Board of Directors - Part 1 - 27/03/2024

Wed 27 March 2024, 08:30 - 12:40

Agenda

08:30 - 08:55
25 min

1. Staff Story

Juliet Sturgess - Associate Director for Allied Health Professionals

08:55 - 09:00
5 min

2. Formalities

David Clayton-Smith

1a DRAFT Agenda BoD Part 1 27 March 2024 DCS MBr.pdf (3 pages)

2.1. Minutes of the meeting dated 31st January 2024

1b Draft Minutes BOD Part 1 31 01 2024.pdf (13 pages)

2.2. Matters Arising: Action Log

1c Action Log BoD PART 1 March 2024.pdf (1 pages)

09:00 - 09:10
10 min

3. Chair's Comments

David Clayton-Smith

09:10 - 09:25
15 min

4. CEO Update

Matthew Bryant

4. CEO Board report Mar24 v4 FINAL.pdf (8 pages)

09:25 - 09:40
15 min

5. Balanced Scorecard and System Performance Update

Anita Thomas

5ai. FINAL Report Front Sheet Balance Scorecard - 27.03.24 - FINAL_.pdf (5 pages)
5aii. Executive Dashboard - Mar 2024 Board.pdf (14 pages)
5b. System Performance - Final - 27.03.24.pdf (9 pages)

09:40 - 09:55
15 min

6. Finance Report

Chris Hearn

6a. Front Sheet Finance Report FPC Month 11.pdf (3 pages)
3b Finance Report M11.pdf (13 pages)

09:55 - 10:10
15 min

Coffee Break

10:10 - 10:30
20 min

7. Maternity Update

Jo Hartley

- 7a. front sheet March 2024 Maternity Board.pdf (2 pages)
- 7b. Maternity report March Board report 2024.pdf (15 pages)

10:30 - 10:45
15 min

8. Board Assurance Framework

Phil Davis

- 8a. Mar RAC_BAF.pdf (2 pages)
- 2 DCH BAF_FINAL.pdf (13 pages)

10:45 - 11:00
15 min

9. Corporate Risk Register

Mandy Ford

- 9. Corporate Risk Report March 2024.pdf (23 pages)

11:00 - 11:10
10 min

10. Gender Pay Gap Report

Nicola Plumb

- 10a. Gender Pay Gap Report 2023 Board FRONT SHEET.pdf (2 pages)
- 10b. Gender Pay Gap Report 2023 Board MAIN PAPER.pdf (11 pages)

11:10 - 11:20
10 min

11. Guardian of Safe Working Report

Kyle Mitchell

- 11a. GoSW report Q3 Front Page.pdf (2 pages)
- 11b. GoSW report Q3 Main paper.pdf (4 pages)
- 11c. GoSW Q3 Appendices.pdf (2 pages)

11:20 - 11:35
15 min

12. Staff Survey Results

Nicola Plumb

- 12. Staff Survey March 2024.pdf (17 pages)

11:35 - 11:45
10 min

13. Walkarounds Outputs Report

Jo Howarth

- 14. Walkaround Executive Report Dec 2023.pdf (2 pages)

11:45 - 11:55
10 min

14. Going Concern Report

Chris Hearn

- 15. Going Concern including front sheet 2023-24 Final (002).pdf (6 pages)

11:55 - 12:10 ***Break***

15 min

12:10 - 12:15
5 min

15. Committee Effectiveness Review Timeline

Jenny Horrabin

12:15 - 12:30
15 min

16. Board Sub-Committee Escalation Reports

16.1. Quality Committee

- Escalation Report QC Feb 2024.pdf (2 pages)
- Escalation Report QC March 2024 - JH.pdf (2 pages)

16.2. Finance and Performance Committee

- Escalation Report FPC Feb 2024.pdf (2 pages)
- Escalation Report FPC March 2024 CH AT.pdf (2 pages)

16.3. People and Culture Committee

- Escalation Report PCC Feb 2024 MB.pdf (1 pages)
- Escalation Report PCC March 2024 EH.pdf (1 pages)

16.4. Risk and Audit Committee

- Escalation Report RAC March 2024 - SP.pdf (2 pages)

16.5. Charitable Funds Committee

- 18e. DCH Charitable Funds Committee - Escalation Report (20.3.24).pdf (2 pages)

16.6. Working Together Committee in Common

- Escalation Report WTC February 2024.pdf (1 pages)

12:30 - 12:35
5 min

17. Questions from the Public

12:35 - 12:35
0 min

18. Consent - Learning from Deaths Report

- 13. 23-24 Q3 Learning from Deaths Report V2 Board.pdf (15 pages)

12:35 - 12:35
0 min

19. Consent - SubCo Quarterly Performance Report

- 5. Performance Report January 2024.pdf (4 pages)

12:35 - 12:35
0 min

20. Consent - Working Together Programme Options Appraisal

- 21a. Front Sheet Options Appraisal - Board Jan 2024.pdf (2 pages)
- 8b. Future Working Together Options Appraisal Jan 2024.pdf (13 pages)

12:35 - 12:35
0 min

21. Consent - Gifts and Hospitality Register

22. Declarations of Interest Report - March 24.pdf (3 pages)

12:35 - 12:35
0 min

22. Consent - ICB Part 1 Board Minutes

25 ICB Board Minutes Part 1 110124 approved.pdf (10 pages)

12:35 - 12:40
5 min

23. Any other business

Ref: DCS/TH

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

You are invited to attend a **public (Part 1) meeting of the Board of Directors** to be held on **27th March 2024** at **8.30 am to 12.40pm** 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	Juliet Sturgess, Associate Director for Allied Health Professionals	Note	8.30-8.55
2.	**FORMALITIES** to declare the meeting open.	Verbal	David Clayton-Smith Trust Chair	Note	8.55-9.00
	a) Apologies for Absence: Trevor Hughes, Alastair Hutchison	Verbal	David Clayton-Smith	Note	
	b) Conflicts of Interests	Verbal	David Clayton-Smith	Note	
	c) Minutes of the Meeting dated 31st January 2024	Enclosure	David Clayton-Smith	Approve	
	d) Matters Arising: Action Log	Enclosure	David Clayton-Smith	Approve	
3.	**Chair's Comments** • Quality Committee Chair	Verbal	David Clayton-Smith	Note	9.00-9.10
4.	**CEO Update**	Enclosure	Matthew Bryant	Note	9.10-9.25
5.	**Balanced Scorecard** • System Performance Update	Enclosure	Anita Thomas Executives	Note	9.25-9.40
6.	**Finance Report**	Enclosure	Chris Hearn	Note	9.40-9.55
Coffee Break 9.55-10.10					
7.	**Maternity Update** (March QC)	Enclosure	Jo Hartley	Note	10.10-10.30
8.	**Board Assurance Framework** (March RAC)	Enclosure	Phil Davis	Approve	10.30-10.45
9.	**Corporate Risk Register** (March RAC)	Enclosure	Mandy Ford	Note	10.45-11.00
10.	**Gender Pay Gap Report** (March PCC)	Enclosure	Nicola Plumb	Approve	11.00-11.10

11.	**Guardian of Safe Working Report** (Feb PCC)	Enclosure	Kyle Mitchell	Approve	11.10-11.20
12.	**Staff Survey Results** (March PCC)	Enclosure	Nicola Plumb	Approve	11.20-11.35
13.	**Walkarounds Outputs Report** (December QC)	Enclosure	Jo Howarth	Note	11.35-11.45
14.	**Going Concern Report** (March RAC)	Enclosure	Chris Hearn	Approve	11.45-11.55
Coffee Break 11.55-12.10					
15.	**Committee Effectiveness Review Timeline**	Verbal	Jenny Horrabin	Note	12.10-12.15
16.	**Board Sub-Committee Escalation Reports** (February and March 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	12.15-12.30
17.	**Questions from the Public**	Verbal	David Clayton-Smith	Note	12.30-12.35
	In addition to being able to ask questions about discussion at the meeting, members of the public are also able to submit any other questions they may have about the trust in advance of the meeting to Trevor.hughes@dchft.nhs.uk or Abigail.baker@dchft.nhs.uk				
	CONSENT SECTION				All items 12.35-12.40
	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.				
18.	**Learning from Deaths Report** (Feb QC)	Enclosure	Alastair Hutchison	Approve	
19.	**SubCo Quarterly Performance Report** (February FPC)	Enclosure	Nick Johnson	Note	
20.	**Working Together Programme Options Appraisal** (January Part 2 Board)	Enclosure	Nick Johnson Dawn Dawson	Note	
21.	**Gifts and Hospitality Register** (March RAC)	Enclosure	Jenny Horrabin	Note	

22.	**ICB Part 1 Board Minutes**	Enclosure		Note	-
23.	**Any Other Business** Nil notified	Verbal	David Clayton-Smith	Note	-
24.	**Date and Time of Next Meeting**				
	The next part one (public) Board of Directors' meeting of Dorset County Hospital NHS Foundation Trust will take place at **8.30am** on **Wednesday 29th May 2024** in the **Board Room, Trust Headquarters, Dorset County Hospital, Dorchester** and via **MS Teams.**				

Part 2 items

- Chair's Update
- CEO's Update
- Working Together Programme Update

Consent Items:

- Contracts for approval
- Estates Strategy

Charitable Trustees meeting

- DCH Charity Business Plan 2024/25

Minutes of a public (Part 1) meeting of the Board of Directors of Dorset County Hospital NHS Foundation Trust held at 8.30am on 31st January 2024 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
Margaret Blankson	MB	Non-Executive Director (via videoconference)
Chris Hearn	CH	Chief Finance Officer
Jo Howarth	JH	Chief Nursing Officer
Nick Johnson	NJ	Deputy Chief Executive and Director of Strategy, Transformation and Partnership
Eiri Jones	EJ	Non-Executive Director (Deputy Chair)
Claire Lehman	CL	Non-Executive Director (via videoconference)
Stuart Parsons	SP	Non-Executive Director
Nicola Plumb	NP	Chief People Officer (from 10am)
Anita Thomas	AT	Chief Operating Officer
David Underwood	DU	Non-Executive Director
In Attendance:		
Abi Baker	AB	Deputy Trust Secretary (Minutes)
Harad Burn	HB	Graduate Management Trainee (Observing)
Dawn Dawson	DD	Chief Nurse, Dorset Healthcare
Jo Hartley	JHa	Head of Midwifery (via videoconference)
Vicki Hyde	VH	Occupational Therapist (Patient Story)
James Metcalfe	JM	Divisional Director, Urgent and Integrated Care Division
Dean Spencer	DS	Chief Operating Officer, NHS Dorset (Observing)
Juliet Sturgess	JS	Associate Director of Allied Health Professions
Carol Thorn	CT	Clinical Practice Educator (Patient Story)
Neil Tomlin	NT	Maternity Advisor
Members of the Public (attending via videoconference):		
Judy Crabb	JC	Governor (until 10:30am)
Kathryn Harrison	KH	Lead Governor
Jean-Pierre Lambert	JPL	Governor
Lynn Taylor	LT	Governor
Apologies:		
Trevor Hughes	TH	Head of Corporate Governance
Alastair Hutchison	AH	Chief Medical Officer
Stephen Tilton	ST	Non-Executive Director

BoD23/132	**Staff Story**	
Baker,Abi 26/03/2024 09:10:11	DCS welcomed VH and CT to the meeting who presented on the topic of Occupational Therapy (OT), through the lens of an OT apprentice. VH outlined that she was one of the first OT apprentices at the Trust and was due to finish her course next year. She had completed a BTEC in social care at Yeovil College and had started a nursing degree at Southampton University, ultimately leaving due to family illness. After this she started working in nursing homes and saw the positive impact that OTs could have on patients lives.	

Since joining the Trust in 2002 VH had been promoted within the OT team a number of times and had supported patients across the hospital in various specialities. This had confirmed to VH that she wanted to be an OT and so she undertook the necessary educational requirements, including functional maths and English, and a foundation degree in Healthcare Practitioner with the Open University, before starting her OT Degree Apprenticeship in September 2021.

VH described the challenges associated with undertaking further education whilst working full time, and with being one of the first OT apprentices at the Trust. However, she noted the support of her colleagues and manager, as well as her work ethic and love for her job as key enablers supporting her through the apprenticeship.

CT described the work of an OT as client centred, concerned with promoting health and wellbeing and quality of life, enabling people to take back control in their lives using occupation as a therapeutic tool. OTs looked at patients holistically and worked with patients of all ages to support them to achieve activities meaningful to them. There was a breadth of OT in the Trust, but there were also significant vacancies in some areas which was a national issue. The OT team was working with Dorset HealthCare (DHC) to consider how the two organisations could work together to develop practice and offer broader development opportunities. CT noted the importance of OTs in enabling people to recover from acute illness, to prevent deconditioning in hospital, and in support safe discharges from hospital.

CT provided an example of an OT at the Trust who had supported a patient at the end of his life with attending his daughter's wedding. This had included arranging for his dress shoes to be delivered to the hospital so he could practice walking in them and arriving for transport to the venue. When he was ultimately not well enough to attend the OT had supported with getting his suit delivered and a tablet arranged so he could join virtually.

Asked what advice she would give to people looking to undertake the OT apprenticeship VH said that she was already in touch with individuals in the next cohort of apprentices and tried to ensure that they understood the expectations and commitment of the course. She described that the course was hard work and she wanted people to understand that, but also how worthwhile it was. From next year there would be individuals completing the course every year as qualified OTs.

DU asked what the Trust could do better to support apprentice OTs and about the difficulties associated with the foundation degree. The meeting heard that individuals undertaking a foundation degree now were able to support each other, but at the time she completed her VH had been one of only two individuals doing so. The change in educational requirements to undertake the OT apprenticeship was also noted as a barrier VH had needed to manage. VH confirmed that she was starting to link with apprentices of other disciplines in the hospital although there were difficulties of availability with this.

	MBr thanked VH and CT for the presentation which detailed an inspiring and powerful story. He explained that hearing the lived experiences of staff and patients at the beginning of Board meetings allowed the remainder of the meeting to be framed by those discussion. He further noted the importance of OT in helping people to participate in activities of daily life and that the work did not stop at the boundary of the hospital. The Chair thanked VH and CT for their presentation and they left the meeting.	
	Resolved that: the Patient Story be heard and noted.	
BoD23/133	**Formalities**	
	The Chair declared the meeting open and quorate and welcomed governors to the meeting. Apologies for absence were received from Trevor Hughes, Alastair Hutchison, and Stephen Tilton.	
BoD23/134	**Conflicts of Interest**	
	There were no conflicts of interest declared in the business to be transacted on the agenda.	
BoD23/135	**Minutes of the Meeting held on the 29th November 2023**	
	The Minutes of the meeting dated 29th November 2023 were approved as an accurate reflection of the meeting, subject to a minor clarification on page 8 of the minutes.	
	Resolved: that the minutes of the meeting held on 29th November 2023 were approved.	
BoD23/136	**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. With reference to page 12 of the papers EJ highlighted the previous discussions around civility and asked if there was any information about how the Trust intended to address the challenges around civility. MBr reflected on the links between civility and the delivery of safe care and effective team working and suggested that the topic be returned to a future Board development session for consideration. This could be conducted jointly with DHC.	**AB**
	Resolved: that updates to the action log be noted with approval given for the removal of completed items.	
BoD23/137	**Chair's Comments**	
Baker,Abi 26/03/2024 09:10:11	The Chair congratulated NJ, NP, and CH on their successful appointments to joint executive roles across the Trust and DHC. The Chair reported that: • He and MBr had presented the long service awards in December for members of staff who had worked at the Trust for over 25 years.	

	• He had visited the Mary Anning unit in December and had delivered mince pies around the Trust with MBr. • There continued to be a great deal of work between the three provider Trusts in the system, and a three-way Board meeting was scheduled for 21st February. • A number of workshops had been undertaken with governors of the Trust and DHC which developed an understanding of how they contribute to the overall governance of the Trust and how they can work together. There had also been a joint engagement session with governors of both organisations on the topic of the joint strategy. • The Chair had been able to welcome Lord Markham to a spade-in-the-ground event for the DHC New Hospital Programme which had offered an opportunity to explain the work the two Trusts were doing together. • The Chair had been invited to speak to the chairs of the league of friends who were keen to engage with governors and talk to members of the Trust and members of the public. The Chair broadly reflected on the growing network of people engaged with the two Trusts in their role of providing health and care across the whole of the Dorset system.	
	Resolved: that the Chair's Comments be noted.	
BoD23/138	**CEO Update**	
	MBr asked AT and JM to provide an update on the operating environment and the experience of industrial action. JM highlighted the following with regards to industrial action: • The Trust was well rehearsed in managing industrial action, but the reality of the operational work was still an exceptional occurrence; the strikes over Christmas and new year were particularly exceptional. • The Trust continued to manage some business-as-usual work, particularly with regards to outpatient, theatres, and urgent work. However, this was not a guarantee that it would also be able to manage this work during future industrial action. • The huge amount of stress the action placed on the workforce • Medical colleagues were represented by just one union; the British Medical Association (BMA). The Trust had fewer BMA members than the national average. MBr thanked all who contributed to the preparation and delivery of safe care during industrial action. He understood that consultants had rejected a pay offer by a narrow margin and junior doctors were being balloted on extending the mandate to strike. AT provided an update on the operational position of the hospital, noting: • The difficulties associated with winter, but that teams were working extremely well both internally and externally. A number of mitigations were in place, but the current position was pressured.	

	• Efforts in 2024 would focus on stepping away from normalising using spaces that should not be used due to operational pressures, such as using day surgery for inpatients. • The Trust was generally in a better position going in to the weekend, but by Sunday evening it was usually necessary to reopen some escalation spaces. • Teams were working hard to prevent unnecessary admissions, but it was recognised that this was difficult, given the elderly population the Trust served. • An internal audit of 300 inpatients demonstrated that staff were working together, but that more could be done to better plan ahead to discharge. • Approximately 60 beds were occupied by patients with no criteria to reside (20% of total beds). There was work to do to reduce this to below 45 as planned. MBr reflected that those pressures were also felt by partner organisations within the system. The Board discussed the number of unfunded, escalated beds and the safety elements of those. The Trust was able to use bank and low-cost agencies to support these beds when needed. The meeting heard that the Trust was funded to 290 beds, but that this usually flexed to between 300 and 330 beds, including unfunded escalation beds. These additional beds were risk assessed. MBr highlighted the following topics of interest: • Pharmacy first launches nationally today • Development of the NHS app • The Government planned to legislate to ban smoking which would be a really important public health initiative • A great deal of work continued on the finance position of the system. The Dorset system had committed to a deficit of £12m, which had been reduced from the originally proposed £30m. Additional processes of control were in place across the system to support meeting this goal, including vacancy controls, and triple lock arrangements for investments over £100,000 which now required external approval by system partners, the ICB, and the region. • An update on the New Hospital Program would be provided in part 2 of the meeting. • Further to discussions at recent Board meetings, Somerset ICB had confirmed their intent to change the commissioning of the stroke service with a Hyper-Acute Stroke Unit (HASU) at Musgrove Park Hospital and here at DCH. • The Trust continued to work within the sphere of provider collaboratives and updates on this topic would form part of the CEO report moving forwards. • Refurbishment of Ridgeway ward • Development of Targeted Lung Health Check service with the goal of reducing health inequalities	**MBr**

	Asked about the publication of the national vaccine strategy, JH outlined that there was no immediate implication for the Trust other than continuing to encourage vaccination amongst staff and patients. DD noted that as a provider of vaccination services there was more implication for DHC who were cognisant of the new strategy. The low staff vaccination rate was noted and was felt to be a reflection of vaccine fatigue amongst staff; this was an area of active focus for the Trust leadership. Commending the work of the targeted lunch health checks, CL asked if the checks were being targeted to people in more deprived areas, and if the scheme would be extended to other conditions such as diabetes or hypertension. It was noted that this required a system response but that there was work targeting health inequalities.	
	Resolved that the CEO Update be noted.	
BoD23/139	**Balanced Scorecard**	
	AT advised of a typographical error on page 25 of the papers; emergency readmissions had risen to 8.9%, not 89%. This would be amended post meeting. AT described how the scorecard covered a number of topics that would be discussed today. An action from part two of the meeting regarding 65-week waits had been answered in this paper. <u>Ambulance Handover Protocol</u> AT outlined that the Trust had a standard operating procedure (SOP) and was one of the best performers in the region for ambulance handovers. The national emphasis on this matter had arisen from a small number of Trusts where some patients had to wait over eight hours to be transferred from an ambulance; AT stressed this was not the case in Dorset or at DCH. Nonetheless, the local SOP had been enhanced to ensure it met the national requirement. It had been discussed in detail at last week's Finance and Performance Committee meeting, and now required Board approval. The Board approved the Ambulance Handover Protocol. <u>Balanced Scorecard</u> CL noted that 30 patients had waited for ambulance handover for more than an hour and asked what proportion of all patients this represented. AT noted that between 45 and 60 patients a day were transferred to the hospital by ambulance; the 30 patients who waited more than an hour took place over the course of a month. AT assured Board members that all patients were rapidly assessed on arrival to the Trust, including those arriving in ambulances, and they were then treated in order of clinical need. EJ advised that both the Quality Committee and the Finance and Performance Committee explored any areas of decreasing performance in detail. She further noted the reduction in falls and health care acquired infections, both of which provided a positive indication of the safety of patients in the hospital. She asked AT to provide further detail on areas where the Trust was more challenged and the mitigations in place. AT	

	noted the challenges surrounding diagnostics and the national lack of echocardiographers. The Trust was dealing with this through the use of retire-and-return and apprenticeships. AT further detailed that challenges relating to cancer services and that the Trust was working with teams to reduce the time between each step of the patient journey. The significant increase in cancer referrals without consequent investments was noted. AT assured the meeting that cancer and urgent services had been prioritised throughout industrial action. DU asked what percentage of the deficit related to unfunded beds. CH advised that this detail could be provided to future Finance and Performance Committee meetings, although there were various elements to this, so it was not easy to accurately quantify. DU highlighted the level of patients with no criteria to reside and asked about the system response to this, noting it had been an issue for more than a year. AT advised there were areas where good progress had been made with no criteria to reside, there were other areas where more work was still needed. The complexity of needs of patients on discharge required services to be commissioned to meet those needs, but there were currently gaps in the provision. The Trust continued to work with system partners to reduce the number of patients in hospital with no criteria to reside and had developed a 12-point action plan on this matter. Asked about theatre utilisation, AT outlined that work continued to improve this. It was recognised that theatre utilisation was not in the best position at present, with the impact of industrial action on this metric recognised. As previously noted, urgent care and cancer cases were prioritised during industrial action, but this came at the cost of running a productive list. Nonetheless small improvements were being made overall to theatre utilisation. MBr asked Board sub-committees to reflect on some of the points raised today, such as cancer performance. He further noted the context that the Trust was working within and that in a number of metrics the Trust was performing well, although it always aspired to do better. It was agreed that Finance and Performance Committee should also be advised of additional productivity metrics, not just theatre touch time. DD noted the broadly improving workforce metrics, including reduction in turnover, but noted that sickness levels were increasing particularly in relation to anxiety, stress and depression. DD asked how the Trust was making sure staff were okay given the incredibly difficult working environment. NP advised that the same theme was observed at DHC. This was thought to be a seasonal uptick; this usually started in December but had started in September this year. A sickness deep-dive had been undertaken at People and Culture Committee recently, but further work was needed. The pressured environment that staff were working in was recognised.	**FPC**
	Resolved that: the Balanced Scorecard and System Performance Update be received and noted, and the Ambulance Handover Escalation Protocol be approved.	

BoD23/140	**Finance Report**	
	CH outlined the Month 9 position: • £600,000 deficit in month, resulting in a year-to-date deficit against plan of £8.9m. • A slight improvement in month in trajectory and run rate, suggesting that some interventions being put in place were starting to work. • An improvement in nationally validated numbers regarding elective recovery funding had also led to improvements in month. • Four key areas were driving the financial position to date and were expected for the remainder of the year: industrial action, agency costs, inflationary pressures, and efficiency. • The system had submitted a deficit of £12m for the remainder of the financial year. This was predicated on provider organisations continuing to deliver trajectories that had been signed up for, developing stretch targets, and interventions put in place such as vacancy controls and triple lock. • The H2 system position was also predicated on there being no further industrial action, although there had been since the position was submitted. There had been a national agreement that any costs directly attributable to industrial action would be an understood overspend. • The £12m system deficit was split between providers and the ICB, but system providers had all submitted a breakeven plan, with the deficit sitting with the ICB. The Trust had therefore submitted a H2 breakeven plan, recognising the challenges that were faced. • The Trust and the system had to provide NHS England with an indication of planning for 2024/25 by the middle of February and the process was underway to develop this plan. SP recognised that £5m of cost improvement plan (CIP) savings had been identified but not started and advised that this should not be forgotten about when planning for 2024/25. He further noted the positive work on reducing agency spend, but that there was still a long way to go to meet the target. The meeting heard about the reductions in vacancy rates and increase in international recruitment, which were supporting the reduction in agency spend. However, NP felt that the increase in demand and activity were the key drivers of the high agency usage, although vacancies would undoubtably exacerbate the issue. CH reflected on the need to track all these elements so that the appropriate interventions could be made. Board members reflected on the significant work in the Trust and the reduction in agency spend. Work at the trust, system and regional levels was required, but there had been a great improvement. MBr reflected on the importance of ensuring that the clinical voice was at the heart of the management of risks. CH and SP confirmed that they were in discussion with the auditors regarding the year-end processes and the going concern statement. This would be picked up routinely through Risk and Audit Committee.	
	Resolved: that the Finance Report be received and noted.	

