharge?
	Have the SAFER medical board and ward rounds been optimised?

Operational management	Are site meetings and trusts communications on operational pressures data driven and robust?
	Is there visibility within site meetings of internal pathway delays and is P0 oversight optimised with ownership at a senior level?
	Is there executive oversight of flow each day, particularly with a heightened OPEL status to support continuous flow through the organisation?
	Is OPEL status mapped to effective action cards?
	Is there an understanding of how patient safety and harm will be overseen with additional capacity / process change?
	Are there appropriate SOP's to support staff managing patients in places like RAT, Boarding, FHP, Cohorting etc.?
	Is there an up to date escalation policy that is clearly understood by staff and key stakeholders?
	Is the role of the SCC role in supporting ambulance handovers at system level clear and optimised?
	Have the CQC been engaged in review/support of processes to manage hospital handover delays?

Report Front Sheet

1. Report Details			
Meeting Title:	Board of Directors, Part 1		
Date of Meeting:	31st January 2024		
Document Title:	Finance Report		
Responsible Director:	Chris Hearn, Chief Financial Officer	Date of Executive Approval	17th January 2024
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	22nd January 2024	Noted

3. Purpose of the Paper	For Information – income & expenditure report on the finance position of the Trust to month nine 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 nine being £0.6 million away from plan after technical adjustments and £8.9 million away from plan year to date. The month nine and year to date performance is largely driven by: • Ongoing industrial action, with £2.4 million of national funding supporting the position based on a fair shares contract allocation. The Dorset allocation is £9.3 million. Elective recovery baseline targets have been reduced to 100% for Dorset, in recognition of ongoing Industrial Action • Ongoing use of high cost agency to meet demands, largely driven by an expanded bed base, heightened operational pressures, vacancies and sickness levels • Above planned levels of inflation, Digital licence costs and Insourcing levels above plan, noting however the latter is expected to recover by year end • Efficiency delivery challenges There has been an improvement to the income position associated with system recovery of elective activity (ERF) following recent national revision to baseline targets. This has resulted in a net benefit of £0.3m across months 1-9 for the Trust and has removed the income risk previously reported for these months. These calculations are currently being validated by the Trusts Finance and BI teams. The net costs incurred associated with supporting industrial action amounts to £1.3 million year to date, with a further £1.5 million estimate of lost income opportunity and is detailed further in the Board report.							

	NHS England announced late December that all organisations must include the estimated cost impact of the December and January planned industrial action within forecast positions. For DCHFT this amounts to £0.6 million. If further industrial action is announced, this will continue to adversely affect the financial performance. Agency currently stands at £3.4 million overspent against plan, with £1.3 million of this incurred with highest Off Framework agencies, and within this £0.2 million has been incurred year to date providing support to mental health patients. Ongoing cover for vacancy and sickness gaps, heightened by operational pressures, with increased acuity and demand whilst supporting circa 23 escalated beds which continues to drive demand. The number of patients at the end of December with no criteria to reside was 40. Continuation of increased cover for medical rota gaps in Unscheduled Care, Medicine for the Elderly, General Medicine and Urology also contribute to the agency overspend. Above planned levels of inflation have been incurred year to date with gas over by 25% and electricity over by 65%. Drugs, catering supplies, blood product contract and other contract increases are between 8% and 13.5% above planned levels. The Trust continues to actively review 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 are being deployed at pace 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. From the start of January 2024, the Dorset system reduced agency rates for all on framework agencies by 15%. It is anticipated that this will generate approx. £0.3 million of savings this financial year with further incremental reductions planned by system partners. There is a risk to the delivery of the break even forecast outturn position noting the ongoing pressures facing the Trust, however financial recovery plans across targeted areas are being deployed. Forecast analysis demonstrates this risk to be in the region of £14 million. Following review with the Executives, further stretch targets linked to efficiency, productivity and agency have been put in place for the remainder of the financial year to reach £10 million forecast outturn. It has been agreed across the Dorset system that acute providers will be supported to a break even position by financial year end, excluding the December and January cost of Industrial Action. The latter has been agreed will be reported in the Provider positions. The Trust has delivered £3.2 million of efficiencies for the year against a year to date plan of £6.6 million. The cash position is currently £10 million as at November, impacted by heightened expenditure and timing of recent payments which is being closely monitored. Without intervention worst case modelling indicates the Trust would need to mitigate a shortfall of cash in the region of £5.6 million in the last quarter of this financial year. Implications and detailed modelling are ongoing to mitigate this requirement.

	The capital spend in month is away from plan by £0.7 million. The year to date position stands at £1.1 million behind plan reflective of timings in expenditure payments including externally funded schemes such as Digital electronic patient record (EPR).
5. Action recommended	The Board is recommended to: 1. **NOTE** the financial position to month nine 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**	

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NHS
Dorset County Hospital
NHS Foundation Trust

Financial Position Update 2023/24

December 2023 - Month 9

Chris Hearn
Chief Financial Officer

Outstanding care for our patients in ways which matter to them

Financial Position Update - December 2023

Executive Summary

A summary of progress is presented for the period to December 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 variance position for the month of December 2023 of £0.6 million against plan after technical adjustments. The year to date position is £8.9 million away from plan.

Ongoing agency costs covering vacancies & sickness, heightened by operational pressures and increased patient acuity are key drivers. Escalated beds stand at 23 with circa 40 no criteria to reside (NCTR) patients being supported during December. 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 December however still remains a significant pressure noting heightend usage linked to patient specialling and acuity challenges. Mental health nurse support has also been ongoing, with £0.2 million incurred to date within off framework spend, and ongoing medical rota gaps across ED, General Medicine and Urology are being covered at higher rates than budgeted.
The adverse position against plan includes an updated income position for elective recovery funding (ERF) following the national baseline target revision to 100% for Dorset. The System income share of Industrial Action funding of £2.4 million has also been recognised in the position, based on a fair shares contract allocation at this stage.

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 £3.2 million with the majority of the total target identified, leaving £2.6 million of opportunities requiring key actions to move into fully developed and delivered schemes. Month nine saw delivery of £0.5 million.

Pay is over plan largely due to increased costs supporting safe cover during industrial action, including agency usage to cover vacancies and to support operational pressures. Patient levels with NCTR did reduce at the start of the financial year only to increase during May with fluctuating levels thereafter.
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.

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 agency usage. From January, an on framework agency rate reduction of 15% has been applied to all suppliers by the Dorset System. This is anticipated to reduce agency costs by £0.3 million by the end of the financial year and with further rate reductions planned incrementally thereafter.

Capital expenditure during month nine was under plan by £0.7 million. Year to date the capital position is £1.1 million behind plan due to timing of expenditure payments and phasing of externally funded programmes.
The cash position to December 2023 amounts to £8.4 million; noting the impact of heightened level of expenditure being incurred and timing of payments.

NHS England requested late December that each organisation formally update their December forecast outturn positions for the impact of ongoing industrial action announced for December and January. For DCHFT this amounts to £0.6 million.

Financial Position Update - December 2023

Key Risks

Red Risks:

Financial Forecast Risk
There is a risk of delivering the break even position noting the combined pressures incurred year to date. Drivers remain the escalated bed base, high cost agency usage, efficiency under delivery, inflationary costs above planned levels and the ongoing impact of Industrial action. The Trust is actively deploying targeted support towards recovery and mitigations, led by the CFO and supported by the wider Executive team in order to mitigate the risk to financial balance with stretch targets agreed for efficiencies, productivity and agency to the end of the financial year. The net forecast risk of approx. £10 million has been agreed will be supported by the System to support the Trust to break even, as with both Acutes within the Dorset system. Late December, NHSE have requested that costs relating to ongoing Industrial Action (IA) for December and January are included within the forecast outturn position. So far, December and January IA estimated costs equate to £0.630 million resulting in a revised FOT of £0.630 million for the Trust. Any further IA will likely worsen the position.

System Elective Services Recovery - income performance
The government has made Elective Services Recovery Funding (ESRF) available to each Integrated Care Board (ICBs) to eventually achieve around 30% more elective activity than was achieved before the COVID-19 pandemic. The financial year 2023-24 national target aims to reach 107% of the activity levels seen in 2019-20 (pre-pandemic).

NHS England, will set individual targets for each ICB, which in turn agrees on individual targets for each provider in its area. These targets are based on the activity recorded in the first half (H1) of 2022/23 (which was below pre-pandemic levels at 98%); the further behind an ICB is, the higher the local target is to recover its position.

Dorset County Hospitals target was set at 108% of its 2019/20 elective activity, this has since been revised down to 100% to mitigate towards the impact of Industrial Action in 2023-24 YTD.

In light of the revised ERF targets, DCHs M1 - M9 ERF performance has resulted in additional income. This has resulted in a net benefit £0.311m in ERF to month 9, removing the previous ERF income risk that had been included. This is currently being reviewed by BI and Finance teams.

Cash Position
The cash position deteriorated from September due to the heightened expenditure reflected in the I&E position as well as timing of a number of payments being made. Worse case scenario showed that without intervention, the Trust would need to mitigate a shortfall in cash in the region of £10 million in the last quarter of the financial year. Mitigating solutions including reviewing local payment terms and driving income collection at pace have reduced this risk.

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 - December 2023

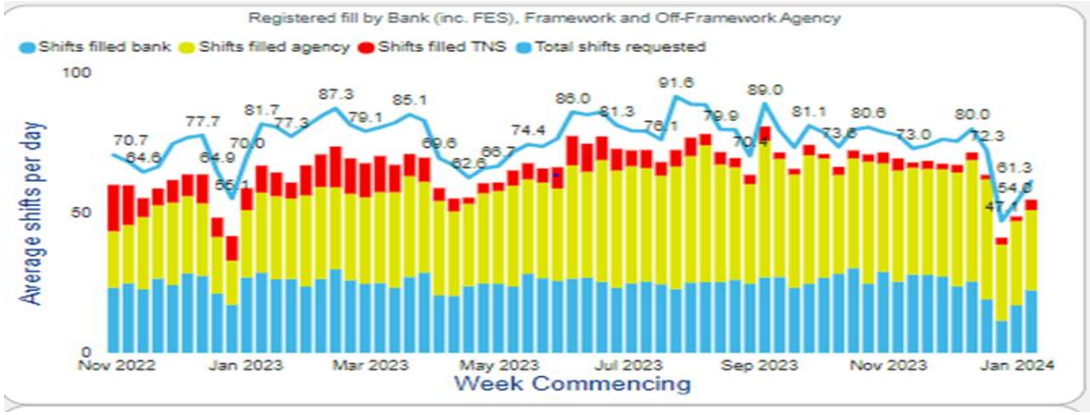
Key Risks

Red Risks:

The Trust has an **efficiency delivery requirement of £10.9 million** in order to reach the planned full year break even position. £3.2 million has been delivered for the full year at month nine. 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 to December is overspent against plan by £3.4 million, with £1.3 million spent with highest cost off framework suppliers and £0.2 million of this supporting mental health patients. Active plans in place as part of the internal High Cost Agency Reduction group, which is primarily focusing on nursing, are being 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. A planned system approach to of reducing on framework agency rates by 15% has been activated from 2nd January 2024. This should see a cost improvement in the region of £0.3 million for the Trust by the end of the financial year.



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 - December 2023

Key Risks

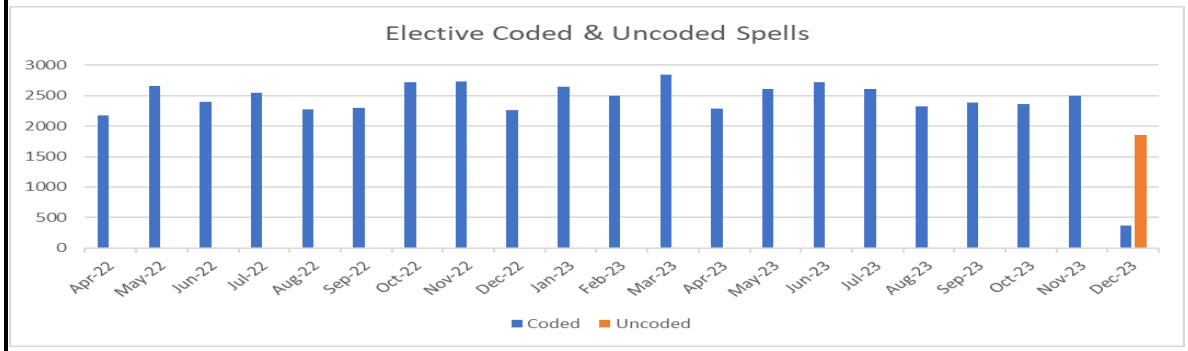
Amber Risk:

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 December 2023 the Trust has 7,154 uncoded spells, 1,858 are for Elective activity and 5,296 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 - December 2023
Income & Expenditure

Income and Expenditure

The overall revenue position is behind plan by £0.6 million in month and £8.9 million YTD. Ongoing run rates linked to inflationary pressures, agency usage including industrial action, with vacancy, sickness cover and demand requirements, including the escalated bed base and NCTR patients continues.

The Operating Income from patient care activities year to date variance is due to income received for fair shares industiral action income, income outside of contracted values, the agenda for change pay award and high cost drugs, including a benefit of £0.3 million of System Elective Recovery Fund income due to improved performance against the revised baseline target for months 1-9.

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 as is consumables.
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.

An impairment relating to the medical systems staffing project was transacted in month six following confirmation that this project will not be completed this financial year.

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	20,483	22,441	1,958	184,090	189,419	5,329	239,006
Private Patients	87	62	(25)	838	793	(46)	1,008
Other clinical revenue	37	29	(8)	333	213	(120)	444
Other non-clinical revenue	2,292	2,123	(170)	19,333	20,057	724	26,377
Operating Income	**22,900**	**24,655**	**1,756**	**204,594**	**210,482**	**5,887**	**266,835**
Charitable income	0	0	0	0	0	0	
Total Income	**22,900**	**24,655**	**1,756**	**204,594**	**210,482**	**5,887**	**266,835**
Raw materials and consumables used	(3,211)	(4,237)	(1,026)	(29,331)	(33,442)	(4,111)	(38,455)
Employee benefit expenses:							
Substantive	(14,135)	(13,991)	143	(122,535)	(122,272)	263	(156,816)
Bank	(787)	(1,250)	(463)	(7,087)	(9,432)	(2,345)	(9,384)
Agency	(833)	(1,003)	(170)	(7,498)	(10,902)	(3,403)	(10,000)
Other operating expenses (excl. depreciation)	(3,015)	(3,998)	(983)	(26,137)	(32,123)	(5,986)	(35,468)
Operating Expenses	**(21,979)**	**(24,479)**	**(2,499)**	**(192,589)**	**(208,171)**	**(15,583)**	**(250,124)**
Profit/(loss) from Operations (EBITDA)	**920**	**177**	**(743)**	**12,006**	**2,310**	**(9,695)**	**16,711**
Other Non-Operating income (asset disposals)	(2)	1	3	(20)	1	21	(27)
Other Non-Operating expenses (Impairments)	0	0	0	0	(592)	(592)	0
Total Depreciation and Amortisation	(957)	(910)	47	(8,544)	(8,379)	165	(11,363)
PDC Dividend expense	(373)	(373)	0	(3,357)	(3,357)	0	(4,476)
Total finance income	29	53	24	258	762	504	194
Total interest expense	(63)	(58)	5	(563)	(482)	82	(752)
Total other finance costs	0	0	0	(2)	(1)	1	(2)
SURPLUS/ (DEFICIT)	**(447)**	**(1,111)**	**(664)**	**(223)**	**(9,738)**	**(9,515)**	**285**
Technical Items Adjusted for:							
DONATIONS CASH FOR ASSETS	(100)	0	100	(97)	(85)	12	(729)
DEPRECIATION DONATED ASSETS	36	38	2	337	340	3	447
IMPAIRMENT OF PPE	0	0	0	0	51	51	0
IMPAIRMENT OF INTANGIBLES	0	0	0	0	542	542	0
SURPLUS/ (DEFICIT)	**(510)**	**(1,073)**	**(563)**	**17**	**(8,890)**	**(8,907)**	**0**

Financial Position Update - December 2023

Industrial Action

2023/24 Industrial Action
Costs incurred year to date relating to Industrial Action cover amount to £1.3 million with a further £1.5 million estimate of lost activity income. NHS England requested late December that the costs associated with December and January industrial action be formally included as part of each organisations forecast outturn position. For DCHFT, December and January costs equate to £0.630 million. If further Industrial Action is announced, this will continue to adversely impact the Trust's forecast outturn position.

												Forecast	
	£'000												
2023/24 Industrial Action Staff Group	**Junior Doctors**	**Nursing**	**Junior Doctors**	**Junior Doctors**	**Consultants**	**Radiographers**	**Junior Doctors**	**Consultants**	**Junior Doctors & Consultants**	**Junior Doctors & Consultants**	***Junior Doctors***	***Junior Doctors***	**Total incl Forecast**
Strike Date	**11-14 Apr**	**30 Apr - 2 May**	**14-17 June**	**13-17 July**	**20-21 July**	**25-26 July**	**11-15 Aug**	**24-25 Aug**	**19-22 Sept**	**2-4 Oct**	***20-23 Dec***	***3-9 Jan***	
Immediate backfill costs to cover services	£218	£6	£112	£158	£0	£0	£195	£67	£132	£310	*£131*	*£256*	**£1,586**
Offset by Salary Savings	-£34	-£2	-£37	-£20	-£22	£0	-£24	-£25	-£45	-£48	*-£28*	*-£43*	**-£328**
Net Cost	**£184**	**£4**	**£75**	**£138**	**-£22**	**£0**	**£171**	**£42**	**£86**	**£262**	***£103***	***£213***	**£1,257**
Number of Industrial Action Days	4	1	3	5	2	2	4	2	4	3	*3*	*6*	39
Estimate of Lost ERF Activity	£209	£0	£193	£127	£92	£0	£110	£222	£183	£291	*£74*	*£240*	**£1,741**
Net Cost & ERF Income Loss	**£393**	**£4**	**£267**	**£266**	**£70**	**£0**	**£282**	**£264**	**£269**	**£553**	**£177**	**£453**	**£2,998**
Estimated Cost Per Day £'000	£98	£4	£89	£53	£35	£0	£70	£132	£67	£184	£59	£76	£77
Rescheduled Elective Inpatients	10	0	12	13	1	0	4	12	21	25	4	9	**111**
Rescheduled Day Case Activity	69	0	73	65	31	0	48	127	55	182	27	9	**686**
Reschedule Outpatient Appointments	732	0	356	177	378	0	239	478	313	274	152	287	**3,386**

Financial Position Update - December 2023
Trust Wide Performance: Agency

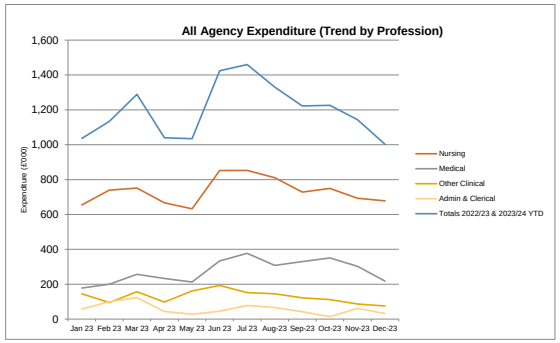
Pay Analysis - Agency

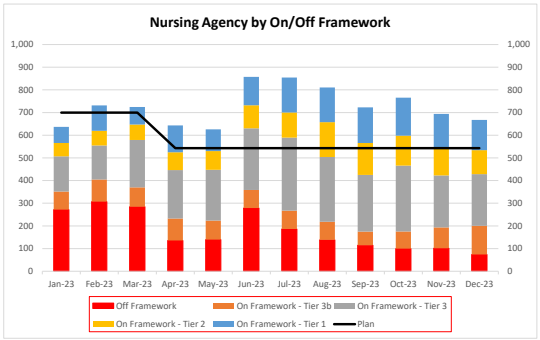
Agency costs equated to £1 million of actual expenditure in month against a plan of £0.833 million, again seeing an improvement of £0.1 million compared to last month. Agency expenditure was 6.2% of total pay and within this highest cost off framework usage was 7.4% equating to £0.074 million in month, an improvement of £28k from last month.

December continues to see agency cover due to short term sickness cover and impact of ongoing industrial action. RN agency covering Healthcare Assistant gaps and ongoing Allocate on Arrival shifts booked to support safe staffing levels have contributed to usage levels. Abbotsbury and Moreton ward in particular has seen an increase in patient specialling and trained support for mental health patients. The Trust has incured £0.2 million of off framework spend relating to supporting this patient cohort year to date. 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 underway to reduce and ultimately remove the usage of highest agency expenditure, aligned to System collaborative workstreams including a 15% agency rate reduction applied from 2nd January 2024 by all organisations.





Areas Using Nursing Agency including Off Framework M1 - M9 (£'000):

Area	On Framework	Off Framework	of which: RNMH	Total Nursing Agency
Crcu	£270	£391	£4	£662
Kingfisher Ward	£175	£213	£3	£388
Emergency Dept Main Dept	£1,031	£177	£30	£1,208
Abbotsbury Ward	£440	£113	£67	£553
The Mary Anning Unit	£301	£94	£58	£395
Evershot Ward	£197	£57	£37	£253
Scbu	£0	£38		£38
Day Surgery Unit	£210	£35		£245
Ilchester Integrated Assessmen	£283	£23	£18	£306
Fortuneswell Ward	£284	£22		£306
Moreton Ward - Respiratory	£284	£17		£301
Purbeck Wd	£276	£16		£292
Ridgeway Wd	£175	£15		£191
Lulworth Ward	£212	£15		£227
Cardiology Care Ward	£145	£15		£160
Stroke Unit	£224	£13		£237
Surge Area	£167	£10		£176
Prince Of Wales	£111	£9		£120
Bank Nurses	£2			£2
Sdec	£30			£30
B'Mth Dialysis	£101			£101
Theatre Suites	£265			£265
Dch Dialysis	£206			£206
Medical Day Unit	£1			£1
Total Nursing Agency M1 - M9	**£5,390**	**£1,272**	**£217**	**£6,663**
	Net OF excl MH:	**£1,056**		

Agency Spend by Profession (£'000)	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23
Nursing	655	740	752	666	633	852	853	811	728	749	693	678
Medical	178	200	257	233	213	334	377	308	329	351	303	218
Other Clinical	145	95	157	97	161	193	152	145	122	112	86	75
Admin & Clerical	58	99	123	43	28	45	78	67	42	14	62	32
Totals 2022/23 & 2023/24 YTD	**1,036**	**1,134**	**1,289**	**1,040**	**1,034**	**1,425**	**1,460**	**1,330**	**1,222**	**1,226**	**1,144**	**1,003**

YTD Actual	YTD Plan	Variance
6,663	4,887	1,776
2,665	1,629	1,036
1,144	630	514
411	351	60
10,884	**7,497**	**3,387**

Nursing Agency Category	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23
Off Framework	272	307	285	135	140	279	187	139	115	100	102	74
On Framework - Tier 3b	80	97	85	97	84	80	81	80	60	76	92	126
On Framework - Tier 3	155	150	209	213	224	272	322	286	250	290	229	228
On Framework - Tier 2	59	65	68	79	83	102	111	154	141	133	120	106
On Framework - Tier 1	71	111	77	118	96	125	154	153	157	167	152	133
Plan	700	700	700	543	543	543	543	543	543	543	543	543
Orders awaiting allocation	0	0	0	23	7	-5	-2	0	5	-17	-1	11
Totals 2022/23 & 2023/24 YTD	**637**	**731**	**724**	**666**	**633**	**852**	**853**	**811**	**728**	**749**	**693**	**678**

Pay Metrics	In Month Actual	YTD Actual
Agency expenditure as % of total pay	6.2%	7.6%
Off framework expenditure as % of total agency	7.4%	8.5%

Financial Position Update - December 2023

Insourcing

Insourcing Narrative

Insourcing spend is above initial budgeted levels year to date due to an acceleration of activity recovery with providers. Plans are in place to ensure activity levels will deliver to planned budget by the end of the financial year.