BoD23/141	**Maternity Update**	
	JHa, LB, and NT attended for this item. <u>Maternity Incentive Scheme</u> JH provided the context to the Maternity Incentive Scheme (MIS). The Board had unanimously agreed last year that the Trust was not fully compliant with the MIS and that this was a correct and accurate submission. The same recommendation was being made to the Board this year. JH noted the increasingly difficult standards of the MIS and that some of these standards had changed in year, making them particularly difficult to meet. LB provided a detailed summary of the MIS submission. There were ten safety actions that maternity services were asked to demonstrate compliance with. The Trust had assessed itself as being compliant with five, and non-compliant with five. LB spoke to the detail of each non-compliant action (actions 5, 6, 7, 8, and 9) as detailed in the papers (pages 145 and 146). As chair of Quality Committee EJ outlined that the purpose of the MIS being tough was to promote safety and highlighted the focus of the team on learning from the recent CQC visit. EJ felt that the MIS submission was accurate but noted some frustrations with not being able to sign off externally verified elements, such as action 9, within the MIS timeframe. EJ reported that JH, JHa and the team were working hard to build relationships with the LMNS and other partners. EJ further reflected on the Trust's positive results in the national maternity survey. NT had fed back to EJ that he was assured the team had the commitment to improve and that a great deal had improved since the CQC inspection. JH added that the internal auditors had audited the MIS submission and had provided constructive challenge and assurance. The internal auditors would also audit the 2024/25 MIS submission with check points throughout the year to ensure progress was made. It was expected that the Trust would be compliant with three of the five noncompliant actions in the coming months. MBr requested that the board declaration for the MIS was circulated to Board members. *Post meeting note: this was circulated after the meeting.* Noting comments about training and jurisdiction of medical staff MBr reflected that the Board had jurisdiction to ensure that mandatory training was completed and needed to work with medical colleagues to improve this. JHa confirmed that AH had been sighted on the matter and would tie mandatory training in with consultant appraisals. NP commended the great deal of work that had taken place to get to this point. JHa and LB's involvement in the work was evident from the amount of detail they could describe. Board members approved the submission of the MIS as recommended. The maternity report was taken as read and JH highlighted the following:	

	• Statistical process control (SPC) charts had been shared live at Quality Committee for the committee to see the detail. • Smoking at time of birth stood at 8% with a target of 6%. This time last year the rate had been 16% so the improving picture was noted. • Work to reduce post-partum haemorrhage over 1500ml continued with enthusiasm. SPC charts indicated a decline in this rate although this would need to be sustained. • One incident of moderate harm • One baby loss; this was managed appropriately • No cases to refer to the perinatal mortality review • One HSIB case under review; baby was home with parents and doing well. • One risk closed; the room in the maternity led unit was usable again after a leak had been addressed • A new risk relating to the impact of industrial action, sickness and annual leave amongst consultants was impacting elective care including antenatal clinics. The Trust was investigating the use of a locum consultant and consultant staff were stepping in to pick up additional clinics. • Two complaints received in December • Quadrumvirate meetings had been embedded within the care group • The Trust continued to perform positively in relation to ATAIN data, which was currently between 5% EJ confirmed that the maternity report was thoroughly reviewed and discussed at Quality Committee each month.	
	Resolved: that the Maternity Update be received and noted, and that the Maternity Incentive Scheme be approved.	
BoD23/142	**Board Assurance Framework**	
	NJ advised that consideration was being given to what an updated Board Assurance Framework looked like in terms of template, format and content. The Board Assurance Framework would be updated once the strategic objectives from the joint strategy were developed, likely in quarter one of 2024/25. PD outlined that the Board Assurance Framework detailed the risks to delivery of the strategic objectives of the Trust and was reviewed quarterly. There had been some changes to the 'people' risks which now required Board agreement: • Seven people risks had been clarified and rewritten in to three risks to allow for clearer links to the controls and mitigations in place • The score of one people risk had been changed from 20 to 16, due to the reduction in vacancies and turnover. Overall, there were nine 'red' risks scoring 15 or more for Board sighting. These were continually monitored. SP was assured that the Board Assurance Framework was well scrutinised at committee level. He reminded Board members of the	

	importance of challenging and critiquing the mitigations in place so that the Board could be fully assured that the risks were controlled for. The Chair noted that the Corporate Risk Register, which would usually be presented alongside the Board Assurance Framework, was being considered in part two on this occasion. It would return to part one in future meetings. Board members agreed the changes made to the Board Assurance Framework.	
	Resolved: that the Board Assurance Framework be received and noted.	
BoD23/143	**Equality Diversity and Inclusion Annual Report**	
	NP outlined that the report had been considered by January's People and Culture Committee and that it provided a fair assessment of the Trust's position and where progress had and had not been made. NP noted the helpfulness of the internal audit on equality, diversity and inclusion and felt that the Trust was trying to do too much in this realm; it would be better to be clear about the specific actions that were being taken.	
	Resolved: that the Equality Diversity and Inclusion Annual Report be received and noted.	
BoD23/144	**Board Subcommittee Escalation Reports**	
	The following subcommittee Escalation Reports were taken as read. Committee Chairs drew attention to the following key points: **Quality Committee** • The committee had escalated the risk of non-compliance in the MIS • Positive shifts in performance and preventing harm • Positive use of overseas recruitment, although challenges relating to culture and helping people settle were noted • First version of the walkaround output report provided a high-level thematic review. • Positive development of escalation reports from subgroup to improve the level of assurance they offered • Good level of cross-referring to other board sub-committees • Never event reported in December, with further detail yet to be received by the committee • Ophthalmology deep dive update showing progress in the service, although further assurance was required to understand any potential or actual harms patients may have come to **Finance and Performance Committee** • An update had been provided on the New Hospitals Programme; the exceptional amount of work gone in to the programme was noted • The December meeting had focussed on financial performance • The December meeting had approved the decision to tender for development of the Fortuneswell pharmacy, pending Board approval in part two today	

	• Risk re patient transport had been referred to Quality Committee **People and Culture Committee** • No meeting in December • Improvement in reducing agency spend, although some way to go to meet the targets. • Development of a new people performance dashboard which would help to provide more insightful data and would support quality discussions at committee • Positive feedback on a medical introduction programme for school students • Change in provider of OSCE exams • Work ongoing to improve the level of data on why people choose to leave the Trust. This would help with developing retention strategies. • The number of internationally educated nurses undertaking band 6 roles had increased from seven in January 2023 to 25 by December. • Funding secured for band 8 and band 6 roles to support with retention. **Risk and Audit Committee** • Risks relating to coding; work in this service was expected to increase in the forthcoming years and recruitment posed a challenge. • A number of reports from the internal auditors, including re cyber security. • Review of the Board Assurance Framework and Corporate Risk Register. • Progress with audit planning. SP was due to meet with the auditors to review the plan for the year end audit and did not foresee any issues. **Charitable Funds Committee** • January meeting was not quorate due to operational pressures; no decisions were made by the committee • Financial income of the charity would be tough this year; this was in line with the conditions in the charitable sector • The charitable business plan would return to the Board in March • Progress on the capital appeal with £380,000 pledged so far. One donor was unable to support with a grant this year, but the charity had been invited to reapply again in December. **Working Together Committee in Common** • Collaborative working had been taking place for 12 months now. The initial work programme had been completed. • Two key items reviewed by the committee were the options appraisal, and committee review. Both of these items would be considered in part two of this meeting.	
Baker,Abi 26/03/2024 09:10:11	**Resolved that: Board subcommittee Escalation Reports be received and noted.**	

BoD23/145	**Questions from the Public**	
	KH had asked a question at the last meeting around car parking, particularly regarding accessibility, and had been advised that a review was underway. She asked if this had been completed and what the result was. CH understood the review had been completed and would provide an update to KH. JPL asked if there had been any cross-referencing of members of staff who had declared a disability and long-term sickness data. NP did not have this information but would consider looking in to the data.	
	CONSENT SECTION	
	The following items were taken without discussion. No questions had been previously raised by Board members prior to the meeting.	
BoD23/146	**ICB Part 1 Board Minutes**	
	Resolved: that the ICB Part 1 Board Minutes be received and noted.	
BoD23/147	**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.	
BoD23/148	**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** and via **MS Teams.**	

Action Log – Board of Directors Part 1

Presented on: 27th March 2024

Minute	Item	Action	Owner	Timescale	Outcome	Remove? Y/N
BoD23/136	**Matters Arising: Action Log**	A future Board development session to consider how to address the challenges relating to civility.	**AB**	March 2024	Added to the Board development session forward planner.	**Y**
BoD23/138	**CEO Update**	Future CEO reports to include detail on provider collaboratives.	**MBr**	March 2024	Detail included in the CEO Report.	**Y**
Meeting dated: 29th November 2023						
BoD23/102	**Strategy Update**	A proposal for further consideration to be developed.	**MBr**	March 2024	Board development sessions will include strategy development.	**Y**

Actions from Committees…(Include Date)						

Actions to Committees…(Include Date)						
BoD23/139 (January 2024)	**Performance Scorecard**	Finance and Performance Committee to seek further assurance on cancer performance.	**FPC**	March 2024		
BoD23/139 (January 2024)	**Performance Scorecard**	Additional productivity metrics, other than just theatre touch time, to be included in the Performance Report	**FPC**	March 2024		

Report Front Sheet

1. Report Details			
Meeting Title:	Board of Directors		
Date of Meeting:	Wednesday 27th March 2024		
Document Title:	CEO Report		
Responsible Director:	Matthew Bryant, CEO	Date of Executive Approval	22.03.24
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:

1. Roll out of Martha Rule from April 2024
2. 2024/25 Operational Planning and Joint Forward Plan Refresh.

Dorset Integrated Care System:

1. Industrial action in February and March 2024 and the impact of recovery with in NHS Dorset.
2. 2023/24 Financial and Operational plan delivery

Joint working

1. Electronic Health Record outline business case is being developed and due for submission in May 2024.
2. Leadership competency framework.
3. System board development session between Dorset County Hospital, Dorset Healthcare and University Hospital Dorset.

Dorset County Hospital:

	1. Opening of South Walks House 2. Positive feedback from a national maternity survey show Dorset County Hospital scored some of the best results in the region in the 2023 Care Quality Commission (CQC) survey of women's experiences of maternity care in England. 3. National Preceptorship Quality Mark 4. NHS Oversight Framework Quarter 3 – Segmentation Review outcome.
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 App Service Update to View Prescriptions

2.1 Following a successful trial in 2023, NHS England has added a new service to the NHS app which enables individuals to see when their prescriptions have been issued and view their prescribed medication. Individuals without a nominated pharmacy will be able to use a barcode in the app to collect their prescription from any pharmacy instead of needing a paper version. Anyone who has a nominated pharmacy can continue to collect medication without a paper prescription or barcode as details are sent to their pharmacy electronically. This new feature is in addition to use of the NHS App to request repeat prescriptions digitally and supports front line staff in providing the most effective service and will support Dorset people in provision of a more convenient prescription service.

Martha's Rule

2.2 NHS England has announced the roll out of Martha's Rule in hospitals across England from April 2024, enabling patients and families to seek an urgent review if their condition deteriorates. This is planned to be rolled out to at least 100 NHS sites and will give patients and their families 24/7 access to a rapid review from an independent critical care team if they are worried about their or a family member's condition. NHS Dorset looks forward to the opening of the pilot across the NHS.

Dental Plan

2.3 NHS England has announced a national dental plan as a first step towards recovering and reforming NHS Dentistry. The government has released increased investment to support access to dental services for those that need it and improve preventative care for the youngest children. This is supported by the NHS Long Term Workforce Plan to increase training places for dentists, dental therapists, and hygiene professionals, which will help to address capacity gaps for the future. A number of areas including Dorset will also be supported with introduction of a new dental van to support in increasing dental access. In Dorset we know that dentistry services were significantly impacted by the pandemic and our current dental capacity does not meet the demand for the NHS dental services. NHS Dorset are working with the Dorset Local Dental Committee to deliver on our collectively agreed dental plan which this NHS England announcement supports and increase NHS Dentist access in Dorset.

2024/25 Operational Planning and Joint Forward Plan Refresh

2.4 NHS England released its initial 2023/24 priorities and operational planning guidance on 23 December 2023 and high level timetable in January 2024, full planning guidance is expected to be released at the start of March 2024. Guidance received set out that the requirements including the priorities and objectives set out in 2023/24 planning guidance for urgent and emergency care, primary care and elective care not expected to fundamentally change, there is a continued focus on recovery of core service delivery and productivity and system

need to achieve and prioritise financial balance. NHS Dorset are now working with NHS partners in Dorset on its System Operating Plan for 2024/25 with full submission to NHS England for 21 March 2024.

NHS England has also issued guidance on updating the Joint Forward Plan for 2024/25, work is now underway in Dorset to refresh our plan in line for submission to NHS England by 31 March 2024. NHS Dorset are now working with system partners to update on progress since publication in July 2023 but significant change to our Joint Forward Plan is not anticipated. This review presents an opportunity to update on progress and reflect the new and emerging areas of work and focus such as Neighbourhood & Place and the Women's Health Hub.

3. Strategic update – Dorset Integrated Care System

Industrial Action

3.1 British Medical Association (BMA) and Hospital Consultant Specialist Association (HCSA) Junior Doctors are undertaking strike action over period 24 – 28 February and 24 – 29 February respectively. The Dorset system is working hard to maintain delivery of safe urgent and emergency care services in line with previous well-established procedures with NHS Dorset providing support through the System Co- ordination Centre. Our focus coming out of this industrial action will be to ensure we do everything we can to reduce the ongoing impact and recover services for the Dorset population. Regardless of the pressures it is important that those individuals that need care continue to come forward using 111 in the first instance or 999 and A&E in life-threatening emergencies.

Over the December 2023 and January 2024 period of Industrial Action, 58 - 70% of BMA Junior Doctors who would normally be working in the Dorset system undertook Industrial Action. Following Industrial Action 536 inpatient and 2528 outpatient elective appointments were rescheduled, noting this does not include the appointments and operations that were not booked at the point strike dates were announced leading to a bigger unknown impact. Work is underway to recover this activity but in conjunction with the February 2024 Industrial Action, there will be an impact on NHS Dorset meeting its operational performance standards trajectories putting waiting time standards and elective recovery targets at increasing risk.

2023/24 Financial and Operational plan delivery

3.2 In line with the re-baselined system allocation, NHS Dorset have implemented the steps to support delivery on the agreed plan. However, NHS Dorset Integrated Care System has continued to face a very challenging financial and operational position over the start of 2024 impacted by the continued Industrial Action, the high operational demand and the winter pressures. The full impact of this on our financial and operational plan delivery is being fully worked through but this will significantly impact how we end 2023/24. How we end this financial year is really important to not only give us the best start to 2024/25 but also in ensuring we deliver the best possible care to the population of Dorset.

BCP Special Educational Needs and Disability (SEND) Provision

3.4 Following consideration of the Joint Ofsted and Care Quality Commission report, the Secretary of State for Education has issued a Statutory Direction for SEND services in the Bournemouth, Christchurch & Poole (BCP) area. It is recognised that it is the collective responsibility of statutory partners to bring about improvements needed for children and young people with SEND. NHS Dorset continues to accept the collective responsibility and accountability for the performance of SEND provision alongside BCP Council and we are fully committed to work together with the council and all partners in the ICS are fully committed to work together with the council on the delivery of SEND improvement activity to bring about improvements in services across the local area and experience and outcomes for the children and young people who depend upon them.

Local Authority elections

3.5 On 02 May 2024 Parish and town councils within the Dorset Council area will hold local elections. While local councils are not directly linked to the NHS, our services can often become the subject of political debate. As an NHS provider organisation, it is very important that we remain impartial. Each of us has a duty to not engage in any activities – as a member of staff – that could call that impartiality into question or make statements/announcements which could be construed, or interpreted, as showing support for a political party or candidate.

4. Joint working

Working Together – Dorset County Hospital and Dorset HealthCare

4.1 Both Boards approved the recommendation from their Committee in Common to move to a federated operating model for the two trusts. This model means that the trusts each retain their individual sovereignty and are separately accountable to NHSE and regulated by the CQC.

The Trusts will have a shared executive team but can also have an identity for the federation. They have a shared executive team and can have shared back office services with some shared structures where this makes sense. The ambition is that they develop a shared culture and strategy. Trust leaders are now working through the detail to agree how the federation will develop in the next phase.

In addition to Jenny Horrobin joining in the role of Joint Director of Corporate Affairs in March, three further joint appointments came into post in February. These are Nicola Plumb, Joint Chief People Officer, Chris Hearn, Joint Chief Finance Officer, and Nick Johnson, Joint Chief Strategy, Transformation and Partnerships Officer.

The two trusts have been running a range of engagement activities to support the development of a joint strategy. This included opportunities for stakeholders – including staff, patients, partners and the public – to give their views about the priorities for our trusts in the coming years. The engagement finished at the end of January and is now being analysed and themed.

Development of the draft strategy is now underway, taking account of what people have told us as well as a number of other drivers including the priorities set out in the

Integrated Care Partnership (ICP) strategy. Further testing with stakeholders is then planned with final approval scheduled by early summer.

Electronic Health Record

4.2 Dorset County Hospital and Dorset Healthcare are in the process of jointly planning with Somerset for an electronic health record across all three Dorset NHS trust. An Outline Business Case is currently in development and is due to be submitted in May to regional and national teams for approval. There are discussions about the wider transformation work and structured clinical and digital consultation will take place ahead of the OBC being submitted.

Leadership Competency framework

4.3 NHS England recently published the Leadership Competency Framework to support the strengthening of NHS leadership arrangements as part of the Fit and Proper Persons process following the Kark review in 2019. The framework recommends the development and implementation of areas of competence for Board Directors and aims to promote diversity, high quality care provision and workforce and is based on wider industry best practice. All Board members will be required to annually self-assess themselves against the six competency areas that are aligned to the NHS Values and take into account NHS England's Operating Framework, Patient Safety Strategy, Workforce Plan, diversity and inclusion and the Well Led Framework (part of the CQC regulatory framework).

The requirements of the framework will be incorporated into trust recruitment processes for Board members and into the annual Board member appraisal process.

Board development meeting between DCH, DHC and UHD meeting

4.4 On 21 February a 3-way board development meeting was held with board members from all 3 providers within the Dorset ICB attending to discuss the future ways of working collaboratively within the Dorset system.

It was the first time that the boards of all three providers had met in this way, and we were able to discuss together our shared goals to improve healthcare for our population and how we might make best use of our collective resources to help improve the delivery of healthcare in Dorset. Much of this will continue to be taken forward by the Provider Collaborative.

Trust Update

Operating position and performance

5.1 During the month of March, Dorset County Hospital entered OPEL4 due to the pressures within the hospital and system having an impact on patient discharge and flow.

Demand at the front door continues to be far above the level set in the operating plan, with year-to-date growth of 8.61% when compared to last year. Performance against the 4-hour standard remained above trajectory, and the average daily number of patients with no reason to reside increasing from 65 to 73 which is 28 patients over trajectory. Demand at the front door and an increasing no reason to reside number, has results in challenged performance of the ambulance handover delay metrics, although improvements were seen in month.

Referral demand analysis has been completed by the ICB, which has shown a decrease in referral demand for the Dorset system, but an increase at DCH, with demand coming from the East. Activity levels, which have been impacted by industrial action, remain below plan but improved in this reporting month. Below plan activity levels, combined with higher referral demand, is resulting in an increasing waiting list (total size).

Clinical Acute Network Dorset

5.2 Progress continues to be made in the Clinical Acute Network Dorset, part of the Provider Collaboration between Dorset County Hospital and University Hospital Dorset and other partners. The programme is on track to deliver a single Rheumatology service, led by UHD and a single Orthodontic service, led by DCH by June 2024.

The aim of the programme is to reduce variation and inequality in health outcomes; improving the resilience, responsiveness and sustainability of services.

Opening of Outpatient Assessment Centre at South Walks House

5.3 The Trust's newly refurbished Outpatient Assessment Centre, funded with more than £14million from the NHS England Elective Recovery and Community Diagnostics Programme, opened at South Walks House in Dorchester in February.

The funding has been used to create two floors of dedicated clinical space that will allow the Trust to run more outpatient clinics, offer diagnostics appointments (such as x-rays and scans), day case local anaesthetic procedures and health and wellbeing services.

DCH started running a pop-up Outpatient Assessment Centre on one floor of the building in November 2021. This was initially set up as a temporary measure to tackle NHS waiting lists and was created as part of a partnership between NHS Dorset, Dorset HealthCare, Active Dorset and Live Well Dorset. After signing a 20-year lease with Dorset Council the permanent clinic space is now in operation.

Positive feedback for Dorset County Hospital maternity service in national survey

5.4 DCH's maternity team scored some of the best results in the region in the 2023 Care Quality Commission (CQC) survey of women's experiences of maternity care in England.

DCH's services were rated better or the same as maternity services across the country in all areas that were surveyed – with several areas among the top results for the region.

The survey asked women about their experiences of care across the whole pregnancy pathway - antenatal care, labour and birth, and postnatal care. 124 responses were received for Dorset County Hospital.

National Preceptorship Quality Mark

5.5 Dorset County Hospital NHS Foundation Trust has been successful in being awarded the National Preceptorship Quality Mark, which is valid for two years from 14 February 2024.

The Quality Mark indicates that the clinical preceptorship programme for nurses and midwives, including newly qualified and internationally educated staff, meets the highest quality standards in training and education.

NHS Oversight Framework Quarter 3 – Segmentation Review outcome

5.6 In line with the Quarter 2 segmentation review process a light touch quarter 3 review was undertaken with a focus on identifying areas of improvement or deterioration against Quarter 2 areas of concern, as well as identifying, by exception any new areas requiring further consideration. On the 5th February RSG agreed that the trust would be moved into segment 3 for Quarter 3.

The concerns being reviewed are Summary Hospital Level Mortality Indicatory (SHMI) and agency spend. It was noted that the trust has shown signs of improvement in recent months, including having addressed the previously noted SHMI with sustained progress.

Dorset County Hospital Celebrates Apprentices

5.7 On 21 February, apprentices at Dorset County Hospital (DCH) have been recognised at a special new awards ceremony.

DCH currently has 188 staff undertaking apprenticeships across a wide range of clinical and non-clinical roles, and at different levels – from Level 2 (GCSE equivalent) through to a Level 7 (master's degree). The Trust held the celebration – its first-ever apprentice awards event – as part of National Apprenticeship Week.

Report Front Sheet

Report Details			
Meeting Title:	Board of Directors		
Date of Meeting:	Wednesday 27th March 2024		
Document Title:	Dorset County Hospital Balance Score Card		
Responsible Director:	Anita Thomas, Chief Operating Officer	Date of Executive Approval	22/03/2024
Author:	Jonquil Williams, Corporate Business Manager		
Confidentiality:	If Confidential please state rationale:		
Publishable under FOI?	Yes/No		
Predetermined Report Format?	No		

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

Purpose of the Paper	To note the report							
	Note (✓)	*x*	*Discuss (✓)*		*Recommend (✓)*		*Approve (✓)*	

Key Issues

1. **Quality and safety**

- The Quality Dashboard trialled at Quality Cttee in March will be used in future as the current scorecard doesn't pull out the key areas for discussion.

- Availability of EDS remains under target – review of DATIX indicates no harm reported but work around data quality underway. Targeted work is underway with EDAU to clarify process and performance data.
- Complaints received – Early Resolution pilot continues with objective to roll out Trust wide.
- Trust remains under trajectory (positive indicator) for all healthcare acquired reportable infections. IPC have fully integrated PSIRF into investigation/audit processes
- In March, patients falling more than once constituted 50% of all incident reported. Work is ongoing to review the approach to known and repeat fallers with an emphasis on reducing the risk of harm. This includes new medication guidelines, Falls Risk Enhancing medications, being highlighted via poster. Shared at Falls Action Group
- Ward dashboards have now gone live to provide information to ward leaders on KPI achievement to drive targeted improvement.
- DCH SHMI has been within the 'expected range' for the past 6 months, against a background of gradual improvement.
- TVN now in post and working through all investigation and reporting processes for pressure damage incidents

2. **Performance**

- Five indicators (Theatres, Diagnostics, Long Waits) all indicate the continuity of improvement may be close to triggering a recalculation (orange F for Assurance). Three indicators (31 day CWT, waiting list size, bed occupancy) indicate continued poor performance and are discussed below. One Indicator (ED performance) demonstrates assurance that the process delivers against the target. Details provided below:

- Urgent and Emergency Care: Performance against the 4-hour standard remained above trajectory, and the average daily number of patients with no reason to reside increasing from 65 to 73 which is 28 patients over trajectory. Demand at the front door and an increasing no reason to reside number, has resulted in challenged performance of the ambulance handover delay metrics, although improvements were seen in month.

- Urgent and Emergency Care: Demand at the front door continues to be far above the level set in the operating plan, with year-to-date growth of 8.61% when compared to last year.

- Elective Care: The number of patients waiting over 65+ weeks is 127 patients better than the revised trajectory that was submitted as part of H2 planning. Patients are treated in clinical order, followed by chronological order, therefore where activity is below plan, the recovery of the long waiter's trajectory is impacted the most. Performance against the 78+ week trajectory is behind plan with 55 at the end of February against a trajectory of zero.

- Elective Care: Referral demand analysis has been completed by the ICB, which has shown a decrease in referral demand for the Dorset system, but an increase at DCH, with demand coming from the East. Activity levels, which have been impacted by industrial action, remain below plan but improved in this reporting month. Below plan activity levels, combined with higher referral demand, is resulting in an increasing waiting list (total size).

- Elective Care: Diagnostic performance achieved 87.6% against a target of 99% in February. This is an increase of 2.6% compared to the previous month. The backlog decreased by 57 patients and the total waiting list size increased by 476 patients.

- Elective Care: Cancer performance for February has been challenged, the trust did not achieve the new 31-day (combined) target, delivering 89% against the 96% target. The trust did achieve the faster to diagnosis target, achieving 77.65% against the 75% target. The 62-day treatment target is 85%, DCH achieved 70.98% an increase of 7.58% compared to January. The 62 day backlog did decrease as did the size of the waiting list.