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 £0.26 million to planned levels.

	Actual	Actual	Actual	Actual	Actual	Actual	Actual	Actual	Actual	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:	**£583**	**£583**	**£583**	**£583**	**£583**	**£583**	**£583**	**£583**	**£583**	**£583**	**£583**	**£583**	**£6,996**
Specialty:													
Orthopaedics	£28	£53	£34	£31	£39	£25	£82	£74	£47	£25	£20	£20	**£479**
Ophthalmology	£62	£48	£113	£57	£58	£59	£21	£19	£17	£11	£0	£0	**£465**
Dermatology	£120	£60	£80	£149	£113	£127	£127	£115	£104	£125	£108	£108	**£1,335**
Gynaecology	£106	£74	£182	£157	£78	£218	£37	£33	£30	£0	£0	£0	**£915**
Urology	£29	£42	£51	£0	£14	£0	£15	£13	£12	£5	£5	£5	**£190**
Endoscopy & Gastro	£156	£143	£124	£146	£113	£146	£74	£67	£61	£70	£60	£60	**£1,220**
Breast	£1	£19	£0	£0	£19	£38	£19	£17	£16	£19	£0	£0	**£147**
Oral Surgery	£88	£110	£187	£159	£198	£189	£210	£191	£173	£116	£107	£107	**£1,835**
Cardiology	£4	£26	£25	£24	£23	£43	£63	£57	£51	£0	£0	£0	**£316**
Radiology/Cardio	£0	£0	£17	£0	£0	£0	£0	£0	£0	£6	£5	£5	**£34**
ENT	£0	£44	£35	£62	£36	£23	£8	£7	£6	£37	£32	£32	**£321**
Total	**£594**	**£620**	**£849**	**£784**	**£690**	**£867**	**£654**	**£593**	**£373**	**£415**	**£337**	**£337**	**£7,258**
Surplus/(Deficit)	**-£11**	**-£37**	**-£266**	**-£201**	**-£107**	**-£284**	**-£71**	**-£10**	**£210**	**£168**	**£246**	**£246**	**-£262**

Financial Position Update - December 2023

COVID Expenditure

Covid Narrative
Covid spend decreased in December to £0.082 million from £0.104 million in November. Pay spend increased marginally in month reflecting the variable costs of backfilling substantive Covid related staff sickness. Non-Pay spend increased in month due purchase of testing supplies for the upcoming months. Security has seen a continued decrease linked to the cessation of roaming security services since October. 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 ceased from 7th October 2023, with ward based insourcing security costs expected to continue for the remainder of the financial year. 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	Sep-23	Oct-23	Nov-23	Dec-23	YTD
Plan:		**£191**	**£191**	**£191**	**£191**	**£191**	**£191**	**£191**	**£191**	**£191**	**£1,715**
Expenditure:											
Pay	Substantive	£40	£22	£13	£12	£15	£38	£32	£22	£27	**£221**
	Bank	£9	£13	£8	£8	£9	£11	£12	£10	£13	**£93**
	Agency	£0	£0	£0	£0	£0	£0	£0	£0	£0	**£1**
Total Pay		**£49**	**£35**	**£21**	**£20**	**£25**	**£49**	**£44**	**£32**	**£40**	**£315**
Non-pay	Clinical Supplies and Services	£27	£26	£7	£0	£0	£0	£1	£29	£7	**£98**
	Other Non-Pay (security)	£50	£56	£43	£52	£60	£55	£31	£28	£18	**£393**
	Premises and Fixed Plant	£11	£14	£14	£14	£14	£14	£11	£15	£16	**£123**
Total Non-pay		**£88**	**£96**	**£64**	**£66**	**£73**	**£70**	**£42**	**£72**	**£41**	**£613**
Total Expenditure		**£137**	**£131**	**£86**	**£86**	**£98**	**£119**	**£86**	**£104**	**£82**	**£928**
Total Surplus/(Deficit)		**£53**	**£60**	**£105**	**£105**	**£93**	**£72**	**£105**	**£87**	**£109**	**£787**

Financial Position Update - December 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.

£3.2 million has been delivered full year effect, with £0.5 million delivered in month.
£3.9 million of schemes are fully developed with £1 million of schemes yet to start. £2.7 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.

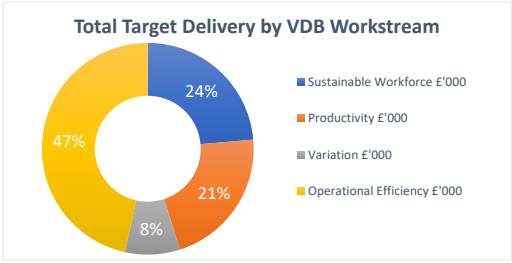
A stretch delivery target has been agreed by Executives for the remainder of the finanicial year relating to efficiency delivery, productivity improvements, and agency reductions.

Efficiencies delivered so far include Covid reduction against plan, Procurement savings, Corporate savings generated from joint posts, Digital programme delivery, non recurrent slippage against existing planned budgets and Prothesis programme savings.

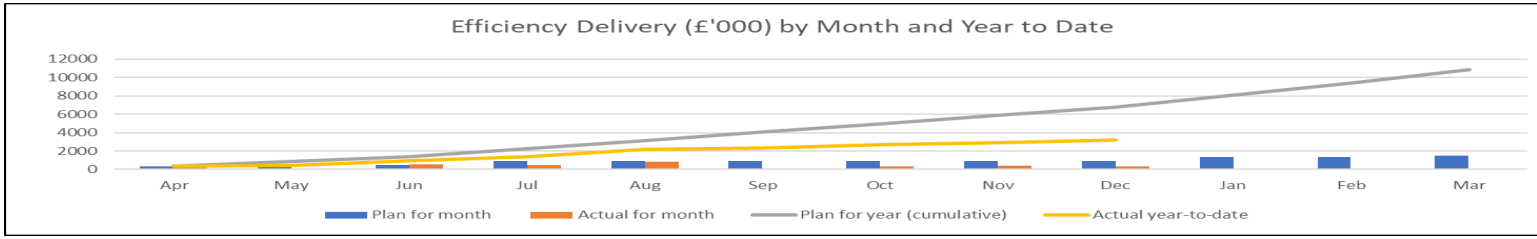
This programme of work has been shared with the Dorset System with collaborative opportunities being actively assessed and reviewed with focus on on flow, bed usage noting improvements to productivity are essential, supported by System partners.

Area	Efficiency Performance (£'000)		
	Full Year Plan	Full Year Realised @ M9	Variance to be Delivered
Division A	3,105	1,028	(2,077)
Division B	3,070	652	(2,418)
	6,175	**1,680**	**(4,495)**
Finance and Resources	717	180	(537)
Digital	311	249	(62)
Nursing	315	0	(315)
Operations	97	0	(97)
Human Resources	108	81	(27)
Corporate	149	125	(24)
Sub-total	**1,697**	**635**	**(1,062)**
Trust Wide schemes	3,000	901	(2,099)
Total CIP	**10,872**	**3,216**	**(7,656)**
Of which:			
Recurrent	6,552	1,078	(5,474)
Non-recurrent	4,320	2,138	(2,182)
Total	**10,872**	**3,216**	**(7,656)**

Value Delivery Board Workstream	Sustainable Workforce £'000	Productivity £'000	Variation £'000	Operational Efficiency £'000	Total £'000	Progress
Delivered	118	137	317	2,644	**3,216**	↑
Identified - in progress	1,720	11	295	1897	**3,923**	↑
Identified - not started	-	247	303	516	**1,066**	↑
Opportunity	730	1,937	-	-	**2,667**	↑
Unidentified					-	
Totals	**2,568**	**2,332**	**915**	**5,057**	**10,872**	



At a glance		
	£ 000	No of schemes
Target	**10,872**	N/A
Delivered	3,216	42
Identified - in progress	3,923	
Identified - not yet started	1,066	37
Opportunity	2,667	12
Unidentified	0	N/A



Outstanding care for our patients in ways which matter to them

Financial Position Update - December 2023

Cash

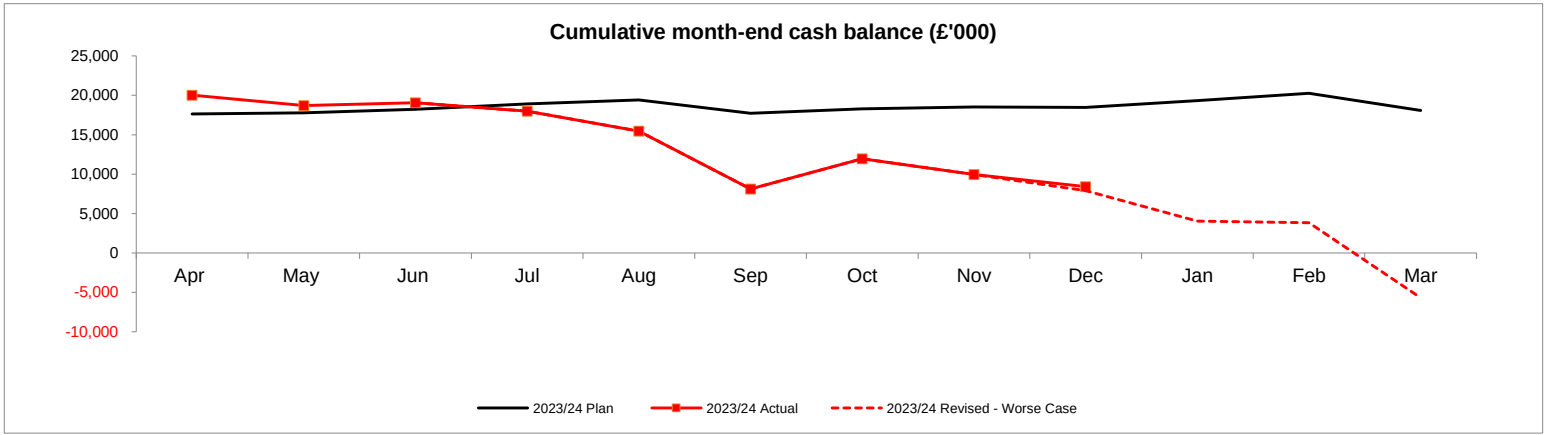
Cash Balance incl Forecast

The graph shows the trajectory of the actual year to date and worse case forecast cash balance during the year, with identified direct intervention required to mitigate the worse case scenario.

The cash position is currently £8.4 million as at 31 December 2023, and ahead of the forecast closing cash position for the month. This is due to Dorset Council income of £0.75 million received a month early offset by the payment of One Dorset Pathology supplier invoice of £0.5m.

The revised forecast displayed is based on a worse case scenario and indicates that with no further direct intervention, the Trust would need to mitigate a shortfall in cash in the last quarter of circa £5.6 million.

Implications and detailed modelling are ongoing to mitigate this position including accelerated pace of income collection and reviewing payments to system partners.



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									17,001	19,414	18,384	17,579
2023/24 Revised - Worse Case										4,057	3,847	(5,687)
2023/24 Actual	20,024	18,694	19,053	17,974	15,452	8,122	11,966	9,962	8,416			

Financial Position Update - December 2023

Capital

Capital Programme Narrative
Capital expenditure year to date to the end of December was £1.1 million behind plan. Internally Funded schemes are overall below plan by £0.13 million due to: Digital Schemes are above plan year to date due timing of expenditure incurred from the firewall upgrade, devices purchases and software purchases. Medical Equipment is above plan due to timing of purchases of equipment, such as Neuro Integrity Monitors (NIMs), operating tables and bladder scanners. The above are offset by Estates schemes being behind plan year to date due to timing of purchases to be made. IFRS 16 Lease Additions are ahead of plan due to the timing of the lease remeasurements for Multi Story Car Park (MSCP) and Carbon Energy Fund (CEF) offset by delay on One Dorset Pathology Lot 5 Microbiology tender process . Externally Funded capital is below planned levels of spend by £0.94 million due to timings of the Digital Electronic Patient Record (EPR) expenditure, offset by works on South Walks House (SWH) and Mental Health that have progressed ahead of plan. Additional external capital funding of £4.6 million has been awarded to the Trust for NHP Enabling works, noting an associated increase in forecast funding and spend since the plan was submitted at the start of the financial year. Electronic Patient 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
Estates	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000
Chemo	0	230	230	0	460	460		1,577	1,962	385
Air-Handling Unit	0	100	100	0	300	300	198	375	750	375
Estates Schemes	153	**148**	(5)	926	**1,534**	608	1,511	1,621	1,819	198
Digital Services										
Digital Schemes	219	**379**	160	1,973	**1,351**	(622)	2,554	2,582	2,005	(577)
Equipment										
Digital Mammogaphy	0	0	0	0	313	313		313	313	0
Haemodialysis Machines	0	0	0	0	119	119		119	119	0
Other Equipment	25	0	(25)	1,040	196	(844)	850	879	498	(381)
Sub-Total Internally Funded Expenditure	**397**	**857**	**460**	**3,939**	**4,273**	**334**	**5,113**	**7,466**	**7,466**	**0**
Donated										
Other Donations		0	0	85	0	(85)	87	150	0	(150)
Chemotherapy Unit Refurbishment		0	0		0	0			733	733
Sub-Total Planned DonatedExpenditure	**0**	**0**	**0**	**85**	**0**	**(85)**	**87**	**150**	**733**	**583**
IFRS 16 Lease Additions										
Warehouse		0	0	0	0	0		2,335	2,335	0
Print Management		0	0	397	600	203	397	421	600	179
One Dorset Pathology		0	0		250	250		250	250	0
MSCP & CEF Lease remeasurement	0	0	0	1,095	700	(395)	1,095	700	700	0
Accommodation & Vehicle Lease Additions	4	0	(4)	583	404	(179)	583	583	404	(179)
Sub-Total Planned IFRS 16 Expenditure	**4**	**0**	**(4)**	**2,075**	**1,954**	**(121)**	**2,075**	**4,289**	**4,289**	**0**
Total Internal & Leased Capital Expenditure	**401**	**857**	**456**	**6,099**	**6,227**	**128**	**7,275**	**11,905**	**12,488**	**583**
Additional funded schemes										
NHP Development	93	191	98	3,160	3,301	141	3,571	7,884	3,868	(4,016)
South Walks House & 24 Bedded Bay	946	573	(373)	6,093	5,157	(936)	6,872	6,872	6,877	5
Mental Health UEC Funding	0	50	50	233	50	(183)	233	233	233	0
Digital EPR Funding	85	318	233	179	1,456	1,277	863	1,000	2,093	1,093
CDC Funding	0	0	0	1,448	1,440	(8)	1,651	1,651	1,440	(211)
CDC Equipment - Dermascopes			0			0		10		(10)
Endoscopy		200	200		650	650		0	2,000	2,000
Total Externally Funded Capital Expenditure	**1,123**	**1,332**	**209**	**11,114**	**12,054**	**940**	**13,190**	**17,650**	**16,511**	**(1,139)**
Total Capital Expenditure	**1,524**	**2,189**	**665**	**17,213**	**18,281**	**1,068**	**20,465**	**29,555**	**28,999**	**(556)**
Expenditure as a % of Plan			70%			94%				102%

Report Front Sheet

1. Report Details			
Meeting Title:	Board of Directors, Part 1		
Date of Meeting:	31st January 2024		
Document Title:	**Maternity & Neonatal 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	23rd January 2023	

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 December 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. Patient identifiable information has been redacted

- SPC charts will be shared live. Smoking at time of birth is 8% with a target of 6%
- 1 incident of moderate harm.
- One babyloss <21 weeks gestation
- No PMRT cases
- SBLCB - the 70% overall compliance required for the MIS has not been met. The requirement to be at least 50% compliant in each element has been met. Key area of risk across all elements is the lack of capacity in the governance team to facilitate the audits required. Element 2: Currently unable to provide uterine artery doppler. However, there is an action plan to address this
- HSIB case under review.
- The risk around access to the MLU is now closed as repair work completed
- New risk relating to the impact of IA, sickness and annual leave on elective work including antenatal clinics

	• 2 complaints received in December. All actions from complaints triangulated with MNVP feedback and the CQC patient survey as an action plan reviewed regularly by the DoM, labour ward lead and postnatal lead and the MNVP representative. • Quadrumvirate Meeting held 19/12/23. Minutes to follow. Next meeting scheduled 23/01/24 • workforce data provided – overall sickness rate midwives 6.14%, 4.28% MSW, 8.25% SCBU 7.09% vacant midwife shifts on the ward (staffed to 5 plus coordinator) 13.97% vacant MSW shifts on the ward • One neonatal transfer out – for surgical review • Training figures show ongoing challenge to ensure all anesthetists have attended PROMPT and BLS. Practice development midwife attended OEG in December with maternity anaesthetic safety champion to mandate attendance. 2024 rota allocation underway. Poor compliance with obstetricians attending SBL study day. This is due to capacity within the consultant body and will proving challenging to mandate until the number of consultants increases • Maternity Incentive Scheme compliance reported. The Trust will not be compliant with specific requirements within elements: 5) midwifery workforce 6) SBLCB 7) MNVP 8)Training 9) Perinatal Quality Surveillance Model (PQSM) – Board assurance
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**		Providing assurance around a number of local and national metrics and KPIs
Impact on CQC Standards	**Yes**		Integral 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		
People	Credibility of Trust		

Strategic Objectives	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 & Neonatal Quality and Safety report (redacted)

January 2024 (December activity)

Submitted by Jo Hartley, Director of Midwifery & Neonatal Services

Executive sponsor: Jo Howarth CNO

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Executive Summary

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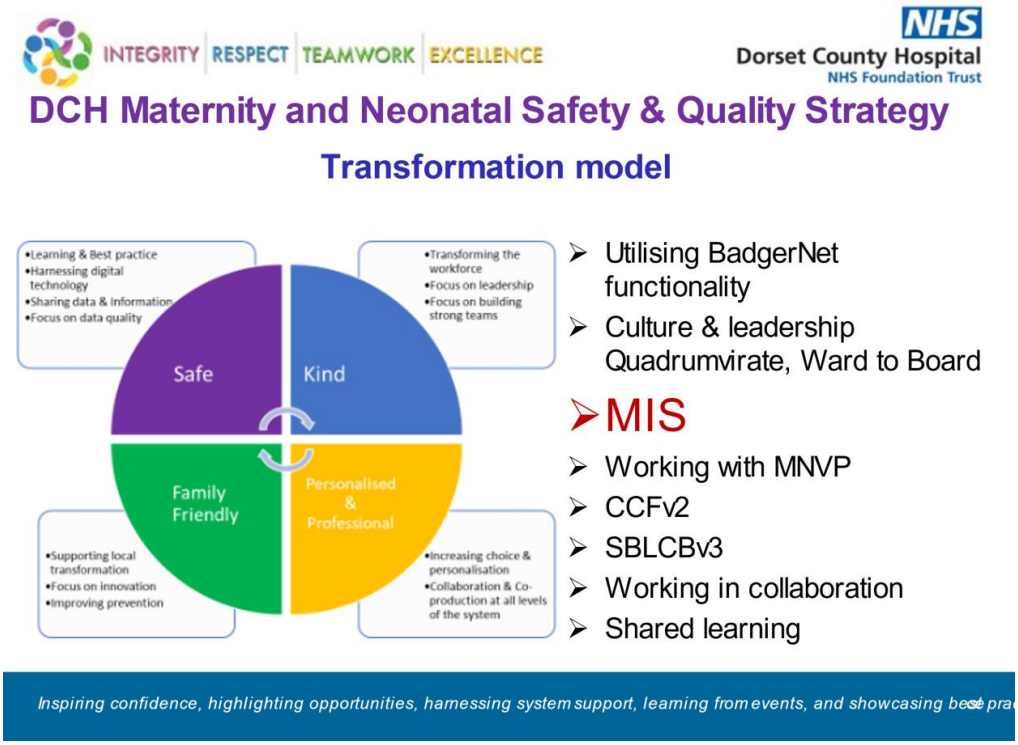
- 2 complaints received in December. All actions from complaints triangulated with MNVP feedback and the CQC patient survey as an action plan reviewed regularly by the DoM, labour ward lead and postnatal lead and the MNVP representative.
- Quadrumvirate Meeting held 19/12/23. Minutes to follow. Next meeting scheduled 23/01/24
- workforce data provided –
  overall sickness rate midwives 6.14%, 4.28% MSW, 8.25% SCBU
  7.09% vacant midwife shifts on the ward (staffed to 5 plus coordinator)
  13.97% vacant MSW shifts on the ward
- One neonatal transfer out – for surgical review
- Training figures show ongoing challenge to ensure all anesthetists have attended PROMPT and BLS. Practice development midwife attended OEG in December with maternity anaesthetic safety champion to mandate attendance. 2024 rota allocation underway. Poor compliance with obstetricians attending SBL study day. This is due to capacity within the consultant body and will proving challenging to mandate until the number of consultants increases
- Maternity Incentive Scheme compliance reported. The Trust will not be compliant with specific requirements within elements:
  5) midwifery workforce
  6) SBLCB
  7) MNVP
  8)Training
  9) Perinatal Quality Surveillance Model (PQSM) – Board assurance



Activity

Exception report for SPC charts (NTI – no target identified)

Metric	target	Current position and mitigation/actions
Smoking at time of delivery	6%	8%. Comprehensive action plan submitted and agreed. Jan 2023 13.9% so a significant improvement overall
stillbirth	NTI	1 this month
Transfer of a baby to a tertiary NICU	NTI	1 this month for further medical investigations
Rates per 1000 of PPH >1500mls	30	16
Rates per 1000 of 3rd/4th degree tears	30.3	25 The mean is 19.3

Total Number of Incidents submitted for December 2023

Maternity	Neonatal
82	21

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

Red flag	Descriptor	Incidents for Dec
RF1	Escalation to divert of maternity services & poor staffing numbers, including medical staffing and SCBU	4
RF2	Missed medication	2
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	12 women affected
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	1
RF10	Delay of time critical activity	0

RF1 – 4 incidents reported does not reflect the extremely challenging shifts worked in December. Over one weekend, the manager on call and another manager were in working clinically for >10hrs on the Saturday. The number of midwives required for safe care over several shifts has been 8-10.

Incidents graded as moderate harm or above for December

reference	grading	detail
DCH89395 25/12/23	Moderate harm	Redacted as patient specific and identifiable

Babyloss for December

Intrauterine death	Medical termination	Neonatal death	Late neonatal death
1	0	0	0

Babyloss at <21 weeks Post-mortem consented to. Follow up will be arranged with fetal medicine consultant in 6 months. Ongoing support from bereavement midwives.

PMRT - Perinatal Mortality Reviews Summary Report

This report has been generated following mortality reviews which were carried out using
the national Perinatal Mortality Review Tool
Dorset County Hospital NHS Foundation Trust
Report of perinatal mortality reviews completed for deaths which occurred in the period: 1/10/2023 to 31/12/2023
There are no published reviews for Dorset County Hospital NHS Foundation Trust in the period
from 1/10/2023 to 31/12/2023

Report GeneratedReport Generated

SBLCB compliance

The 70% overall compliance required for the MIS has not been met. The requirement to be at least 50% compliant in each element has been met.