3. People

- Two indicators (Essential Skills, Appraisal) all indicate the continuity of improvement may be close to triggering a recalculation (orange F for Assurance). Sickness indicates continued performance below the required standard. Staff Turnover demonstrates that the process should deliver the required standard of the rend continues (blue P for Assurance) and Vacancy rate demonstrates improvement but as yet not assurance that the requirement can be consistently be delivered through the current

processes. See below for further detail:

- Overall **essential Skills** compliance dropped to 89% in month 11. There was a general small decrease across most mandatory training subjects.

- During Month 11 the education team celebrated being awarded the National Preceptorship Quality Mark. This is valid for two years and is external verification of the high quality of our programme. The first ever DCH apprentice awards event was held during National Apprenticeship Week in February. There were ten award categories with winners from throughout the Trust and the event attracted much positive publicity including an article in the Dorset Echo.

- The **appraisal** rate remained at 78% in month 11, with small increases in both clinical divisions. The annual staff survey also includes questions about the appraisal process. 79.4% of respondents stated that they had had an appraisal in the past 12 months, which is an improvement from the previous year (76.3%) but remains below the average for the sector. We continue to receive positive feedback monthly from appraisees, but within the annual staff survey, feedback was less positive, with only 36% of respondent stating that the appraisal made them feel valued. More work will be undertaken to triangulate this information.

- The overall **sickness** percentage slightly increased in month 10 (January) by 0.06% to 4.29%. Long term and short-term absences both increased very slightly, by 0.04% and 0.02% respectively. Five of the eight staff groups saw a slight increase to their absence rates. The top reason for absence in Month 10 remained as Anxiety/Stress/Depression, followed by Cough, Cold, Flu. The number of staff accessing counselling (both on-site and via Vivup) is remaining stable, although unfortunately due to increased demand the wait to access counselling has increased and is nearing the 4-week mark. This is still considerably quicker than accessing support via the GP/Steps to Wellbeing route (approx. 6 months) but work is underway to increase capacity and shorten this wait for staff. In the meantime, staff still have access to immediate support, via the Vivup helpline and Health and Wellbeing coaches. During February 150 Health and Wellbeing folders were also distributed throughout the hospital and peripheral sites. The folders are full of information about the support available for staff and are designed for those who are not easily able to access the intranet.

- **Turnover** decreased in Month 11 and is now 10%, the lowest rate in two years. The top reason for leaving the Trust is Other/Not Known, followed by Retirement. It is positive to note that the number of staff leaving due to work life balance continues to reduce. The Other/Not known option in ESR is unhelpful but cannot be removed, however an online anonymous questionnaire is also in place to collate and report more useful information as part of the bi-annual leavers report. A key element of retention is encouraging staff to bring their whole selves to work. It was LGBT+ History Month in February and the theme was particularly pertinent to the Trust, celebrating LGBT+ peoples' contribution to the field of Medicine and Healthcare both historically and today. There was a display in the main hospital and the Pride Staff Network organised a celebration day in Damers Restaurant. The People Promise Exemplar Programme launched in month 11. The aim of the programme is to improve staff experience and retention by effectively communicating, implementing, and embedding practices and interventions across the whole of the People Promise in a

	focused way. The two externally funded programme support roles have been recruited to and the self-assessment tool is underway. • The **vacancy rate** has decreased each month since November and is now 3.71%, the lowest rate in two years. The vacancy rate peaked at 10.1% in April 2023. Since that point the contracted WTE has increased from 3,032 to 3,309, closing the vacancy gap. A successful centralised recruitment event for HSCWs was held in February. Offers totalling 21.01 FTE were made on the day and 4 bank workers were also recruited. We are on track to meet the planned intake of Internationally Educated Nurses for 23/24 with six arrivals in February. **4. Finance** • Two indicators (Capital and Adjusted Financial position do not lend themselves well to SPC and further consideration will be given to how best to demonstrate these in the next financial year. Agency spend indicates the continuity of improvement may be close to triggering a recalculation (orange F for Assurance). Efficiency delivery demonstrates that while it is not meeting the required standard there is assurance the current process should deliver the standard. Details below: • **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 per 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 (draft):** The position is currently behind plan year to date due to timings of capital expenditure purchases made for both internally and externally funded schemes however is expected to recover throughout the year. • **Efficiency Delivery:** Delivery against plan covering Corporate, Digital, Covid and Prothesis programmes, however key schemes such as Insight security reduction and reduction of high cost agency remain away from plan YTD. • **Off Framework Agency Spend:** Impact of using RN agency to cover HCA gaps as well as supporting operational pressures including specialist areas ED, CrCU, SCBU, Kingfisher. Bank rates and on framework agency rate reviews currently underway to mitigate off framework usage aligned to collaborative System working.
5. Action recommended	The Board of Directors are asked to Note this report.

6. Governance and Compliance Obligations			
Legal / Regulatory Link	**Yes**	**No**	*If yes, please summarise the legal/regulatory compliance requirement. (Please delete as appropriate)*
Impact on CQC Standards	**Yes**	**No**	*If yes, please summarise the impact on CQC standards. (Please delete as appropriate)*
Risk Link	**Yes**	**No**	*f yes, please state the link to Board Assurance Framework and Corporate Risk Register risks (incl. reference number). Provide a statement on the mitigated risk position. (Please delete as appropriate)*
Impact on Social Value	**Yes**	**No**	If yes, please summarise how your report contributes to the Trust's Social Value Pledge
Trust Strategy Link	**How does this report link to the Trust's Strategic Objectives?** *Please summarise how your report will impact one (or multiple) of the Trust's Strategic Objectives (positive or negative impact). Please include a summary of key measurable benefits or key performance indicators (KPIs) which demonstrate the impact.*		
Strategic Objectives People			
Place			
Partnership			
Dorset Integrated Care System (ICS) goals	**Which Dorset ICS goal does this report link to / support?** *Please summarise how your report contributes to the Dorset ICS key goals.* *(Please delete as appropriate)*		
Improving population health and healthcare	**Yes**	**No**	*If yes - please state how your report contributes to improving population health and health care*
Tackling unequal outcomes and access	**Yes**	**No**	*If yes - please state how your report contributes to tackling unequal outcomes and access*
Enhancing productivity and value for money	**Yes**	**No**	*If yes - please state how your report contributes to enhancing productivity and value for money*
Helping the NHS to support broader social and economic development	**Yes**	**No**	*If yes - please state how your report contributes to supporting broader social and economic development*
Assessments	**Have these assessments been completed?** *If yes, please include the assessment in the appendix to the report.. If no, please state the reason in the comment box below. (Please delete as appropriate)*		
Equality Impact Assessment (EIA)	**Yes**	**No**	
Quality Impact Assessment (QIA)	**Yes**	**No**	

Executive Dashboard March 2024 Board

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

NHS
Dorset County Hospital
NHS Foundation Trust

Summary of Data

Report Reference
Executive Dashboard

Purpose of Report
Provide insight into a broad range of DCH metrics for executive level overview and understand where processes have failed and/or improved through the use of SPC chart tool provided by the national making data count team.

Source of Report
Data sources are primarily from the BI Data Warehouse but also includes information from manual sources as well as system data. Refer to glossary page for further information.
This report is a snapshot report taken at an agreed point in the month in line with Committee and Board Meetings.

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

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

pdf version

Executive Dashboard (Refreshed Live)

Making Data Count

Understanding and Interpreting SPC Charts

DCHFT Power BI User Guide
DCHFT BI Gateway User Guide

Business Intelligence Gateway

2024-03-10 12:08:38
data last refreshed:

30 April 2019
metric data from:

29 February 2024
to:

Report Version 2.0 (Mar-23)
Produced by Dorset County Hospital Business Intelligence Team

Please contact the Team if you have any questions regarding this report
BusinessIntelligence@dchft.nhs.uk

Cover Page | Executive Summary | Matrix Overview | Exception Report | Quality & Safety | Performance | People | Finance | Glossary | Useful Links | Appendix A: SPC Basics | Appendix B: SPC Icon Descriptions | Appendix C: Understanding Assurance | Appendix D: When+Why Recalculate Process Limits

Executive Summary

Variation

Assurance

PERFORMANCE

Metric Name	Assurance	Variation	Value	Target
Cancer - 28 Day Faster Diagnosis Standard Performance			77.42%	75%
Cancer - 31 Day Decision to Treatment Standard Performance			90.91%	96%
Cancer - Patients Waiting 62+ Days from Referral to Treatment			86	75
Diagnostic - Percentage Patients Waiting <6 Weeks Test			87.58%	99%
ED - Ambulance Handovers % < 15 Minutes			60.32%	65%
ED - Ambulance Handovers % < 30 Minutes			91.67%	95%
ED - Ambulance Handovers > 60 minutes			46	0
ED - Overall 4 Hour Performance %			80.64%	76%
Inpatient - Adult General and Acute (G&A) % No Criteria to Reside Bed Occupancy			23.55%	
Inpatient - Average Adult General and Acute (G&A) Bed Occupancy			310	279
RTT - 65+ Week Waits			383	34
RTT - 78+ Week Waits			55	0
RTT - Waiting List Size			21023	19523
Theatres - Capped Utilisation			73.28%	85%
Theatres - Uncapped Utilisation			77.79%	85%

PEOPLE

Metric Name	Assurance	Variation	Value	Target
Appraisal rate			78.36%	90%
Essential Skill Rate			89%	90%
Sickness Rate (1 month in arrears)			4.29%	3.75%
Staff Turnover Rate			10.02%	12%
Vacancy Rate			3.71%	5%

QUALITY

Metric Name	Assurance	Variation	Value	Target
Complaints - Formal Complaints Received			27	
Friends and Family - Overall % Recommendation Rate			86.88%	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			96	
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			3	3
Infection Control - Gram Negative Blood Stream Hospital Onset Infections			4	5
Inpatient - EDS % Available < 24 Hours of Discharge			67.29%	90%
Inpatient - EDS % Available < 7 Days of Discharge			83.12%	100%
Inpatient - EDS Applicable Discharges % Recorded within 30 Minutes			50.42%	
Inpatient - Emergency Re-Admissions % (1 month in arrears)			9.73%	13%
Inpatient - SHMI Value			1.12	

FINANCE

Metric Name	Assurance	Variation	Value	Target
Adjusted Financial Position			855	-453
Agency Spend			803	833
Capital Expenditure			1555	1935
Efficiency Delivery			450	1312
Local Supplier % of Catering Spend			26.81%	
Local Supplier % of Total Spend			7.2%	
Off Framework Agency Spend			128	83

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26/03/2024 09:10:11

Matrix Overview

NHS
Dorset County Hospital
NHS Foundation Trust

Assurance

Variance	P	?	F	◌	Total
H			5		5
L		1	4	2	7
?	1	10		3	14
H	3	3		1	7
L		2	2	1	5
◌				3	3
Total	4	16	11	10	41

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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
Friends and Family - Overall % Recommendation Rate	?	L	86.88%	94%
Incidents - Medication Incidents by Reported Date		H	96	
Inpatient - EDS % Available < 24 Hours of Discharge	F	L	67.29%	90%
Inpatient - EDS % Available < 7 Days of Discharge	F	L	83.12%	100%
Inpatient - EDS Applicable Discharges % Recorded within 30 Minutes		L	50.42%	
Inpatient - Emergency Re-Admissions % (1 month in arrears)	P	H	9.73%	13%

Commentary

Availability of EDS remains under target – review of DATIX indicates no harm reported but work around data quality underway. Targeted work is underway with EDAU to clarify process and performance data.

Ward dashboards have now gone live to provide information to ward leaders on KPI achievement to drive targeted improvement.

PEOPLE

Metric Name	Assurance	Variation	Value	Target
Appraisal rate	F	H	78.36%	90%
Essential Skill Rate	F	H	89%	90%
Sickness Rate (1 month in arrears)	?	H	4.29%	3.75%
Staff Turnover Rate	P	H	10.02%	12%

Commentary

Appraisal Rate: Remained at 78% in month 11, with small increases in both clinical divisions. The annual staff survey also includes questions about the appraisal process. 79.4% of respondents stated that they had had an appraisal in the past 12 months, which is an improvement from the previous year (76.3%) but remains below the average for the sector. We continue to receive positive feedback monthly from appraisees, but within the annual staff survey, feedback was less positive, with only 36% of respondent stating that the appraisal made them feel valued. More work will be undertaken to triangulate this information.

Essential Skills: Overall compliance dropped to 89% in month 11. There was a general small decrease across most mandatory training subjects. During Month 11 the education team celebrated being awarded the National Preceptorship Quality Mark. This is valid for two years and is external verification of the high quality of our programme. The first ever DCH apprentice awards event was held during National Apprenticeship Week in February. There were ten award categories with winners from throughout the Trust and the event attracted much positive publicity including an article in the Dorset Echo.

Turnover: Turnover decreased in Month 11 and is now 10%, the lowest rate in two years. The top reason for leaving the Trust is Other/Not Known, followed by Retirement. It is positive to note that

PERFORMANCE

Metric Name	Assurance	Variation	Value	Target
Cancer - 31 Day Decision to Treatment Standard Performance	?	L	90.91%	96%
Diagnostic - Percentage Patients Waiting <6 Weeks Test	F	H	87.58%	99%
Inpatient - Average Adult General and Acute (G&A) Bed Occupancy	?	H	310	279
RTT - 65+ Week Waits	F	L	383	34
RTT - 78+ Week Waits	F	L	55	0
RTT - Waiting List Size	?	H	21023	19523
Theatres - Capped Utilisation	F	H	73.28%	85%
Theatres - Uncapped Utilisation	F	H	77.79%	85%

Commentary

Elective Care: Cancer performance for February has been challenged, the trust did not achieve the new 31-day (combined) target, delivering 89% against the 96% target. The trust did achieve the faster to diagnosis target, achieving 77.65% against the 75% target. The 62-day treatment target is 85%, DCH achieved 70.98% an increase of 7.58% compared to January. The 62 day backlog did decrease as did the size of the waiting list.

Elective Care: Diagnostic performance achieved 87.6% against a target of 99% in February. This is an increase of 2.6% compared to the previous month. The backlog decreased by 57 patients and the total waiting list size increased by 476 patients.

Elective Care: Referral demand analysis has been completed by the ICB, which has shown a decrease in referral demand for the Dorset system, but an increase at DCH, with demand coming from the East. Activity levels, which have been impacted by industrial action, remain below plan but improved in this reporting month. Below plan activity levels, combined with higher referral demand, is resulting in an increasing waiting list (total size).

Elective Care: The number of patients waiting over 65+ weeks is 127 patients better than the revised trajectory, that was submitted as part of H2 planning. Patients are treated in clinical order, followed by chronological order, therefore where activity is below plan, the recovery of the long waiter's trajectory is impacted the most. Performance against the 78+ week trajectory is behind plan with 55 at the end of February against a trajectory of zero.

Urgent and Emergency Care: Demand at the front door continues to be far above the level set in the

FINANCE

Metric Name	Assurance	Variation	Value	Target
Agency Spend	F	L	803	833
Efficiency Delivery	P	H	450	1312

Commentary

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

Agency Spend: as per 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

- Availability of EDS remains under target – review of DATIX indicates no harm reported but work around data quality underway. Targeted work is underway with EDAU to clarify process and performance data.
- Complaints received – Early Resolution pilot continues with objective to roll out Trust wide.
- DCH SHMI has been within the 'expected range' for the past 6 months, against a background of gradual improvement.
- In March, patients falling more than once constituted 50% of all incident reported. Work is ongoing to review the approach to known and repeat fallers with an emphasis on reducing the risk of harm. This includes new medication guidelines, Falls Risk Enhancing medications, being highlighted via poster. Shared at Falls Action Group.
- Trust remains under trajectory for all healthcare acquired reportable infections. IPC have fully integrated PSIRF into investigation/audit processes.
- TVN now in post and working through all investigation and reporting processes for pressure damage incidents.
- Ward dashboards have now gone live to provide information to ward leaders on KPI achievement to drive targeted improvement.

VariationIcon	Pass	Hit or Miss	Fail	Empty	Total
Improvement			1	2	3
Common Cause		3		2	5
Concern	1	1	2	2	6
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	Feb-24	67.29%	90%	-22.71%	77.89%		67.29%		
Effectiveness	Inpatient - EDS % Available < 7 Days of Discharge	0 - Total	Feb-24	83.12%	100%	-16.88%	88.09%		83.12%		
Effectiveness	Inpatient - EDS Applicable Discharges % Recorded within 30 Minutes	0 - Total	Feb-24	50.42%			55.38%		50.42%		
Effectiveness	Inpatient - Emergency Re-Admissions % (1 month in arrears)	0 - Total	Jan-24	9.73%	13%	-3.27%	8.11%	5.71%	9.73%		
Experience	Complaints - Formal Complaints Received	0 - Total	Feb-24	27			26.88		254		
Experience	Friends and Family - Overall % Recommendation Rate	0 - Total	Feb-24	86.88%	94%	-7.12%	91.68%		86.88%		
Safety	Incidents - Confirmed Never Events	0 - Total	Feb-24	0	0.02	-0.02	0.07		1		
Safety	Incidents - Falls Resulting in Severe Harm or Death by Reported Date	0 - Total	Feb-24	0			0.2		0		
Safety	Incidents - Medication Incidents by Reported Date	0 - Total	Feb-24	96			59.46		861		
Safety	Incidents - Pressure Ulcers Reportable Confirmed Avoidable and Hospital A…	0 - Total	Feb-24	1			0.68		10		
Safety	Incidents - Serious Incidents Investigated and Confirmed Avoidable by Pan…	0 - Total	Feb-24	0	0	0.00	0.46		3		
Safety	Infection Control - C-Diff Hospital Onset Healthcare Associated Cases	0 - Total	Feb-24	3	3	0.00	2.64		34		
Safety	Infection Control - Gram Negative Blood Stream Hospital Onset Infections	0 - Total	Feb-24	4	5	-1.00	3.02		34		
Safety	Inpatient - SHMI Value	0 - Total	Sep-23	1.12			1.14	1.18	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

Urgent and Emergency Care: Performance against the 4-hour standard remained above trajectory, and the average daily number of patients with no reason to reside increasing from 65 to 73 which is 28 patients over trajectory. Demand at the front door and an increasing no reason to reside number, has results in challenged performance of the ambulance handover delay metrics, although improvements were seen in month.

Urgent and Emergency Care: Demand at the front door continues to be far above the level set in the operating plan, with year-to-date growth of 8.61% when compared to last year.

Elective Care: The number of patients waiting over 65+ weeks is 127 patients better than the revised trajectory, that was submitted as part of H2 planning. Patients are treated in clinical order, followed by chronological order, therefore where activity is below plan, the recovery of the long waiter's trajectory is impacted the most. Performance against the 78+ week trajectory is behind plan with 55 at the end of February against a trajectory of zero.

Elective Care: Referral demand analysis has been completed by the ICB, which has shown a decrease in referral demand for the Dorset system, but an increase at DCH, with demand coming from the East. Activity levels, which have been impacted by industrial action, remain below plan but improved in this reporting month. Below plan activity levels, combined with higher referral demand, is resulting in an increasing waiting list (total size).

Elective Care: Diagnostic performance achieved 87.6% against a target of 99% in February. This is an increase of 2.6% compared to the previous month. The backlog

VariationIcon	Pass	Hit or Miss	Fail	Empty	Total
Improvement			5		5
Common Cause	1	5		1	7
Concern		3			3
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	Feb-24	77.42%	75%	2.42%	69.85%		77.42%		
Cancer	Cancer - 31 Day Decision to Treatment Standard Performance	0 - Total	Feb-24	90.91%	96%	-5.09%	96.44%		90.91%		
Cancer	Cancer - Patients Waiting 62+ Days from Referral to Treatment	0 - Total	Feb-24	86	75	11.00	80.27		997		
Elective	Theatres - Capped Utilisation	0 - Total	Feb-24	73.28%	85%	-11.72%	68.38%		73.28%		
Elective	Theatres - Uncapped Utilisation	0 - Total	Feb-24	77.79%	85%	-7.21%	73.53%		77.79%		
Outpatient	Diagnostic - Percentage Patients Waiting <6 Weeks Test	0 - Total	Feb-24	87.58%	99%	-11.42%	74.71%		87.58%		
Outpatient	RTT - 65+ Week Waits	0 - Total	Feb-24	383	34	349.00	717.38		383		
Outpatient	RTT - 78+ Week Waits	0 - Total	Feb-24	55	0	55.00	344.29		55		
Outpatient	RTT - Waiting List Size	0 - Total	Feb-24	21023	19523	1,500.00	19118.41		21023		
UEC	ED - Ambulance Handovers % < 15 Minutes	0 - Total	Feb-24	60.32%	65%	-4.68%	72.02%		60.32%		
UEC	ED - Ambulance Handovers % < 30 Minutes	0 - Total	Feb-24	91.67%	95%	-3.33%	89.69%		91.67%		
UEC	ED - Ambulance Handovers > 60 minutes	0 - Total	Feb-24	46	0	46.00	62.15		555		
UEC	ED - Overall 4 Hour Performance %	0 - Total	Feb-24	80.64%	76%	4.64%	82.24%		80.64%		
UEC	Inpatient - Adult General and Acute (G&A) % No Criteria to Reside Bed Occup…	0 - Total	Feb-24	23.55%			21.75%		23.55%		
UEC	Inpatient - Average Adult General and Acute (G&A) Bed Occupancy	0 - Total	Feb-24	310	279	31.00	296.46		310		

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.

NHS
Dorset County Hospital
NHS Foundation Trust

Commentary

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Vacancy Rate: Rate has decreased each month since November and is now 3.71%, the lowest rate in two years. The vacancy rate peaked at 10.1% in April 2023. Since that point the contracted WTE has increased from 3,032 to 3,309, closing the vacancy gap. A successful centralised recruitment event for HSCWs was held in February. Offers totalling 21.01 FTE were made on the day and 4 bank workers were also recruited. We are on track to meet the planned intake of Internationally Educated Nurses for 23/24 with six arrivals in February.

VariationIcon	Pass	Hit or Miss	Fail	Empty	Total
Improvement		1	2		3
Common Cause					
Concern	1	1			2
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	Feb-24	89%	90%	-1.00%	88.92%		89%		
Looking After our People	Appraisal rate	0 - Total	Feb-24	78.36%	90%	-11.64%	75.65%		78.36%		
Looking After our People	Sickness Rate (1 month in arrears)	0 - Total	Jan-24	4.29%	3.75%	0.54%	4%	4.64%	4.29%		
Looking After our People	Staff Turnover Rate	0 - Total	Feb-24	10.02%	12%	-1.98%	9.74%		10.02%		
Looking After our People	Vacancy Rate	0 - Total	Feb-24	3.71%	5%	-1.29%	6.5%		3.71%		

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 per 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 (draft): The position is currently behind plan year to date due to timings of capital expenditure purchases made for both internally and externally funded schemes however is expected to recover throughout the year.
Efficiency Delivery: Delivery against plan covering Corporate, Digital, Covid and Prothesis programmes, however key schemes such as Insight security reduction and reduction of high cost agency remain away from plan YTD.
Off Framework Agency Spend: Impact of using RN agency to cover HCA gaps as well as supporting operational pressures including specialist areas ED, CrCU, SCBU, Kingfisher. Bank rates and on framework agency rate reviews currently underway to mitigate off framework usage aligned to collaborative System working.

VariationIcon	Pass	Hit or Miss	Fail	Empty	Total
Improvement			1		1
Common Cause		2			2
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	Feb-24	1555	1935	-380.00	1923.15		20841		
Revenue	Adjusted Financial Position	0 - Total	Feb-24	855	-453	1,308.00	-339.92		-8959		
Sustainability	Local Supplier % of Catering Spend	0 - Total	Feb-24	26.81%			25.01%		26.81%		
Sustainability	Local Supplier % of Total Spend	0 - Total	Feb-24	7.2%			6.72%		7.2%		
Value Board	Agency Spend	0 - Total	Feb-24	803	833	-30.00	1165.86		12604		
Value Board	Efficiency Delivery	0 - Total	Feb-24	450	1312	-862.00	187.93		3960		
Value Board	Off Framework Agency Spend	0 - Total	Feb-24	128	83	45.00	135		1485		

Glossary

Metric Name

All

NHS
Dorset County Hospital
NHS Foundation Trust

MetricName	MetricDescription
Cancer - 28 Day Faster Diagnosis Standard Performance	Percentage of patients meeting the 28 day faster diagnosis cancer standard (from referral to point where given an all clear or confirmed diagnosis). Sourced from Somerset Cancer Register (SCR).
Cancer - 31 Day Decision to Treatment Standard Performance	Percentage of patients meeting the 31 day decision to treatment cancer standard (based Treatment for DCH treated patients). Sourced from Somerset Cancer Register (SCR).
Cancer - Patients Waiting 62+ Days from Referral to Treatment	Number of patients waiting longer than 62 days from cancer referral to treatment following a screening service referral. Sourced from the DCH Manual Data Collection Portal via the Cancer Team.
Complaints - Formal Complaints Received	Number of formal and complex complaints raised based on received date. Sourced from Datix.
Diagnostic - Patients % Waiting < 6 Weeks for Diagnostic Test	Percentage of Patients waiting less than 6 weeks for a diagnostic test in line with DM01 methodology. Sourced from DM01 Monthly Position.
ED - Ambulance Handovers % < 15 Minutes	Percentage of DCH ambulance handovers that took less than 15 minutes. Sourced from ED SWAST information.
ED - Ambulance Handovers % < 30 Minutes	Percentage of DCH ambulance handovers that took less than 30 minutes. Sourced from ED SWAST information.
ED - Ambulance Handovers > 60 minutes	Number of DCH ambulance handovers that took longer than 60 minutes. Sourced from ED SWAST information.
ED - Overall 4 Hour Performance %	Percentage of patients with an unplanned Emergency Department/MIU visits lasting longer than the 4 hour peformance standard. Sourced from ED Agyle/PAS and MIU information.
Finance - Adjusted Financial Position	Finance Spend (£000) Adjusted financial performance surplus or deficit. Sourced from Finance team.
Finance - Agency Spend	Agency Spend (£000). Sourced from Finance team.
Finance - Capital Expenditure	Capital Expenditure (£000). Sourced from Finance team.
Finance - Efficiency Delivery	Paid CIP (£000) for efficiency delivery. Sourced from Finance team.
Finance - Local Supplier % of Catering Spend	Percentage of catering spend with local suppliers. Sourced from the Procurement team.
Finance - Local Supplier % of Total Spend	Percentage of total spend with local suppliers. Sourced from the Procurement team.
Finance - Off Framework Agency Spend	Off Framework Agency Spend (£000). Sourced from Finance team.
Friends and Family - Overall % Recommendation Rate	Percentage of overall Friends and Family recommendation. Sourced from the Patient and Public Experience team.
Incidents - Confirmed Never Events	Number of occurances of confirmed Never Events based on updated date excluding any rejected or duplicated incidents. Sourced from Datix.
Incidents - Falls Resulting in Severe Harm or Death by Reported Date	Number of occurances of falls catagorised as severe or death severity of harm caused, based on reported date excluding any rejected or duplicated incidents. Sourced from Datix.
Incidents - Medication Incidents by Reported Date	Number of occurances of medicine incidents based on reported date excluding any rejected or duplicated incidents. Sourced from Datix.
Incidents - Pressure Ulcers Reportable Confirmed Avoidable and Hospital Acquired (Category 3) by Reported Date	Number of occurances of hospital acquired category 3 pressure ulcers by panel date excluding any rejected or duplicated incidents. Sourced from Datix.
Incidents - Serious Incidents Investigated and Confirmed Avoidable by Panel Date	Number of occurances of serious incidents investigated and confirmed avoidable by panel date excluding any rejected or duplicated incidents. Sourced from Datix.
Infection Control - C-Diff Hospital Onset Healthcare Associated Cases	Number of occurances of hospital onset healthcare associated Clostridium difficile (C. diff) incidents by specimen date. Sourced from HCAI data.
Infection Control - Gram Negative Blood Stream Hospital Onset Infections	Number of occurances of hospital onset gram negative blood stream infection incidents by specimen date. Sourced from HCAI data.
Inpatient - Adult General and Acute (G&A) % No Criteria to Reside Bed Occupancy	Percentage of total adult G&A beds occupied (as per reported in UEC Daily SitRep) by No Reason To Reside (NRTR) patients (as per reported in EPPR Daily Discharge SitRep). Original source PAS / Patient Action Tracker.
Inpatient - Average Adult General and Acute (G&A) Bed Occupancy	Average adult G&A beds occupancy (as per reported in UEC Daily SitRep). Original source BedBoss.
Inpatient - EDS % Available < 24 Hours of Discharge	Percentage of electronic discharge summaries (EDS) available for GPs to access within 24 hours of discharge from an inpatient spell. Sourced from EDS reporting, original source ICE / PAS.
Inpatient - EDS % Available < 7 Days of Discharge	Percentage of electronic discharge summaries (EDS) available for GPs to access within 7 days of discharge from an inpatient spell. Sourced from EDS reporting, original source ICE / PAS.
Inpatient - EDS Applicable Discharges % Recorded within 30 Minutes	Percentage of EDS applicable inpatient spells recorded systemically within 30 minutes of patient discharge. Sourced from PAS.

Useful Links

Dorset County Hospital
NHS Foundation Trust

FutureNHS

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

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

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

Events

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

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

Guides & Cards

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

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

SPC Surgery

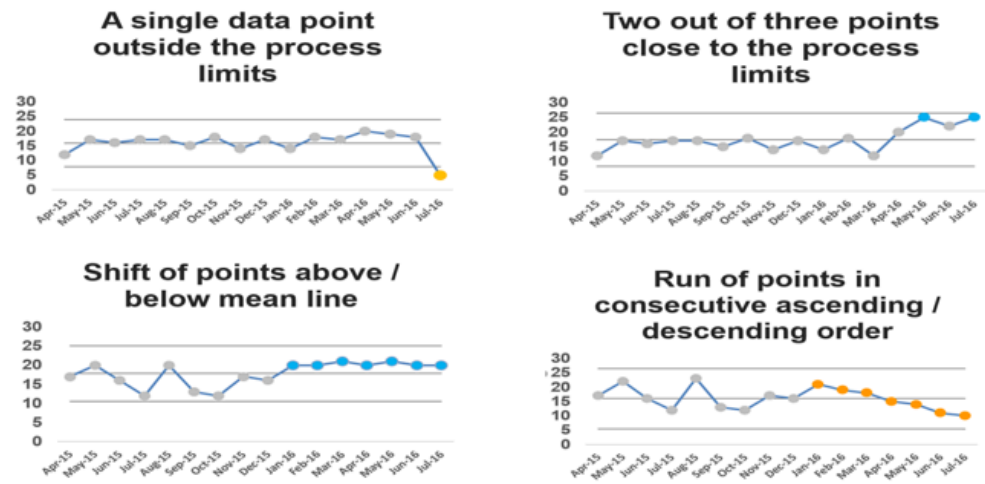
If you have any questions on the national teams tools, training, or anything else SPC related, send the national team an email to nhsi.improvementanalyticsteam@nhs.net. If they do not answer immediately, you can book a virtual meeting slot.

Is Performance Changing?

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

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

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



What are Summary Icons showing?

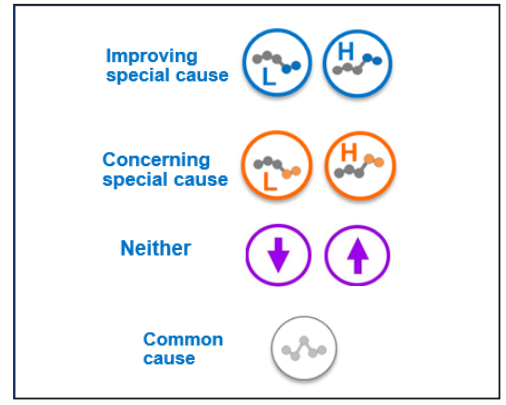
Blue icons indicate significant improvement or low pressure.

Orange icons indicate significant concern or high pressure.

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

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

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



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

What is a Moving Range Chart showing?

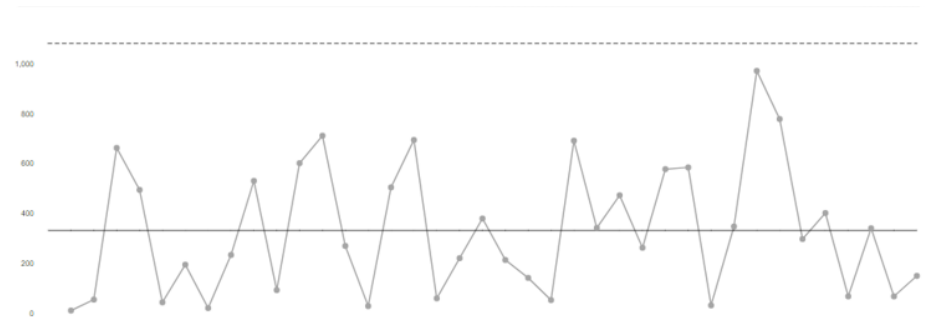
Moving range chart (seen on right) helps to assess the variation in a process by taking the absolute difference between consecutive points.

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

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

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

The moving range chart will display below all SPC visualisations.



SPC Icon Descriptions

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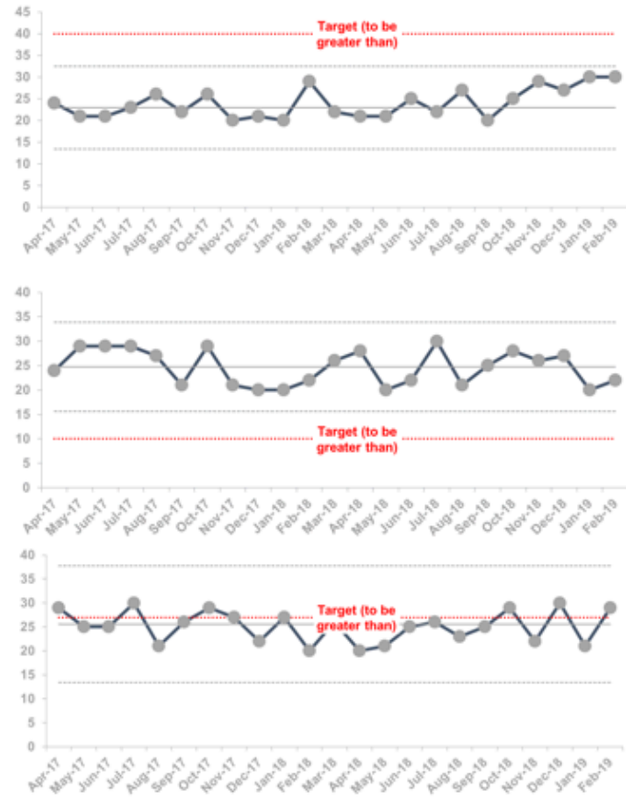
Variance	Assurance: P	Assurance: ?	Assurance: F	Assurance: ○
H	Special cause of an improving nature where the measure is significantly **HIGHER**. This process is capable and will consistently **PASS** the target.	Special cause of an improving nature where the measure is significantly **HIGHER**. This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

Assurance icon

Up is good (need to be greater than the target



Failing process

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

Capable process

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

Unreliable process (flip flop)

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

When+Why Recalculate Process Limits

Dorset County Hospital
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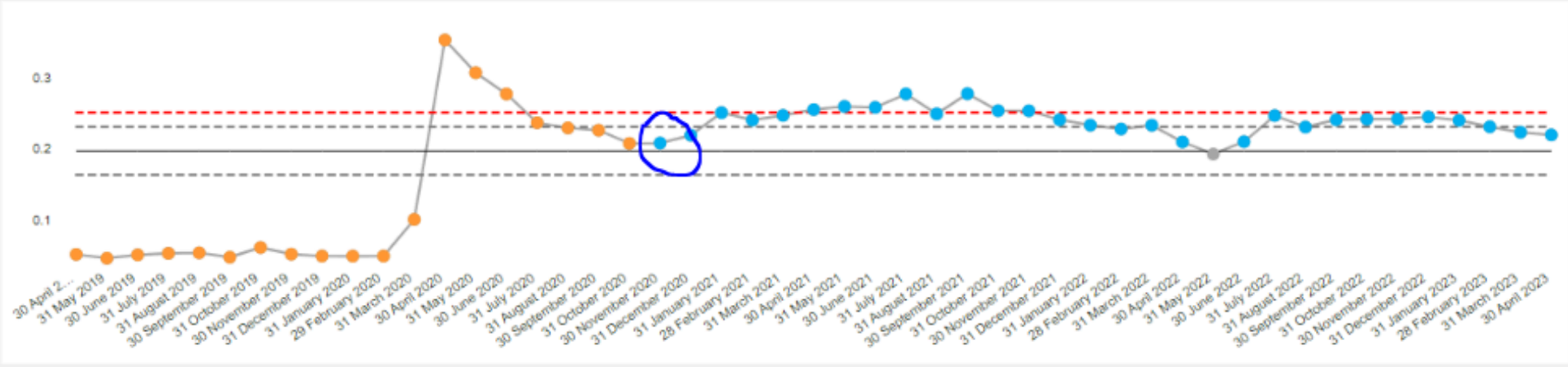

Here we see a brilliant example of the need to recalculate process limits (dashed grey lines).

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

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

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

Report Front Sheet

1. Report Details			
Meeting Title:	Board of Directors		
Date of Meeting:	Wednesday 27th March 2024		
Document Title:	System Performance Report		
Responsible Director:	Matthew Bryant, Chief Executive	Date of Executive Approval	20.03.24
Author:	Jonquil Williams, Corporate Business Manager		
Confidentiality:	If Confidential please state rationale: No		
Publishable under FOI?	**Yes**/No		
Predetermined Report Format?	Has the format of the report been set in order to meet a regulatory or statutory requirement? i.e., to satisfy the reporting requirements following a national inquiry / been determined by NHSE/I / CQC? Yes / No? if yes please state.		

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

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

4. Key Issues

Appendix to the Dorset County Hospital Board papers:
ICB System Board report – taken to ICB Board on 07 March 2024

The purpose of this paper is to provide an overview of performance against the H2 standards, a performance overview against all operating plan standards, and highlight areas of focus.

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

Performance progress reports in Appendix 2 outline whether each standard is achieving trajectory and whether performance has deteriorated, improved, or maintained compared to the previous month.

The performance progress reports (appendix 2) also contain statistical process control (SPC) charts along with associated actions.

This report includes thirty-nine standards, of which:

- Twenty-one areas are performing as expected when compared to the agreed operating plan trajectories.
- Nine areas are not performing as expected when compared to the agreed operating plan trajectories, however performance was either maintained or improved.
- Nine areas are not performing as expected when compared to the agreed operating plan trajectories and performance deteriorated.

There are three top standards at risk of achieving the H2 trajectories which are virtual wards, 78-week waiters, and the four-hour emergency department standard.

5. Action recommended	N/A

6. Governance and Compliance Obligations			
Legal / Regulatory Link	**No**	*If yes, please summarise the legal/regulatory compliance requirement.* *(Please delete as appropriate)*	
Impact on CQC Standards	**No**	*If yes, please summarise the impact on CQC standards.* *(Please delete as appropriate)*	
Risk Link	**No**	*f yes, please state the link to Board Assurance Framework and Corporate Risk Register risks (incl. reference number). Provide a statement on the mitigated risk position.* *(Please delete as appropriate)*	
Impact on Social Value	**No**	If yes, please summarise how your report contributes to the Trust's Social Value Pledge	
Trust Strategy Link	**How does this report link to the Trust's Strategic Objectives?** *Please summarise how your report will impact one (or multiple) of the Trust's Strategic Objectives (positive or negative impact). Please include a summary of key measurable benefits or key performance indicators (KPIs) which demonstrate the impact.*		
Strategic Objectives	People		
	Place		
	Partnership		
Dorset Integrated Care System (ICS) goals	**Which Dorset ICS goals does this report link to / support?** *Please summarise how your report contributes to the Dorset ICS key goals.* *(Please delete as appropriate)*		
Improving population health and healthcare	**No**	*If yes - please state how your report contributes to improving population health and health care*	
Tackling unequal outcomes and access	**No**	*If yes - please state how your report contributes to tackling unequal outcomes and access*	
Enhancing productivity and value for money	**No**	*If yes - please state how your report contributes to enhancing productivity and value for money*	
Helping the NHS to support broader social and economic development	**No**	*If yes - please state how your report contributes to supporting broader social and economic development*	
Assessments	**Have these assessments been completed?** *If yes, please include the assessment in the appendix to the report.* *If no, please state the reason in the comment box below.* *(Please delete as appropriate)*		
Equality Impact Assessment (EIA)	**Yes**	**No**	
Quality Impact Assessment (QIA)	**Yes**	**No**	

NHS Dorset Integrated Care Board

Meeting Title	ICB Board
Date of Meeting	7 March 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**
Productivity and Performance Committee	22 February 2024	Received, discussion reflected in Chair's escalation report to the Board.
Deputy Chief Operating Officer, NHS Dorset	12 February 2024	Approved.
Deputy Director of Performance and Planning	08 February 2024	Approved.
Provider Performance Leads, Chief Operating Officers, and Delivery Group Senior Responsible Officers	January/February 2024	Paper developed in collaboration.
ICB Heads of Service and Deputy Directors	January/February 2024	Narrative for service areas 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 purpose of this paper is to provide an overview of performance against the H2 standards, a performance overview against all operating plan standards, and highlight areas of focus. An overview of the performance against all operating plan standards can be found in Appendix 1. This is broken down by provider, where applicable. Performance progress reports in Appendix 2 outline whether each standard is achieving trajectory and whether performance has deteriorated, improved, or maintained compared to the previous month. The performance progress reports (appendix 2) also contain statistical process control (SPC) charts along with associated actions. This report includes thirty-nine standards, of which:						

	• Twenty-one areas are performing as expected when compared to the agreed operating plan trajectories. • Nine areas are not performing as expected when compared to the agreed operating plan trajectories, however performance was either maintained or improved. • Nine areas are not performing as expected when compared to the agreed operating plan trajectories and performance deteriorated. There are three top standards at risk of achieving the H2 trajectories which are virtual wards, 78-week waiters, and the four-hour emergency department standard.
Action recommended	The ICB Board is recommended to **NOTE** the content of this paper.

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

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

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

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

System Working

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

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. In November 2023, upon request from NHS England following a letter regarding the impact of industrial action, the Dorset system submitted a revised operating plan for the remainder of 2023/24 (known as H2). Consequently, key performance standards were agreed.

1.4. The H2 submission committed to deliver the following standards by the end of March 2024:

Standard	End of March 2024
Virtual ward utilisation	80%
Virtual ward capacity	360 beds
78-week waiters	Zero
65-week waiters	1,053 (previously zero)
100% of 2019/20 activity (ERF)	100%
Faster diagnosis standard	75%
62-day cancer backlog	290
4-hour emergency department standard	76%
Category 2 ambulance response times	21 minutes

1.5. The submission did not commit to deliver the standard of zero patients waiting beyond 65-weeks.

1.6 The submission did not include any impact of further industrial action and industrial action by junior doctors announced for December 2023 and January 2024 will impact performance.

1.7 H2 operational standards are monitored through the System Recovery Group and Chief Executives Meeting on a weekly basis.

2. Performance Overview

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

2.2 Performance progress reports in appendix 2 outline whether the operating plan standards are achieving trajectory and whether performance has deteriorated, improved, or maintained compared to the previous month. This is summarised below showing **H2 standards** in **bold**. The reports in appendix 2 also contain statistical process control (SPC) charts along with associated actions and supporting narrative.

2.3 The following twenty-one areas were performing as expected at the end of December 2023 when compared to the agreed operating plan trajectories:

- 2-hour urgent community response contacts
- 2-hour urgent community response times
- 2-week primary care access
- **78-week waiters**
- **65-week waiters**
- **100% activity (ERF)**
- Elective recovery – first outpatient appointments
- Elective recovery – follow-up appointments
- Patient initiated follow-ups
- Reduction in total waiting list
- Reduction in follow-up outpatients
- Diagnostics
- **4-hour emergency department standard**
- Bed occupancy
- 40-minute handover delays
- Out of area placements
- NHS Talking Therapies
- Dementia diagnosis rates
- Children and young people mental health – urgent access to eating disorders
- Reduce inpatient care for people with a learning disability and autism – adults
- Reduce inpatient care for people with a learning disability and autism – CYP

2.4 The following nine areas were not performing as expected at the end of December 2023 when compared to the agreed operating plan trajectories, however performance was either maintained or improved:

- **Virtual ward capacity**
- Elective recovery – inpatient ordinary activity
- **62-day backlog**
- No criteria to reside
- Overall access to core community mental health services for adults and older adults with severe mental illness
- Perinatal mental health access
- Children and young people mental health access
- Children and young people mental health – routine access to eating disorders
- People aged over 14 on GP LD registers to receive an Annual Health Check

2.5 The following nine areas are not performing as expected at the end of December 2023 when compared to the agreed operating plan trajectories and performance deteriorated:

- **Virtual ward utilisation**
- Increase in primary care appointments
- Elective recovery – day case activity
- Advice and guidance
- Theatre utilisation
- Day case rates
- **Faster diagnosis standard**
- **Category 2 ambulance response times**

- Children and young people mental health – CAMHS Gateway

3. Areas of Focus

3.1 The following areas have been identified through this report as requiring additional focus with actions addressing the challenges detailed in the performance progress reports (appendix 2).

3.2 There are three top standards at risk of achieving the H2 trajectories which are:

- **Virtual wards:** performance did not achieve the required utilisation percentage or capacity numbers outlined in the H2 plan for the end of December. Utilisation was 50% against a trajectory of 60%. From a capacity perspective, there are 60 remote monitoring beds which are not included in the numbers. If included the system would achieve the required number of beds but reduce the utilisation further. Good progress has been made to increase the number of virtual ward beds and the number of patients using them. However, there needs to be another significant step change by the end of March 2024; an additional 166 in addition to the current 194 (including remote monitoring beds). January's performance trajectories are not expected to be achieved. Virtual ward performance is monitored through the System Recovery Group and Chief Executives Meeting on a weekly basis.

- **78-week waiters:** performance against the 78-week trajectory was achieved in December 2023, however this will not be maintained in January. It is important to note the H2 trajectories did not include the impact of any further industrial action however, four days of industrial action took place in December 2023 with a further four days announced for February 2024. Providers make every effort to protect the 78-week waiter cohort, however due to industrial action and operational pressures this is not always possible. The predicted end of January position is 146 patients waiting beyond 78-weeks (60 at Dorset County Hospital, and 86 at University Hospitals Dorset). This will be 72 beyond trajectory. Due to the upcoming strikes in February 2024, the 78-week trajectory is not expected to be achieved. Conversations continue through the tiering meetings to monitor 78-week performance with a national expectation of zero by the end of March 2024. At the end of January 2024, national guidance was published regarding Community Paediatric reporting. It confirmed this cohort of patients is not reportable against the referral to treatment (RTT) standard from February 2024. This will reduce the cohort of 65-and-78-week patients at University Hospitals Dorset.

- **4-hour emergency department standard:** performance at University Hospitals Dorset is not improving at the rate required to achieve the trajectory of 76% treated or admitted within 4-hours by March 2024. The main barrier relates to the time it takes to admit a patient through the emergency department. To achieve 76%, 4 in 10 patients would need to be admitted within 4-hours from the time of arrival and 9 out of 10 patients need to be treated and leave to go home within 4-hours. There are insufficient empty beds on the wards in the two hospitals to admit patients quickly enough. A system wide plan has been agreed to speed up the time it takes to put the required support in place for those who no longer need the resources of an acute hospital but cannot manage by themselves, i.e. they need domiciliary care in their own homes or in a community bed or care home.

3.3 Other, areas to note are:

- **Faster diagnosis standard:** performance for December 2023 is yet to be available however, performance at the end of November 2023 was 67.2%. 2.7% below trajectory. This is attributed to University Hospitals Dorset due to eight dermatology clinicians being unwell in November 2023. To mitigate impact insourcing options were explored however capacity levels to maintain the October 2023 position were not available. December's performance is expected to be below trajectory however, insourcing was booked for every weekend in January 2024 to recover the position. University Hospitals Dorset at expecting their performance to be 72.7%, 0.2% above their plan.

- **Category 2 ambulance response times:** in December, performance was 35.1 minutes, 7.1 minutes above trajectory. South Western Ambulance reported extremely high activity volumes across the first two weeks of the month; rising to over 3,300 incidents per week in Dorset and 20,800 incidents per week across the South West. Combined with poor handover times, this impacted their ability to deliver the category 2 response times trajectory. To mitigate the pressures South Western Ambulance delivered significantly high levels of operational resourcing, not previously seen, however this was still insufficient to meet the level of handover delays reported. Performance is expected to return to trajectory from January 2024 with December's performance being associated with unprecedented demand. It is important to note South Western Ambulance Trust were removed from Urgent and Emergency Care tiering, by the national team, in January 2024.

3.4 Areas outside of the H2 standards which require additional focus are:

- **Outpatient follow-up waiting list:** the number of follow-up patients waiting past their clinical to be seen date continues to maintain at around 36,000. Both providers have plans in place to reduce the number of patients on their follow-up waiting lists with the System Quality Group planning to incorporate this cohort of the patients within a Quality and Safety Committee deep dive into the waiting list. A deep dive into ophthalmology follow-ups to identify harm because of delays will be presented by Dorset County Hospital at the next System Quality Group in March 2024.

- **Audiology reporting:** Dorset HealthCare continue to resolve the data quality issues relating to diagnostic reporting (DM01) with reporting expected to recommence in February 2024. Regular progress updates are being provided to the Planned Care Improvement Group, with escalation to the Planned Care Delivery Group if necessary.

- **Diagnostic surveillance audit:** following a request from the National Diagnostics Board Meeting the system submitted a diagnostic surveillance audit to ensure providers were appropriately applying the diagnostic (DM01) guidance for patients requiring surveillance treatment. Consequently, Dorset Healthcare indicated the guidance has not been followed for audiology assessments. Historically not patients were breaching however since the transfer of the service from Dorset County Hospital it was identified there were patients outside of the surveillance period not added to the DM01 reporting. Due to the data quality issues currently experienced It is expected, from March 2024 the service should be able to ensure all surveillance patients are reported as part of DM01. In the meantime, patients are all actively monitored whilst the data issues are resolved.

- **No criteria to reside and bed occupancy:** the number of patients with no criteria to reside remain high at 276, 70 beyond trajectory. Delays in community beds are contributing to this position which is linked to the completion of Care Act assessments. Targeted work is underway to look at how this can be addressed; the ambition is to reduce community bed

delays by 50% by the end of March 2024. Weekend discharges remain low in comparison to weekday discharges. Work is ongoing to improve the discharge pipeline linked to better use of expected discharge dates (EDDs) to drive discharge planning. Proof of concept work is starting in both acute Trusts in February 2024 which will test using the ward list as a trigger for discharge planning rather than waiting for a discharge to assess (D2A) referral.
Test sites are also being established in community hospitals.

4. Conclusion

4.1 The ICB Board is recommended to **NOTE** the content of this paper.

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

Date: 22 February 2024

Report Front Sheet

1. Report Details			
Meeting Title:	Board of Directors, Part 1		
Date of Meeting:	27th March 2024		
Document Title:	Finance Report		
Responsible Director:	Chris Hearn, Chief Financial Officer	Date of Executive Approval	12th March 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	18th March 2024	Noted

3. Purpose of the Paper	For Information – income & expenditure report on the finance position of the Trust to month eleven 2023/24 financial year							
	Note (✓)	✓	*Discuss (✓)*		*Recommend (✓)*		*Approve (✓)*	

4. Key Issues

Dorset County Hospital NHS Foundation Trust (DCHFT) has delivered a surplus position in month eleven being £0.9 million away from plan after technical adjustments and £8.9 million actual deficit away from plan year to date, in line with planned forecast trajectory.