Key area of risk across all elements is the lack of capacity in the governance team to facilitate the audits required

Element 2: Currently unable to provide uterine artery doppler. However, there is an action plan to address this

Intervention Elements	Description	Element Progress Status (Self assessment)	% of Interventions Fully Implemented (Self assessment)	Element Progress Status (LMNS Validated)	% of Interventions Fully Implemented (LMNS Validated)	NHS Resolution Maternity Incentive Scheme
Element 1	Smoking in pregnancy	Partially implemented	70%	Partially implemented	60%	CNST Met
Element 2	Fetal growth restriction	Partially implemented	50%	Partially implemented	50%	CNST Met
Element 3	Reduced fetal movements	Partially implemented	50%	Partially implemented	50%	CNST Met
Element 4	Fetal monitoring in labour	Fully implemented	100%	Partially implemented	60%	CNST Met
Element 5	Preterm birth	Partially implemented	52%	Partially implemented	56%	CNST Met
Element 6	Diabetes	Partially implemented	67%	Partially implemented	67%	CNST Met
All Elements	TOTAL	Partially implemented	59%	Partially implemented	56%	CNST Not Met

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

DCH88563

Update
Mother of baby has confirmed MNSI can access her records. Duty of candour letter sent

DCH87453

Update: CIA 15/1/24
CIA - case review presented by Tara Pointer-Putt with the following questions were discussed with the Group:
- IR was not available during the day. O&G were not aware of this. TC confirmed this was a planned 4 week shutdown to replace equipment. Radiology to review what communication was sent out and when to be able to establish where the breakdown came from.
- should have been earlier Consultant to Consultant discussion with UHD and MDT with the O&G Teams. Add to learning & recommendations section.
- could have been escalated to the Service Manger to escalate to the Divisional Manager/Chief Operating Officer to be able to escalate to equivalents in UHD. Add to learning & recommendations section.
- Out of hours SOP needs to be updated with plan for when no IR service available in the day, also to be added to Business Continuity Plan.
- Case review to be fed back to UHD via LMNS safety meeting. Add this as an action.
- To be reviewed and discussed at the next O&G Governance meeting. Add this as an action.
- Check patient has a follow up appointment booked (does not need to be added into the case review but just for noting).
Group confirmed this was a near miss incident, could have been severe had the patient started to bleed. Level of harm to be amended on case review and the incident. DOC not required but patient will have a post birth review where this will be discussed with them

DCH85684
CIA - Case review presented. Group noted detailed report and investigation, known complication of procedure. No changes requested. Moderate harm so DOC to be completed at post birth review meeting in December with consultant. Clinic letter to be attached to incident once taken place to confirm DOC **Update** Post birth clinic cancelled. Not rescheduled currently due to LTS
DCH86461
Update: contact by DoM and regular contact from Safety Lead Midwife. Referral to Plastics to be arranged. DCH Safety Lead Midwife has met with Portsmouth Midwife to discuss their learning from a similar incident. This will inform DCH's response to the incident and subsequent actions
DCH79162
RCA completed and to be presented at LiP
DCH85814
Safety Lead presented case at CIA. Group happy with investigation and outcome, no further questions. Being presented at Reproductive Health Meeting in January. CIA happy to close
DCH79954 - 25/01/2023
Observations not completed on baby as required. Discussed with Neonatal Matron. She is reviewing how ward attenders are documented on SCBU and will be discussing with staff and sending out guidance for SCBU staff with regard to this and using Maternity Badgernet and SBAR function to ensure information is passed on correctly. If training is required she will ensure this is facilitated. Listed for LiP Feb 2024

Risk Register

ID	Title	Risk Statement	Open	Risk	responsibility
1758	Compliance with catheter and cannula use in maternity	Following audit of EPR, it was identified that maternity does not always manage cannulas and catheters safely. there are omissions in the notes around VIP, insertion and removal. Significant ongoing work with the Education Team and Digital Team to raise the importance of this, including 1:1 training, safety reminder for maternity coordinators to check all patients with catheters and cannulas during the shift. Monthly audit via the EPR and an upcoming presentation at the IPC meeting to provide assurance around ongoing work	16/11/23 managed by Tara Pointer-Putt, quarterly	moderate	Care group

1759	delays in elective obstetric work due to industrial action , sickness and AL	this risk has been reviewed in light of daily pressures around consultant availability and the impact on outpatient clinics for high risk pregnant women. Currently one consultant off sick and the impact has been sustained and significant. Many women have clinic appointments cancelled 2-3 times, the medical disorders clinic is being covered by an (extremely able) trainee. Many women being seen through the Day Assessment service which is inappropriate as this service is for triage and is currently managing the introduction of BSOTS. there is no specialist lead for Perinatal Mental Health during this period of sickness so currently, these high risk women are having their care coordinated by a (extremely able) midwife lead for the service. whilst this risk pertains to obstetrics, a very significant amount of gynaecological work is also being cancelled including PMB clinics. Recruitment has been agreed for a ninth consultant but the advert has had a poor response thus far. There is no scope to expand the preterm birth service as required and releasing consultants to attend mandatory training remains very challenging	16/11/23 managed by Jo H. monthly review	high	division
1689	Opening a second theatre in an emergency	All incidents where a second theatre is required are reviewed by the Safety Team and where relevant through M&M or other specialist groups. Particular issues noted currently are the number of times a second theatre is required has increased - whilst still a low number, the increased use of maternity theatre for elective work results in there being less capacity for emergencies. Furthermore the availability of a second theatre team is proving challenging and there has been one occasion where the unavailability of a theatre team (including FSA) has resulted in a delay (but not a poor outcome). A second issue is the lack of a senior midwife to accompany the team to a second theatre out of hours (only one band 7 midwife overnight). This inevitably results in a midwife with considerably less experience coordinating a high risk situation (as the coordinator cannot leave labour ward). MBRRACE recommendation is all maternity services have a second dedicated theatre for elective work and this is being discussed in a preliminary manner. The SoP is being reviewed again by a coordinator following recent incidents	29/06/2023 managed by Jo Hartley DoM, quartely review	moderate	division

1742	additional obstetric consultant capacity required to meet national KPIs	currently providing obstetric and gynae services on a 1:7 rota with 8 consultants. Unable to provide nationally mandated level of care to some high risk groups of women. Also unable to provide a consultant evening (8pm) face to face handover. Funding is available for recruitment from external bodies (LMNS, NHSE) and recruitment request soon to be submitted. Some concerns about sustainability of the funding as not all recurring. The requirement for a ninth consultant is pertinent to aspects of the recent CQC report. Risk graded as high as the lack of an evening handover/ward round happens every day and it is possible care could be compromised. The failure to address the lack of consultant clinic capacity for some high risk women, could have very significant consequences on the woman or her baby's health. Currently recruiting a ninth consultant	013/10/2023, managed by James Male, service Manager, monthly review	high	Division
1578	Triage and the use of BSOTS Birmingham Symptom Specific Obstetric Triage System	BSOTS was commenced in our DAU on Monday 11th November. It has been a challenging transition, but positive improvement is evident. Currently reviewing staffing in DAU to ensure triage can be facilitated. This remains high risk as we have not yet audited the process and further training is required for all midwives to be able to use BSOTS out of hours	08/01/2023 Managed by Jane Hall, Matron Monthly review	high	Corporate
1569	Birthing room out of use in The Cove, reducing the availability of the birthing unit by 50%.	Work has been completed and this risk can be closed		closed	divisional
1497	Emergency buzzers not heard consistently throughout the Maternity unit when activated	the work is scheduled to start within the next month with a comprehensive plan for a temporary call bell system during the work. There have been no further incidents recently in which the emergency bell hasn't been heard	02/09/2022 Managed by Paul Daniell, Estates. quarterly review	moderate	divisional
1456	lack of capacity within the neonatal network, impacting on in-utero transfer	the situation remains the same with occasions where there isn't a level 2 cot or labour ward bed available locally and pregnant women are transferred out of area	14/07/2022 Managed by Jo Hartley, DoM Quarterly review	moderate	Care group

871	Levels of Entonox Exposure on the maternity unit	rooms back in use. The next step is a review of Entonox levels using Cairns Technology devices. This is not a quick process as they have to be used for a minimum amount of time, whilst a woman is using Entonox. several test devices need to be collected from each room	24/12/2019 Managed by Jane Hall, Matron,	High	Corporate
876	Maternity Staffing	workforce business plan almost ready for submission and consideration. recent recruitment for band 6 midwives saw moderate success - however shortlisting will not cover all vacancies if all appointed. The majority of shifts have gaps for midwives and MSWs. Thus far in January, there have been 5 incidents of escalation to OPEL 3 and one to OPEL 4.	21/09/2021 Managed by Jo Hartley, Director of Midwifery, Monthly	high	corporate

Complaints

Total informal and formal

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

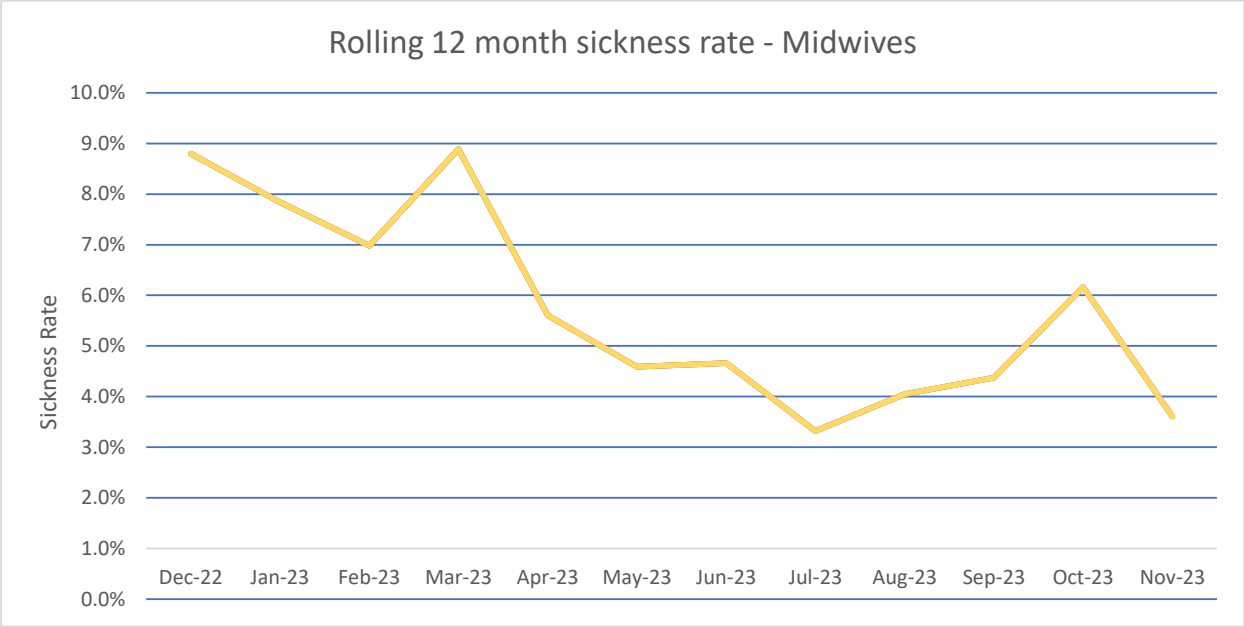
Brief synopsis and learning points	
C24267	Concerns around the management of perineal suturing
. **24266**	Concerns around the management of pain relief during suturing

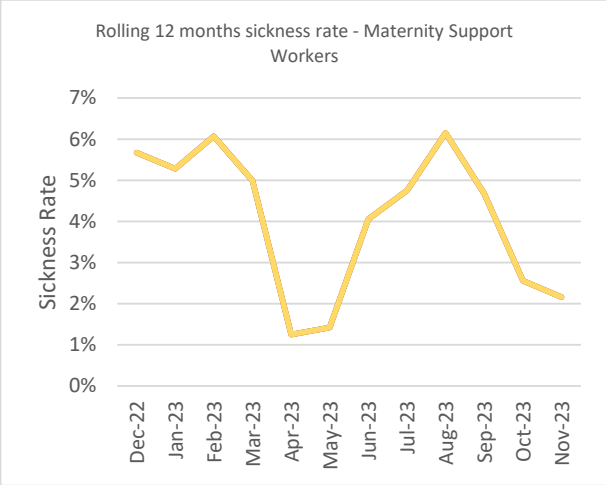
Actions identified in December from complaints	**Description** All staff must be aware they can be overheard in public areas & must ensure their conversations are courteous & professional should anyone overhear them. Changes to baby's care must be made in discussion with parents. Parent's desires and concerns must be central to all care planning. It is essential that parents with a baby in the Neonatal unit are treated with compassion and kindness. Due attention & time must be given to understanding their experiences, the way in which they are caring for their baby, what works and what doesn't. Overall learning is to continue to improve postnatal care and for all of them to remember how difficult it is to recover from a caesarean and care for a newborn on a busy postnatal ward without your partner being able to stay overnight. Discuss possible discharge dates & times with women to agree to plan suitable for the family. Ensure women can always reach their call bell. Where possible, arranging for postnatal women to self-administer their pain relief. Where this is not possible prioritise both formal drug-rounds & regular check-ins with postnatal women.. Continue to do all they can to provide single rooms postnatally whilst also ensuring all women understand there is no guarantee a single room is available Remind midwives women must be able to come off a CTG monitor quickly if they wish to go to the toilet. Remind midwives of the importance of handing over care formally if they are going on a break. **Description** Remind midwives of th eimportance of pain relief during early labour &/or the induction process. This can be met initially by women self-administering simple analgesia but a record must be kept of all medication taken/administered. Explain carefully to women & their partners about the likely delays when induction of labour is planned & where possible, provide regular updates & apologies if there are delays expected

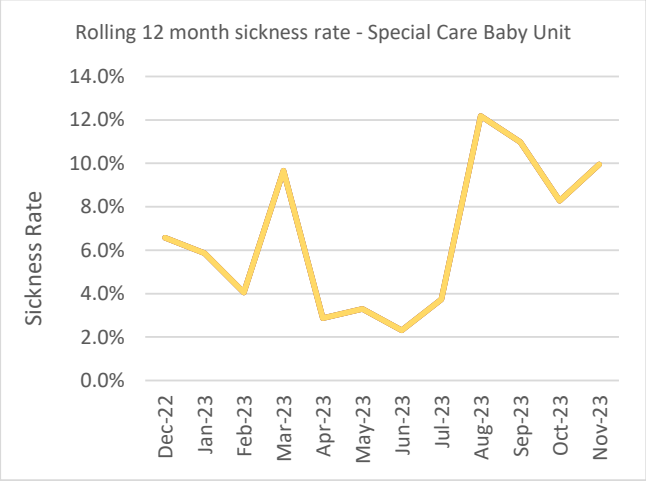
Quadrumvirate meeting

Meeting held 19/12/23. Minutes to follow.
Meeting scheduled 23/01/24

Workforce data





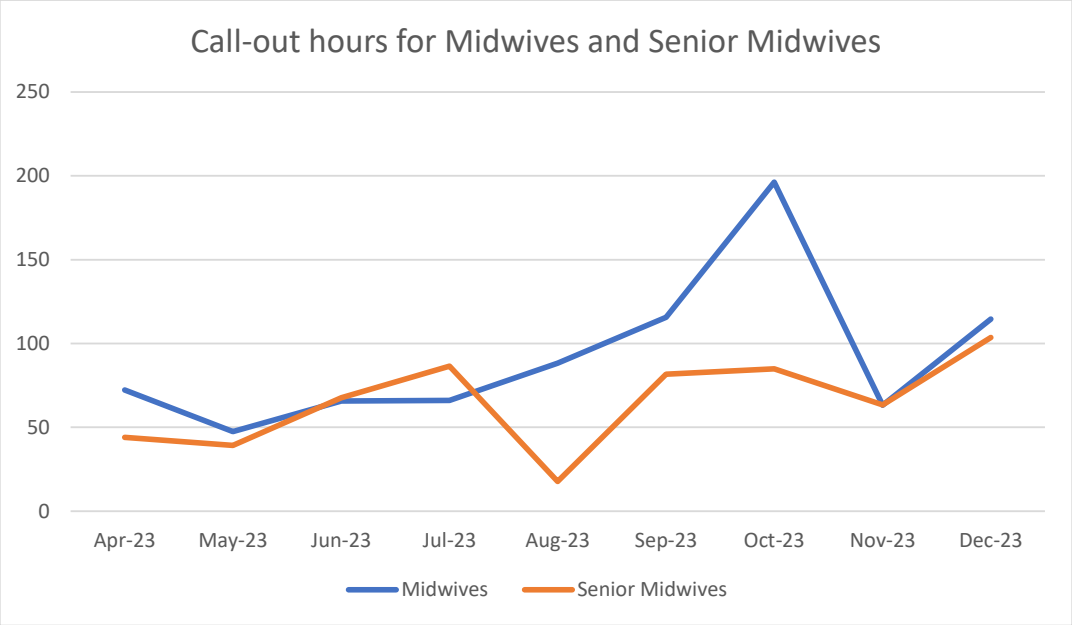


Overall sickness rates from 1st December 2022 – 30th November 2023
Midwives – 6.14%
Maternity Support Workers – 4.28%
Special Care Bay Unit – 8.25%

8 shifts covered by specialist midwives being reallocated to address ward acuity

hours worked by midwives during oncall

Midwife call-out for the unit – **114.5 hours**
Senior Midwives call-out – **103.6 hours**



Bank and Excess hours

	Maternity Unit/ DAU	Midwifery Excess/OT	Community	Band 2 MSW's	SCBU Band 5/6	SCBU Band 2
Bank	250.5 hrs / 37 hrs	425 hrs	250.25 hrs	220 hrs	176.5 hrs	0 hrs
Excess				87 hrs	140.5 hrs	0 hrs
Incentives	8			1	3	0

Shifts not covered by substantive or bank staff

Community	
Chesil	13.15 %
Dorchester	16.66 %
Cranberries	36.84 %
Moonfleet	14.6 % (80 % staffed by bank)
Maternity Unit	
Day Shift	7.74 %
Night Shift	5.8 %
Total	7.09 %
ANDAU	13 shifts not covered

Note: the 'maternity unit' figures are based on 5 midwives per shift (temporary change)

Maternity Support Workers	
Shifts	13.97 %

Band 3 – Antenatal - 22 shifts not covered.

Band 3 – Postnatal - 12 shifts not covered

Neonatal transfer out data for December 2023

One case. Term baby found to have an imperforate anus requiring immediate surgical assessment and treatment at a tertiary unit

Training compliance

Key	
≥80% compliance	
≥80%-89% compliance (BLS only, as per Trust policy)	
<80% compliance	

Training	Role	Compliance (percentage)	Non-compliance (number)	Narrative
Practical Obstetric Emergency Procedure Training (PROMPT)	Obstetric Anaesthetist	65%	13	37 Anaesthetists covering obstetric anaesthetic rota, including occasional on call. MIS action plan: PDM attended OEG in December with maternity anaesthetic safety champion to mandate attendance. 2024 rota allocation underway.
	Consultant Obstetrician	75%	2	1 consultant booked in Q4 as per MIS action plan, 1 pending cover for clinical workload to attend in February 2024.
	Registrars	100%	0	
	ST1/F2	50%	2	2 SHO's booked Q4 as per MIS action plan.
	GP Trainees	100%	0	
	Midwives	93%	9	BAU.
	MSW	91%	3	MIS action plan: non-compliant rostered in Q4.
Basic life support (BLS)	Obstetric Anaesthetist	73%	10	To be mandated by OEG and Governance Lead to liaise regarding MIS action plan.
	Consultant Obstetrician	75%	2	1 booked January. MIS action plan: expected compliance by end Q4.
	Registrars	66.6%	2	MIS action plan: expected compliance by end Q4.
	ST1/F2	100%	0	
	GP trainee	100%	0	
	Midwives	89%	14	MIS action plan: expected compliance by end Q4.
	MSW	89%	4	MIS action plan: expected compliance by end Q4.
	Paediatric Consultants	54.5%	5	3/5 are booked to attend BLs in January and February 2024.
	Paediatric Registrars	100%	0	
	ST1/F2	100%	0	

	GP trainee	100%	0	
	Neonatal nurses	95%	1	Booked for January 2024
	HCAs	83.3%	1	Booked for 15.01.2024. MIS action plan: managed by neonatal training coordinator.
Newborn life support (NLS) Yearly	Midwives	91%	11	BAU.
	Neonatal nurses	37%	12	Action plan in place to capture all staff out of date by 19th January 2024.
NLS 4 Yearly	Senior & Cygnet Midwives	96%	1	1 booked to attend NLS training in February. Has had update with GIC NLS instructor one-to-one. MIS action plan: expected compliance end Q4.
	Neonatal nurses	90%	2	Both booked onto February NLS in Poole One is just out of date but is on long term leave and has been unable to update. First NLS for new member of team – was initially booked for November 2023 but this was cancelled by venue.
	Paediatric Consultants	82%	2	MIS action plan: Both booked for February 2024.
	Paediatric Registrars	100%	0	BAU
Saving Babies Lives study day	Midwives	91%	11	Work with roster midwife in process to maintain compliance.
	Obstetricians	12.5%	6	MIS action plan: Obstetricians invite and attendance to be coordinated by service manager.
SBLv3 Element 1	Intervention 1.8 – CO monitoring Midwives and MSWs giving AN care	90%	14	MIS action plan: Managed by PDM.
	Intervention 1.9 – VBA all staff – m/w's, obstetricians and MSWs	78%	39	MIS action plan: MWs 91% compliance but other staff groups not compliant. Managed by PDM, Work with roster midwives in process to improve compliance >90% for midwives and MSWs. OEG and Governance Lead and PDM working to mandate training for doctors to improve compliance.
K2 CTG & IA	Consultants	100%	0	BAU
	Registrars	87.5%	1	MIS action plan: Managed by Fetal Monitoring Lead Midwife and Service Manager.
	Midwives	92%	9	BAU

Maternity incentive scheme compliance update

Safety Action	Current compliance	Expected compliance – brief overview and comments	Page(s)
1.Perinatal Mortality Review Tool (PMRT)		We have had 1 case within the MIS reporting year. All timescales were met. The case was reviewed at the DCH/UHD joint PMRT review panel in November and care graded as A & A – no care issues identified that affected the outcome. Case remains open until the postmortem and investigations are available then the case will go back to the PMRT joint review panel for agreement to close. Continue to produce quarterly PMRT reporting to board. No risks identified for being fully compliant in this MIS reporting year.	4-6
2. Maternity Services Data Set (MSDS)		Final verification and publication occurred on 26th October – full compliance across all 11 CQUIMS (minimum standard to achieve is 10).	7-9
3. Transitional Care (TC) & Avoiding Term Admissions into Neonatal unit (ATAIN)		Work underway to ensure BadgerNet can correctly record admission to virtual TC. Staff training sessions on recording mechanisms, new guideline, and care pathway as well as escalation tool NEWTT2 ran throughout November. 'TC week' led by TC project lead with twice daily tea trollies to promote discussion and learning opportunities for MDT. Preparations for 'go live' on 4th of December on track. ATAIN deep dive undertaken for Q2, and resultant action plan agreed via clinical governance and quadrumvirate ready for sharing with LMNS and Trust Board. Full compliance met in MIS reporting year.	9-12
4. Clinical workforce planning		Obstetric medical and obstetric anaesthetic workforce(s) has been audited and can demonstrate full compliance with required standards. The calculations and benchmarking for Neonatal medical and neonatal nursing workforce highlight non-compliance against BAPM standards therefore an action plan has been developed and submitted to the board and shared with the LMNS and the ODN in December. Ongoing monitoring of actions will occur in MIS year 6.	13-16
5. Midwifery workforce planning		Remains non-compliant For compliance, evidence required that Trust Board (Quality Committee) evidence midwifery staffing budget reflects funded establishment that is compliant with BirthRate+ and that this is line with Ockenden recommendations, or if not, that an agreed plan is in place that has been shared with the ICB.	17&18
6. Saving Babies' Lives Care Bundle version Three (SBLCBv3)		Recent Q2 review with LMNS lead confirms current compliance at 50% or above in all elements and 56% overall. CNST met but as 70% overall threshold not met then this safety action is non-compliant in year. Next Q3 review scheduled for January 2024. 100% implementation not anticipated before the end of Q4 in line with the NHSE ambition – Action plan to achieve full implementation will be covered by overall MIS action plan submitted with the board declaration to NHSR by the 1st February 2024.	19&20
7. Maternity & Neonatal Voices Partnership (MNVP)		Actions from CQC Picker survey 2022 incorporated into MNVP action plan, triangulated with complaints and feedback. Delayed sharing with LMNS strategic Board due to time constraints therefore non-compliant.	21&22

8. MDT training		TNA and plan agreed by the quadrumvirate and submitted for approval to Quality Committee and OEG. Mandatory training compliance threshold of 90% lowered to 80% by NHSR in recognition of the strike action of Dr's and Consultants. Compliance between 80-90% requires an action plan to be over 90% within a 12-week timeframe. There is also a requirement for obstetric anaesthetists to attend PROMPT annually and as this is currently not mandated locally engagement has been difficult. Practice development midwife, Anaesthetic safety champion and maternity governance lead have joined the OEG and attended Dec meeting to raise this risk and mandate attendance. End Nov position: Non-compliant due to 50% attendance of Obs anaesthetists and 75% attendance of Obs Consultants on PROMPT and 47% neonatal nurses in date with yearly newborn life support ***– Action plan developed to address non-compliance – submitted as a separate document in December***	23-26
9. Perinatal Quality Surveillance Model (PQSM) – Board assurance		To be compliant with this safety action evidence of a revised written pathway in line with the PQSM and PSIRF is required with a subsequent full review by the DoM, LMNS lead and regional chief midwife. The pathway has been written and the review will be undertaken at the LMNS strategic board meeting in February 2024 which is outside the MIS year 5 timeframe. Need to evidence that Board Safety Champion(s) are meeting with the Perinatal 'Quad' leadership team at a minimum of quarterly (a minimum of two in the reporting period). This format took place in Nov'23 and is planned for Jan'24 for Q3 and Q4 respectively.	27-29
10. Healthcare Safety Investigation Branch (HSIB) – ***Now MNSI***		The Trust have reported 100% of qualifying cases to MNSI (formerly HSIB) and NHSR EN Scheme. 2 cases eligible for reporting in this MIS reporting year and all timescales and targets were met.	29-31

Report Front Sheet

1. Report Details			
Meeting Title:	Board of Directors Meeting		
Date of Meeting:	31 Jan 2024		
Document Title:	Board Assurance Framework (BAF)		
Responsible Director:	Nicolas Johnson	Date of Executive Approval	22 Jan 2024
Author:	Philip Davis - Head of Strategy		
Confidentiality:	If Confidential please state rationale:		
Publishable under FOI?	Yes		
Predetermined Report Format?	No		

2. Prior Discussion		
Job Title or Meeting Title	**Date**	**Recommendations/Comments**
Feedback from PCC	22 Jan 24	PCC approved changes to People Objectives and risks, and to changing the risk score for PL1.3 from 20 to 16
Feedback from Chief People Officer	11 Jan 24	Further refinements to mitigations, controls and assurance
Feedback from each SRO owner of discrete risks on BAF	27 Nov 23 to 08 Dec 23	Executive Directors provided any edits to BAF risk scores or how risks are laid out
PCC Committee	23 Oct 23	Changes to People risks presented and approach approved
Board Development Session	28 Jun 23	Actions taken to simplify the People related risks

3. Purpose of the Paper	To give an update to Board on recent changes to the BAF approved through Committees, and in response to the actions taken at the Board Development session 28 Jun 2023.							
	Note	✓	Discuss	(✓)	Recommend	(✓)	Approve	(✓)

4. Key Issues

The People section of the BAF has had the wording of the three objectives simplified, whilst retaining the original scope of each:

People Objective 1
We will build a Culture of Wellbeing and Inclusion

People Objective 2
Recruitment & Retention

People Objective 3
Learning and development and workforce modernisation

The original 7 risks have been rationalised down to just 3 risks, that sit under each of the Strategic Objectives above. Where there was duplication previously, this has been removed, and the wording has been simplified. The remaining 3 People risks are:

PE1.1
We do not develop a compassionate, inclusive and open culture in the Trust within which staff feel involved, empowered, that they belong and that they are at their best

PE1.3
We are unable to recruit and retain sufficient staff to deliver the Trust's strategy and ambitions

PE3.3
We are unable to support the development of a sustainable workforce to meet future needs

	The scoring of risk PE1.3 has been reduced from 20 to 16, reflecting the work that has been ongoing in the people Strategy, Staff Wellbeing initiatives and other programmes of work – which has led to the vacancy rate falling. **The above changes were approved at PCC 22 Jan 23.** **There have been no other changes to risk scoring this month.**
5. Action recommended	The Jan-24 Board of Directors Meeting is recommended to: 1. **NOTE** the Jan-24 changes to BAF described above

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?**		
Strategic Objectives	People	Objective 1. MDTs to support outstanding care and equity of outcomes Objective 2. improving safety through culture of openness, innovation & learning		
	Place	Objective 4. Delivering safe & effective high quality personalised care Objective 7. Create opportunities for people to improve their own health 7 wellbeing, co-designing services		
	Partnership			
Dorset Integrated Care System (ICS) goals		**Which Dorset ICS goals does this report link to / support?** Please summarise how your report contributes to the Dorset ICS key goals. (Please delete as appropriate)		
Improving population health and healthcare		**Yes**		By close monitoring of the Strategic Risks to delivery of high Quality care, the Trust can identify where it needs to make improvements, understand what the drivers are, work better with its system partners to mitigate them.
Tackling unequal outcomes and access		**Yes**		
Enhancing productivity and value for money		**Yes**		The BAF identifies Strategic risks to improving our efficiency and wider value for Dorset
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 **Jan-24**

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	25
4	Major	4	8 PA1.1, PA3.1, PA3.2	12 PE3.3, PA2.2 PL1.10 PL2.2	16 PE1.1, PL1.2, PL1.11, PA2.1, PL1.1 PL1.3, PL1.6, PE1.2	20. PL1.5
3	Moderate	3	6 PL1.4, PA1.3, PA2.3	9 PA1.2, PA4.1, PL2.3	12 PA3.3, PL3.2, PL 3.3, PL4.1, PL4.2, PA1.4	15
2	Minor	2	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 Inclusive Culture of Wellbeing and Inclusion															
PE 1.1	PCC QC FPC	CPO	Deputy CPO	1642	**Risk description:** We do not develop a compassionate, inclusive and open culture in the Trust within which staff feel involved, empowered, that they belong and that they are at their best	4	4	16	• EDI strategy • Wellbeing strategy • Staff engagement and recognition strategy • Staff survey action plan • FTSU campaigns and promotion • Delivery of pan-Dorset cultural interventions through the ICS People Plan	• Evaluation of Annual People Plan delivery • People Dashboard reviewed at PCC • Regular reports at PCC and FPC • Divisional performance reviews • Quarterly people pulse survey • National NHS staff survey • The work of our staff networks • FTSUG reports • Staff listening exercises • Exit interviews	Good	Good	12	January 24 Gaps in Control and required actions are identified and in progress	
									Gaps in Control and Actions: EDI strategic objectives and action plan due to be updated following EDI maturity audit and PCC discussion in January 2024 Staff engagement and recognition strategy in development following all-staff survey in Autumn 2023 Strategic wellbeing approach to be reviewed in line with DHC strategy Staff survey results not due until early 2024 Delivery of pan-Dorset cultural interventions through the ICS People Plan						
People Objective 2 Recruitment & Retention															
PE 1.3	PCC	CPO	CPO	1642	**Risk description:** We are unable to recruit and retain sufficient staff to deliver the Trust's strategy and ambitions	4	4	16	• System People Plan • Trust People Plan • Managing staffing levels in services and unplanned absence processes • Recruitment and retention strategy The overall vacancy rate has reduced for four consecutive months and is at its lowest figure since June 2022 Turnover has reduced for three consecutive months and is at its lowest figure since March 2022. On this basis, we have reduced the risk score for recruitment and retention to 16 (Likelihood: 4, likely; Consequence: 4, Major)	• Evaluation of Annual People Plan delivery • People Dashboard reviewed at PCC • PCC and FPC reports & workplan • Divisional performance reviews • Recruitment Control Panel • System workforce plan and annual delivery plan • Annual NHS Staff Survey results and Quarterly Pulse Survey • Targeted recruitment and retention plans	Good	Good	15	January 24 Gaps in Control and required actions are identified and in progress	
									Gaps in Control and Actions: A strategic approach to workforce modernisation and new ways of working; this is now in development with DHC as part of the Working Together Programme, allowing us to trial new ways of working, new clinical models and workforce arrangements National workforce supply challenges System workforce planning approach & new ways of working						
People Objective 3 Learning and development and workforce modernisation															
PE 3.3	PCC	CPO	Head of Education	1642	**Risk description:** We are unable to support the development of a sustainable workforce to meet future needs	4	3	12	• Workforce planning approach established • BAU Learning and Development service delivery • Apprenticeship placements expansion - Established approach to widening participation • Talent management and career conversations available to all staff	• Mandatory training programme and KPIs • Appraisal KPIs • Monthly performance review • PCC and QC reports • Medical and nursing revalidation • System education workstreams	Good	Good	8	January 24 Gaps in Control and required actions are identified and in progress	
									Gaps in Control and Actions: A strategic approach to workforce modernisation and new ways of working; this is now in development with DHC A review will be undertaken in Q4 2023/24 of the strategic workforce framework in DCH, to ensure we are clear on our approach to key areas of activity, in line with our People Plan						

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 & retention, 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 objective of high-quality care that is safe and effective will not be met.	4	4	16	• Capacity and workforce producitivty planning • Key quality and safety metrics • Risk Strategy • Clinical Audit Programmes • Ward and Quality dashboards • PSIRF and Quality Improvement Strategy • 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 • Quality Improvement to redesign pathways to more efficient or productive with funded capacity • 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	• Sub-board committee FPC, QC & PC • Quality Governance Framework • Quality Reports and Quality Account • 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), Emergency Accountable Officer and suitably 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 Committee 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		
									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**						

Risk Ref:	Committee	Accountable Executive	Risk register ref no.	Risk Owner	Risk Description/Risk Owner:	Consequence Score	Likelihood Score	Risk Score	Existing Mitigation/ Controls	Assurance/ Evidence	Strength of Control	Strength of Assurance	Target Risk	Mitigations - Target Date	# Place Risks: 17
PL 1.5	FPC - performance QC - Harm related concerns	COO	1221 and 450	COO	**Risk description:** If our emergency and urgent care pathways do not meet the increase in unplanned attendances then patients will wait too long for appropriate care in emergency situations and therefore the objective of high-quality care that is safe and effective will not be met. Similarly the above concern would mean we are not contributing to a strong, effective Integrated Care System, focussed on meeting the needs of the population	4	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						
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:						

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

DOMAIN C5: FINANCIAL IMPACT OF RISK OCCURING					
	1	2	3	4	5
Domain	**Negligible**	**Minor**	**Moderate**	**Major**	**Catastrophic**
Finance including claims	Small loss Risk of claim remote	Loss of 0.1–0.25 per cent of budget Claim less than £10,000	Loss of 0.25–0.5 per cent of budget Claim(s) between £10,000 and £100,000	Uncertain delivery of key objective/Loss of 0.5–1.0 per cent of budget Claim(s) between £100,000 and £1 million Purchasers failing to pay on time	Non-delivery of key objective/ Loss of >1 per cent of budget Failure to meet specification/ slippage Loss of contract / payment by results Claim(s) >£1 million
Environmental impact	Minimal or no impact on the environment	Minor impact on environment	Moderate impact on environment	Major impact on environment	Catastrophic impact on environment

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

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

Risks	RAC Dates: Nov-21	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	Scoring matrix changed at this point !! Adoption of DHC methodology 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

Report Front Sheet

1. Report Details			
Meeting Title:	Board of Directors, Part 1		
Date of Meeting:	31 January 2024		
Document Title:	**Equality Diversity and Inclusion Annual Report and Action Plan**		
Responsible Director:	Nicola Plumb Interim Joint Chief People Officer	Date of Executive Approval	EH 12/01/24
Author:	Julie Barber, Head of Organisational Development		
Confidentiality:	No		
Publishable under FOI?	Yes		
Predetermined Report Format?	No		

2. Prior Discussion		
Job Title or Meeting Title	**Date**	**Recommendations/Comments**
People and Culture Committee	22 January 2024	Discussed

3. Purpose of the Paper	To provide an overview of activity undertaken by the Trust in relation to Equality, Diversity and Inclusion (EDI) during 2023.							
	Note (✓)	✓	*Discuss (✓)*	✓	*Recommend (✓)*		*Approve (✓)*	
4. Key Issues	This report provides an overview of activity undertaken by the Trust in relation to Equality, Diversity and Inclusion (EDI) during 2023. Our EDI Strategy which was shared with the Committee in March 2023 outlines three clear objectives. 1. Deliver better health access, experience and outcomes for our diverse communities and patients 2. Develop an Inclusive culture for all staff that promotes representation and health and wellbeing support 3. Demonstrate Inclusive leadership practices and culture across the trust A wealth of work has been undertaken to progress these three objectives as outlined in this report, including the production of a communication pack to aid staff in communicating with SEN patients, scholarship and supported internship programmes as part of our commitment to widening participation and a targeted career conversation project to develop and retain internationally educated nurses (IENs). During 2023 we have also continued to progress our statutory and contractual obligations by reporting against the National and NHS frameworks. Additionally, we have continued to monitor our compliance with the Equality Act 2010 and our Public Sector Equality Duty. Our EDI Action Plan (Appendix A) brings together the Y1 actions necessary to meet our EDI objectives and the actions identified through the national and NHS frameworks. An EDI Maturity Assessment was undertaken by internal auditors in November 2023. An assessment was undertaken in five EDI areas, encouragingly the tone from the top was rated as ‘mature’ and the other areas rated as ‘defined’. Areas requiring improvement were provided and next steps have been identified.							

	Moving forward, in 2024 the focus will be on implementing clearer measures and milestones to ensure the greatest impact and sustainability of all our workstreams. Whilst our three objectives remain the same, there will be an additional focus on Belonging, in the context of improved staff experience and retention. The ongoing collaboration with DHC and the development of a joint strategic approach to Inclusion and Belonging will aid this renewed focus as many of the Y2 actions will be joint actions.
5. Action recommended	To note and discuss the report.

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

Dorset County Hospital
NHS Foundation Trust

People & Culture Committee
Equality, Diversity & Inclusion (EDI) Annual Report 2023

Executive Summary

This report provides an overview of activity undertaken by the Trust in relation to Equality, Diversity and Inclusion (EDI) during 2023. Our EDI Strategy which was shared with the Committee in March 2023 outlines three clear objectives;

1. Deliver better health access, experience and outcomes for our diverse communities and patients
2. Develop an Inclusive culture for all staff that promotes representation and health and wellbeing support
3. Demonstrate Inclusive leadership practices and culture across the trust

A wealth of work has been undertaken to progress these three objectives as outlined in this report, including the production of a communication pack to aid staff in communicating with SEN patients, scholarship and supported internship programmes as part of our commitment to widening participation and a targeted career conversation project to develop and retain internationally educated nurses (IENs).

During 2023 we have also continued to progress our statutory and contractual obligations by reporting against the following National and NHS frameworks:

- Equality Delivery System (EDS2022)
- Gender Pay Gap
- Workplace Race Equality Standard (WRES)
- Workplace Disability Equality Standard (WDES)

Additionally, we have continued to monitor our compliance with the Equality Act 2010 and our Public Sector Equality Duty. Our EDI Action Plan (Appendix A) brings together the Y1 actions necessary to meet our EDI objectives and the actions identified through the national and NHS frameworks.

An EDI Maturity Assessment was undertaken by internal auditors in November 2023. An assessment was undertaken in five EDI areas, encouragingly the tone from the top was rated as ‘mature’ and the other areas rated as ‘defined’. Areas requiring improvement were provided and next steps have been identified.

Moving forward, in 2024 the focus will be on implementing clearer measures and milestones to ensure the greatest impact and sustainability of all our workstreams. Whilst our three objectives remain the same, there will be an additional focus on Belonging, in the context of improved staff experience and retention. The ongoing collaboration with DHC and the development of a joint strategic approach to Inclusion and Belonging will aid this renewed focus as many of the Y2 actions will be joint actions.

1 Introduction

Our EDI Strategy which was shared with the Committee in in March 2023 and outlines three clear objectives;

1. Deliver better health access, experience and outcomes for our diverse communities and patients
2. Develop an Inclusive culture for all staff that promotes representation and health and wellbeing support
3. Demonstrate Inclusive leadership practices and culture across the trust

We are also required to publish equality information annually in line with the Equality Act 2010, to show how we have complied with our Public Sector Equality Duty.

The DCH People Plan (2022-2025) recognises the link between high levels of staff satisfaction, an inclusive culture and improving patient experience, with inclusion being the 'golden thread'.

The EDI work at DCH is overseen by the Interim Joint Chief People Officer, Nicola Plumb. Progress on EDI activity is monitored by the Trust's Equality, Diversity and Inclusion Steering Group (EDISG). DCH is also actively involved in the Dorset ICS EDI Programme Group, chaired by Emma Hallett, Deputy Chief People Officer. The Trust is an active member of the Southwest Inclusion Network, which brings together EDI leads from across the public sector.

1.2 Monitoring of progress

The Trust met all statutory reporting requirements within the past year, including the Workforce Race Equality Standard (WRES), Workforce Disability Equality Standard (WDES), the Equality Delivery System and the Gender Pay reporting requirements. Reports are presented to the People and Culture Committee and the Board.

Our involvement in these activities goes beyond statutory requirements. It increases accountability and drives action to advance equity in the workplace. It allows us to measure our progress to date and provides transparency about what more needs to be done to create a culture of inclusion and belonging at DCH.

The actions from these reports are contained within the EDI action plan (Appendix A). The statistical outcomes can be seen in the reports published on the DCH website:

Equality Delivery System Report and Action Plan 2022

Workforce Race Equality Standard Report and Action Plan 2023

Workforce Disability Equality Standard Report 2023

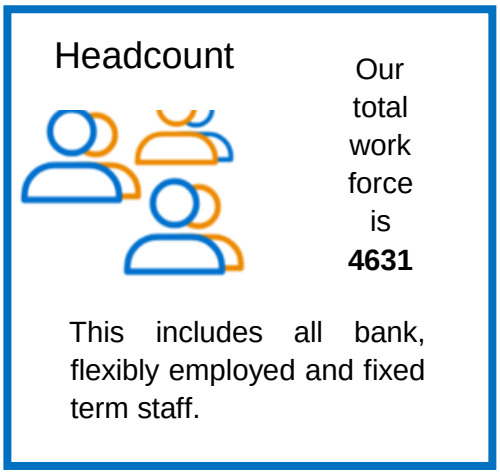
Gender Pay Gap Report March 2022

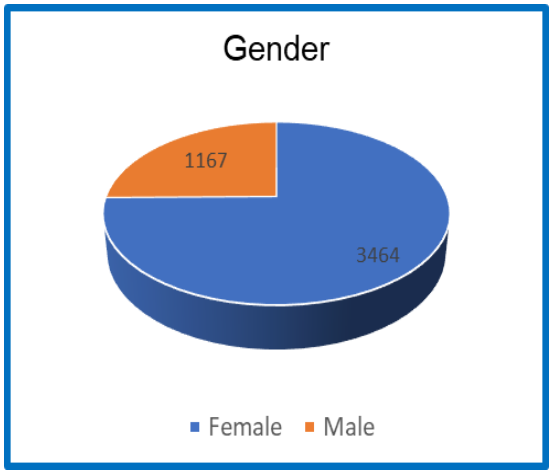
Dorset County Hospital NHS Foundation Trust

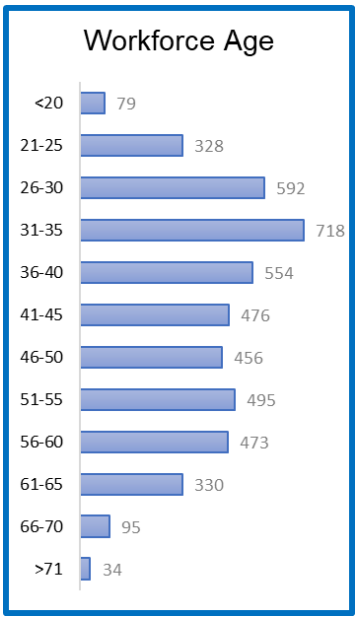
2. Our Workforce

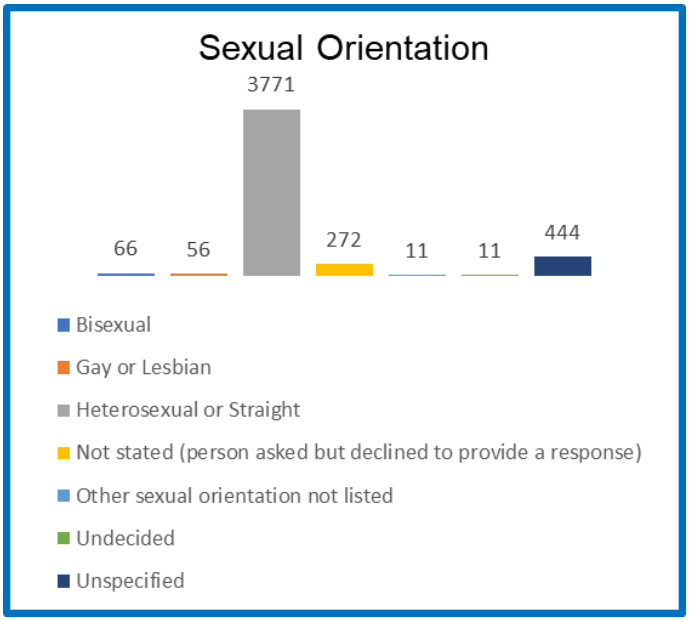
These graphics outline our diversity information as at 30 September 2023. The data was gathered using the Power BI server. The data criteria was set to include all staff (bank, permanent and fixed term), and show the most recent disability categories. A request has been made to the Business Intelligence team to set up a live dashboard for this data, to ensure that future snapshots use the same criteria thus providing ongoing comparable data. This will be useful to monitor progress of the 'Count Me In' campaign to increase staff declaration of disability status on Electronic Staff Record (ESR).