The month eleven and year to date performance is largely driven by:

- Ongoing industrial action, with £3.3 million of national funding supporting the position based on a fair shares contract allocation. 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 £0.9m across months 1-11 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 £1.5 million year to date, with a further £1.8 million estimate of lost income opportunity and is detailed further in the Board report.

	Agency currently stands at £3.4 million overspent against plan, with £1.5 million of this incurred with highest Off Framework agencies, and within this £0.3 million has been incurred year to date providing support to mental health patients. February continues to see significant decrease in agency costs from previous months following a combination of system applied agency rate reduction, positive internal substantive recruitment increases and reduced medical locum usage. The Trust has supported circa 19 escalated beds which continues to drive demand. The number of patients at the end of February with no criteria to reside was 70. Continuation of increased cover for medical rota gaps in Unscheduled Care, Medicine for the Elderly, General Medicine and Urology contribute to the medical agency overspend, however less locum usage was seen in February due to availability. 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. As previously reported to the Committee, the forecast analysis demonstrates the risk to forecast break even 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, however with national funding offsetting the costs incurred relating to industrial action, this forecast outturn position reduces to £7.5 million. It has been agreed across the Dorset system that acute providers will then be supported to a break even position by financial year end. The Trust's year to date deficit as at month eleven stands at £8.9 million. A reduction of £1.4 million is required to reach £7.5 million. This will be achieved by non recurrent measures linked to service level agreement review, expected VAT rebate, balance sheet review and timing of revenue funding expected linked to external capital programmes. The Trust has delivered £4 million of efficiencies for the year against a year to date plan of £9.5 million. The cash position is £10.8 million as at February, 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, however a number of implemented mitigations have been actioned with H2 trajectories reducing this shortfall level. The capital spend in month is away from plan by £0.6 million. The year to date position stands at £2.2 million behind plan reflective of timings in expenditure payments including externally funded schemes such as Digital electronic patient record (EPR) and the New Hospitals Programme (NHP).
5. Action recommended	The Finance & Performance Committee is recommended to: 1. **NOTE** the financial position to month eleven 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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Financial Position Update 2023/24

February 2024 - Month 11

Chris Hearn
Chief Financial Officer

Financial Position Update - February 2024

Executive Summary

A summary of progress is presented for the period to February 2024 and is compared with the plan submitted to NHSE on the 30th March 2023.

Dorset County Hospital NHS Foundation Trust (DCHFT) has delivered a surplus actual position for the month of February 2024 of £0.9 million after technical adjustments. The year to date position is a £8.9 million actual deficit.

Ongoing agency costs covering vacancies & sickness, heightened by operational pressures and increased patient acuity are key drivers. Escalated beds stand at 19 with circa 70 no criteria to reside (NCTR) patients being supported during February. Industrial action has continued however has received national funding to offset the costs incurred year to date. Above planned levels of inflation continue, with gas, electricity, catering supplies, blood products, drugs and maintenance contracts significantly above planned levels. Agency expenditure has continued to decrease due to the impact of the agency rate reduction and increase in substantive recruitment. Mental health nurse support has been ongoing, with £0.3 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 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 £4 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 eleven saw delivery of £0.6 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.

Capital expenditure during the month was under plan by £0.6 million. Year to date the capital position is £2.2 million behind plan due to timing of expenditure payments and phasing of externally funded programmes.
The cash position to February amounts to £10.8 million due to the receipt of external income and public dividend funding.

The forecast outturn position reported last month of £0.6 million due to the impact of December and January industrial action, has now been mitigated following receipt of further national funding to support IA costs up to February. As such, the Trust has returned to forecasting a break even position with support of £7.5 million funding from Dorset ICB by year end.

Financial Position Update - February 2024

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 any further industrial action announced for the reminader of the financial year. 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. £7.5 million following receipt of income to cover the cost of industrialaction, has been agreed to be allocated by the System to support the Trust to a break even position, in line iwth treatment of both Acutes within the Dorset system. Costs relating to ongoing Industrial Action (IA) for December, January and February are included within the position with income received to offset. 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 - M11 ERF performance has resulted in additional income. This has resulted in a year to date net benefit of circa £0.9m in ERF, 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. Mitigating solutions including reviewing local payment terms and driving income collection at pace have minimised 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 - February 2024

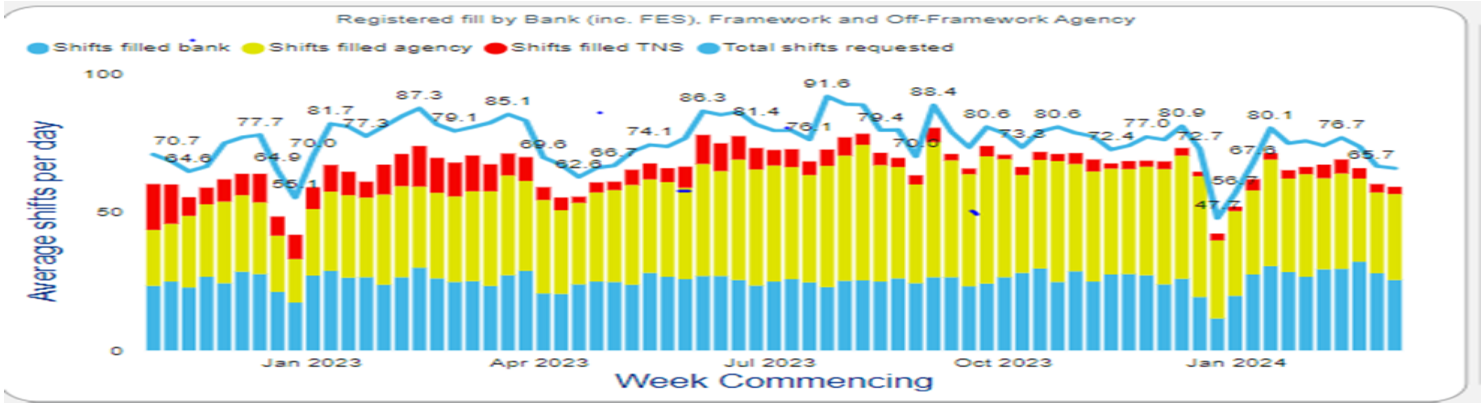
Key Risks

Red Risks:

The Trust has an **efficiency delivery requirement of £10.9 million** in order to reach the planned full year break even position. £4 million has been delivered for the full year at month eleven. 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 led by the Value Delivery Board. This is designed to reinforce the accountability and deliverables of programmes across the Trust.

Agency expenditure to February continues to improve due to a combination of factors including system agency rate reduction and vacancy level decreases. The overspend against plan for the year remains at £3.4 million given February spend was belowplan levels for the firsttime this financial year. £1.5 million has been spent with highest cost off framework suppliers and £0.3 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 continuing to help prevent further deterioration of the position against plan. The table below shows registered nursing shift fill by bank, on framework agency and highest cost off framework agency. The Trust must increase bank usage and decrease agency usage whilst maintaining patient and staff safety and quality levels.



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

Financial Position Update - February 2024

Key Risks

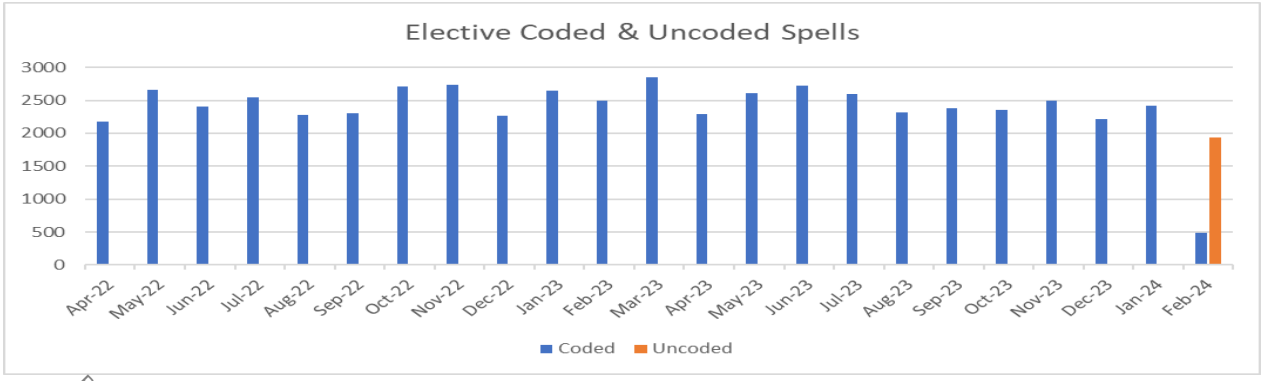
Amber Risk:

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 February 2024 the Trust has 7,205 uncoded spells, 1,938 are for Elective activity and 5,267 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.

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Financial Position Update - February 2024
Income & Expenditure

Income and Expenditure

The overall revenue position is a £0.9 million in month actual surplus with an actual deficit of £8.9 million YTD after technical adjustments. Ongoing run rates linked to inflationary pressures, agency usage with heightened levels throughout the year relating to vacancy, sickness cover and demand requirements, as well as an escalated bed base and NCTR patients drive the adverse position.

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 an estimated benefit of System Elective Recovery Fund income due to improved performance against the revised baseline target for months 1-11.

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 and a number of patients requiring mental health support. February has again seen an improvement in agency costs incurred due to the agency rate reduction applied at the start of January. 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.

Baker,Abi
26/03/2024 09:10:11

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	20,438	23,635	3,197	224,925	235,787	10,862	239,006
Private Patients	113	113	0	1,038	969	(69)	1,008
Other clinical revenue	37	21	(16)	407	256	(151)	444
Other non-clinical revenue	2,377	4,565	2,189	24,099	27,031	2,932	26,377
Operating Income	**22,965**	**28,335**	**5,370**	**250,469**	**264,044**	**13,575**	**266,835**
Charitable income	0	0	0	0	0	0	0
Total Income	**22,965**	**28,335**	**5,370**	**250,469**	**264,044**	**13,575**	**266,835**
Raw materials and consumables used	(2,614)	(5,396)	(2,336)	(35,612)	(43,722)	(8,110)	(38,455)
Employee benefit expenses:							
Substantive	(14,071)	(14,372)	(301)	(150,765)	(150,762)	3	(156,816)
Bank	(792)	(1,022)	(230)	(7,525)	(11,529)	(4,004)	(9,384)
Agency	(833)	(803)	30	(9,163)	(12,571)	(3,408)	(10,000)
Other operating expenses (excl. depreciation)	(3,130)	(4,586)	(1,456)	(32,347)	(40,838)	(8,491)	(35,468)
Operating Expenses	**(21,439)**	**(26,179)**	**(4,293)**	**(235,412)**	**(259,422)**	**(24,010)**	**(250,124)**
Profit/(loss) from Operations (EBITDA)	**1,525**	**2,156**	**1,078**	**15,057**	**4,622**	**(10,435)**	**16,711**
Other Non-Operating income (asset disposals)	(2)	0	2	(25)	1	26	(27)
Other Non-Operating expenses (Impairments)	0	0	0	0	(592)	(592)	0
Total Depreciation and Amortisation	(958)	(952)	6	(10,458)	(10,094)	364	(11,363)
PDC Dividend expense	(373)	(373)	0	(4,103)	(4,103)	0	(4,476)
Total finance income	29	52	23	315	869	553	194
Total interest expense	(63)	(65)	(2)	(689)	(612)	78	(752)
Total other finance costs	0	0	0	(2)	(2)	0	(2)
SURPLUS/ (DEFICIT)	157	818	1,107	95	(9,911)	(10,006)	285
Technical Items Adjusted for:							
DONATIONS CASH FOR ASSETS	(200)	0	200	(497)	(84)	412	(729)
DEPRECIATION DONATED ASSETS	35	38	2	408	417	7	447
IMPAIRMENT OF PPE (PUR)	0	0	0	0	51	51	0
IMPAIRMENT OF INTANGIBLE (PUR)	0	0	0	0	542	542	0
SURPLUS/ (DEFICIT)	(7)	855	1,308	7	(8,986)	(8,995)	0

Financial Position Update - February 2024
Industrial Action

2023/24 Industrial Action

Costs incurred year to date relating to Industrial Action cover amount to £1.5 million with a further £1.8 million estimate of lost activity income.

For DCHFT, December, January & February costs equate to £0.9 million. Funding has been received to cover the costs incurred to February.

If further Industrial Action is announced, this will continue to adversely impact the Trust's forecast outturn position.

	£'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	Junior Doctors	Total
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*	*24-28 Feb*	
Immediate backfill costs to cover services	£218	£6	£112	£158	£0	£0	£195	£67	£132	£310	*£131*	*£277*	*£221*	**£1,827**
Offset by Salary Savings	-£34	-£2	-£37	-£20	-£22	£0	-£24	-£25	-£45	-£48	*-£28*	*-£47*	*-£35*	**-£367**
Net Cost	**£184**	**£4**	**£75**	**£138**	**-£22**	**£0**	**£171**	**£42**	**£86**	**£262**	***£103***	***£230***	***£186***	**£1,460**
Number of Industrial Action Days	4	1	3	5	2	2	4	2	4	3	*3*	*6*	*5*	44
Estimate of Lost ERF Activity	£209	£0	£193	£127	£92	£0	£110	£222	£183	£291	*£74*	*£197*	*£74*	**£1,772**
Net Cost & ERF Income Loss	**£393**	**£4**	**£267**	**£266**	**£70**	**£0**	**£282**	**£264**	**£269**	**£553**	**£177**	**£427**	**£260**	**£3,232**
Estimated Cost Per Day £'000	£98	£4	£89	£53	£35	£0	£70	£132	£67	£184	£59	£71	£52	£73

Rescheduled Elective Inpatients	10	0	12	13	1	0	4	12	21	25	4	13	10	**125**
Rescheduled Day Case Activity	69	0	73	65	31	0	48	127	55	182	27	99	14	**790**
Reschedule Outpatient Appointments	732	0	356	177	378	0	239	478	313	274	152	434	153	**3,686**

Financial Position Update - February 2024
Trust Wide Performance: Agency

Pay Analysis - Agency

Agency costs equated to £0.803 million of actual expenditure in month against a plan of £0.833 million, again seeing a further improvement compared to last month, with spend being below plan for the first time this financial year.

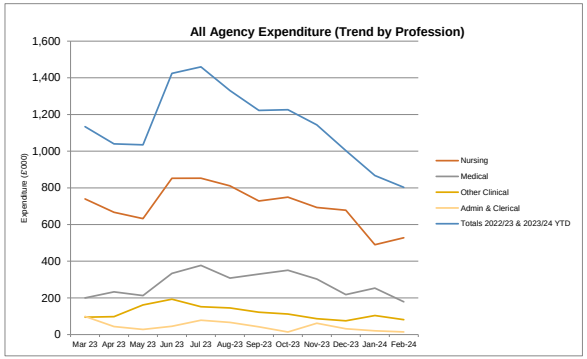
Agency expenditure is an improved 5% of total pay budgets, noting NHSE target is 3.7% for 2023/24. Highest cost off framework usage has increased compared to last month by £0.053 million.

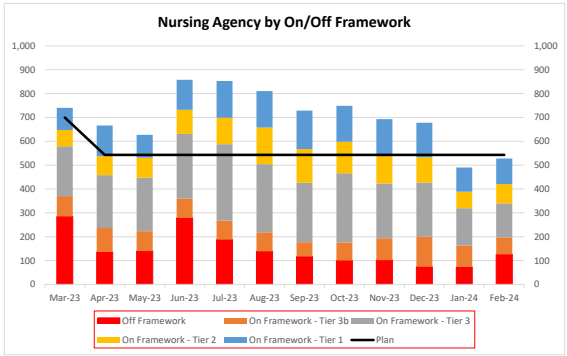
February continues to see significant improvement in agency expenditure, however Illchester, Abbotsbury and Moreton wards in particular have seen an increase in patient specialling and trained support for mental health patients.

The Trust has incurred £0.3 million of off framework spend relating to supporting this patient cohort year to date. Medical agency has improved from the prior month recognising usage within ED, Medicine for the Elderly, General Medicine and Urology covering vacancies, outliers and rota gaps. This is a combination of successful recruitment and availability of cover.

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.

System collaborative workstreams including a 15% agency rate reduction was applied from 2nd January 2024 by all organisations which has driven the improved position in conjunction with a decrease in overall vacancies for the Trust. Further % rate reductions are planned as a system from the end of March 2024.





Areas Using Nursing Agency including Off Framework M1 - M11 (£'000):

Area	On Framework	Off Framework	of which: RNMH	Total Nursing Agency	%
Crcu	£316	£427	£4	£742	10%
Kingfisher Ward	£201	£290	£20	£491	6%
Emergency Dept Main Dept	£1,189	£219	£52	£1,408	18%
Abbotsbury Ward	£507	£112	£67	£619	8%
Moreton Ward - Respiratory	£347	£94		£440	6%
Evershot Ward	£213	£70	£48	£283	4%
Scbu	£0	£39		£39	1%
Theatre Suites	£279	£37		£316	4%
The Mary Anning Unit	£357	£31	£58	£388	5%
Lulworth Ward	£257	£31	£11	£287	4%
Fortuneswell Ward	£330	£23		£353	5%
Ilchester Integrated Assessmen	£349	£18	£63	£367	5%
Purbeck Wd	£327	£16		£344	4%
Cardiology Care Ward	£154	£15		£169	2%
Ridgeway Wd	£186	£14		£200	3%
Day Surgery Unit	£265	£14		£279	4%
Prince Of Wales	£123	£10		£133	2%
Surge Area	£168	£9		£177	2%
Sdec	£32	£2		£34	0%
Stroke Unit	£272	£0		£272	4%
Dch Dialysis	£228	£0		£228	3%
B'Mth Dialysis	£108	£0		£108	1%
Bank Nurses	£2	£0		£2	0%
Medical Day Unit	£1	£0		£1	0%
Total Nursing Agency M1 - M11	**£6,210**	**£1,471**	**£324**	**£7,681**	
		Net OF excl MH:	**£1,148**		

Agency Spend by Profession (£'000)	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	YTD Actual	YTD Plan	Variance
Nursing	740	666	633	852	853	811	728	749	693	678	490	528	7,681	5,973	1,708
Medical	200	233	213	334	377	308	329	351	303	218	253	179	3,097	1,991	1,106
Other Clinical	95	97	161	193	152	145	122	112	86	75	104	82	1,330	770	560
Admin & Clerical	99	43	28	45	78	67	42	14	62	32	20	15	446	429	17
Totals 2022/23 & 2023/24 YTD	**1,134**	**1,040**	**1,034**	**1,425**	**1,460**	**1,330**	**1,222**	**1,226**	**1,144**	**1,003**	**867**	**803**	**12,553**	**9,163**	**3,390**

Nursing Agency Category	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24
Off Framework	285	135	140	279	188	139	116	100	102	74	73	126
On Framework - Tier 3b	85	101	83	81	80	80	60	76	92	126	90	71
On Framework - Tier 3	209	221	224	272	320	286	250	290	229	227	157	142
On Framework - Tier 2	68	80	84	101	111	154	141	133	120	106	69	81
On Framework - Tier 1	93	129	96	126	154	153	161	150	151	145	102	107
Plan	700	543	543	543	543	543	543	543	543	543	543	543
Orders awaiting allocation	0	0	6	-6	0	0	0	0	0	0	0	0
Totals 2022/23 & 2023/24 YTD	**740**	**666**	**633**	**852**	**853**	**811**	**728**	**749**	**693**	**678**	**490**	**528**

Pay Metrics	In Month Actual	YTD Actual
Agency expenditure as % of total pay	5.0%	7.2%
Off framework expenditure as % of total agency	15.7%	9.8%

Outstanding care for our patients in ways which matter to them

Financial Position Update - February 2024

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 £0.3 million to planned levels.

	Actual Apr-23	Actual May-23	Actual Jun-23	Actual Jul-23	Actual Aug-23	Actual Sep-23	Actual Oct-23	Actual Nov-23	Actual Dec-23	Actual Jan-24	Actual Feb-24	Forecast Mar-24	Forecast 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	£88	-£3	£74	£52	£94	**£596**
Ophthalmology	£62	£48	£113	£57	£58	£59	£21	£70	-£34	-£11	£0	£0	**£444**
Dermatology	£120	£60	£80	£149	£113	£127	£127	£113	£84	£84	£103	£106	**£1,265**
Gynaecology	£106	£74	£182	£157	£78	£218	£37	-£12	£4	£0	£0	£0	**£843**
Urology	£29	£42	£51	£0	£14	£0	£15	£0	£2	£0	£0	£0	**£153**
Endoscopy & Gastro	£156	£143	£124	£146	£113	£146	£74	£83	£67	£101	£77	£75	**£1,305**
Breast	£1	£19	£0	£0	£19	£38	£19	£0	£19	£19	£19	£19	**£171**
Oral Surgery	£88	£110	£187	£159	£198	£189	£210	£119	£207	£139	£66	£100	**£1,773**
Cardiology	£4	£26	£25	£24	£23	£43	£63	-£9	£10	£74	£27	£22	**£331**
Radiology/Cardio	£0	£0	£17	£0	£0	£0	£0	£0	£0	£0	£0	£0	**£17**
ENT	£0	£44	£35	£62	£36	£23	£8	£83	£16	£36	£27	£34	**£405**
Total	**£594**	**£620**	**£849**	**£784**	**£690**	**£867**	**£654**	**£534**	**£373**	**£516**	**£372**	**£449**	**£7,303**
Surplus/(Deficit)	**-£11**	**-£37**	**-£266**	**-£201**	**-£107**	**-£284**	**-£71**	**£49**	**£210**	**£67**	**£211**	**£134**	**-£307**

Financial Position Update - February 2024
COVID Expenditure

Covid Narrative
Covid spend slightly increased in February to £0.12 million from £0.11 million in January. Pay spend decreased 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 lives 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	Jan-24	Feb-24	YTD
Plan:		**£191**	**£191**	**£191**	**£191**	**£191**	**£191**	**£191**	**£191**	**£191**	**£191**	**£191**	**£2,097**
Expenditure:													
Pay	Substantive	£40	£22	£13	£12	£15	£38	£32	£22	£27	£26	£16	**£263**
	Bank	£9	£13	£8	£8	£9	£11	£12	£10	£13	£4	£6	**£103**
	Agency	£0	£0	£0	£0	£0	£0	£0	£0	£0	£1	-£1	**£1**
Total Pay		**£49**	**£35**	**£21**	**£20**	**£25**	**£49**	**£44**	**£32**	**£40**	**£30**	**£22**	**£367**
Non-pay	Clinical Supplies and Services	£27	£26	£7	£0	£0	£0	£1	£29	£7	£47	£52	**£197**
	Other Non-Pay (security)	£50	£56	£43	£52	£60	£55	£31	£28	£18	£21	£33	**£446**
	Premises and Fixed Plant	£11	£14	£14	£14	£14	£14	£11	£15	£16	£13	£13	**£148**
Total Non-pay		**£88**	**£96**	**£64**	**£66**	**£73**	**£70**	**£42**	**£72**	**£41**	**£81**	**£98**	**£792**
Total Expenditure		**£137**	**£131**	**£86**	**£86**	**£98**	**£119**	**£86**	**£104**	**£82**	**£111**	**£120**	**£1,158**
Total Surplus/(Deficit)		**£53**	**£60**	**£105**	**£105**	**£93**	**£72**	**£105**	**£87**	**£109**	**£79**	**£71**	**£867**

INTEGRITY | RESPECT | TEAMWORK | EXCELLENCE

NHS
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Financial Position Update - February 2024
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.

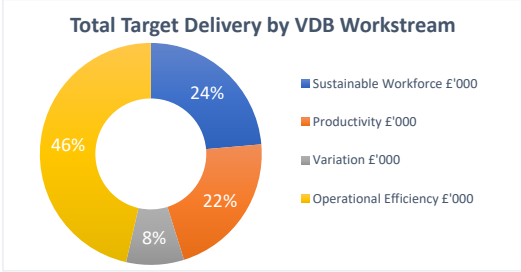
£4 million has been delivered full year effect, with £0.6 million delivered in month.
£3.1 million of schemes are fully developed with £1 million of schemes yet to start. £2.7 million of opportunities have been identified and are in the process of being developed into tangible schemes for delivery.
This 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. All schemes are being actively reviewed for delivery in both this financial year and assessment for roll forward into next financial year.