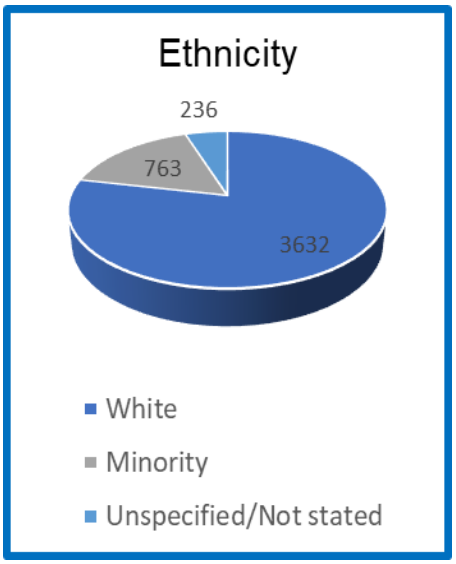
Overall, the demographics of our workforce remain relatively static year on year. There has been an increase in staff from ethnic minority communities, who now account for just under 20% of our workforce, a 4% increase in the last 12 months. Ethnic minority representation is highest in the Medical and Dental and Nursing and Midwifery staff groups, correlating with the areas of targeted international recruitment.

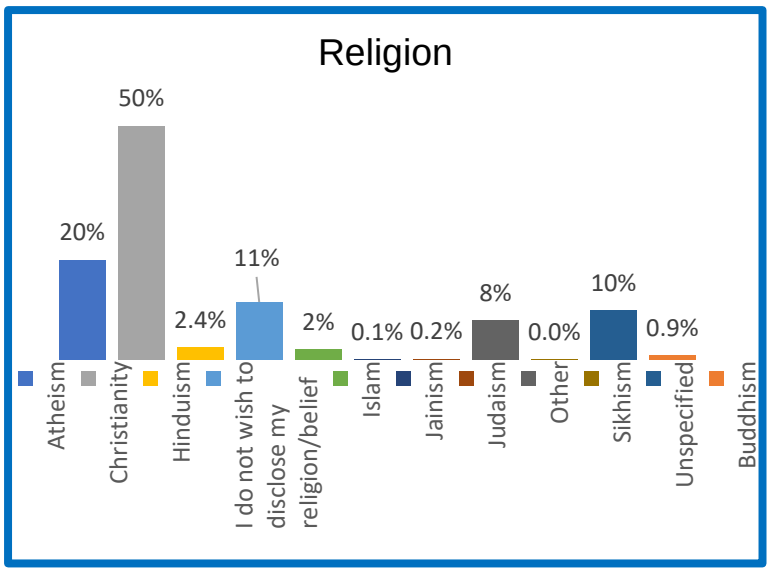


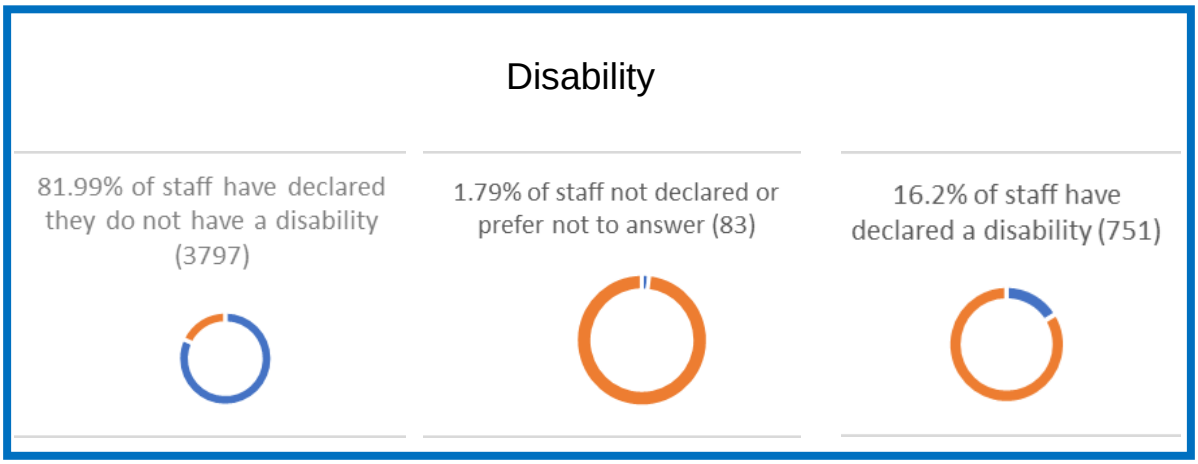


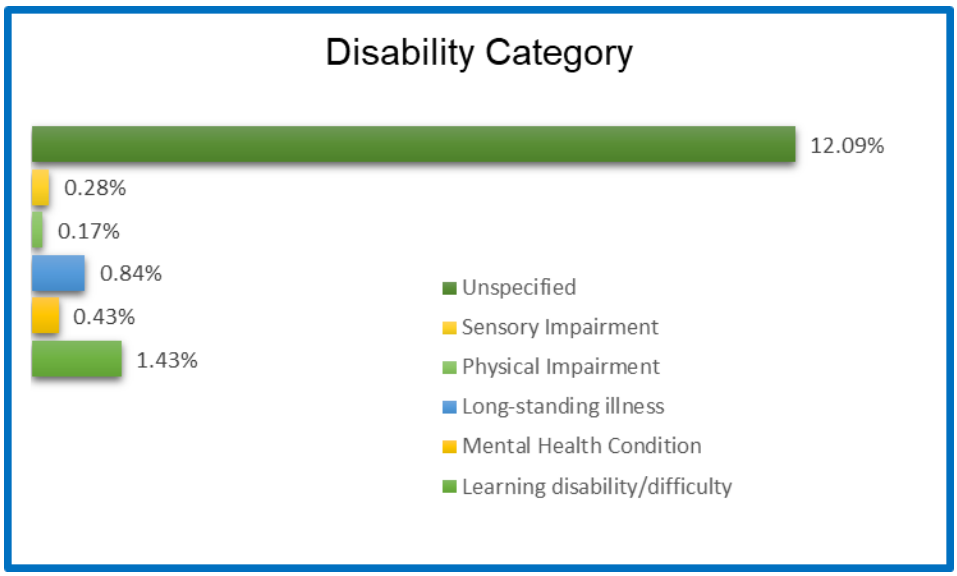





Ethnicity
236
763
3632
White
Minority
Unspecified/Not stated


Religion
20%
50%
2.4%
11%
2%
0.1%
0.2%
8%
0.0%
10%
0.9%
Atheism
Christianity
Hinduism
I do not wish to disclose my religion/belief
Islam
Jainism
Judaism
Other
Sikhism
Unspecified
Buddhism


Disability
81.99% of staff have declared they do not have a disability (3797)
1.79% of staff not declared or prefer not to answer (83)
16.2% of staff have declared a disability (751)


Disability Category
12.09%
0.28%
0.17%
0.84%
0.43%
1.43%
Unspecified
Sensory Impairment
Physical Impairment
Long-standing illness
Mental Health Condition
Learning disability/difficulty

3. Our vision

Our vision, as set out in the EDI Strategy 2023 – 2026, is to create an environment where all our patients irrespective of their characteristics, background or socio-economic status, have equitable treatment and to be looked after with dignity and respect when in our care.

We want all our staff to be able to maximise their potential in a supportive environment, free from bullying, harassment, incivility and discrimination. Our vision is to develop and reward our staff equitably, identify hidden talent and educate our staff to value and celebrate diversity.

4. Our performance against our EDI Strategy objectives

Our EDI strategy outlines three clear objectives from form the basis of the EDI Action Plan and against which our performance can be measured. A summary of progress and success is included below, by objective, while areas of improvement and next steps are covered at the end of this section. Please see the EDI Action Plan (Appendix A) for further detail.

4.1 Delivering better health access, experience and outcomes for our diverse communities and patients.

- The Diagnostic Imaging department implemented an Inclusive Pregnancy Status form to perform imaging tests more safely for transgender patients.
- Work has commenced on ensuring the Top 10 correspondence letters are Accessible Information Standard (AIS) compliant, via the AIS Working Group.
- An updated communication pack to aid staff in communicating with SEN patients was distributed throughout the hospital in November 2023 by the Learning Disability and Autism Acute Health Facilitator, Candi Sidey. This includes picture cards, a copy of a *This is me* hospital passport, information on our advocate programme, a reasonable adjustment risk assessment care plan, tips to help with sensory issues and contacts for the Safeguarding team.
- Access to employment improved via Scholarship and Supported Internship programmes set up by the Widening Participation team in collaboration with Weymouth College.

4.2 Developing an Inclusive culture for all staff that promotes representation and health and wellbeing support.

- Cultural Competence train the trainer training provided by 17Seconds has been completed by four line managers and three trainers. Further rollout of this training is being developed in collaboration with DHC.
- Diversity calendar dates that had associated events and/or displays during 2023 included Overseas Staff Network Day, Pride Month, Windrush 75th anniversary, South Asian Heritage Month, Black History Month, National Inclusion week and World Menopause Day.
- Bias and Interview training and Workforce Planning Essentials training has been included in the Management Matters Programme.

- Inclusive recruitment and retention programmes of work have been included in the Recruitment and Retention strategy launched in April 2023.
- FTSU month in October saw an increase in Speak Up eLearning. A FTSU "post box" was put up in the hospital, making it easier for staff to raise concerns.
- There was an increased uptake in Dignity and Respect training in Q3, increasing the number of staff who have completed this training from 489 in October to 549 by the end of 2023.
- The Uniform Policy was updated, following specific feedback from the Menopause Forum.
- The Sickness Absence Management Policy has been updated, with additional guidance on Reasonable Adjustments, following feedback from line managers and members of the Without Limits staff network.
- EDI Mandatory training compliance is at 89% only 1% away from the Action Plan target. Other EDI training delivered in 2023 included Gender Identity, Disability Awareness and Communication and Assertiveness skills for second language speakers.
- The "Count Me In" campaign ran throughout 2023. A video guide on *How to disclose your disability status on ESR* was then created in response to staff. This was highlighted in the CEO brief in September 2023.

4.3 Demonstrating Inclusive leadership practices and culture across the trust

- An Inclusive Leadership for Middle Management programme is being developed in conjunction with DHC and UHD, overseen by the Dorset ICS EDI Programme Group.
- A second cohort of Reciprocal Mentoring Programme was launched in September 2023.
- 78 managers completed the International Communication for Leaders course.

5. Areas requiring Improvement and Next steps

There are some actions that have yet to be put into action, or that have been implemented, but lack significant progress, as highlighted in the EDI Action Plan. While our vision and objectives remain the same for the coming year, the next step will be to draft the Y2 EDI Action Plan which will include input from the new EDIB Lead, Jan Wagner, in consultation with the EDI Steering Group and amendments as suggested by the EDI Maturity Assessment undertaken by internal auditors BDO LLP**.**

Next steps will also involve further system collaboration. The Inclusion Leads at DCH and DHC started working closely during 2023 on a variety of EDI priorities. Mutual areas of focus for both Trusts have been identified as Inclusive recruitment, Inclusive leadership, EDI Champions, Staff retention and EDI Training and these will be taken forward in collaboration. A joint Board development session is planned in Q4 to develop the thinking of the two organisations and to agree a joint strategic approach to Inclusion and Belonging.

6. Our performance as assessed by the Maturity Assessment

To obtain assurance on our overall approach to EDI a maturity assessment was undertaken by internal auditors BDO LLP in November 2023. The assessment report is included in Appendix B. The assessment assesses and then rates five EDI areas. The tone from the top is rated as 'Mature' and Governance, Compliance and Strategy; Structure; Policies, Procedures, Training and Development; Measurement, Accountability and Continuous Improvement are all rated as 'Defined'. The same maturity assessment was undertaken at Dorset Healthcare in 2022 with a similar outcome. The tone from the top was rated as 'Mature', as was Governance and Policies. All other areas were rated as 'Defined'. Comparing the assessment outcomes will allow us to identify further areas of collaboration.

6.1 Areas of progress and success

The Tone from the top was recognised as a strength due to the clear vision and values of the Trust, the recognition of importance of inclusion in strategy, the role of and engagement from executive leaders in EDI and Health Inequalities workstreams and as sponsors of the staff networks, and the participation of senior leaders in the Inclusive Leadership programme.

It was recognised that the Trust has an EDI Steering Group, which aims to provide leadership and strategic direction to both workforce and patient experience strands of the Trust's inclusion approach. The Steering Group has a broad membership from across the Trust.

It was also recognised that the Trust has a Health Inequalities Group to oversee deliver of the DCH aim for addressing health inequalities. The Group help DCH take every opportunity to ensure equity of access and outcomes for all our communities. The Group provides escalation to the Quality Committee.

In relation to the Staff Networks, it was recognised that they had been allocated increased funding and protected time, alongside additional administrative support from the OD Coordinator. It was noted that membership had also increased.

6.2 Areas requiring improvement and next steps

Even with the additional administrative support, the assessment identified that staff network chairs are at risk of experiencing burnout due to taking on volume of work that should be owned by other teams e.g. identifying and addressing barriers that they may already be disproportionately affected by. A communications and engagement plan will be developed to involve more network members to assist leads and to assign deputies.

Staff network leads felt the EDI Steering Group only required them to give updates on the network activity, rather than giving them a chance to address issues or have collaborative discussion about EDI strategy and monitoring. It was agreed to periodically evaluate the EDI Steering Group effectiveness; asking all members to contribute to the effectiveness review.

For Domain 1 of the EDS 2022, all Dorset Trusts jointly assessed the Maternity services and found it to be "Achieving". The Maturity Assessment findings highlighted that while the Trust may wish to collaborate with system partners, it should evaluate its role and contribution to

the rating, using specific local and Trust level data to inform the rating rationale. The decision to use Maternity for Domain 1 of EDS2022 was due to the timescales given and the availability of existing data via the ICS Maternity Programme. Discussions have begun (via the Dorset ICS EDI Programme Group) in preparation for the next EDS return to identify an alternative service to assess and to clarify the assurance and data required from each provider organisation.

The Maturity Assessment findings identified the Y1 EDI Action plan (covering April 2023 to March 2024) target dates to be too vague and there is inconsistency in how measurable the "measures" are e.g. evidence of increased awareness vs evidence of 90% compliance. The Y2 EDI action plan will drafted to ensure it captures all live actions from all relevant workstreams. Milestones will be updated to reflect progress to date and to ensure that the outstanding milestones are specific, measurable, achievable, and realistic.

7. Other examples of EDI work

In addition to the formal measures in the EDI Action Plan, there is evidence of other actions across the Trust that contribute to the progression of the EDI strategy at DCH. These include the NSEI-funded Accelerated Development project to support Internationally Educated Nurses (IENs). As part of the project, career development conversations have been held with 141 (out of 195) IENs and feedback obtained indicated was that these provided clarity on career pathways and goals. Employability Skills Workshops have also been held for IEN spouses, which has resulted in increased shortlisting and placements.

The Children's Therapy Centre approached the OD team for help with resources to make their reception area more accessible to all youth, following members of their team attending the Gender Identity Awareness workshops. Similarly NHS Charities monies are being used to refurbish the chapel in Q4, which will make it a more inclusive space.

During 2024 we will seek to renew our Disability Confident registration. The Disability Confident scheme aims to help employers make the most of the opportunities provided by employing disabled people. We will also continue to act on the commitments contained within the Armed Forces Covenant. DCH maintained silver award status in 2023.

8. Conclusion

Reviewing the progress and successes over the past year, it is fair to say that DCH has made a good start on many initiatives. In 2024 the focus will be on implementing clearer measures and milestones to ensure the greatest impact and sustainability of all our workstreams. The collaboration with DHC will aid this renewed focus as many of our Y2 actions will be joint actions.

Whilst our three objectives remain the same, there will be an additional focus on Belonging, so that our golden thread is "inclusion and belonging". This supports the work of the DCH People Plan and the NHS Long Term Workforce Plan as a sense of belonging is integral to attracting and retaining staff, and ensuring the health and wellbeing of our staff, which in turn

leads to better patient care. It is also in line with DHC's collaboration with Dorset Healthcare and the development of a joint strategic approach to inclusion and belonging.

9. Recommendations

The Committee is recommended to:

1. NOTE the report

2. APPROVE the Action Plan

Appendix A – EDI Action Plan

Appendix B – EDI Maturity Audit

Appendix A

Equality Diversity and Inclusion Year 1 Action Plan
April 2023 – March 2024

EDI Objective 1: Delivering better health access, experience and outcomes for our diverse communities and patients.

Action(s)	Measure(s)	Lead/Owner (s)	National Driver	Target date	Update(s)
(a) Implement staff knowledge campaign to raise awareness and understanding of health inequalities within the local population	Improved staff knowledge and understanding of health inequalities & potential disparities Evidence of reduced disparity in levels of care received	**DCH Health Inequalities Group**	**Equality Delivery System (EDS) 2022 Domain 1**	**March 2024**	Information on local health inequalities included in Trust Induction.
(b) Review the mechanisms and systems in place to engage with patients from different protected characteristics.	Analysis of patient feedback by protected characteristics undertaken EDI-related trends identified	**Patient Experience Lead**	**EDS 2022 Domain 1 Public Sector Equality Duty (PSED)**	**January 2024**	Sept 2023: call for EDI-related activity from departments yielded one result: The Diagnostic Imagining department implemented an Inclusive Pregnancy Status form to perform imaging tests more safely for transgender patients
(c) Provide communication support for patients, their families and carers with a disability, impairment, or sensory loss as part of implementing the Accessible Information Standard	90% of all public areas across DCH display posters about the AIS. Top 10 letters/correspondence are 'accessible-ready' for diverse patients	**Informatics Team**	**EDS 2022 Domain 1 Workforce Disability Equality Standard (WDES) 2022**	**March 2024**	Work has commenced on ensuring the Top 10 correspondence letters are AIS compliant, via the AIS Working Group (set up in May 2023) November 2023: An updated communication pack to aid staff in communicating with SEN patients was distributed throughout the hospital by the Learning Disability

					and Autism Acute Health Facilitator, Candi Sidey. This includes picture cards, a copy of a This is me hospital passport, information on our advocate programme, a reasonable adjustment risk assessment care plan, tips to help with sensory issues and contacts for the Safeguarding team
(d) EDI to be added as an agenda item at all senior leadership meetings across all our service areas	EDI themes, discussions & actions evidenced in minutes of meetings	**Senior Leadership Group**	**EDS 2022 Domain 3**	**January 2024**	The commitment for EDI to be discussed at senior leadership meetings is being monitored via the EDI Steering Group
(e) Build strong and effective relationships & partnerships with all our stakeholders to address issues of inequality and exclusion, including access to services and employment, across our communities	Evidence of DCH participation in Stakeholder Groups Evidence of agreed DCH action from Stakeholder Groups	**Patient Experience Lead** **Widening Participation Lead** **Health Inequalities Group**	**EDS 2022 Domain 1**	**January 2024**	Access to employment improved by the Supported Internships set up by the Widening Participation team in collaboration with Weymouth College. In 2023 we had 5 placements at DCH. 2 have stayed on as volunteers and will continue to gain invaluable employability skills.

EDI Objective 2: Developing an inclusive culture for all staff which promotes representation and health & wellbeing support.

Action(s)	Measure(s)	Lead/Owner(s)	National Driver	Target date	Update(s)
(a) Roll out of cultural awareness sessions across divisions and other professional services	Cultural awareness session and engagement campaign designed & implemented Evidence of increased cultural awareness in individuals & teams through capture of EDI initiatives/best practice Visible diversity calendar showcases events & milestones	**EDI Lead**	**EDS 2022 Domain 2**	**March 2024**	Nov 2023: Cultural Competence training provided by 17Seconds has been completed by four line managers and three trainers. Further rollout of this training is being developed in collaboration with DHC. Diversity calendar dates that had associated events and/or displays during 2023 included: o Overseas Staff Network Day o Pride Month (Raising of Pride flag; stand at Damers restaurant with info of social events and mental health awareness information; increase in network numbers; LQGTQ+ movie night) o Windrush 75th anniversary (Poster display; free tickets to symposium in Poole) o South Asian Heritage Month (Poster display) o Black History Month (Poster display; external speaker; free tickets to external event) o National Inclusion week (stand at Damers with representatives from Staff Networks) o World Menopause Day (stand at Damers; info leaflets distributed; free Pilates and yoga sessions given)
(b) Implement programme of Talent Development within the organisation with the emphasis on unlocking potential.	Clear narrative on the talent development opportunities within the trust. Increased uptake of mentoring, shadowing	**Leadership & Personal Development Lead** **EDI Lead**	**DCH People Plan** **PSED**	**March 2024**	

	& coaching opportunities amongst staff network members Scoping exercise undertaken with Staff Network Leads & members as baseline for co-creation of tailored development programmes	**Education, Learning & Development Team**			
(c) Ensure our recruitment and selection processes are free from bias so we make the fairest and best selection decisions and positively attract and retain diverse individuals within the workforce	Recruitment & selection training for managers includes bias element Develop Equality and Diversity Representatives (EDR) Programme Workforce Planning session for line managers introduces succession planning approaches & tools Monitor panel member training compliance Increased number of applicants with disclosed disabilities. Reduction of ratio gap from shortlisting to appointment between	**HR and Recruitment team**	**WRES/WDES/ Gender Pay Gap PSED**	**March 2024**	Recruitment progress includes: o Bias and Interview training and Workforce Planning Essentials training has been included in the Management Matters Programme. o Inclusive recruitment and retention programmes of work carried out in 2023 have been written into the Recruitment and Retention strategy (this includes actions from the EDI Action Plan the WRES report)

	Disabled/non-Disabled candidates Extend the accelerated career progression for internationally educated nurses to all ethnically diverse staff. Evidence of disabled staff having positive career conversations				
(d) Implement visible campaign for zero tolerance to all forms of discrimination, bullying, harassment and victimisation, supporting a safe and caring environment for staff	Engagement campaign accessible to all trust staff Posters/videos/podcasts visible & accessible across the trust Increased uptake in staff participating in Dignity & Respect at Work workshops Pilot project to create panel to investigate reported incidents of bullying and harassment	**Inclusion Lead** **HWB Lead** **FTSU Guardian**	**WRES/WDES** **EDS 2022 Domain 2**	**March 2024**	Supporting a safe and caring environment for staff: ○ October 2023: FTSU month in October saw an increase in Speak Up eLearning; a FTSU "post box" has gone up in hospital making it easier for staff to raise concerns. ○ December 2023: There was an increased uptake in Dignity and Respect in Q3, raising the number of staff who have completed this training from 489 in October to 549 by the end of 2023.
(e) Further develop line manager knowledge, skills and confidence in the inclusion agenda by providing developmental	Action Learning model in place for Inclusive Leadership (IL) participants (cohorts 1-8) to develop work-based actions	**Leadership & Personal Development Lead** **EDI Lead**	**EDS 2022 Domain 3**	**January 2024**	Inclusive Leadership for Middle Management programme is being developed in conjunction with DHC (timelines and progress being monitored by the Dorset ICS EDI Programme Group) and second cohort of Reciprocal Mentoring Programme launched