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 @ M11	Variance to be Delivered
Division A	3,105	1,039	(2,066)
Division B	3,070	1,017	(2,053)
	6,175	**2,056**	**(4,119)**
Finance and Resources	717	490	(227)
Digital	311	249	(62)
Nursing	315	0	(315)
Operations	97	0	(97)
Human Resources	108	112	4
Corporate	149	125	(24)
Sub-total	**1,697**	**976**	**(721)**
Trust Wide schemes	3,000	974	(2,026)
Total CIP	**10,872**	**4,006**	**(6,866)**
Of which:			
Recurrent	6,552	1,176	(5,376)
Non-recurrent	4,320	2,830	(1,490)
Total	**10,872**	**4,006**	**(6,866)**

Value Delivery Board Workstream	Sustainable Workforce £'000	Productivity £'000	Variation £'000	Operational Efficiency £'000	Total £'000	Progress
Delivered	118	148	317	3,423	**4,006**	↑
Identified - in progress	1,720	17	295	1108	**3,140**	↑
Identified - not started	-	247	303	516	**1,066**	⇨
Opportunity	730	1,930	-	-	**2,660**	↑
Unidentified					-	
Totals	**2,568**	**2,342**	**915**	**5,047**	**10,872**	



At a glance		
	£ 000	No of schemes
Target	10,872	N/A
Delivered	4,006	42
Identified - in progress	3,140	
Identified - not yet started	1,066	37
Opportunity	2,660	12
Unidentified	0	N/A

Outstanding care for our patients in ways which matter to them

Financial Position Update - February 2024

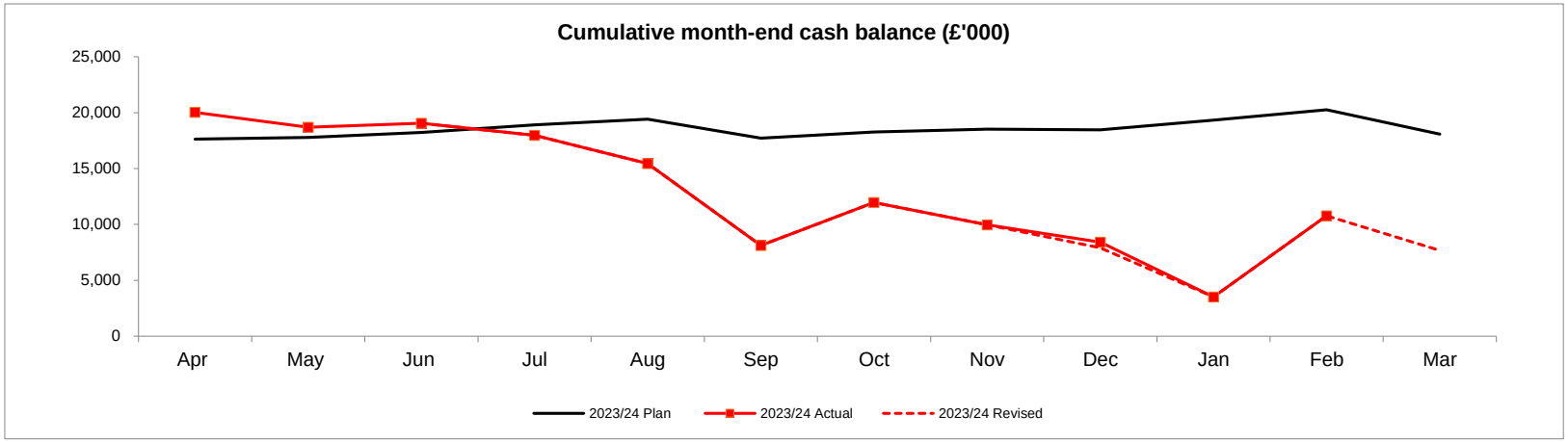
Cash

Cash Balance incl Forecast

The graph shows the trajectory of the actual year to date and forecast cash balance during the year, with identified direct intervention taking place to mitigate the shortfall in cash.

The cash position is currently £10.8 million at February. Funding has been recevied from NHS England in relation to winter pressures with public dividend funding for Digital also received. Capital payments have been below forecast in the month due to timing.

Ongoing mitigations are in place including accelerated pace of income collection and reviewing payments to system partners. A further £7.5 million has been included in the forecast for March linked to the Dorset ICB funding to support the Trust reaching a break even position.



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												7,672
2023/24 Actual	20,024	18,694	19,053	17,974	15,452	8,122	11,966	9,962	8,416	3,518	10,782	

Financial Position Update - February 2024

Capital

Capital Programme Narrative

Capital expenditure year to date to the end of February was £2.3 million behind plan.

Internally Funded schemes are overall below plan by £0.5 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 below plan due to timing of purchases of equipment, which will catch up in March.

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. There is a reduction of £1m in IFRS 16 forecast outturn expenditure as a consequence of NHS England reducing the Dorset ICS IFRS 16 budget by £7.5m following national guidelines.

Externally Funded capital is below planned levels of spend by £1.7 million due to timings of the Digital Electronic Patient Record (EPR) expenditure, offset by works on South Walks House (SWH) that have progressed ahead of plan.

Additional external capital funding of £2 million has been awarded to the Trust for New Hospitals Programme (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 increase by £1.5 million to £2.5 million with additional funding awarded by NHS England (NHSE).

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

CAPITAL	CURRENT MONTH			YEAR TO DATE			FULL YEAR 2023/24			
	Actual	Plan	Variance	Actual	Plan	Variance	Committed Spend	Forecast	Annual Plan	Variance
	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000
Estates										
Chemo	0	530	530	0	1,220	1,220	93	100	1,962	1,862
Air-Handling Unit	0	100	100	0	500	500	35	309	750	441
Estates Schemes	415	**15**	(400)	1,609	**1,714**	105	2,591	2,591	1,819	(772)
Digital Services										
Digital Schemes	218	**259**	41	2,596	**1,702**	(894)	3,099	3,099	2,005	(1,094)
Equipment										
Digital Mammogaphy	0	0	0	0	313	313	0	0	313	313
Haemodialysis Machines	0	0	0	0	119	119	133	133	119	(14)
Other Equipment	294	0	(294)	1,378	262	(1,116)	1,384	1,236	498	(738)
Sub-Total Internally Funded Expenditure	**927**	**904**	**(23)**	**5,583**	**5,830**	**247**	**7,335**	**7,468**	**7,466**	**(2)**
Donated										
Other Donations	0	0	0	85	0	(85)	125	150	0	(150)
Chemotherapy Unit Refurbishment	0	200	200	0	500	500	0	0	733	733
Sub-Total Planned DonatedExpenditure	**0**	**200**	**200**	**85**	**500**	**415**	**125**	**150**	**733**	**583**
IFRS 16 Lease Additions										
Warehouse	0	0	0	0	0	0	0	1,190	2,335	1,145
Print Management	0	0	0	397	600	203	397	412	600	188
One Dorset Pathology	0	0	0	0	250	250	0	0	250	250
MSCP & CEF Lease remeasurement	0	0	0	1,095	700	(395)	1,095	1,095	700	(395)
Accommodation & Vehicle Lease Additions	4	0	(4)	583	404	(179)	592	592	404	(188)
Sub-Total Planned IFRS 16 Expenditure	**4**	**0**	**(4)**	**2,075**	**1,954**	**(121)**	**2,084**	**3,289**	**4,289**	**1,000**
Total Internal & Leased Capital Expenditure	**931**	**1,104**	**173**	**7,743**	**8,284**	**541**	**9,544**	**10,907**	**12,488**	**1,581**
Additional funded schemes										
NHP Development	170	191	21	3,311	3,683	372	4,073	5,234	3,868	(1,366)
South Walks House & 24 Bedded Bay	237	573	336	6,672	6,303	(369)	6,872	6,877	6,877	0
Mental Health UEC Funding	0	50	50	763	150	(613)	233	233	233	0
Digital EPR Funding	435	118	(317)	859	1,692	833	995	2,500	2,093	(407)
CDC Funding	0	0	0	1,448	1,440	(8)	1,651	1,646	1,440	(206)
CDC Equipment - Dermascopes	0	0	0	0	0	0	10	10	0	(10)
Cyber Security	0	0	0	0	0	0	140	140	0	(140)
Future Connectivity	0	0	0	0	0	0	33	38	0	(38)
LED Lighting	0	0	0	0	0	0	20	20	0	(20)
Mental Health UEC Funding	0	0	0	0	0	0	10	35	0	(35)
Endoscopy	0	350	350	0	1,500	1,500	0	0	2,000	2,000
Total Externally Funded Capital Expenditure	**842**	**1,282**	**440**	**13,054**	**14,768**	**1,714**	**14,037**	**16,733**	**16,511**	**(222)**
Total Capital Expenditure	**1,772**	**2,386**	**614**	**20,797**	**23,052**	**2,255**	**23,581**	**27,640**	**28,999**	**1,359**
Expenditure as a % of Plan			74%			90%				95%

Report Front Sheet

1. Report Details			
Meeting Title:	Board of Directors, Part 1		
Date of Meeting:	27th March 2024		
Document Title:	**Maternity Quality and Safety Report**		
Responsible Director:	Jo Howarth, CNO	Date of Executive Approval	
Author:	Jo Hartley, Director of Midwifery & Neonatal Services		
Confidentiality:	No		
Publishable under FOI?	Yes		
Predetermined Report Format?	Yes		

2. Prior Discussion		
Job Title or Meeting Title	**Date**	**Recommendations/Comments**
Quality Committee	19th March 2024	Noted

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

3. Executive Summary

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

- SPC charts will be shared live. CO measurement at booking exceeded target. Smoking at time of birth improving slight reduction. Access to vapes (Swap to Stop) will improve this. Admissions to SCBU for babies >37 weeks gestation has increased. All cases will be reviewed through the ATAIN process. Currently the Trust's rate is below the 5% maximum KPI (please see quarterly report)
- Two babyloss – neonatal deaths. I baby had significant fetal anomalies and the other baby was very premature and died 2/52 of necrotising entercolitis
- All cases of 3rd & 4th degree tears for Jan and Feb reviewed (6 cases)
- SBLCB - the 70% overall compliance required for the MIS has not been met but overall 64% which shows a very significant improvement. Key area of risk across all elements is the lack of capacity in the governance team to facilitate the audits required.
- HSIB case under review.
- The risk around access to the MLU is now closed
- All other risk reviewed. Where appropriate mitigation added and rating revised
- 2 complaints received in February focusing on postnatal care, access to analgesia and to the frenulotomy service. The postnatal team are reviewing women's access to self medication of all analgesia

	• Workforce data presented. Sickness for midwives – 5.65%, MSW – 3.82%, SCBU – 7.59%. 11.8% shifts on the maternity unit remain unfilled • No neonatal transfers out • Claims data presented using NHSR slides and locally compiled current open cases • Training figures show ongoing challenges. Some improvement in attendance at SBLCB and BLS for obstetricians but anaesthetic attendance at PROMPT and BLS has not improved. K2 completion for all groups
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		
Strategic Objectives – People	Credibility of Trust		
Strategic Objectives – Place	Serving the population of Dorset		
Strategic Objectives – 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**	

NHS
Dorset County Hospital
NHS Foundation Trust

Maternity & Neonatal Quality and Safety report

March 2024

Submitted by Jo Hartley, Director of Midwifery & Neonatal Services

Executive sponsor: Jo Howarth CNO

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Executive Summary

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

- SPC charts will be shared live. CO measurement at booking exceeded target. Smoking at time of birth improving slight reduction. Access to vapes (Swap to Stop) will improve this. Admissions to SCBU for babies >37 weeks gestation has increased. All cases will be reviewed through the ATAIN process. Currently the Trust's rate is below the 5% maximum KPI (please see quarterly report)
- Two babyloss – neonatal deaths. I baby had significant fetal anomalies and the other baby was very premature and died 2/52 of necrotising entercolitis
- All cases of 3rd & 4th degree tears for Jan and Feb reviewed (6 cases)
- SBLCB - the 70% overall compliance required for the MIS has not been met but overall 64% which shows a very significant improvement. Key area of risk across all elements is the lack of capacity in the governance team to facilitate the audits required.
- HSIB case under review.
- The risk around access to the MLU is now closed
- All other risk reviewed. Where appropriate mitigation added and rating revised
- 2 complaints received in February focusing on postnatal care, access to analgesia and to the frenulotomy service. The postnatal team are reviewing women's access to self medication of all analgesia
- Workforce data presented. Sickness for midwives – 5.65%, MSW – 3.82%, SCBU – 7.59%. 11.8% shifts on the maternity unit remain unfilled
- No neonatal transfers out
- Claims data presented using NHSR slides and locally compiled current open cases
- Training figures show ongoing challenges. Some improvement in attendance at SBLCB and BLS for obstetricians but anaesthetic attendance at PROMPT and BLS has not improved. K2 completion for all groups

DCH Maternity and Neonatal Safety & Quality Strategy

Transformation model

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

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

Activity

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

Metric	target	Current position and mitigation/actions
Smoking at time of delivery	6%	8.3% The introduction of vaping as an alternative will make a significant contribution to this KPI
CO recorded at booking	95%	100%
stillbirth	NTI	nil
% babies >37 weeks admitted to SCBU	5%	8.2% - all cases will be reviewed by the ATAIN team
Rates per 1000 of PPH >1500mls	30	52.6 (mean 43.4)
Rates per 1000 of 3rd/4th degree tears	30.3	15.2
Babies transferred to a level 2 or 3 Neonatal unit	NTI	Nil
Hypoxic Ischemic Encephalopathy incidents		Nil

Total Number of Incidents submitted for February 2024

Maternity	Neonatal
104	2

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

Red flag	Descriptor	Incidents for Jan
RF1	Escalation to divert of maternity services & poor staffing numbers, including medical staffing and SCBU	13 midwifery
RF2	Missed medication	4
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	Approx. 8 women
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	1 datix for multiple ANC cancelled

Incidents graded as moderate harm or above for February

reference	grading	detail
		None noted

Babyloss for February

Intrauterine death	Medical termination	Neonatal death	Late neonatal death
0	0	2	0

3rd & 4th degree tears – monthly thematic analysis (Jan and Feb)

OASI – obstetric anal sphincter injury

Evaluation

According to RCOG, risk factors for OASI include nulliparous women, aged >40 years, women of South-Asian origin, instrumental birth, birthweight >4kg, malpresentation and prolonged 2nd stage.

All the women whose births were reviewed were of White, European origin with birthweights of <4kg. All of the births were documented to have been "hands on" by the facilitating midwife, however, the OASI bundle principles had yet to be implemented. The majority of the women did not have a prolonged 2nd stage of labour. The only woman whose 2nd stage of labour was prolonged, had a forceps birth.

4/6 of the women were primiparous and <40 years old. Only one of these women had an instrumental birth and the majority gave birth in a semi-recumbent or seated position. The remaining two women were multiparous; one of these was a pool birth and therefore, a "hands off" approach was used.

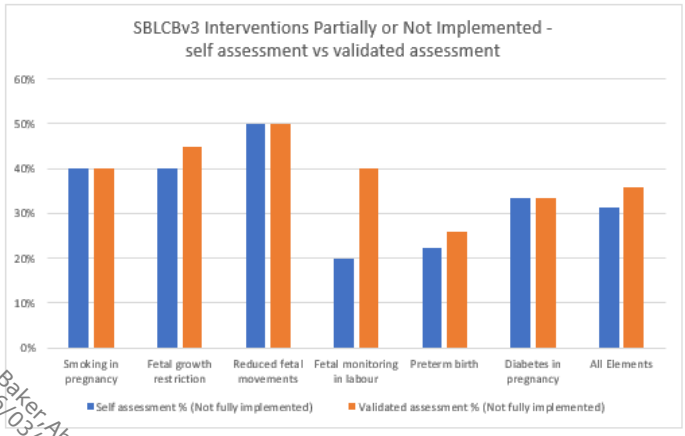
The OASI bundle was implemented by DCH on 29th January and training for staff is ongoing. There will be afternoon OASI Training sessions in April and May with the aim to train all outstanding staff. OASI has been added to yearly update days. The OASI Bundle will be evaluated by the Education Team in the future but a timescale has yet to be agreed.

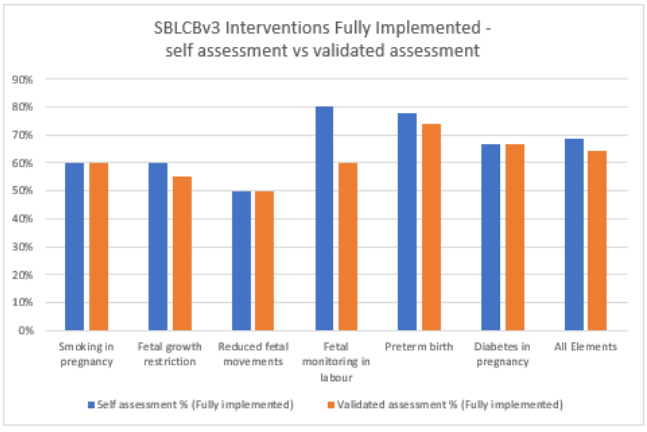
Cases of OASI are currently reported by staff via the online DATIX system and investigated by members of the Risk Team. Going forward, cases shall be reviewed monthly so themes and learning can be identified and actioned. Review of electronic records will also help to evaluate staff's compliance with the use of the OASI Bundle.

SBLCB final position

Implementation Progress

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	60%	Partially implemented	60%	CNST Met
Element 2	Fetal growth restriction	Partially implemented	60%	Partially implemented	55%	CNST Met
Element 3	Reduced fetal movements	Partially implemented	50%	Partially implemented	50%	CNST Met
Element 4	Fetal monitoring in labour	Partially implemented	80%	Partially implemented	60%	CNST Met
Element 5	Preterm birth	Partially implemented	78%	Partially implemented	74%	CNST Met
Element 6	Diabetes	Partially implemented	67%	Partially implemented	67%	CNST Met
All Elements	TOTAL	Partially implemented	69%	Partially implemented	64%	CNST Not Met





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

DCH88563 – 27/11/23
DCH87453 – 15/10/23
DCH85684 – 31/08/23
DCH86461 – 20/09/23
DCH79162 - 23/12/22
DCH79954 - 25/01/2023

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. **Update:** a ninth consultant has been appointed and the consultant off-sick is returning to work at the end of March. The challenges with outpatient clinics continue for both obstetrics and gynaecology. Mitigation is challenging as obstetric clinics should only be provided by consultants. However, the situation is such that some clinics are covered by trainees or specialty doctors with access to a consultant for advice.	16/11/23 managed by Jo H. quarterly review	moderate	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, quarterly 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. **Update**: a ninth consultant appointed with a keen interest and significant experience in obstetrics. One she starts, it will be possible to review job planning in relation to specialist roles and responsibilities, both for patient facing and leadership	013/10/2023, managed by James Male, service Manager, monthly review	Moderate - 12	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 **Update** Progress reviewed. whilst BSOTS is being used, it is not effective yet due to the amount of elective & planned work also managed by ANDAU. Approx half the women triaged as requiring immediate review are not being reviewed within the timescale. Consideration of different ways to manage USS review considered but will not be an immediate improvement. Increasing the midwifery staffing to three midwives would allow for triage to continue uninterrupted by elective/planned work. This will be added to the workforce business plan. This is a CQC priority focusing on review times	08/01/2023 Managed by Jane Hall, Matron Monthly review	Moderate - 12	Corporate

1569	Birthing room out of use in The Cove, reducing the availability of the birthing unit by 50%.	**Update** The work is now complete and the room will go back into use.		closed	
1497	Emergency buzzers not heard consistently throughout the Maternity unit when activated	Awaiting commencement of work. Most recent costing significantly more than original costing causing a delay **Update:** no further update this month	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. **Update:** There is more joined up working now with UHD for women >32 weeks. A recent incident for a baby <32 weeks required several calls but the woman was accepted by our local tertiary unit eventually - the coordinator did ask if LW was in escalation (as this was the obstacle) which was correct and this may have prompted the change of decision. Given this is not something DCH can influence, I recommend this is a tolerated risk	14/07/2022 Managed by Jo Hartley, DoM annual review	managed	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 **Update:** The risk rating has been reduced as the work has now been completed. Whilst we await the results of the analysis from Cairns to confirm the results, the risk remains as moderate	24/12/2019 Managed by Jane Hall, Matron, quarterly review	Moderate - 12	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. **Update:** funding agreed for BR Plus review – this will happen later in the year (depending on BR Plus team availability). Currently out to recruitment for midwives. Awaiting agreement to recruit MSWs. Please see workforce information below for further detail	21/09/2021 Managed by Jo Hartley, Director of Midwifery, Monthly reviews	high - 15	corporate

Complaints

Total informal and formal

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

Brief synopsis and learning points	
C24485	Concerned about lack of explanation about bleeding during an elective caesarean. There was no single room available on the postnatal ward Pain relief not given on time Delay in removing her abdominal drain Confusion as to whether baby had his NIPE Incorrect management of the indwelling catheter (attached to bedrail)
C24500	Failure to respond to vaginal blood loss after birth promptly Bed not properly cleaned between one patient and another Significant confusion about whether baby required a referral for frenulotomy assessment, then a delay in the referral with contradictory advice and eventually resorting to a private practitioner

DCHFT Obstetrics - Scorecard

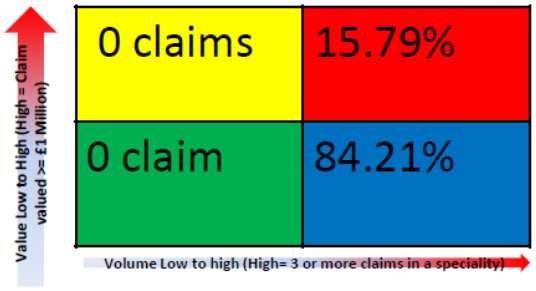
NHS Resolution

Incidents occurring between: April 2013 — March 2023

19 claims

Total value **£20.8 million**

Snapshot data correct 30/06/2023



Volume of claims by Incident Year

Year	Open	Closed	Periodical Payments
2013/14	0	2	0
2014/15	0	1	0
2015/16	0	1	0
2016/17	0	4	0
2017/18	0	2	0
2018/19	0	3	0
2019/20	1	1	0
2020/21	2	0	0
2021/22	1	0	0
2022/23	0	1	0
Total	4	15	0

Advise / Resolve / Learn

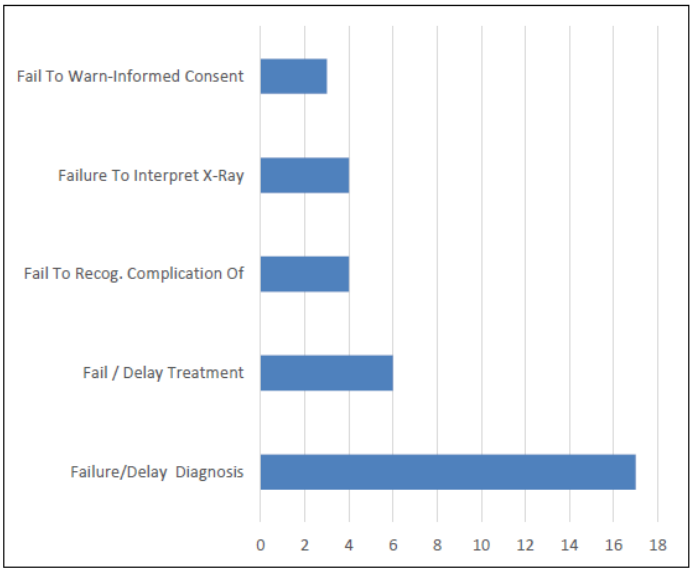
*some financial figures have been rounded

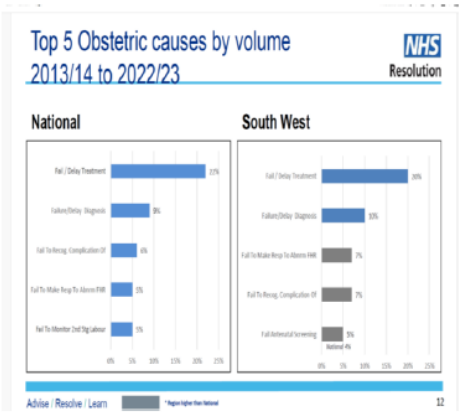
19

Cause	Value	Nr Claims
Perineal Tear-1st,2nd,3rd Deg	£1,870,581.15	1
Fail Antenatal Screening	£3,300,000.00	1
Fail To Warn-Informed Consent	£14,130,001.00	1
Grand Total	£19,300,582.15	3

Cause	Value	Nr of Claims
Assault, Etc By Hospital Staff	£463,371	2
Fail To Warn-Informed Consent	£441,052	2
Fail / Delay Treatment	£183,363	1
Fail To Monitor 1st Stg Labour	£162,335	2
Perineal Tear-1st,2nd,3rd Deg	£118,406	1
Fail To Recog. Complication Of	£75,895	2
Inadequate Nursing Care	£47,500	1
Fail To Correctly Apply Forcep	£42,500	1
Not Specified	£13,584	2
Foreign Body Left In Situ	£12,037	1
Inappropriate Treatment	£450	1
Grand Total	£1,560,493	16

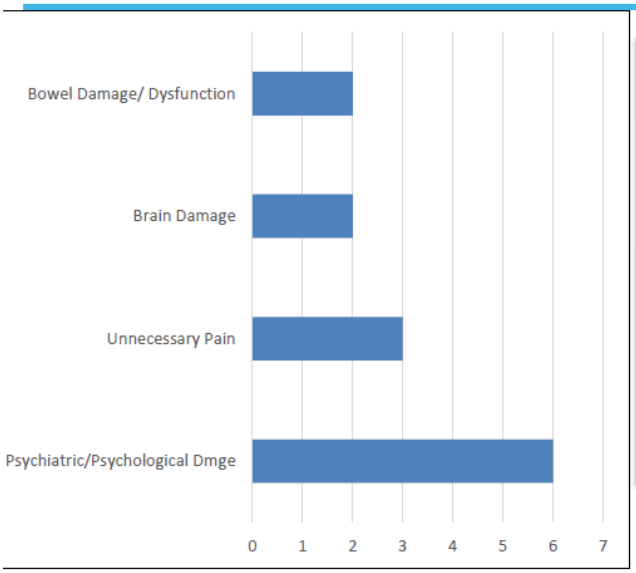
DCHFT - Obstetrics Top 5 Cause by volume