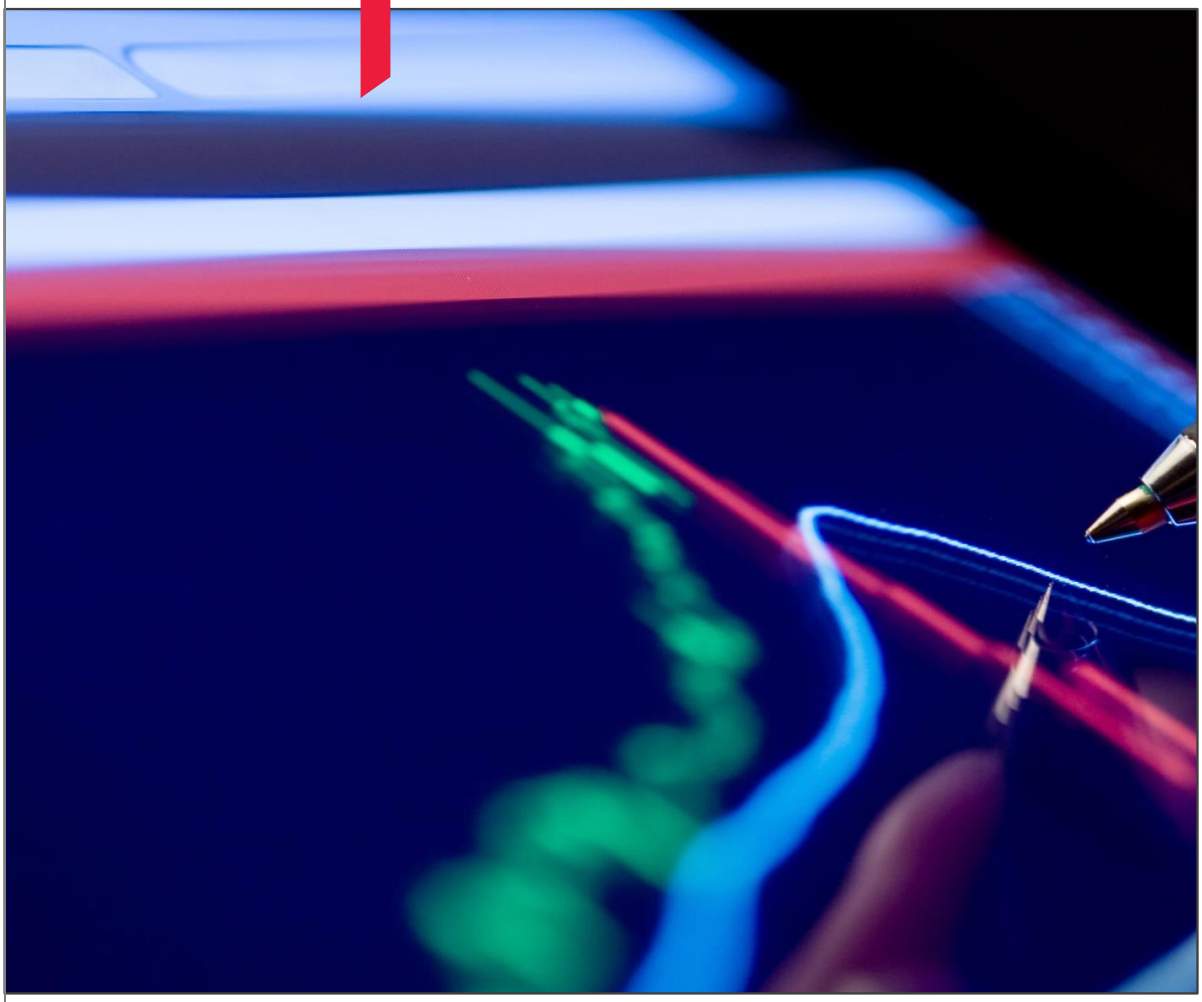
opportunities to support inclusion	IL good practice initiatives shared across the trust Reciprocal Mentoring Programme implemented				
(f) Review policies and processes to support good equalities practice and a Just & Learning Culture	Implement Menopause Forum Develop and launch Women's Career Development Group Evidence of 90% staff compliance with EDI mandatory training Undertake scoping study that pulls together EDI activities across of all divisions and departments that include good practice, initiatives, innovation and gaps.	**HWB Lead** **Inclusion Lead** **All line managers**	**People Plan** **EDS 2022**	**January 2024**	Review Policies and Processes: ○ In 2023 the Uniform Policy was updated, following feedback from the Menopause Forum. ○ The Sickness Absence Management Policy is being updated and will include Guidance on Reasonable Adjustments (following feedback from line managers and members of Without Limits staff network). Training: ○ EDI Mandatory training compliance is at 89% (as at 3/1/2024) only 1% shy of the Action Plan target ○ Number of staff completed other training as at 3/1/2024: Dignity and Respect - 549 Gender Identity Basic Awareness - 96 Gender Identity Mental Health Awareness - 17 Disability Awareness - 21 International Communication for Leaders – 78

					Communication and Assertiveness skills for second language speakers - 64
(g) Continue to report on the WRES and WDES metrics and develop action plans that tackle the main issues of concern	Launch 'Count Me In' campaign to increase in staff declaring their disability status on the Electronic Staff Record (ESR) Evidence of uptake of the Staff Health Passport Evidence of range of reasonable adjustments made including for staff with communication difficulties (this includes, but not limited to, people with cognitive impairment, people with learning disabilities, people that speak English as a second language)	**All line managers Organisational Development HR & Recruitment Estates**	**WRES and WDES People Plan PSED**	**February 2024**	In preparation of launching the "Count Me In" campaign: ○ April 2023: item in the OD Bulletin highlighting the importance of declaring one's disability status ○ a video guide on *How to disclose your disability status on ESR* was created in response to staff member saying they didn't know how to declare their status. This was highlighted in the CEO brief in September 2023. Staff Health Passport developed by Without Limits staff network in collaboration with HR department and signed off by Governance team.

EDI Objective 3: Demonstrating inclusive leadership practices and culture across the trust.

Action(s)	Measure(s)	Lead/ Owner(s)	National Driver	Target date	Update(s)
(a) Each Executive to initiate and sponsor an EDI-related project or actvity around staff retention, improvement in services, civility or health and wellbeing	Executives regularly participate in staff network events. Executives sponsor a range of EDI-related activities	**Trust Board** **Trust Directors** **EMT/SLG** **EDI Lead**	**EDS 2022 Domain 3**	**January 2024**	Meetings held during 2023 with Staff Network Chairs and Executive Sponsors to identify hot topics and additional support needed.
(b) Develop shadow scheme for Trust Board members & governors around increasing visible ethnic diverse representation in the future	Shadow scheme developed & launched Evidence shadow activities collected & communicated	**Trust Board** **Trust Directors** **EMT/SLG** **EDI Lead**	**EDS 2022 Domain 3**	**March 2024**	
(c) Introduce a standing agenda item on EDI at all senior level (including sub-board) meetings	EDI themes, discussions & actions evidenced in minutes of meetings	**Trust Board** **Trust Directors** **EMT** **SLG**	**EDS 2022 Domain 3**	**January 2024**	The commitment for EDI to be included as a standing agenda item at senior leadership meetings is being monitored via the EDI Steering Group.
(d) Monitor the participation in leadership and management development programmes by equality group and set targets for future participation	Equality data gathered & analysed for Inclusive Leadership, Management Matters & tailored programmes e.g., Beyond Difference Targets for future participation set and engagement activities tailored to audience	**EDI Lead** **EMT**	**EDS 2022 Domain 3**	**March 2024**	There has been a steady increase in Internationally Educated staff enrolled in the Management Matters Programme: From November 2022 to October 2023, six IENs completed the Introductory session (an average of 1 per session). In the November 2023 session alone there were three, and another five are enrolled to the first 3 sessions of 2024.

APPENDIX B



DORSET COUNTY HOSPITAL NHS FOUNDATION TRUST

INTERNAL AUDIT REPORT - FINAL

EDI MATURITY
NOVEMBER 2023

IDEAS | PEOPLE | TRUST

BDO

CONTENTS

DISTRIBUTION	
Nicola Plumb	Chief People Officer
Emma Hallett	Deputy Chief People Officer

BDO LLP APPRECIATES THE TIME PROVIDED BY ALL THE INDIVIDUALS INVOLVED IN THIS REVIEW AND WOULD LIKE TO THANK THEM FOR THEIR ASSISTANCE AND COOPERATION.

REPORT STATUS	
Auditors:	Sherv Cheung – Manager Charlie Webb - Internal Auditor
Dates work performed:	August - October 2023
Draft report issued:	2 November 2023
Final report issued:	14 November 2023

EXECUTIVE SUMMARY

SCOPE

BACKGROUND

- The public sector equality duty requires NHS organisations to have due regard to the need to:
  - Eliminate discrimination, harassment and victimisation and any other conduct that is prohibited by or under the Equality Act
  - Advance equality of opportunity between people who share a relevant protected characteristic and people who do not share it
  - Foster good relations between people who share a relevant protected characteristic and those who do not share it.
- Additionally, an organisation's approach to equality, diversity, and inclusion is indicative of its culture, which is intrinsically linked to its development and performance. It is also integral to service planning to ensure that the Trust is able to demonstrate its commitment to integrating equality, diversity, and inclusion into its service delivery.
- The Equality Delivery System (EDS) was first launched for the NHS in 2011, with an updated version, EDS2, published in November 2013. It aimed to help organisations improve services they provide for their local communities and meet the requirements of the Public Sector Equality Duty as part of the Equality Act 2010.
- A further review of EDS was undertaken to incorporate system changes, new system architecture, and the impact of COVID. The refreshed EDS, 'EDS2022' was available for live testing during 2022/23. The revised guidance is split into three domains:
  - Domain 1 – Commissioned or Provided Services
  - Domain 2 - Workforce health and well-being
  - Domain 3 – Inclusive Leadership.
- There is an increased focus on assurance, reporting, and meaningful engagement with key stakeholders and system partners.
- At Dorset County Hospital NHS FT ('DCHFT' or 'the Trust'), an Inclusion Lead has been appointed, who is supporting the development of the EDI framework in place.
- Key activities to date include:
  - Being a Disability Confident Employer
  - Supporting the latest cohort of Staff Support Networks
  - Creating a buddying system for overseas staff
  - Reviewing recruitment and retention frameworks.
- The Trust has also recently completed its EDS2022 return.

PURPOSE

- The purpose of the BDO Equality, Diversity and Inclusion Maturity Assessment is to help ensure an effective approach to Equality, Diversity and Inclusion becomes embedded across the Trust by highlighting areas where the framework could be improved.
- As primarily an advisory piece of work assessing the Trust's current position against the BDO Equality, Diversity, and Inclusion Matrix, this assessment will not generate an assurance opinion.

OUR APPROACH

We considered the maturity of the Trust's current arrangements by assessment against BDO's Cultural Maturity model. The following elements were assessed:

Tone from the Top	• Mission, Vision, Values, and Strategy • The Board and Senior Management • Roles and Responsibilities • EDI Risk Management
Governance, Compliance and Strategy	• EDI Strategy • Operational Planning • Compliance • Pay Gap Analysis • Third parties
Structure	• Committees, Networks and Forums • Resources
Policies, Procedures, Training and Development	• Policies and Procedures • Training and Development
Measurement Accountability and Continuous Improvement	• Measurement • Accountability • Continuous Improvement

The current and target levels of maturity for each area were assessed in accordance with five categories, defined in Appendix I:

Immature	Aware	Defined	Mature	Continuous Improvement

The EDI Maturity Assessment Matrix is at Appendix I and sets out the definitions for each level of maturity. It is the intention that the results of the assessment assist those charged with governance in the further development of an effective and embedded EDI framework.

We have summarised below the current and target maturity levels, based on our work performed and a realistic trajectory of progress for the Trust.

Scope Area	Maturity	Significance of Recommended Actions			Total of Recommended Actions
		Low	Medium	High	
Tone from the Top	Mature*	-	-	-	**0**

Governance, Compliance and Strategy	Defined	-	1	-	**1**
Structure	Defined	-	1	-	**1**
Policies, Procedures, Training and Development	Defined		1	-	**1**
Measurement, Accountability and Continuous Improvement	Defined	-	1	-	**1**

Total of Recommended Actions		**-**	**4**	**-**	**4**

We have not raised any findings against 'Tone from the Top' and have rated 'Mature'. This is due to work in place to strengthen 'Working Together' arrangements across DCH and DHFT, including Board composition that is taking place. Effort and resource would be better placed addressing recommendations under other domains.

AREAS OF STRENGTH

- **Vision and values:** The Trust have outlined a clear vision and has four key values:
  - Integrity
  - Respect
  - Teamwork
  - Excellence.
- **Social Value Pledge:** The Trust has developed a Social Value Pledge to help reduce *'avoidable inequalities and improve health and wellbeing across its community'*. The Pledge outlines the Trust's commitments to helping to improve the overall well-being of our community.
- **Embedding inclusion in the strategy:** As part of the Trust strategy, there are three key themes: People, Place, and Partnership. Sub-actions include:
  - **People:** develop managers to build team effectiveness by supporting racial equality, inclusion and a culture where people express their knowledge, skills, perspectives, needs and potential
  - **Place:** develop a Health Inequalities Programme including our social value pledge to improve outcomes and improve health and wellbeing.
- **BAF Alignment:** BAF risks are aligned to the three key themes. Key inclusion risks include:
  - **People:** If we fail to create a culture and environment where all staff feel valued, heard, and that they belong then attraction, availability and retention will be compromised

  - **Place:** If we fail to utilise population health data in a meaningful way to improve service development then services will not meet the needs of the population in ways that means an improvement in health and wellbeing
  - **Partnership:** 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.
- **Executive Leadership:** There are defined executive leads for EDI and health inequalities, being the Chief People Officer and Executive Medical Director respectively. Staff networks also have executive sponsors, and network leads expressed that they found this relationship to be beneficial and felt that executive sponsors were accessible
- **Board Engagement:** We reviewed Board meeting minutes for November 2022, January 2023, and March 2023. We identified good engagement from Board members on the status of the EDI strategy, including escalation from the People and Culture Committee
- **DCH and Dorset Healthcare University NHS FT (DHC) Working Together Committee:** Part of the terms of reference of the DCH and DHC outlines as part of roles and responsibilities, to ensure that stakeholders, both internal and external, are actively engaged in identifying areas for greater integration and can improve population health, address inequality, improve patient experience and provide excellent value for money
- **Procurement Strategy:** The Trust's procurement strategy aims to drive change through its supply chain and has outlined requirements for all tendering activity, including:
  - The tenderer must have an Equality and Diversity statement/policy or must be able to evidence that it is currently in development and will be completed in the next 12 months. The policy also stats that weighting for social value (including environmental impact, equality impact will increase to a minimum of 10% from 5%)
- **EDI Steering Group:** The Trust has set up an EDI Steering Group, which aims o provide leadership and strategic direction to both workforce and patient experience strands of the Trust's inclusion approach. The Steering Group has a broad membership from across the Trust
- **Health Inequalities Programme:** The Trust has outlined a Health Inequalities Programme. A vision, aim, scope, and high-level desired outcomes have been outlined
- **Health Inequalities Group:** The Trust has set up a Health Inequalities Group to oversee deliver of the DCH aim for addressing health inequalities: to ensure that we take every opportunity at DCH to ensure equity of access and outcomes for all our communities. The Group provides escalation to the Quality Committee
- **Inclusive Leadership Programme:** Since 2021, approximately 170+ senior managers in the Trust have participated in an Inclusive Leadership Programme focused on Seeing Differently, Responding Differently, and Leading Differently (as reported in the EDS2022 submission and to the April 2023 People and Culture Committee meeting)
- **Mandatory EDI training:** The Trust has mandatory EDI training, which is aligned to the core skills training framework, with some additional focus on inclusion. As at the end of October 2023, compliance was at 91%
- **Equality Impact Assessment:** The Trust has an equality impact assessment in place that requires the individual completing to outline any consultation of stakeholders, reference to protected characteristics, and also both potential positive and adverse impacts on staff and/or patients
- **Recruitment and Retention Strategy:** Ambitions in the Recruitment and Retention strategy are linked to the Trust's inclusion goals, for example:
  - We will improve to ensure our processes are promoting diversity and inclusion at this important stage of the employee lifecycle.

WORK IN PROGRESS

We identified several areas where the Trust are taking clear action on areas for improvement:

- **Inclusive Leadership Programme (with DHC):** The Trust is developing an inclusive leadership programme collaboratively with DHC. The programme consists of four sessions and aims to develop inclusion capabilities
- **Our Dorset ICS EDI Programme Group:** The Trust is collaborating with system partners on a shared EDI Programme. The central objective is to align Dorset ICS activities to the Southwest region Leading for Inclusion strategy
- **EDI Resource:** At the time of review, the Trust is recruiting to a vacant Inclusion Lead role. Additional resource is currently being reviewed, as is how EDI will be resourced as part of the 'working together' arrangements with DHC
- **Use of data in addressing health inequalities (workforce and patients):** The Trust aims to further improve the use of data including:
  - Collating anonymous equalities data from occupational health (and other places of referral) (EDS2022)
  - Use the right data, reporting, and insights are collected to inform decision-making and ensure health inequality reduction (HIR) is considered in all activity (Health Inequality Programme).

AREAS FOR CONSIDERATION

We identified the following areas for consideration:

- **Staff networks** – While staff network leads expressed good support from their executive sponsors, it was a shared perception that not all felt networks were as effective as they could be, citing challenges with capacity and resource, and challenges in formalising governance (such as minutes, and action logs). This is a known risk in the Trust, and actions are being implemented to address these. Effectiveness should be appropriately reviewed **(Finding 1 – Medium)**
- **Commissioned/Provided Services (EDS 2022)** – While the Trust has collaborated with system partners to assess against Domain One of EDS, it is difficult to see the Trust's specific role and contribution to the rating (**Finding 2 – Medium)**
- **Success outcomes** – Specific measurable outcomes are not always consistently in place in the Equality, Diversity and Inclusion Strategy, Gender Pay Gap Action Plan, EDS2022 action plan, and Health Inequality Programme **(Finding 3 – Medium)**
- **Policy Review** – While there is a public EDI policy in place, which outlines key roles, responsibilities and signposts to other key policies (including raising of concerns), the policy has not been reviewed and updated since 2019, which is before the current strategy period **(Finding 4 – Medium).**

CONCLUSION

- The Trust has outlined clear ambitions for EDI, which includes activity to address workforce and health inequalities, and working with system partners to achieve these goals (especially DHFT and the ICB). A number of these (especially health inequalities) are in development or already in progress, which reflects the 'Mature' rating for Tone from the Top.
- Challenges that staff networks faced had already been proactively identified by the Trust, and action has started to improve effectiveness.
- We identified two areas of improvement (to how EDS2022 is administered and how the EDI strategy and subsequent EDI action plan) that aim to aid the Trust in better demonstrating the impact of the work being carried out. By

communicating expected outcomes and being able to consistently use data to demonstrate the impact of initiatives will move the Trust closer to a Mature rating in other domains.

DETAILED FINDINGS

Structure	
1	Staff Networks
Significance	Medium

FINDING

Staff networks can be effective organisational mechanisms to improve inclusivity and tackle discrimination in the workplace, and in understanding staff views, driving organisational improvement and change. Typically, staff network remits would include:

- Provide a safe space for discussion of issues
- Help to raise awareness of issues within the organisation
- Provide a support for individuals that may be facing challenges at work
- Be a collective voice for staff they represent to communicate with management.

Protected time

Network leads expressed that while there is a protected time agreement, this does not always work in practice, and some additional work is undertaken in their own time. However, this may be due to the volume of work taken on by some networks that should be owned by other teams.

EDI Steering Group

Network leads expressed that they were not always consistently able to attend steering group meetings and felt that discussions can feel heavily focused on reporting network activity rather than collaborative discussion about EDI strategy and monitoring.

We reviewed the meeting minutes for January, March, June, and September 2023. We would support the views expressed by network leads as meeting minutes demonstrate 'update-heavy' agendas.

There are risks of:

- Staff network Leads experiencing burnout
- The Trust may be asking colleagues from marginalised communities to take on additional work in identifying and addressing barriers that they may already disproportionately affected by
- EDI Steering Group not being effective in involving the staff networks.

The Trust has considered some of these risks, and a staff networks paper was presented to the Executive Meeting held on 1 June 2023, which outlined that recommendations for networks to have increased funding, additional time allocation, and administrative support.

RECOMMENDATION

A) Once additional measures have been put in place to support networks (additional time and administrative resource), effectiveness of these should be evaluated.
B) Periodically, EDI Steering Group effectiveness should be evaluated, and all members should be asked to contribute to the effectiveness review.

MANAGEMENT RESPONSE

The recommendations in the staff network paper (June 2023) have now been put in place, including increased funding, additional time allocation for Chairs, and administrative support for all networks, provided by the OD Coordinator. An effectiveness review of the EDI Steering Group will be scheduled for Q4.

Responsible Officer:	Inclusion Lead
Implementation Date:	Q4

Governance, Compliance, and Strategy	
2	Commissioned/Provided Services (EDS 2022)
Significance	Medium

FINDING

Domain One of the EDS2022 guidance outlines that NHS organisations, with other health and care partners where appropriate, should choose three services that they commission and/or provide for patients for assessment. Service 1 should be a service where data indicates a service is doing well, service 2 where data indicates a service is not doing so well, and service 3 should be where its performance is unknown.

As part of the transition to the new guidance, the Trust undertook the assessment against one service as a trial (Maternity Services) alongside peers and partners in the Dorset ICS.

This approach was taken due to the timing of the guidance being issued.

The system has self-assessed this domain as 'Achieving'. We found:

- The Dorset ICS Maternity Programme Lead is the owner for sub-domains in domain one, and not any members of the DCH leadership team – therefore it is difficult to see the Trust's specific contribution
- Activities undertaken are listed, however, data sources are not outlined, and it is challenging to see the impact/outcomes of the activities undertaken, for example:
  - Patients from all protected characteristic groups are seen and treated equally
  - Women with poor mental health receive a bespoke service from a multi-professional team, including a limited amount of case loading.

There is a risk that insufficient evidence has been provided for the Trust to be assured that its role and contribution to service selected is aligned to the 'Achieving' rating.

RECOMMENDATION

While the Trust may wish to collaborate with system partners, it should evaluate its role and contribution to the rating, using specific local and Trust level data to inform the rating rationale.

MANAGEMENT RESPONSE

The decision to use Maternity for Domain 1 of EDS2022 was due to the timescales given and the availability of existing data via the ICS Maternity Programme. Discussions have begun (via the Dorset ICS EDI Programme Group) in preparation for the next EDS return to identify an alternative service to assess and to clarify the involvement and data required from the provider organisations.

Responsible Officer:	Inclusion Lead
Implementation Date:	Q4

Measurement, Accountability and Continuous Improvement	
3 Success outcomes	
Significance	Medium

FINDING

Clear success outcomes (specific, measurable, achievable, realistic and timely) provide direction, and sets shared expectations of what is achievable in the timescales set.

EDI Strategy and Action Plan

The Trust has a defined EDI strategy in place, which covers the period 2023-2026, and sets out the Trust's vision, aims and objectives to create and inclusive culture. Four key priorities are outlined.

One of the key planned actions in the year is to revise the EDI strategy and action plan to include Trust-wide activities related to both staff and patients, exploring a joint strategic approach with DHC.

An integrated Equality, Diversity, and Inclusion Action plan covering April 2023 to March 2024 is in place, and actions to be completed, measures, responsible owners, target date are outlined.

However, target completion dates are set for 2024, and do not break these down into smaller interim milestones.

Furthermore, there is also inconsistency in how measurable the 'measures' are, for example:

- Evidence of increased cultural awareness in individuals and teams, through capture of EDI initiatives/best practice (not measurable)
- Evidence of 90% staff compliance with EDI mandatory training (measurable).

EDS 2022 Action Plan

For actions in Domains Two and Three in the Trust's EDS 2022 Action Plan, completion dates have been set at 2023/24, and have not yet been broken down into smaller milestones, which may increase difficulty in monitoring these actions.

Gender Pay Gap Actions

The has outlined several actions as part of its Gender Pay Gap action plan, including:

- Support the development of female employees through mentoring and leadership development
- Give focus to our female employees in the lower bands to equip them with the skills and the give them the confidence to apply for our more senior posts.