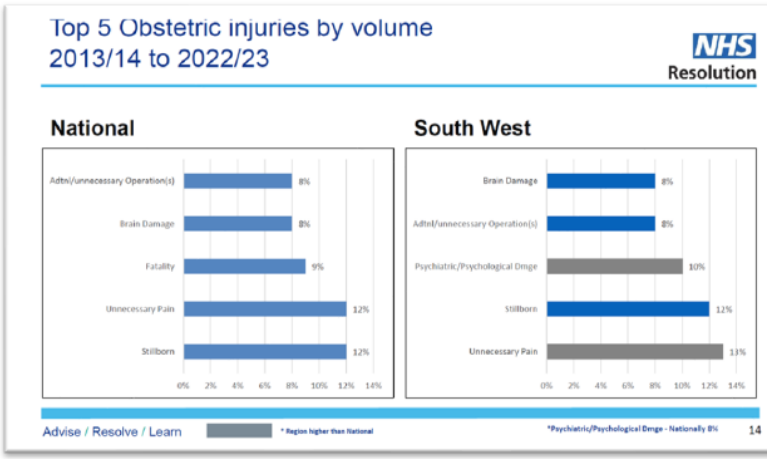




Advise / Resolve / Learn

DCHFT - Obstetrics – Top 5 Injuries by volume





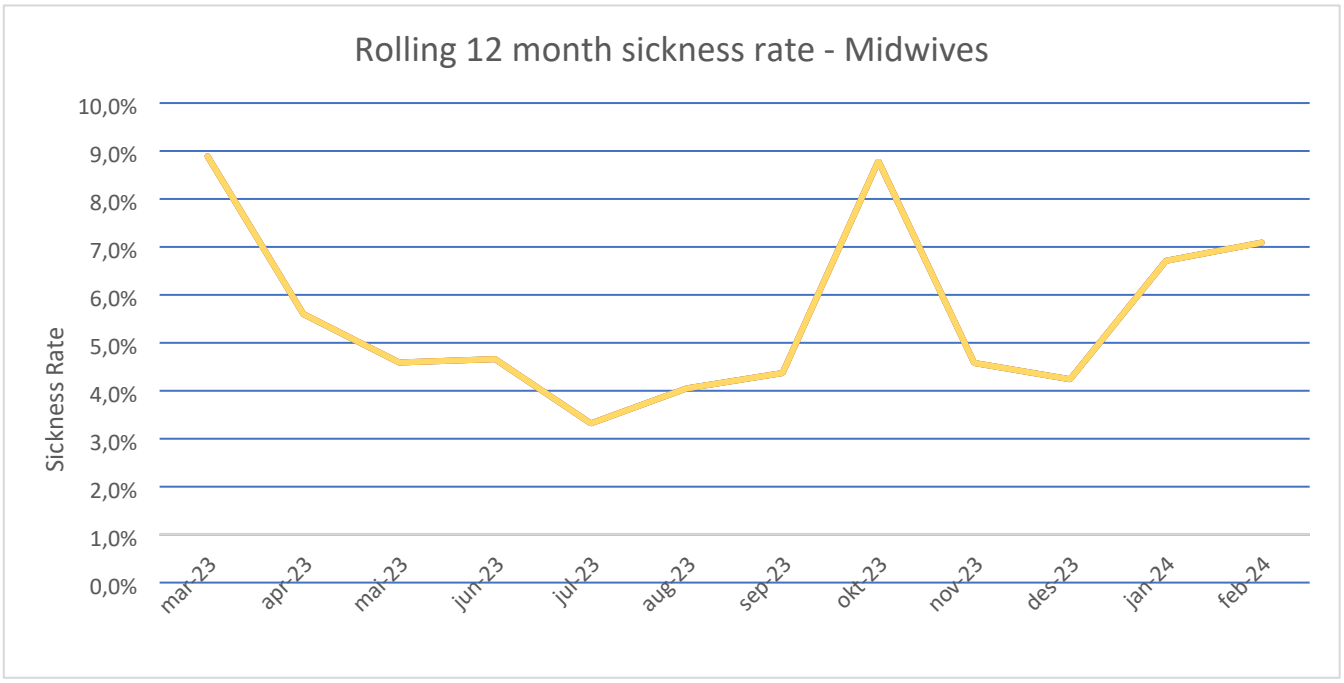
Advise / Resolve / Learn

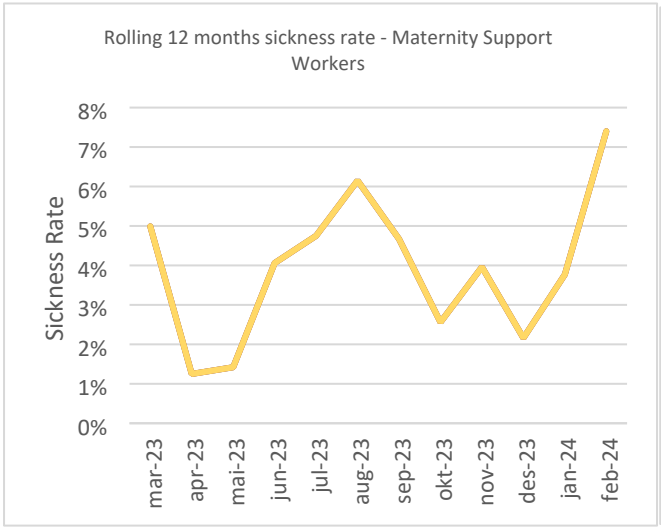
Open Claims

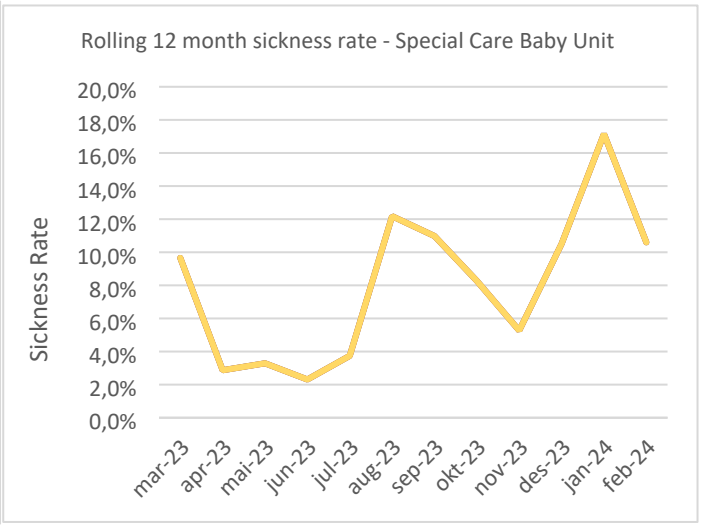
reference	Incident date	Details of claim
2566	Aug 2021	
2616	July 2022	

1952	Sept 2011	

Workforce data





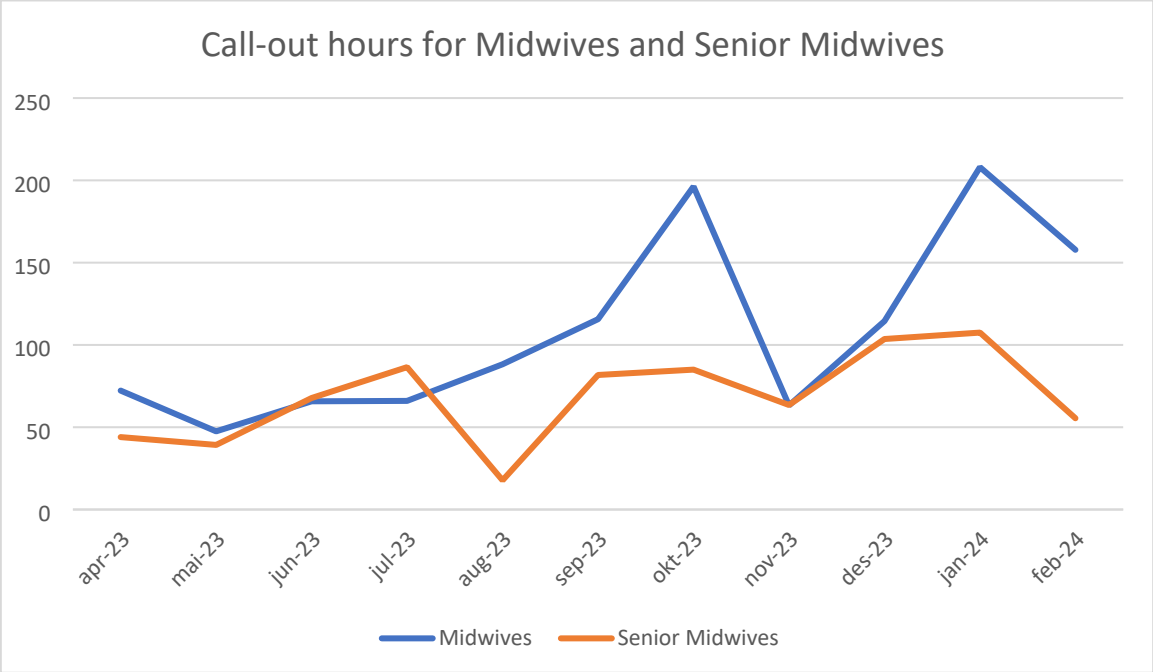


Overall sickness rates from 1st February 2023 – 31st January 2024

Midwives – 5.65%
Maternity Support Workers – 3.82%
Special Care Bay Unit – 7.59%

February Call-Out Hours

Midwife call-out for the unit – **157.8 hours**
Senior Midwives call-out – **55.45 hours**



Bank and Excess hours

	Maternity Unit/ DAU	Midwifery Excess/OT	Community	Band 2 MSW's / DAU	SCBU Band 5/6	SCBU Band 2
Bank	319.75 hrs / 82 hrs	388.25 hrs	229.5 hrs	181.5 hrs / 16.5 hrs	226 hrs	0 hrs
Excess				87 hrs	140.5 hrs	0 hrs
Incentives	5 Substantive 8 Bank			1	1	0

Shifts not covered by substantive or bank staff

Community	
Chesil	13.04 %
Dorchester	12.3 %
Cranberries	24.6 %
Moonfleet	14 % (62.7% covered by bank)
Maternity Unit – based on 6 midwives per shift	
Day Shift	14 %
Night Shift	7.47 %
Total	11.8 %
ANDAU	2 shifts not covered

Maternity Support Workers	
Inc. PM Shifts	23.6 %
Exc. PM Shifts	14.3 %

Neonatal transfer out data for february

Nil

Training compliance

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

Rolling 12-month period ending February 2024

Training	Role	Compliance (percentage)	Non-compliance (number)	Narrative
Practical Obstetric Emergency Procedure Training (PROMPT)	Obstetric Anaesthetist	60.5%	15	ESR team progressing with plan to mandate prompt for Anaesthetists. Option will be full day or half day of 4 simulations that meets the minimum CCFv2 requirement.
	Consultant Obstetrician	87.5%	1	Booked 4/3/24.
	Registrars	87.5%	1	Booked ……
	ST1/F2/GP Trainees	37.5	5	1 booked 4/3/24.
	Midwives	89.8%	12	Plan to roster staff on 10-month basis from February 2024 to improve compliance to consistently meeting 90% minimum.
	MSW	86.4%	5	3 new staff, one booked in may 2024.
Basic life support (BLS)	Obstetric Anaesthetist	60.5%	15	
	Consultant Obstetrician	100%		
	Registrars	87.5%	1	
	ST1/F2/GP trainee	100%	0	
	Midwives	90.7%	12	BAU
	MSW	84.2%	6	2 only just out of date, all staff emailed to book asap.
	Paediatric Consultants	80%	2	One has booked for March 2024.
	Paediatric Registrars	100%	0	
	ST1/F2	50%	3	Email has been sent to those out of date.
	GP trainee	100%	0	

	Neonatal nurses	82%	3	1 has returned from sick and has rebooked for 12/03/2024. One was booked for Jan 2024 but had to be taken off study day and missed BLS update – has been rebooked.
	HCAs	90%	1	BAU
Newborn life support (NLS) Yearly	Midwives	86.78%	16	Compliance was 92% last month and 91% previous month, normal variation, BAU.
	Neonatal nurses	94%	1	Creating plan to capture the one left – on nights.
	Paediatric Consultants	70%	3	Neonatal Medical Lead to action pathway for this to be addressed.
	Paediatric Registrars	50%	3	Neonatal Medical Lead to action pathway for this to be addressed.
	ANNP	100%	0	
NLS 4 Yearly	Senior & Cygnet Midwives	100%	0	
	Neonatal nurses	100%	0	
	Paediatric Consultants	100%	0	
	Paediatric Registrars	100%	0	
Saving Babies Lives study day	Midwives	89.3%	13	Plan in place to roster staff on 10-month rota to reduce compliance slippage when pulled to work clinically or sick.
	Obstetricians	28.5%	5	All Doctors now booked to attend throughout the year.
SBLv3 Element 1	Intervention 1.8 – CO monitoring midwives and MSWs giving AN care	86.6%	18	MSW day in March will improve compliance. Added to MSW induction and new midwife induction to capture new staff – to take effect from March 2024.
	Intervention 1.9 – VBA all staff – midwives, obstetricians and MSWs	74.8%	46	Pending consultant input regarding adding to doctor induction so new staff captured – will improve compliance. Added to MSW induction and new midwife/preceptor induction.
K2 CTG & IA	Consultants	100%	0	MIS action plan: Managed by Fetal Monitoring Lead Midwife and Service Manager.
	Registrars	89%	1	MIS action plan: Managed by Fetal Monitoring Lead Midwife and Service Manager.
	Midwives	88%	11	Managed by Fetal Monitoring Lead.

Report Front Sheet

1. Report Details			
Meeting Title:	Board of Directors, Part 1		
Date of Meeting:	27 Mar 2024		
Document Title:	**Board Assurance Framework (BAF)**		
Responsible Director:	Nick Johnson – Deputy CEO	Date of Executive Approval	19/03/24
Author:	Philip Davis, Head of Corporate Planning		
Confidentiality:	No		
Publishable under FOI?	Yes		
Predetermined Report Format?	n/a		

2. Prior Discussion		
Job Title or Meeting Title	**Date**	**Recommendations/Comments**
Feedback from each SRO owner of discrete risks on BAF	Mar-24	Executive Directors provided any edits to BAF risk scores or how risks are laid out
Finance and Performance Committee, People and Culture Committee, Quality Committee, Risk and Audit Committee	18th and 19th March 2024	Noted

3. Purpose of the Paper	*To give assurance to Board Committees that the Risks to Delivery of our Trust Strategy (and the benefits therein) are understood, that actions to mitigate them have been put in place, and we are actively monitoring these risks over time.*							
	Note	✓	*Discuss*	✓	*Recommend*	✓	*Approve*	✓
4. Key Issues	*The BAF is in its 13th iteration, having initially run bimonthly reviews after publication of the Trust Strategy in Nov-21, before changing to quarterly reviews in Mar-23.* ***Risk & Audit Committee Risks Scored >15 (High Risk):*** ***PL1.11 Owned by RAC, with CIO as Accountable Exec. Score 16.*** *If we do not deliver robust, accurate and timely coding then data submitted to NHSE and NHS Digital will not be reflective of the care delivered, so workload will be inaccurate and there will be a negative impact on reputation through KPI's such as the Summary Hospital-level Mortality Index.* *Mitigations include hire of new Coding manager and increasing banding to attract new staff/trainees, to shift off agency reliance.* ***No changes since Jan-24.*** ***Changes to Risk Scores since Dec-23 BAF*** *Actions were taken at the Board Development session held in Jan-24, to consider adoption of the four lines of defence model, and to further refine the BAF risks – but to wait until the Joint Strategy with DHC is available, and use this to check Strategic Objectives and associated risks.* *Note the changes to the risk score for PL1.3 (owned by the FPC Committee).*							
5. Action recommended	The Mar-24 Board is recommended to: 1. **NOTE** the Mar-24 Quarterly version of BAF 2. **Review** and **Comment** on those risks scoring 16 or higher, and the adequacy of the mitigations and controls in place, and also the changes in since the last Quarterly BAF in Dec-23.							

	3. **Recommend** that the changes that in this iteration (marked in Red) be accepted. 4. **APPROVE** taking to the Mar-23 Board.

6. Governance and Compliance Obligations				
Legal / Regulatory Link			**No**	
Impact on CQC Standards		**Yes**		Clinical Plan is closely focused on improving Patient Outcomes & Patient Experience, and People Plan strongly focused on staff wellbeing
Risk Link		**Yes**		
Impact on Social Value		**Yes**		Social Value Action plan sits within Sustainability & Efficiency Workstream, underlying the Trust Strategy
Trust Strategy Link		**How does this report link to the Trust's Strategic Objectives?** *Please summarise how your report will impact one (or multiple) of the Trust's Strategic Objectives (positive or negative impact). Please include a summary of key measurable benefits or key performance indicators (KPIs) which demonstrate the impact.*		
Strategic Objectives	People	BAF directly linked to Trust Strategy Objectives		
	Place	As above		
	Partnership	As above		
Dorset Integrated Care System (ICS) goals		**Which Dorset ICS goals does this report link to / support?** *Please summarise how your report contributes to the Dorset ICS key goals.* *(Please delete as appropriate)*		
Improving population health and healthcare		**Yes**		
Tackling unequal outcomes and access		**Yes**		
Enhancing productivity and value for money		**Yes**		
Helping the NHS to support broader social and economic development		**Yes**		
Assessments		**Have these assessments been completed?** *If yes, please include the assessment in the appendix to the report.* *If no, please state the reason in the comment box below.* *(Please delete as appropriate)*		
Equality Impact Assessment (EIA)			**No**	
Quality Impact Assessment (QIA)			**No**	

BOARD ASSURANCE FRAMEWORK - SUMMARY

DATE: 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

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	# People Risks: 7
People Objective 1 We will build a 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	• Evaluation of Annual People Plan delivery • People Dashboard reviewed at PCC	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						
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	# 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 producitvty 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	• 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.					

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	# Place Risks: 17
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%	3	4	12	• 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) ICB led weekly meetings and BI-monthly Tiering meetings in place for further oversight and support NOTE: H2 planning guidance for latter part of financial year reframes the specific performance asks in light of continued impact of Industrial Action - focus is on: 62 day backlog reduction, achievement of FDS at 75% by end of March 2024 eliminatiion of 78wk waits, achievement of 76% ED standard by end of March 2024	• 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 Weekly performance dashboard provided to Joint Execs for discussion Tiering information packs updated Bi-monthly	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: UPDATE: As H2 Plan for latter part of 203/24 has altered the ask of Trusts in light of ongoign industrial action and its impact on performance - the Trust is on track to achieve all but the elimination of the 78 week waiters by the end of March. There is a plan to reduce these to less than 30 patients and this has been accepted by ICB and Region and is in line with other Systems' returns. Further to this the score has been altered to amber (12) for the end of year position						
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.	1	2	3	• 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 reviewed by ICB and Region and found to be substantial compliance - two areas for focus identifed for furhter training and evidence of training and these form part of the EPRR action plan taken through the Trust EPRR group and reported to FPC through the Group Exception Report.						
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.	• 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						

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	# Place Risks: 17
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 Winter funding evidence - reduced LoS on Maud Alex Assessment Ward, two months of Q4 over 80% ED acheivement against 4 hr standard, improved morning discharge ratio and achievement of 7 day discharge services. Engament with ICB over developments to improve D2A achievement movign to Transfer of Care Hub on site at DCH in Q4	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.** **Q3 - 4 - deteriaoration in NRTR across P1-3 leadign to further MADE and other interventions to inform improvements required across System partners to improve flow out of acute setting. Transfer of Car ehub launch in March 24 on site a culmination of the first phse of the system improvements. Further work needed on commissioning of beds which meet patient needs, recognising increasing acuity and complexity in patients admitted in the West of the County.** **Internal improvements can be tracked via various internal and external reports on early discharges, increased discharges weekday/weekends, use of admission avoidance work at the front door and Ilchester Ward and ability to flex down escalation areas at times of reduced pressure on beds.** **Overall this remains a high risk area for the Trust as System measures are not consistently supporting a reduction to 45 NRTR or below.**					
~~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~~	~~4~~	~~8~~	~~• 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						

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	# Place Risks: 17
PL 2.3	FPC	CFO	1646	CFO	**Risk Description:** If we do not work to improve our sustainability as an organisation then we will increase our environmental impact and so we will not improve the environmental, social and economic well-being of our communities, populations and people.	3	3	9	• Sustainability champions & Sustainability Group in place at DCH to encourage long term improvements and sustainability • Sustainability Programme in development in line with the Kings Fund Sustainability Theory bringing together Social, Environmental and Economic factors • Social Value Pledge and Action Plan in place emphasising the commitment to improving the wellbeing of the population • Green plan published and monitored annually	• Regular reporting to Strategy and Transformation SLG • Annual reporting on Green Plan to FPC and Board	Good	Good	9	Ongoing	
									Gaps in Control and Actions:						
Place Objective 3: We will utilise digital technology to better integrate with our partners and meet the needs of patients															
PL 3.1	FPC	CIO	1287, 1344, 1352, 1300, 1417 and 1337	CIO	**Risk description:** If we do not achieve a Dorset wide integrated electronic shared care record then we run the risk of not making the right information available to care professionals, so we will not be able to make sure the right information is available to the right person in the right place at the right time about the right patient increasing the likelihood of patient harm	1	3	3	Dorset Care Record project lead is the Director of Informatics at UHD. Project resources agreed by the Dorset Senior Leadership Team. Project structure in place overseen by ICS Digital Portfolio Director	• Reports to the Dorset System Leadership Team. Updates provided to Dorset Operation and Finance Reference Group and the Dorset Informatics Group.	Good	Good	3	Achieved - currently at Target Risk	
									Gaps in Control and Actions:						
PL 3.2	FPC/QC/RAC	CIO	1357,1365 and 690	CIO	**Risk description:** If we do not have adequate cyber security defences to protect the Trust's digital assets then we increase the likelihood of impact from a cyber event, so the Trust will suffer partial or complete loss of digital services including access to critical applications, data and/or digitised processes.	3	4	12	Patching of perimeter defences, firewalls, servers, switches, desktop/laptop equipment, penetration tests and regular audits	• Annual Penetration Test Results and associated action plan • Annual DSPT submission • Regular reports to Quality Committee, Risk and Audit Committee, Trust Board • Annual Internal Audits • Annual renewal of ISO27001 accreditation • Tools deployed by the Trust to monitor and report on cyber threats • Use of tools made available by NHSE to monitor alerts/threats i.e. CareCERT • SIRO, Deputy SIRO, Information Security Manager, Data Protection Officer - all posts filled	Good	Good	9	Ongoing task, no fixed delivery date	
									Gaps in Control and Actions:						
PL 3.3	QC/RAC	CIO	690	CIO	**Risk description:** If Trust staff are not trained sufficiently to minimise targeted and social engineering threat attempts then we increase the likelihood of the impact of a cyber event, so the Trust will suffer partial or complete loss of digital services including access to critical applications, data and/or digitised processes.	3	4	12	Part of DSPT annual assurance, digital training team providing training for all new starters and annual refresh training . Regular phishing campaigns.	• Annual DSPT submission • Regular reports to Quality Committee, Risk and Audit Committee, Trust Board • Targeted training resulting from output of internal campaigns • Annual Internal Audits • Annual renewal of ISO27001 accreditation • Tools deployed by the Trust to monitor and report on cyber threats • Use of tools made available by NHSE to monitor alerts/threats i.e. CareCERT	Good	Good	9	Ongoing task, no fixed date	
									Gaps in Control and Actions:						
Place Objective 4: We will listen to our communities, recognise their different needs and help create opportunities for people to improve their own health and wellbeing and co-designing services															
PL 4.1	Quality Committee	CNO	1647	Hannah Robinson - Patient Engagement Jo Hartley: Maternity voices partners	**Risk description:** The Trust fails to engage and work with partners and stakeholders to effectively maximise the opportunities to engage and co-design with our communities and services will not meet the needs of those that use them.	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	• 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	

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	# Place Risks: 17
									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 Jo Wilson - DiiS Health Inequalties data, Flagship Transformation Support CMO - AHSN CEO/Director of	**Risk description:** The Trust fails 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 • GP Alliance and Flagship Programmes • 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	• 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		

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
									Gaps in Control and Actions: The Provider Collaborative is in theprocess of agreeign the 23/24 focus DCH/DHC collaboration on transfrormation in development						
PA 3.2	FPC	CEO		CMO	**Risk description:** If the Trust does not initially support the appropriate delegation of authority to the Provider Collaborative and then does not adequately acknowledge and accept the delegation then effective functioning of the Provider Collaborative will not be possible and appropriate and measured solutions which improve sustainability and reduce variation will not be implemented	4	2	8	• Engagement of Trust Board in ICS discussions and planning • Trust Board review and approval of any delegation. The Trust has a legal obligation to collaborate outlined in the amended provider licence	• Trust Board papers	Good	Good	8		
									Gaps in Control and Actions:						
PA 3.3	QC	CMO		CMO	**Risk description:** If the Trust does not invest and support key services identified as 'centres of excellence' by the clinical strategy then investment into key services integral to the future sustainability of the Trust will not be forthcoming	3	4	12	• The Clinical Strategy will set out the areas for investment and prioritisation. • Investment through business planning will be aligned to clinical strategy to ensure investment in key areas which are integral to the future sustainability if the Trust • Review of investment and impact via divisional performance framework and sub-committee structure.	• Monitoring of clinical strategy via S&T SLG and divisional performance • Business Planning processes	Good	Good	8	?	
									Gaps in Control and Actions GAP: Centres of Excellence need to be identified across all Dorset Trusts and developed jointly. ACTION: Joint working 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

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

Risks	RAC Dates: nov-21	11-jan-22	15-mar-22	10-mai-22	12-jul-22	20-sep-22	22-nov-22	17-jan-23	20-mar-23	01-jun-23	01-sep-23	01-des-23	01-mar-24	Trend vs Mar-23		Trend vs Nov-21	
PE 1.1	16	16	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	16	16	-4	Improving	0	Unchanged
PE2.1	12	12	12	12	12	12	12	12	12	12	12						
PE 3.1	8	8	8	8	8	8	8	8	8	8	8						
PE 3.2	12	12	15	15	15	15	15	15	15	15	15						
PE 3.3	12	12	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			-6	Improving	0	Unchanged
PL 1.1	20	20	20	20	20	20	20	20	20	20	16	16	16	-4	Improving	-4	Improving
PL 1.2	16	16	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	16	12	-4	Improving	0	Unchanged
PL 1.4	6	6	6	6	6	6	6	6	6	6	6	3	3	-3	Improving	0	Unchanged
PL 1.5	20	20	20	20	20	20	20	20	20	16	20	20	20	0	Unchanged	0	Unchanged
PL 1.6	12	12	12	12	12	12	12	12	12	12	16	16	16	4	Worsening	4	Worsening
PL1.7	12																
PL1.8	16																
PL 1.9	2	2	2	2	2	2	2	2	2								
PL 1.10	16	16	16	16	16	16	16	16	16	16	12	12	12	-4	Improving	-4	Improving
PL 1.11			16	16	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	10	10	0	Unchanged	-5	Improving
PL 2.2	16	16	20	16	16	16	16	16	16	16	12	12	12	-4	Improving	-4	Improving
PL 2.3	9	9	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	3	3	0	Unchanged	-3	Improving
PL 3.2		12	12	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	12	12	0	Unchanged	12	Worsening
PL 4.1	12	12	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	12	12	0	Unchanged	0	Unchanged
PA 1.1	8	8	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	9	9	0	Unchanged	0	Unchanged
PA 1.3	6	6	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	12	12	0	Unchanged	0	Unchanged
PA 2.1	20	20	20	16	16	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	12	12	0	Unchanged	0	Unchanged
PA 2.3	6	6	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	8	8	0	Unchanged	0	Unchanged
PA 3.2	8	8	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	12	12	0	Unchanged	-4	Improving
PA 4.1	9	9	9	9	9	9	9	9	9	9	9	9	9	0	Unchanged	0	Unchanged

1. Report Details			
Meeting Title:	Board of Directors, Part 1		
Date of Meeting:	March 2024		
Document Title:	Corporate Risk Register		
Responsible Director:	Jo Howarth Interim Chief Nursing Officer	Date of Executive	*Approved by*
Author:	Mandy Ford, Head of Risk Management and Quality Assurance		
Confidentiality:	*n/a*		
Publishable under FOI?	*No*		
Predetermined Report Format?	*No*		

2. Prior Discussion		
Job Title or Meeting Title	**Date**	**Recommendations/Comments**
Relevant staff and executive leads for the risk entries	Various	Risk register and mitigations updated,
Risk and Audit Committee	19/03/2024	Noted

3. Purpose of the Paper	The Corporate Risk Register assists in the assessment and management of the high level operational risks. The corporate risk register provides the Board with assurance that corporate risks are effectively being managed and that controls are in place to monitor these. The risks detailed in this report are to reflect the operational risks, rather than the strategic risks reflected in the Board Assurance Framework.							
	Note (✓)	✓	*Discuss (✓)*		*Recommend (✓)*	✓	*Approve (✓)*	✓
4. Summary of Key Issues	All current active risks continue to be reviewed with the risk leads to ensure that the risks are in line with the Risk Management Framework and the risk scoring has been realigned. All risks have been aligned with the revised Board Assurance Framework. The DCH Board of Directors conducted a Development Session on 31January 2024. The Results of the session were that the Risk Appetite statement should be reviewed after the Joint Strategy with Dorset Healthcare is agreed.							
5. Action recommended	The Board is recommended to: • review the current Corporate Risk Register • note the High risk areas and mitigations • consider overall risks to strategic objectives and BAF • request any further assurances							

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

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

Board of Directors
Corporate Risk Register as at 29 February 2024

Executive Summary

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

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

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

Following the implementation of the revised Risk Management Framework, each Board Assurance Committee will commence receiving the Corporate Risk Register report with the specific risks assigned to them. These were revised at the end of January 2024, when the Trust Board took the opportunity to verify which primary committee certain risks on the risk register should report to. These have been amended and this report is reflective of those changes.

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

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

A review of all items currently scoring 15 or above has been undertaken, however work remains ongoing with the relevant Executives and teams to review and reframe risks that have been on the Register for a period of 18 months or longer. These continue to be reviewed alongside the governance arrangements within the Divisions to ensure that they are aligned appropriately.

We will add any new risks to the Risk and Audit Committee for raising awareness. These will also be reported to the relevant Sub Board Committees for discussion.

NEW RISKS ADDED January – February 2024.

Date risk added to register	Initial Risk Score at time of addition	Risk Register Reference	Risk Title	Risk Description	Reporting Committee
01.02.2024	15	1605	General Paediatric Outpatient waiting lists.	Waiting lists for new and follow up general paediatric outpatient appointments far exceeding capacity - new patient wait over 12 months in some patches.	Finance and Performance Committee
04.01.2024	16	1780	Macular FOWL Long Waiters	Due to capacity within service, we are unable to see patients for their follow ups in the appropriate timeframe.	Finance and Performance Committee
05.02.2024	20	1786	Ophthalmology Injection Capacity	Ceasement of insourcing and in house workforce/training will result in patients having their Eylea Injections delayed. Overall there are 408 patients on the waiting list	Finance and Performance Committee
04.01.2024	16	1781	Glaucoma FOWL Long Waiters	Due to capacity within service, we are unable to see patients for their follow ups in the appropriate timeframe.	Finance and Performance Committee
04.01.2024	16	1782	Diabetic Follow Up Long Waiters	Due to capacity within service we are unable to see patients for their follow ups in the appropriate timeframe.	Finance and Performance Committee
05.02.2024	16	1786	Ophthalmology Injection Capacity	Ceasement of insourcing and in house workforce/training will result in patients having their Eylea Injections delayed.	Finance and Performance Committee
22.01.2024	16	1799	Cold Room Food Storage	A few of the cold rooms we have in the kitchen for the storage of fresh produce are at high risk of failure. They have failed intermittently and an engineer on visit said the equipment is at end of life and the likelihood of failure is high. We also have a temperature monitoring system that is outdated so the food safety risk for contamination due to poor storage is also high.	Finance and Performance Committee
22.01.2024	16	1800	Temperature Holding Equipment Inadequate	Several pieces of equipment that are responsible for the safe hot holding of food are not fit for purpose and represent a food safety Risk.	Finance and Performance Committee
02.02.2024	20	1814	Electronic Health Record business case pace of change.	Following a requirement by the National Frontline Digitisation (FD) initiative and	Finance and Performance Committee

Date risk added to register	Initial Risk Score at time of addition	Risk Register Reference	Risk Title	Risk Description	Reporting Committee
				Regional Finance and Digital teams, Dorset ICS is required to work on a joint Dorset and Somerset Outline Business Case (OBC) for a single electronic health record across acute, community and mental health. Based on the availability of FD funding over the next few years the timeline for completing the OBC is by March 2024. The investment is likely to be in excess of £100m and could be up to £500m across both ICSs with only a small percentage of the capital investment coming from the FD allocation. The required due diligence for a business case of this nature is typically a 6 month process at the very least. Each Trust will be required to approve the joint OBC but given the timelines an insufficient level of due diligence will have been applied to the OBC from a Dorset perspective. This has major financial, reputational and commercial risks associated with the process we have been required to adopt.	
02.02.2024	16	1815	Electronic Health Record, risk of not receiving FD Funding	In the event a joint outline business case for a single Electronic Health Record across Dorset and Somerset is not deemed affordable or is too high risk for Dorset the ICS may not qualify for the remainder of the £26m allocated to Dorset for an Electronic Patient Record. This represents a proportion of the £5.5m allocated to DCH specifically. This may mean a failure to achieve an EPR for DCH and the wider Dorset system. Delivering an EPR for the Trust and converged across the ICS is a critical requirement to support strategic developments across the ICS, improve clinical effectiveness, Trust and ICS wide productivity, improved clinical safety and improved patient experience and is a national requirement to achieve by 2025.	Finance and Performance Committee
02.02.2024	16	1816	Pace required for implementing National Virtual Ward	National virtual ward initiative is driving very fast paced procurements and implementation	Finance and Performance Committee

Date risk added to register	Initial Risk Score at time of addition	Risk Register Reference	Risk Title	Risk Description	Reporting Committee
			requirements present clinical safety risks	of remote monitoring and other digital developments which the Trust does not have the resource to support in terms of participating in requirements definition, procurement, systems integration and/or overall solution fit.	
26.02.2024	16	1828	High risk of Fraud in regards to use of pool cars and fuel cards	Due to the lack of formal policy/procedures and given the discrepancies identified during a Counter fraud review, the likelihood of fraud occurring is high. However, any financial impact /material loss would be relatively low, hence overall recommendations have been given important/amber ratings as opposed to urgent/red ratings on the Counter Fraud report.	Finance and Performance Committee
28.12.2023	16	1778	Urology Template Biopsy Machine Failure	Ultrasound probe for performing template prostate biopsies under GA failed completely and is no longer working.	Finance and Performance Committee
26.02.2024	16	1827	Electronic health record unavailable for SCBU	Paper documentation used for infants admitted to SCBU. Electronic health record (Badgernet) plus minimal use of paper records used for infants under Transitional Care. This has resulted in two different systems being used for infants admitted to SCBU/TC by the same team. Additionally SCBU staff are reliant upon desktop PC's rather than the I-Pads which are outdated and unreliable.	Finance and Performance Committee
26.02.2024 Baker,Abi 26/03/2024 09:10:11	15	1832	VIE at Weymouth Hospital is now failing	Weymouth Hospital VIE is currently not correctly functioning. The pressure relief valve is failing, and requiring manual venting, with various gauges broken. Does not appear on DCH's asset register, and unclear if sits with DHC but DCH currently pay rental on it. With the reintroduction of theatres at Weymouth Hospital, this will require resolution prior to opening	Finance and Performance Committee

1. Introduction

1.1 This report provides an update to the report presented to the December 2023 Risk and Audit Committee meeting.

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

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

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

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

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

- Heat Map (detailed in Appendix 1)
- Risk and Audit Committee Corporate Risk Register detail (Appendix 2)
- Corporate Risk Register items scoring 20 (Appendix 3)

2. Spotlight report – new risks added.

2.1 1828 High risk of Fraud in regards to use of pool cars and fuel cards. (HIGH risk score 16 (4 Major x 4 Likely))

2.1.1 Counterfraud were requested to review the processes in place for the management of fuel cards and pool cars. The draft report was received 20 February 2024, and was discussed with the Deputy Head OF Estates and Facilities, Head of Financial Management. Head of Risk Management and the TIAA team.

2.1.2 A number of anomalies were found with some actions recommended. The Deputy Head of Estates and Facilities has discussed this report with the responsible managers.

2.1.3 Due to the lack of formal policy/procedures and given the discrepancies identified during th3 review, the likelihood of fraud occurring is high. However, any financial impact /material loss would be relatively low, hence within the TIAA report, overall recommendations have been given important/amber ratings as opposed to urgent/red ratings.

2.1.4 Some of the issues identified were:

- The Trust has no policy and no formal procedures regarding fuel cards and pool cars. Current basic written procedures are informal and for the use of the transport team only and content is insufficient.

- There is no assurance that driving licence checks are completed six monthly for staff who use pool/fleet cars.
- Completion of the vehicle log sheets are inconsistent across the Trust.
- Mileage readings are not always provided to garages when vehicles refuelled.
- Fuel cards are not linked to specific vehicles, which provides a greater opportunity for abuse of fuel cards.
- Safety checks forms for vehicles are not completed consistently.

2.1.5 The Transport Manager and Facilities Manager responsible for the service are working to address the recommendations and actions in the report and a report will be provided to the June RAC meeting.

2.1.6 The Counter fraud Team and Risk Management will assist with the governance and development of processes and policies to ensure the risk is mitigated as far as possible and robust processes and audits are in place.

3. System Wide Risks

3.1. Following the Trust Board Workshop on 31 January 2024, w have also added a category for System Wide Risks, where these may sit outside of the Trust to manage but impacts on the service provision. These will be detailed in this report for awareness and to highlight the impact of these risks at this Committee.

3.2 **1816 Pace required for implementing National Virtual Ward requirements present clinical safety risks. (HIGH risk score 16 (4 Major x 4 Likely)) NEW**

3.2.1 This is a new risk added to the Risk Register 02.02.2024. The National virtual ward initiative is driving very fast paced procurements and implementation of remote monitoring and other digital developments, which the Trust does not have the resource to support in terms of participating in requirements definition, procurement, systems integration and/or overall solution fit.

3.2.2 Remote monitoring tools and a new solution for outpatient prescribing are the digital solutions that are being procured and implemented at pace to support the national requirement for Virtual Ward development. The projects to deliver the procurement and implementation are largely driven by ICB resources to ensure the ICS can comply with national requirements. Digital resources are required to participate in each stage, but this cannot be supported given the current workload for DCH digital teams including but not limited to the EHR business case work.

3.2.3 Most of these digital developments are third party products that will create new silos of patient clinical data that will not be integrated with Trust patient records. Some have potential to be integrated but the Trust does not have resource to support the requirements definition, design, testing or implementation resource to accommodate this at the pace the Virtual ward projects require. There is a concern that patient data from remote monitoring output and some OP prescribing data will not be available to clinicians where a third-party remote monitoring or OP prescribing tool (Cleo) are being used to support Virtual Ward developments.

3.2.4 In order to mitigate this, a review of requirements are being undertaken where possible and clinical safety assessments are being conducted as best we can including reviewing SoPs to mitigate the risks associated with not being able to integrate these new tools with Trust systems. An update will be provided in the next Committee report.

3.3 1819 Disparity in the provision of Powered Wheelchairs to Paediatric Patients (HIGH risk score 16 (4 Major x 4 Likely)) NEW

3.3.1 Wheelchairs Services (Dorset Healthcare) are responsible for providing powered wheelchairs for children and young people (CYP) who have significant mobility issues (e.g. cerebral palsy GMFCS 4 and 5). However, we are being told that they cannot provide these for CYP if the home is not accessible and the chair will not be used inside the house.

3.3.2 This criteria is adult based and does not take into account the developmental needs of CYP to develop independence and have access to education, community facilities and play/leisure.

3.3.3 Dorset Health Care have advised that there is no a clear delineation in the national guidance for the prescribing of wheelchairs to adults and paediatric. In both cases, it must meet a health need within the home. NHS Wheelchair services are funded for physical health needs only within the home and not funded for education, work, sport (manual or power chairs) or outdoors only (power chairs)

3.3.4 NHS funded wheelchair services nationally work from the guidelines of powered wheel chair services are in place to maintain the wheelchair service user health within the home to be able to do things such as going to the toilet, bed, getting food etc, to maintain their health in the home. All WCSs are the same, and criteria for provision of a power chair is based on use inside the home.

3.3.5 Until guidelines change and funding for other aspect of the individual life, whether education, sports or going out, changes the Dorset Wheelchair service must prescribe within the guidelines of the NHS Wheelchair services.

3.4 456 Patient Transport Provision & Urgent Patient Transfers (HIGH risk score 20 (4 Major x 5 Certain was previously Moderate scored 9) ⬆

3.4.1 Potential delays to treatment and disruption to services arising from difficulties accessing PTS service or urgent patient transfers to other centres due to ambulance or Patient Transport service capacity. This is affecting all patients across all services, with attending outpatient appointments and with facilitating discharges from the hospital.

3.4.2 In addition, there are a number of patients that attend dialysis, at Bournemouth, DCH and Yeovil that are now refusing to attend for their treatment due to transport issues. We have 364 incidents linked to this risk (273 (75%) reported between 01.04.2023 and 29.02.2024)

3.4.3 The admission contractors (HTG) are struggling to meet their contact (managed by NHSD), so the discharge support provider are having to facilitate the admission journeys which impact on the discharges.

3.4.4 This has been escalated to NHS D as part of the contract performance review. This is raised at various system meetings on a regular basis.

3.5 461 Risk of harm to patients that are MFFD remaining in hospital. (HIGH risk score 16 (4 Major x 4 Likely)) ⟺

3.5.1 Patients who remain in hospital for longer than they should are at risk of harm, pressure damage, falls, infection, loss of mobility and independence or risk of becoming institutionalised. We still have a high volume of patients residing in the hospital with no medical need or reason to remain in a hospital bed, which is likely to impact on the patient's well-being and the flow of patients across the hospital. (72 patients across all pathways as at 06.03.2024).

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

3.5.3 Clinical teams continue to report incidents for patients that have no reason to reside due to the impact on their physical and mental well-being, whilst this is difficult to evidence fully, we are aware

that delays in discharge are affecting patients. As their condition deteriorates, their care needs increase, which means the assessment and brokerage process must be recommenced. Asking whether a patient was MFFD at the time of the incident is a mandatory field within the incident reporting form, to better assist in capturing data.

3.5.4 There was a reintroduction of Fast Track on two wards on 01 September 2023 by the ICB as the MDT process using CHC consideration just was not working so referring to the SPoA as this was the only option. However, this was taking too long, which defeats the object of Fast Track and individuals were not accessing the right end of life service. It is hoped that the full reintroduction of Fast Track will help. However, even with the reintroduction of Fast Track a gap has been identified with frailty patients, and we have highlighted this to the ICB strategic commissioning team.

3.6 **866 External Multiagency Delays Resulting in Delayed Discharge of Complex Paediatric Patients (HIGH risk score 16 (4 Major x 4 Likely))** ⟺

3.6.1 Increasing amount of children and young people are experiencing extended hospital admissions due to requiring either local authority provision of accommodation / placement, or mental health tier 4 inpatient beds on discharge from Kingfisher Ward. Many of these children have no initial medical need to be admitted, but are admitted as a safe place, and are also brought in if their care placement breaks down, or behaviours escalate to being unmanageable in the care or home environment. Some children are admitted with no medical need for their own safety.

3.6.2 These children often have complex emotional or mental health issues and may require mental health inpatient admission or a safe, nurturing environment away from the family home for their own safety and/or the safety of family/siblings.

3.6.3 There are often delays in processes and locating appropriate placements resulting in prolonged hospital admission in an inappropriate environment.

3.6.4 Additionally the Trust have seen a significant increase in patients admitted with Eating Disorders, requiring specialist input and / or inpatient bed. This has been highlighted both locally and nationally.

3.6.5 A memorandum of understanding, in regards to escalating within the appropriate organisations, is in place and is being used in appropriate cases, with some success. The Trust also continues to seek and use legal support and representation to escalate complex cases to the High Court, in order to ensure that the Trust is detaining patients appropriately and for the shortest amount of time possible.

3.7 **1037 Transition Service for Young People to Improve Health Outcomes (HIGH risk score 16 (4 major x 4 likely)).** ⟺

3.7.1 From October 2021, DCH employed a Transition Nurse Specialist 1.0wte to begin leading and developing the child to adult transition service for young people with long term health conditions and their families. This is supported by an Adult EM Consultant co-leading on a transition project for DCH which is not funded and is managed on good-will only.

3.7.2 There are over 300 transitionable conditions spanning at least 20 services within DCH exclusive to wards and departments. The Transition workforce is insufficient to manage this vast service. Without a comprehensive service, our local young people are at high risk of disengaging with services, risk taking self-management with conditions, non-compliance with treatment, and poor outcomes leading to complications of their condition and potential mortality.

3.7.3 Steering group for transition now formed, led by an ED consultant and the Transition Nurse Specialist. The Chief Medical Officer is the Executive lead for transition. The Trust has developed good regional links through the Burdett Trust, sharing knowledge and ideas.

3.7.4 Some Paediatricians liaise with adult counter parts or primary care when they feel a child is ready to transition, however there is no robust pathway to follow for referring and transferring these young people, and therefore no consistency and young people are getting lost to services.

4. Updates on Previous report

4.1 **1746: Core Network Upgrade 2023 (15 HIGH (Catastrophic (5) x Possible (3)) March Report**
Core work including wireless was completed successfully. Risk fully mitigated and closed.

4.2 **1752: 2003 Servers Out of Support Since 2010 (16 HIGH (Major (4) x Likely (4)) MARCH REPORT**
Progress is being made and reported via DTAG.
Key points to note:

- Delays related to the EHR prioritisation of associated resource.
- Infrastructure team have been unable to recruit to the vacant position which is a key enabler to remediation of legacy systems.
- Legacy desktops decommissioned 18
- Legacy servers decommissioned 2
- Progress from the 18th of January has included the decommissioning of the legacy finance system (Smartstream). DTI are grateful for the ongoing engagement and support from our finance colleagues in decommissioning this server.

4.2.1 There are two systems that DTI are awaiting end user information before they are decommissioned, these are used for finance and information reporting purposes.

4.2.2 There are 6 systems that are planned to be reviewed during the next 4 weeks, and another 7 systems then remain to be reviewed, which has been delayed. Some of the delays are due to cost pressures, but only a small amount of these systems awaiting review are legacy systems.

4.2.3 Many of these systems have dedicated action plans, but unfortunately many are unable to be immediately upgraded due to operational pressures, financial constraints, lack of clear upgrade paths or several other factors, including those listed above.

4.2.4 The remaining legacy systems are no longer receiving security updates or vendor patching, if a vulnerability is found, it will never be fixed, therefore increasing the risk exposure to the Trust. This is being mitigated as far as possible.

5 **Corporate Risk register**

5.1 There are currently 93 risks on the risk register that are scored 15 or above. Services are continuing work through their risk registers to align with the new framework and as part of their governance review processes.

5.2 In addition the Board undertook a review of the Corporate Risk Registers at the end of January 2024, working through them by Committee.

5.3 Whilst a full revision of the risk registers has been completed, operational pressures can result in delays to updates of risks and mitigations. The introduction of the revised Risk Framework and the planned training programmes, as well as proactive follow up and reporting by the Risk Team should assist in maintaining accurate and up to date registers.

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

6.1 1646 – Financial Sustainability 2023/24 (20 HIGH (Major (4) x Certain (5)) ⟺

6.1.1 The financial plan for 2023/24 reflects a breakeven position for the Trust. This includes a CIP of £10.9m (4.2%) and unfunded inflationary pressures of c. £3m, which poses a risk to the financial sustainability strategic objective. The Dorset system is currently forecasting a deficit of £12.1m for the financial year.

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

6.1.3 Mitigation:

Value Delivery Board has been established focusing on in year and longer-term financial sustainability, and is a formal subgroup of the Finance and Performance Committee. System Recovery Group has been established to support system wide recovery.

7. Conclusion

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

8. Recommendation

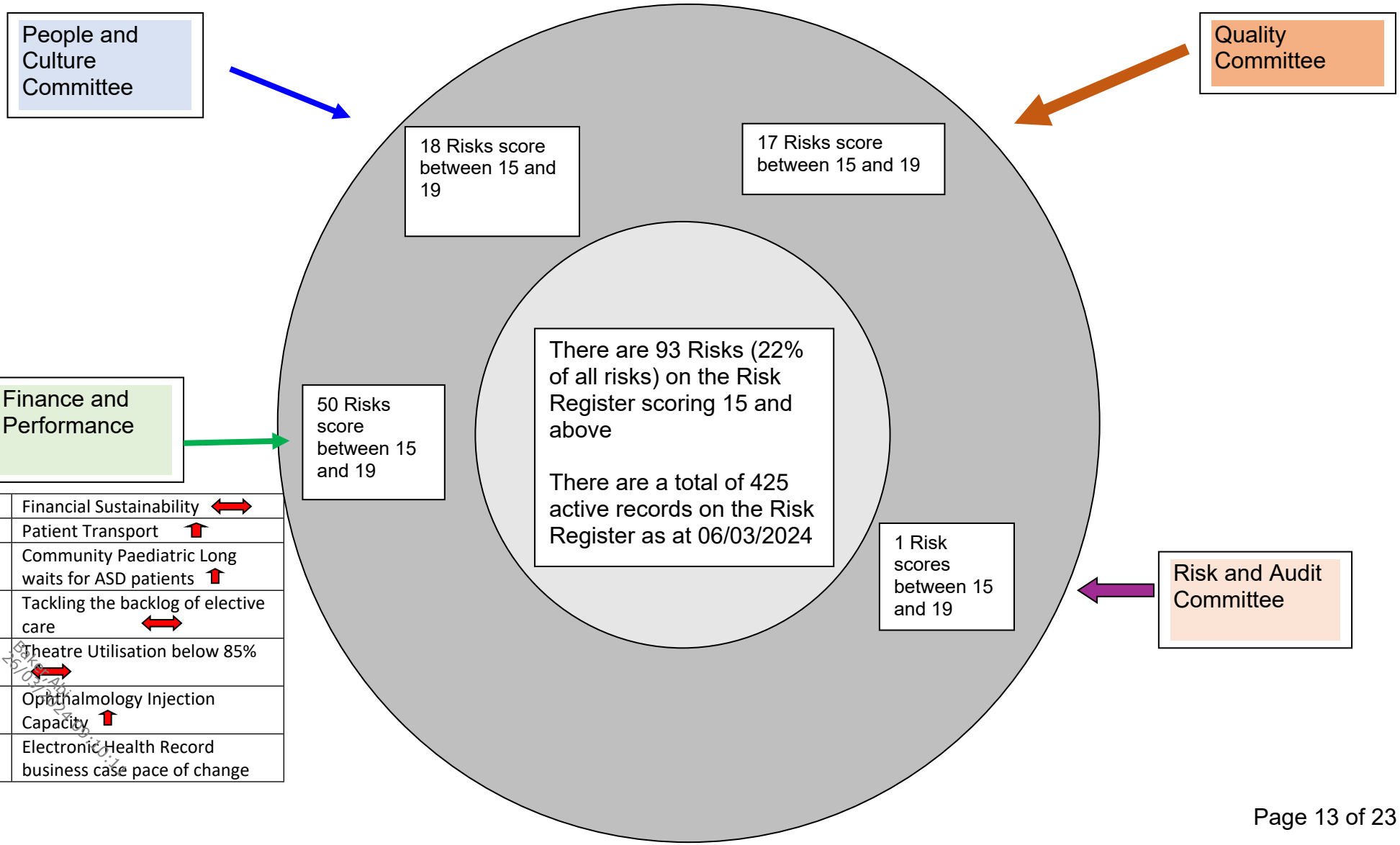
The Board is recommended to:

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

Name and Title of Author:
Mandy Ford, Head of Risk Management and Quality Assurance
Date: data correct as at 06.03.2024
Appendices

- Heat Map (Appendix 1)
- Corporate Risk Register for Risk and Audit Committee (Appendix 2)
- Corporate Risk Register items scoring 20 (All committees) (Appendix 3)

Corporate Risk Register – Risks scoring 20 or above detailed in the table



1646	Financial Sustainability ⟷
456	Patient Transport ↑
472	Community Paediatric Long waits for ASD patients ↑
1221	Tackling the backlog of elective care ⟷
1749	Theatre Utilisation below 85% ⟷
1786	Ophthalmology Injection Capacity ↑
1814 