While there is some high-level mapping in place from the EDI Action Plan to the Gender Pay Gap, there are no specific actions mapped, or measurable outcomes that will demonstrate that Gender Pay Gap actions have made an impact.

Health Inequalities Programme

Desired outcomes have been outlined, however, these are high-level and not yet specific and measurable, for example:

- Health inequality reduction (HIR) is considered as part of our quality improvements
- Prevention and HIR approaches are embedded within our day-to-day business, operational processes, digital process, and clinical pathways.

There is a risk that there is not a shared and consistent understanding of what constitutes a successful outcome, which increases the risk that adequate progress is not made against the Trust's inclusion priorities.

RECOMMENDATION

A) Outcomes in the Equality, Diversity, and Inclusion strategy, EDS 2022 action plan, and Health Inequalities Programme should be reviewed to ensure they are specific, measurable, achievable and realistic. Interim milestones should also be identified.

B) The Trust should review Gender Pay Gap actions and ensure there are measurable targets. Where possible, these should be mapped to actions already being taken as part of the EDI Action plan or EDS2022 action plan.

MANAGEMENT RESPONSE

The Equality, Diversity, and Inclusion Action plan (covering April 2023 to March 2024) will be reviewed to ensure it captures all live actions from all relevant workstreams listed above. Milestones will be updated to reflect progress to date and to ensure that the outstanding milestones are specific, measurable, achievable, and realistic.

Responsible Officer:	Inclusion Lead
Implementation Date:	December 2023

Policies, Procedures, Training and Development	
4 Policy review	
Significance	Medium

FINDING

Clear policies and procedures, that are regularly updated, set the framework for expected behaviours and practices – when consistently applied in a fair manner, these encourage psychological safety as expectations have been clearly communicated.

The Trust has an Equality Policy that outlines the Trust's approach to EDI, key roles and responsibilities, and associated guidance and other policies.

The policy is publicly available, and is dated September 2019, which is before the Trust launched its current EDI strategy and made progress in advancing its inclusion goals. The review date was due in September 2022.

If policies are not regularly reviewed, there is a risk that documented expectations, and actual practices are divergent, leading to inconsistencies.

RECOMMENDATION

The equality policy should be reviewed in line with the Trust's current EDI position, and ratified.

MANAGEMENT RESPONSE

The Equality Policy was withdrawn and removed from the intranet in June 2022 but was not removed from the internet. This has now been rectified - thank you for drawing this to our attention. The removal of the policy was approved by the EDI Steering Group and the rationale was that it was no longer needed due to there being separate equality references in all relevant policies and an overarching EDI Strategy and Action Plan.

Responsible Officer:	NA
Implementation Date:	NA

APPENDIX I - DEFINITIONS

RECOMMENDATION SIGNIFICANCE	
High	A weakness where there is substantial risk of loss, fraud, impropriety, poor value for money, or failure to achieve organisational objectives. Such risk could lead to an adverse impact on the business. Remedial action must be taken urgently.
Medium	A weakness in control which, although not fundamental, relates to shortcomings which expose individual business systems to a less immediate level of threatening risk or poor value for money. Such a risk could impact on operational objectives and should be of concern to senior management and requires prompt specific action.
Low	Areas that individually have no significant impact, but where management would benefit from improved controls and/or have the opportunity to achieve greater effectiveness and/or efficiency.

APPENDIX II – MATURITY TOOLKIT DEFINITIONS

	Tone from the Top	Governance, Compliance, and Strategy	Structure	Policies, procedures, training and development	Measurement, accountability, and continuous improvement
Continuous Improvement	There is a formal process in place to ensure EDI is embedded into the organisation's strategy, values and key objectives. There is an identified lead for EDI at Board and/or Executive level. Lessons learned are documented. The Board and/or senior management have considered whether there is a need for a Board Diversity Action Plan.	There is a formal organisational strategy that strives for good practice beyond minimum legislative or regulatory standards for EDI that takes into account not just employees but how EDI is incorporated into operations. EDI issues are considered in evidence-based strategic and operational decision-making.	The organisation's representative forums and networks have clear support from senior management. Representative forums have appropriate terms of reference and are proactively consulted to ensure EDI objectives are met.	The organisation's EDI policies and procedures differentiate between and appropriately address genuine mistakes (systems are undeveloped), risky behaviours (where systems need to be improved and more training is required) and reckless behaviours (where systems and processes are set up to encourage compliance but there is deliberate override) while acknowledging the potential for harm regardless of intent. Training is frequently reviewed to incorporate best practice and is role-specific to the organisation's needs. The organisation's policies and procedures are designed to ensure that there are no negative and unjust consequences for those that have raised issues, concerns and highlighted areas of non-compliance to policies and/or legislation.	High quality, accurate and timely information is available to operational and executive management. The organisational performance management framework and reward structure drives improvements in EDI. EDI is a defined management competency. Management assurance is provided on the effectiveness of EDI initiatives on a regular basis.
Mature	There is a clear and formal Board and senior management commitment	There is a formal organisational strategy in place for EDI that takes into account not just	Relevant representative forums are in place with appropriate terms of reference	A framework of EDI policies and procedures relevant to the organisation are in place and	Key performance indicators and success criteria are clearly defined with regard to the EDI

	to EDI, and EDI is considered in Board level processes such as recruitment.	employees but how EDI is incorporated into operations. There is a formal process in place to facilitate consideration of EDI issues in evidence-based operational decision-making, for example, in service planning and new projects. The organisation has a formal process to ensure that regulatory reporting standards are met.	that allow for escalation of issues. Accessibility to forums is considered with areas for improvement identified. Resourcing is regularly reviewed in context of EDI objectives to ensure that there is not an inappropriate amount of additional work is placed on representative forum chairs or leads that is unremunerated.	subject to regular review. There are formal processes in place to ensure that they take into account legislative and regulatory standards. Training is given that supports the organisation's EDI objectives and clearly communicates expected behaviours. Compliance to training is monitored. Policies and procedures clearly distinguish between acceptable and unacceptable behaviours and are aligned to the organisation's EDI objectives. There are sufficient procedures in place to identify and address undesirable behaviour.	strategy, aimed to encourage desired behaviours. Management assurance is provided on the effectiveness of EDI initiatives on an ad hoc basis. Values and EDI are linked to objectives.
Defined	EDI is addressed at senior management and Board level, however there may not be a formal approach. Senior management and the Board have begun identifying actions to proactively address EDI across the organisation.	The organisation has begun to formulate an EDI strategy that is largely focused on EDI in the context of staff and employees. There is some consideration of EDI in decision-making, however, this may not yet be consistently applied across all areas of the organisation.	Relevant representative forums and networks have been identified with some operating effectively. Resourcing is formally considered, however, there may be a significant reliance on unpaid additional work for EDI initiatives.	The organisation has begun to outline a framework of policies and procedures relevant to its EDI objectives and obligations, though not all may be implemented. Some managers are trained in EDI and this is limited to minimum EDI legislative requirements in the workplace. Some procedures are in place to identify and address undesirable behaviour.	Data is collected and turned into meaningful information. Reporting requirements aligned to the organisation's objectives may be defined, however are not yet fully implemented.
Aware	Risks surrounding EDI are escalated to Board level. EDI is implicitly linked to organisational values.	The organisation has a range of EDI programmes and initiatives in place, however, these may not be fully aligned to	Some representative forums and networks have been set up. However, there may be a scattered or grassroots	Some EDI policies are in place that are relevant to the organisation's minimum legislative requirements. Objectives of	Some measurement of data is collected, with limited management information and analysis produced.

		overarching defined EDI objectives. A documented EDI strategy is not formally in place and there is limited consideration of EDI in decision making.	approach. These may not be aligned with organisational objectives or governance Resourcing is not formally considered.	policies and procedures are identified. Gaps have been identified where the organisation could improve. Training gaps have been identified. Policies and procedures may not be effectively communicated or sufficiently accessible across the organisation.	However, this is largely aligned to meeting minimum legislative standards rather than defined organisational objectives for EDI.
Immature	Risks with regard to EDI are not considered by senior management and escalated to the Board.	There is a scattered approach to EDI programmes and initiatives.	There are no formal or informal provisions that the organisation is aware of. Resourcing is not considered.	Appropriate policies are not in place and there is not a defined process to ensure that they are up-to-date and meet minimum legislative standards.	Key performance indicators are not identified and measurement of data does not consistently take place.

FOR MORE INFORMATION:

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NHS
Dorset County Hospital
NHS Foundation Trust

Escalation Report

Committee: Quality Committee

Date of Meeting: 19th December 2023

Presented by: Eiri Jones

Significant risks / issues for escalation to Board for action	• Risk to Maternity Incentive Scheme (MIS) year 5 as previously noted

Key issues / matters discussed at the Committee	The committee received, discussed and noted the following reports:
	• Quality Report noting:
	  ○ Impending improvements in corporate oversight of external visits.
	  ○ Concerns regarding transport of renal patients.
	  ○ Improving robustness of quality structures and quality improvement.
	  ○ Reduction in falls, positive position re infection prevention and control
	  ○ Positive overseas recruitment but noting the challenges that brings in terms of culture and helping people settle.
	• Maternity Safety Report noting:
	  ○ Positive examples of multiprofessional working identified
	  ○ Neonatal staffing needs investment; this is being processed through business case and annual planning.
	  ○ Risk to the MIS year 5 as previously noted
	  ○ Progress against the CQC action plan
	• Walkarounds Output Report with themes starting to be developed
	• Quality Risk Report and the Board Assurance Framework, noting that these are closely linked and linked with other sub-committees
	• Escalation Reports from the following subgroups, generating assurance questions from committee members
	  ○ Patient Safety Committee
	  ○ Clinical Effectiveness Committee
	  ○ Infection Prevention and Control Committee
	  ○ Health Inequalities Group
	• Positive feedback from governors, with thanks for their role in the committee.

Decisions made by the Committee	• Nil
Implications for the Corporate Risk Register or the Board Assurance Framework (BAF)	• Nil new noted.
Items / issues for referral to other Committees	• People and Culture Committee to be updated on the progress of a just and restorative culture plan, as the Trust moved towards implementing PSIRF.

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NHS
Dorset County Hospital
NHS Foundation Trust

Escalation Report

Committee: Quality Committee

Date of Meeting: 23rd January 2024

Presented by: Eiri Jones

Significant risks / issues for escalation to Board for action	• As previously raised the Trust would not be declaring compliance with the Maternity Incentive Scheme

Key issues / matters discussed at the Committee	The committee received, discussed and noted the following reports:
	• Quality Report noting:
	  ○ Work regarding grade 2 and 3 pressure ulcers continues; Tissue Viability Nurse due to start in February
	  ○ One never-event reported in December 2023, relating to a retained product in September 2022.
	  ○ PSIRF continues to be rolled out; the Trust is working with an early-adopter trust to gain insight in to their experience.
	  ○ Further assurance required regarding the timeliness of Electronic Discharge Summaries
	• Ophthalmology Deep Dive Update noting a staffing matter within optometry under review.
	• Maternity Safety Report noting
	  ○ A presentation of the services SPC charts
	  ○ That the Trust would not be declaring compliance with the Maternity Incentive Scheme
	  ○ Continued difficulties in mandatory training for doctors, primarily relating to lack of capacity
	• Quality Dashboard Presentation, highlighting the new datasets to be reported by exception.
	• Escalation Reports from the following subgroups, generating assurance questions from committee members
	  ○ Medicines Committee
	  ○ End of Life Committee
	  ○ Mental Health & Learning Disabilities Steering Group
	• ICB Quality Committee minutes

Decisions made by the Committee	• The Committee recommended the Trust position and submission of the Maternity Incentive Scheme to the Board for approval.
Implications for the Corporate Risk Register or the Board Assurance Framework (BAF)	• Nil new noted.
Items / issues for referral to other Committees	• Nil

INTEGRITY | RESPECT | TEAMWORK | EXCELLENCE

NHS
Dorset County Hospital
NHS Foundation Trust

Escalation Report

Executive / Committee: Finance and Performance Committee

Date of Meeting: Monday 18th December 2023

Presented by: Stuart Parsons

Significant risks / issues for escalation to Committee / Board for action	• The New Hospitals Programme Update. • The commissioning of the new ward and South Walks House has been delayed until the new year. • Concerns about the deliverability of the revised operating plan targets, cost improvement trajectories and agency expenditure reduction targets given the sustained operational pressures and ongoing industrial action.

Key issues / matters discussed at the Committee	The meeting considered the following:
	• The Family and Surgical Services and Urgent and Emergency Care Divisional Reports were stood down due to operational pressures and key aspects were contained within the Performance Report.
	• Performance Report noting:
	  ○ The impact of winter pressures (including increased trauma cases) combined with continued high numbers of patients with No Reason to Reside and industrial action planning have impacted expected elective recovery plans.
	  ○ Arrangements for the nurse led Discharge Lounge were being developed further.
	  ○ A care provider located within the Emergency Department was supporting patient assessment and brokerage on ongoing care on behalf of the local authority.
	  ○ The use of Acute Hospital at Home service to support patient flow was being optimised.
	  ○ Theatre productivity improvements relating to late starts and early finishes.
	  ○ DM01 was improving with targeted review in the urodynamic service.
	  ○ Reporting against the new trajectories would commence from December 2023.
	  ○ Further system-wide review of the patient pathway was required to support development of realistic planning assumptions for the coming financial year.
	• Finance Report noting:
	  ○ An update on the system financial position and continued discussions with regional and national colleagues.
	  ○ Continued challenging run rates.
	  ○ Additional funding to support the impact of continued industrial action.
	  ○ The risks to elective recovery funding presented by periods of further industrial action.
	  ○ Additional stretch targets relating to agency expenditure reductions.
	  ○ Delivery of £3m cost improvement schemes to date.
	  ○ No significant capital spending concerns.

	○ Slight improvement to the cash position with further exploration of mitigating actions with system partners. • The committee was assured by the RAAC report presented and planned further actions. • Patient Pathway Improvement Programme noting delays in the commissioning to the new ward and South Walks House. • New Hospitals Programme Update noting plans to return costs of the scheme to nearer the Guaranteed Maximum Price and descoping of some aspects of the scheme. Negotiations with the nation NHP Team were ongoing. • Fortuneswell Pharmacy Development Cost Update noting the intention to tender the work in order to test the market and reduce costs. • Dorset Council Reablement Facility Update although greater clarity on the costs was sought and the position regarding the ITFF Loan. • The following Escalation reports were received: ○ CPSUG ○ Sustainability Working Group ○ Digital Transformation and Assurance Group ○ Information Governance Group ○ Emergency Planning and Resilience Group
Decisions made by the Committee	• The committee approved the decision to tender the development work for the Fortuneswell Pharmacy. A further decision would be required to approve commencement of the work following closure of the tender process.
Implications for the Corporate Risk Register or the Board Assurance Framework (BAF)	• Board Assurance Framework Quarterly Update
Items / issues for referral to other Committees	• None

INTEGRITY | RESPECT | TEAMWORK | EXCELLENCE

NHS
Dorset County Hospital
NHS Foundation Trust

Escalation Report

Executive / Committee: Finance and Performance Committee

Date of Meeting: Monday 22nd January 2024

Presented by: Stephen Tilton

Significant risks / issues for escalation to Committee / Board for action	• Patient transport - risk of renal patients stopping treatment to be raised through Quality committee

Key issues / matters discussed at the Committee	The meeting considered the following:
	• Inpatient Audit Outcome:
	  ○ The recommendations were discussed as a committee, highlighting the importance of needing to work as a system to reduce unfunded beds. This will drive the plan for 2425.
	  ○ The report highlighted the need for more work with the end-of-life process within the system and work is underway, looking at the pathway and commissioning of the service.
	  ○ The data will be used in discussion with the ICB and wider system partners.
	  ○ MADE events with the system generated a 12 point action list which is being worked through by all providers.
	• Performance Report noting:
	  ○ Positive feedback from both UEC board and Elective board on the progress DCH has made especially with ED performance and handover performance.
	  ○ DCH have been placed into tier 2 for enhanced support for 65 week trajectory end of year declared outturn.
	  ○ Demand and capacity work is underway to review waiting lists and potential reasons of increase demand. Considering if there is any post code drift. Data will be presented to ICB to enable conversation to look at pathway re-design as a system.
	• Finance Report noting:
	  ○ Month 9 position showed a £0.6m deficit with an overall YTD of £8.9m adverse to plan.
	  ○ System submitted a revised position of £12m deficit as part of the H2 process. With the risk sitting in the ICB with providers breaking even.
	  ○ As part of H2 planning there was an assumption that there would be no more industrial action and therefore all costs associate with the December and January industrial action have been collated and Dorset County hospital have a forecast £630k deficit.
	  ○ Key interventions to ensure a breakeven position are System Recovery Group, System Investment Group and vacancy control panels.
	• Update on Business Planning 2024/25

	○ It was noted that there is a delay in guidance however planning on previous years assumption. Aware that there will be a tight financial envelope and review of productivity. • Cyber Security Quarterly Update ○ Report received and noted to bring a table with more detail of the risk management to next quarter. • No escalation reports were received this month • ICB Finance Committee Minutes
Decisions made by the Committee	• The committee approved the Ambulance Handover Escalation Protocol • The committee recommended for Board approval: ○ The New Hospital Programme Business Case and associated Capital Business Planning ○ Contracts: ▪ System C Vital Pac Contract Renewal ▪ Crown Commercial Service – NHS England Energy
Implications for the Corporate Risk Register or the Board Assurance Framework (BAF)	• Nil new.
Items / issues for referral to other Committees	• Patient Transport to quality committee

INTEGRITY | RESPECT | TEAMWORK | EXCELLENCE

NHS
Dorset County Hospital
NHS Foundation Trust

Escalation Report

Executive / Committee: People and Culture Committee

Date of Meeting: Monday 22nd January 2024

Presented by: Margaret Blankson (Chair)

Significant risks / issues for escalation to Board for action	• Improvements in the reduction of agency spend, but some way to go to meet the 3% target • Equality, Diversity and Inclusion Annual Report and Action Plan • Updates to the 'people' elements of the Board Assurance Framework
Key issues / other matters discussed by the Committee	The committee considered the following items: • People and Performance Report and Dashboard noting a broadly positive picture with increase in appraisal compliance, reduction in agency spend, and reduction in vacancy and turnover rates. • Estates and Facilities Divisional Report • Board Assurance Framework and Workforce Risk Report • Education, Training, Development Quarterly Report • Leavers and Retention Biannual Report • Just and Learning Culture Biannual Update • Talent Management and Appraisal Biannual Report • Equality, Diversity and Inclusion Annual Report and Action Plan • There were no subgroup Escalation Reports. • ICB People and Culture Committee Minutes.
Decisions made by the Committee	• Nil
Implications for the Corporate Risk Register or the Board Assurance Framework (BAF)	• Nil new
Items / issues for referral to other Committees	• None

INTEGRITY | RESPECT | TEAMWORK | EXCELLENCE

NHS
Dorset County Hospital
NHS Foundation Trust

Escalation Report

Committee: Risk and Audit Committee

Date of Meeting: 19th December 2023

Presented by: Stuart Parsons

Significant risks / issues for escalation to Board for action	• The coding risk, increased number of vacancies and forecast increases in future workload.

Key issues / other matters discussed by the Committee	The committee considered the following items:
	• Risk Summit arrangements are to be finalised.
	• The Annual Report timeframes are yet to be confirmed nationally.
	• Security Incidents Deep Dive and reducing Violence and Aggression Action Plan noted.
	• Internal Audit Progress Report noting:
	  ○ The Cyber Security Audit had indicated moderate assurance for process design and moderate assurance for effectiveness.
	  ○ The Equality, Diversity and Inclusion advisory report
	  ○ The Maternity Incentive Scheme audit noting the increased complexity and detailed requirements and areas of non-compliance with scheme requirements.
	  ○ Actions arsing from the previously reported Safeguarding Audit had revised timescales for completion.
	  ○ Actions arising from the previously reported subcontracting governance audit had revised timescales for completion.
	• Anticrime Update
	• External Audit noting planning for the forthcoming annual audit process.
	• The Health and Safey Group Escalation Report.
	• There were again no governor observers at the meeting.

Decisions made by the Committee	• The Board Assurance Framework and Corporate Risk register were approved. • Key risk management performance indicators were approved. • Minor amendments to audit timings within the internal audit plan were approved. • Draft Equity, Equality Impact Assessment was noted.
Implications for the Corporate Risk Register or the Board Assurance Framework (BAF)	• The Board Assurance Framework was discussed noting the clinical coding risk remained high, a new vacancy within the coding team and predicted increases in admissions and coding workload subsequently. • Corporate Risk Register noting the recent thorough review and reframing of risks. • The Risk Maturity Matrix Action Plan and the significant work undertaken to review risk management arrangements, policy and training for staff were noted.

Items / issues for referral to other Committees	• All committees to ensure regular monitoring of risk mitigations and controls.

INTEGRITY | RESPECT | TEAMWORK | EXCELLENCE

NHS
Dorset County Hospital
NHS Foundation Trust

Escalation Report

Executive / Committee: Charitable Funds Committee

Date of Meeting: 23 January 2024

Presented by: Dave Underwood

Significant risks / issues for escalation to Committee / Board for action	•
Key issues / matters discussed at the Committee	**DCHC Charitable Funds Committee (23.1.24)** • **DCH Charity Finance/Income 23/24** reports (M9 Dec 2023) received. Total income to date as of end Dec £398,954. Unrestricted funds were £339,204, providing a surplus of £119,204 against the reserves target of £220K. Major notified legacy income now expected Q1 2024/25. • **DCH Charity Business Plan 24/25 (final draft)** – Key elements include the proposed fundraising team structure, annual budget and income targets for 24/25. Reviewed by CFC (non-quorate) 23.1.24. Business Plan to be circulated ex-committee to committee members for decision. If committee support the final version, they will recommend for submission to Trust Board (Corporate Trustee) in March 2024 for final approval. • **Capital Appeal (ED/CrCU)** report received. £383K income/pledges to date as of Jan 2024. Major grant £100K application to Garfield Weston Foundation declined - opportunity to re-apply Dec 2024. Promotion underway for DCH100 Jurassic Coast Challenge (May 2024) targeted to raise £100K. Corporate engagement ongoing. Grants funding and donor engagement programme ongoing.
Decisions made by the Committee	•
Implications for the Corporate Risk Register or the Board Assurance Framework (BAF)	• Nil
Items / issues for referral to other Committees	• Nil

Working Together

Dorset County Hospital NHS Foundation Trust

Dorset HealthCare University NHS Foundation Trust

Escalation Report

Executive / Committee: Working Together Committee

Date of Meeting: Thursday 14th December 2023

Presented by: David Clayton-Smith (Joint Chair)

Significant risks / issues for escalation to Committee / Board for action	• The Model Options Appraisal is presented to both Boards of DCH and DHC for further discussion and agreement of the recommendation to move to a federated model of operation. • The Governance Review option 3 to operate a combination of joint committees and trust only committees was endorsed in principle, noting the need for a phased approach to implementation in order that further work and discussion could be had by each Board. The paper is presented to both Boards of DCH and DHC for further discussion and agreement.

Key issues / matters discussed at the Committee	The committee in common considered the following items:
	• Working Together Monthly Highlight Report noting:
	  ○ Further development of the Benefit Realisation Framework
	  ○ Further development of outcomes measures and impact of the programmes of work.
	  ○ The appointment of the joint Director of Corporate Governance.
	• Review of the Deloiite's Workstream and completion of actions.
	• Update on Flagship programmes and the involvement of clinicians in establishing these programmes.
	• Road Map 2024/25.
	• Review of the Working Together Programme against the NHS Forward Plan.
	• Other System Partnership Developments.

Decisions made by the Committee	• The Model Options Appraisal was endorsed and is recommended to the Boards of DCH and DHC for approval. • The Governance Review option 3 to operate a combination of joint committees and trust only committees was endorsed in principle, noting the need for a phased approach to implementation in order that further work and discussion could be had by each Board. The paper is to be presented to both Boards of DCH and DHC for further discussion and agreement.
Implications for the Corporate Risk Register or the Board Assurance Framework (BAF)	• The revised Risk Register focussing on workstream risks. • Digital risks relating to federation of Microsoft applications and the integration of clinical systems were noted.

Working Together

Dorset County Hospital NHS Foundation Trust

Dorset HealthCare University NHS Foundation Trust

Items / issues for referral to other committees	• As Above

Minutes of the meeting of the Part 1 Public ICB (ICB) Board of NHS Dorset
Thursday 2 November 2023 at 10am
Board Room at Vespasian House, Barrack Road, Dorchester, DT1 1TS
and via MS Team

Members Present:		
	Jenni Douglas-Todd (JDT) (virtual)	ICB Chair
	Rhiannon Beaumont-Wood (RBW) (virtual)	ICB Non-Executive Member
	John Beswick (JB) (virtual)	ICB Non-Executive Member
	Matthew Bryant (MB) (virtual)	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
	Spencer Flower (SF) (virtual)	Leader Dorset Council and ICB Local Authority Partner Member (West)
	Siobhan Harrington (SH) (virtual) (part)	Chief Executive University Hospitals Dorset NHS Foundation Trust and ICB NHS Provider Trust Partner Member
	Paul Johnson (PJ) (virtual)	ICB Chief Medical Officer (member)
	Patricia Miller (PM)	ICB Chief Executive
	Rob Morgan (RM)	ICB Chief Finance Officer
	Debbie Simmons (DSi) (virtual)	ICB Chief Nursing Officer
	Vikki Slade (VS) (virtual)	Leader BCP Council and ICB Local Authority Partner Member (East)
	Kay Taylor (KT)	ICB Non-Executive Member
	Forbes Watson (FW) (virtual) (part)	GP Alliance Chair, Primary Care Partner Member
	Dan Worsley (DW) (virtual)	ICB Non-Executive Member
Invited Participants Present:		
	Jim Andrews (JA) (virtual)	Chief Operating Officer, Bournemouth University
	Neil Bacon (NB) (virtual)	ICB Chief Strategy and Transformation Officer
	Louise Bate (LBa) (virtual) (part)	Manager, Dorset Healthwatch
	Zoe Bradley (ZB) (virtual)	Interim Chair, Dorset VCSE Board
	Cecilia Bufton (CB)	Integrated Care Partnership Chair
	Graham Farrant (GF) (virtual)	Chief Executive, Bournemouth, Christchurch and Poole Council
	David Freeman (DF) (virtual)	ICB Chief Commissioning Officer
	Dawn Harvey (DH)	ICB Chief People Officer (participant)
	Andrew Rosser (AR) (part)	Chief Finance Officer, South Western Ambulance Service Foundation Trust
	Ben Sharland (BS) (virtual) (part)	Primary Care Participant
	Jon Sloper (JS)	Interim Programme Director, VCS Assembly
	Dean Spencer (DSp)	ICB Chief Operating Officer
	Stephen Slough (SS)	ICB Chief Digital Information Officer (participant)

In attendance:		
	Liz Beardsall (LBe)	ICB Head of Corporate Governance
	Anita Counsell (AC) (for item ICBB23/187) (virtual)	ICB Deputy Director, Health Inequalities and Population Management
	Gavin Dudfield (GD) (for item ICBB23/189)	Chief Superintendent, Devon and Cornwall Police and Dorset Police Force
	Jane Ellis (JE)	ICB Chief of Staff
	Steph Lower (SL) (minutes)	ICB Deputy Head of Corporate Governance
	Charlotte Pascoe (CP) (for item ICBB23/179) (virtual)	ICB Deputy Director of Personal Health Commissioning (FTSU Guardian)
	Rob Payne (RP) (for item ICBB23/190) (virtual)	ICB Deputy Director of Strategic Commissioning
	Katrina Percey (KP) (for item ICBB23/188) (virtual)	National Association of Primary Care (NAPC)
Public:		
	No members of the public were present in the room. The meeting was also available via livestream.	
	Rachel Pearce (virtual)	Director of Commissioning, NHS England, South West
Apologies:		
	Leesa Harwood (LH)	ICB Interim Non-Executive Member (member)
	Matt Prosser (MP)	Chief Executive, Dorset Council (participant)

ICBB23/175 Welcome, apologies and quorum

The Chair declared the meeting open and quorate. There were apologies from Leesa Harwood and Matt Prosser.

ICBB23/176 Conflicts of Interest

It was noted that agenda item 4.1 Patient Safety Incident Response Plans made reference to Southampton University and the NHS Dorset ICB Chair sat on the Southampton University Council. There was no conflict of interest or associated action required in relation to this item.

ICBB23/177 Minutes of the Part One Meeting held on 7 September 2023

The minutes of the Part One meeting held on 7 September 2023 were agreed as a true and accurate record.

Resolved: the minutes of the meeting held on 7 September 2023 were approved.

ICBB23/178 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.

Standing Items

ICBB23/179 Staff Story: Freedom to Speak Up

The Chief People Officer introduced the staff story video which highlighted the importance of Freedom to Speak Up (FTSU). This coincided with October's national Speak Up Month campaign. The video featured Dorset NHS partner FTSU guardians sharing their views on the importance of the role and enabling a culture of speaking up safely. The Board was invited to discuss the featured themes and to consider its role in continuing to support and advocate speaking out safely within the ICS.

A Rosser joined the meeting.

Key issues to note included:-

- The importance of creating cultures where staff felt psychologically safe and confident that when a concern was raised the right action would be taken promptly.
- Each partner organisation had its own mechanisms for raising concerns and capturing information.
- The need to be curious if there were parts/groups within an organisation where no voice was coming through.
- The recent ICB campaign to capture information regarding any barriers to speaking up.
- The need for early resolution and a mature culture of investigating issues raised.
- The importance of having a system overview of themes and issues.

The Board noted the arrangements in relation to the handling of FTSU reporting including matters relating to quality and safety being reported to the Quality, Experience and Safety Committee and annual reporting to the Board commencing in 6 months' time.

Action: SL

The Chief People Officer would give considered thought to the key points raised with colleagues across the system and would discuss further with the Chief Nursing Officer.

Action: DH/DS

The Chair thanked everyone for the important discussion.

ICBB23/180 Chief Executive Officer's Report

The ICB Chief Executive Officer (CEO) introduced the CEO's Report which provided an overview of the strategic developments across the NHS and more locally across the Dorset Integrated Care System. Key issues raised included:-

- The impact of the national industrial action on the delivery of the elective care targets. National conversations continued regarding the threshold for the delivery of elective care and the significant costs incurred in providing cover. The industrial action had currently been suspended following further talks with the Department of Health and Social Care and it was hoped a resolution would be reached.
- Initial feedback had been provided following the conclusion of the Dorset ICS Care Quality Commission (CQC) pilot assessment. The draft report was expected in December with the final report due to be published in the spring following the conclusion of the second pilot assessment being undertaken with Birmingham and Solihull ICS.
- Consideration by the Dorset Chief Executives' group of the significant financial challenges across the system. It was proposed a meeting be held in December to

understand what actions partners were taking in terms of cost improvements/ transformation.

The Chair passed on thanks for the significant amount of work undertaken in relation to the CQC assessment process.

The Chair encouraged partner members to contribute to the Chief Executive Officer's report, particularly from primary care and the voluntary and community sector to enable a rich picture from across the system.

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

ICBB23/181 Quality Report

The ICB Chief Nursing Officer introduced the Quality Report which had been previously scrutinised by the Quality and Safety Committee. Key issues included:-

- A number of potential quality and safety concerns related to performance and meeting the expected standards.
- Work was underway to produce an integrated performance and quality report.
- The impact of follow-on waiting lists on patient safety and outcomes was being taken forward by the System Quality Group including taking any preventable action.
- The Shared Learning Panel which provided a forum for the exploration of emerging themes in patient safety across the Dorset system was working well. An example of shared learning was included as Appendix 2.

The hydration pilot had been successfully completed in a number of care homes/older people's wards and it was hoped the real data of improvements/positive impact would help promote further.

In relation to suicide prevention, ligature incidents were a key metric considered by the Dorset Healthcare Board. CQC compliance visits were undertaken regularly across all mental health facilities. A reduction had been seen over the past 12 months and some good focus work and learning had been undertaken from incidents. This had been shared regionally with Dorset Healthcare nominated for a Health Service Journal safety award. Suicide prevention remained a key issue for the ICS as a whole.

The Board discussed the ongoing IT issues at University Hospitals Dorset NHS Foundation Trust. There were a number of mitigations being put in place and it was acknowledged the solution would take time and was part of the wider Electronic Patient Record programme work across Dorset providers.

At a recent South West ICB Chief Executives meeting the risk of harm due to long ambulance handover delays was discussed. It was agreed that ICB Chief Nursing Officers and Chief Medical Officers would work through an agreed framework for dynamic risk assessment. A key area of focus would be discharge planning.

Work would continue to look at clinical harm incident reporting in relation to waiting list deterioration and how to increase the visibility of incident reporting from primary care and the local authorities to enable a broader system picture.

Resolved: the Board noted the Quality Report.

ICBB23/182 Dorset ICS Finance Update

The ICB Chief Finance Officer introduced the Dorset Integrated Care System Finance Update covering the financial position of the Integrated Care Board and Integrated Care System NHS providers as at August 2023 (month five). The report had been previously scrutinised by the Finance and Performance Committee. Key issues included:-

- The system was reporting a £20M deficit as at month 6 which was a deterioration from month 5.
- All organisations were currently reporting a forecast outturn of break even in line with plans submitted to NHS England.
- Operational pressures relating to the industrial action were a key theme related to the financial performance. In addition, inflationary pressures above the level assumed in national modelling were impacting the deficit. This has also impacted the system's ability to recover elective activity with a significant amount being undertaken in the independent sector.
- To enable delivery of cost improvement programmes, good clinical engagement would be required which was being impacted by the industrial action.
- The ICB had reported a break-even position against plans as at month 6, however there were several significant risks to in-year break even, predominantly in relation to prescribing and personal health commissioning. Work was ongoing to address the PHC spend increases and it was hoped this would have a positive impact.
- National and regional discussions were ongoing in relation to future funding which would provide more clarity in terms of the forecast outturn.
- A Medium-Term Financial Plan meeting had been held with system executive to accelerate focus on areas within control to hopefully enable a better financial position by year end.
- Dorset Healthcare was showing a lower spend on establishment, but the Board noted this was in part due to recruitment difficulties.

Resolved: the Board noted the Dorset ICS Finance Update.

ICBB23/183 System Performance Report

The ICB Chief Operating Officer introduced the System Performance Report which provided an overview of performance against the 2023-24 national operating plan trajectory, identified areas of concern, detailed mitigating actions and highlighted areas for additional focus.

Key issues included:-

- Over 3% of elective activity had been lost due to the industrial action.
- Although the position remained stable with regard to the number of 78 and 65 week waiters, this was unlikely to be sustained.
- Deterioration in the faster diagnosis standard in relation to two specialities.
- An increase in dermatology referrals but with additional activity by both providers an improvement would be expected.
- An increase in activity particularly within the A&E departments. Work was ongoing with University Hospitals Dorset to understand the challenges and what action could be taken to improve the position before the winter period.
- A renewed effort to meet the 40-minute hospital handover standard.

The Board noted the visit to Dorset by the Getting It Right First Time Chair, Professor Tim Briggs. There were a number of challenges as well as highlighting the areas performing well. A further visit would look at theatre utilisation.

In relation to dermatology referrals, concern was raised regarding the advice and guidance service functionality particularly in the West which had led to GPs having to initiate additional referrals.

There was a keenness to see the strategic issues in relation to performance along with commitment from partners as to when performance would improve to enable Board assurance around delivery.

System discussions were ongoing to address the cultural issues regarding the use of virtual wards to stimulate a higher level of occupancy of the service.

Productivity was one of the key themes in developing the medium-term financial plan and further detail would be included in the next report. The report also needed to link to the five-year forward view to ensure the impact of the prevention work being undertaken was seen.

The Board requested future reports include more information in relation to primary care and mental health.

Action: DS

Resolved: the Board noted the System Performance Report.

ICBB23/184 Committee Escalation Reports

The Board Committee Chairs presented the committee escalation reports from the October meetings. All issues discussed were included in the previously circulated reports and key issues included:

- Clinical Commissioning Committee – a key discussion was the integrated neighbourhood teams update with leadership development recognised as a key enabler. There needed to be linkage between the other various areas of work to ensure effectiveness. In relation to the corporate risk register, the benefits of receiving a view from the risk owner on the likelihood of a reversal in trend and estimated time frame was considered.
- Finance and Performance Committee – the main escalation to the Board was the recommendation that work be undertaken in relation to Personal Health Commissioning to include the service, quality, operating model, performance and budget. The committee discussed the performance challenges in relation to mental health noting there would be a deep dive at the December meeting.
- People and Culture Committee – the communications and engagement approach to support the Integrated Care System transformation outcomes and the communications and engagement plan for the winter pressures and vaccination programmes were welcomed. The committee received a deep dive into the ICS recruitment strategy.
- Primary Care Commissioning Committee – approval was given to the minor surgery directed enhanced service funding and the Dorset Delivery Plan for Recovering Access. Key issues raised were the number of GP practices closing and the increased difficulty of distributing those patient lists and the sustainability of the model of high street primary care. Consideration was being given to the latter being included on the corporate risk register.
- Quality and Safety Committee – approval was given for the Patient Safety Incident Response Plans for two provider organisations noting the remaining plans would be brought to the December meeting. The Medicines Optimisation Patient Safety Report was received with a request that further work be undertaken in relation to a number of areas of concern.
- Risk and Audit Committee – there was no escalation report as the next meeting would be held on 7 November 2023.

In respect of all committees, consideration needed to be given to ensuring the right balance in terms of the length of discussion and scrutiny on individual agenda items, recognising the focus needed on the financial and performance challenges.

Resolved: the Board noted the Committee Escalation Reports.

Items for Decision

ICBB23/185 ICB Governance Arrangements including Committee Terms of Reference (ToRs) and Work Plans

The Head of Corporate Governance introduced the ICB Governance Arrangements including Committee Terms of Reference and Work Plans.

The Governance Handbook brought together key documents to support the Constitution and was required to be brought to the Board annually. Changes had been made throughout the year with the appropriate approvals where required. Following its annual review, a number of proposed changes had been made as summarised in section 1.3 of the report. The key changes related to the committee refresh and the impact on a number of associated documents within the Handbook. There were no issues of concern highlighted to the Board.

Work had been underway on a committee refresh since the summer with a shared ambition throughout to ensure the ICB's governance was properly designed to deliver a collective vision and goals for the population of Dorset.

The key changes to the revised ToRs were summarised in the report at section 1.7.

In relation to the proposed two new committees, the ToRs and work plans would be taken to their respective inaugural meetings in December and may therefore come back to the Board following this.

Due to the Committee timing, the Risk and Audit Committee would receive its ToR and work plan at its November meeting.

Sections 6.1.2-6.1.3 of the Governance Handbook incorrectly made reference to several Primary Care Networks in the East being coterminous with the administrative boundary of Bournemouth, Christchurch and Poole Council and would be amended accordingly. There was also a need to ensure clear, consistent language around East/West place references.

Action: LB

The Board noted that agency spend would come within the remit of the Productivity and Performance Committee cross-linking to the People, Engagement and Culture Committee as required.

It was requested that consideration be given to the Prevention, Equity and Outcomes Committee membership including academic, Local Enterprise Partnership and the voluntary and community sector. This would be reviewed outside of the meeting.

Action: DF

The Chair extended thanks to all for the significant work involved.

Resolved: the Board approved the recommendations set out in the ICB Governance Arrangements including Committee Terms of Reference and Work Plans subject to the actions above.

Items for Noting/Assurance/Discussion

ICBB23/186 Patient Safety Incident Response Framework (PSIRF)

The ICB Chief Nursing Officer introduced the Patient Safety Incident Response Framework.

The PSIRF replaced the current Serious Incident Framework and provider trusts were expected to transition during Autumn 2023.

It was a national requirement for ICBs to sign off the provider patient safety incident response plans. The plans for Dorset Healthcare University NHS Foundation Trust and South Western Ambulance NHS Foundation Trust had been approved by the ICB's Quality and Safety Committee in October, with the remaining plans for Dorset County Hospital and University Hospitals Dorset NHS Foundation Trusts to be presented to the December Committee meeting for approval.

Resolved: the Board noted the Patient Safety Incident Response Framework.

ICBB23/187 Health Inequalities Update

This item was taken after item ICBB23/188.

The Chief Medical Officer introduced the Health Inequalities update and updated the Board on the approach, progress and next steps for addressing health inequalities in Dorset. Key points included:-

- Recruitment of a new Deputy Director of Health Inequalities to strengthen capacity and to bring together health inequalities, prevention, population health management and patient equality and sustainability into a single portfolio of work.
- Further work would continue on the priority areas including a review of the approach, resources and tools, identification of areas requiring further focus and growing partnership working and programme governance.
- Following establishment of the building blocks for an integrated at scale transformation programme to address health inequalities, the next phase would focus on establishing rapid delivery, benefits realisation and working with partners to align and embed action on health inequalities across all programmes.
- The Health Inequalities sub-group was developing an ICS integrated strategic plan to look at not only the individual organisational strengths but the barriers enabling people to have good outcomes. It was proposed the plan would be in place by the end of December 2023.

Resolved: the Board noted the Health Inequalities Update and supported the direction of travel.

ICBB23/188 Integrated Neighbourhood Teams – Next Steps and Implementation Plan

This item was taken before item ICBB23/187.
K Percy and G Dudfield joined the meeting

The Chief Commissioning Officer introduced the Integrated Neighbourhood Teams – Next Steps and Implementation Plan and provided an update on the work undertaken so far, supported by the National Association of Primary Care.

The ambition for this model would be key to improving population health and wellbeing outcomes and to mitigate health inequalities.

The current ways of working were fragmented, and the draft Development Framework set out the ambition and common ground on some of the *what* and *how* for delivering a Dorset integrated model of care for local communities. Initially the work was focused on older people but there was a desire to adopt this as an all-age approach.

There was a need to ensure the design of the front-end health element of the model enabled the inclusion of the local authorities and the voluntary and community sector.

It was noted on page 34 of Appendix 2 there was no reference to local authority representative leadership.

The wider social and economic issues that were impacting individuals' wellbeing were recognised and the work would need to tie in with the voluntary sector support in these areas. There was also a keenness to consider how to get local people involved.

It was recognised this was an ambitious programme of work and there would need to be appropriate resource to enable the programme to succeed.

It was proposed to link the work through the provider collaborative to ensure the right provider engagement and secondly through the place-based partnerships which would bring in key local authority leadership.

In terms of next steps, the intention was for a proposal to be brought to the System Executive Group followed by the Board outlining the next steps.

The Board supported the progression of the work to develop the business case and programme plan for implementation.

K Percy left the meeting

Resolved: the Board noted the Integrated Neighbourhood Teams – Next Steps and Implementation Plan.

ICBB23/189 Right Care Right Person Implementation in Dorset

The Chief Commissioning Officer introduced the Right Care Right Person Implementation in Dorset.

The National Partnership Agreement (NPA) was published in response to the ongoing challenges related to a lack of a consistent response to mental health crisis presentations across the country and subsequent scope for improvement through new ways of cross agency working. Police were routinely being relied upon to respond to mental health crisis presentations even if there was no immediate risk of harm or a crime committed. More police time was spent nationally on this area despite being within the remit of other agencies.

The Board noted the full discussion that had taken place at the Integrated Care Partnership meeting earlier in the week.

The Board was asked to support the NPA and the proposed approach to implementation based on a system-wide multi-agency partnership approach. In addition to ensuring that

police services were not utilised inappropriately this approach would ensure the Dorset population would receive the appropriate care required.

Work had commenced to convene a multi-agency implementation steering group and a high-level jointly developed plan committing to a 12-18 month implementation timeline. It was recognised there would be potential challenges where gaps with other agencies or resources were identified.

A more detailed report would be taken to the System Executive Group at the end of November including addressing any identified gaps and additional resource requirements.

The Board would receive a further update at its meeting in January 2024.

Action: DF

G Dudfield left the meeting.

Resolved: the Board noted the Right Care Right Person update with support for the plan and direction of travel.

ICBB23/190 The Dorset Delivery Plan for Recovering Access

R Payne joined the meeting.

The Chief Commissioning Officer introduced the Dorset Delivery Plan for Recovering Access which set out NHS Dorset's progress against the key areas utilising the NHS England (NHSE) published checklist.

The report was approved at the recent Primary Care Commissioning Committee and was being brought to the Board in line with the NHSE directive for a public paper.

Currently NHS Dorset continued to meet the expectations of the NHSE checklist. It was important to acknowledge that the direction of travel for access in Dorset needed to align to the wider Dorset vision.

There was a need to ensure resources were used in the most efficient way and part of the access work was supporting the direction of patients to the most appropriate service. The work around integrated neighbourhood teams would be part of the solution.

There was a need to think differently about how to engage with NHSE in terms of specific asks and associated funding and how things could be taken forward differently if considered the right way forward to enable the best outcomes for the population of Dorset.

The Board was assured that the programme had been adopted and delivery plans were in place.

R Payne left the meeting.

Resolved: the Board noted the Dorset Delivery Plan for Recovering Access.

ICBB23/191 ICB Annual Assessment Outcome

The Chief Operating Officer introduced the ICB Annual Assessment Outcome.

The Board noted that work was underway to cover any identified gaps.

Resolved: the Board noted the ICB Annual Assessment Outcome.

Items for Consent
The following items were taken without discussion.

ICBB23/192 NHS Enforcement Guidance

Resolved: the Board noted the NHS Enforcement Guidance.

ICBB23/193 Questions from the Public
There were no questions received from members of the public.

ICBB23/194 Any Other Business
There was no other business.

ICBB23/195 Key Messages and review of the Part 1 meeting

The Chair summarised the key messages from the meeting as:-

- The Board's commitment to, and support for, freedom to speak up mechanisms across the system to support a culture of learning and psychological safety.
- The challenges relating to operational performance and the NHS system financial position, especially noting the impact on these of industrial action and the resulting impact on quality and safety.
- The Board's commitment to the approach to Integrated Neighbourhood Teams, health inequalities and Right Care Right Person.
- The Board was assured on the Dorset Delivery Plan for Recovering Access, noting the collaboration across the system which had contributed to this plan.

The Board reflected on:

- A need to ensure Board conversations reflected the system infrastructure.
- The need to ensure the right balance in terms of the length of discussion and scrutiny of individual agenda items, recognising the focus needed on the financial and performance challenges.
- The need through each covering report to link the specific agenda items to the five pillars and other workstreams/programmes.

The Chair thanked everyone including the public, for their attendance.

ICBB23/196 Date and Time of Next Meeting
The next meeting of the ICB Board would be held on Thursday 11 January 2024 at 10am, in the Boardroom, Vespasian House, Barrack Road, Dorchester, Dorset DT1 1TS.

ICBB23/197 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: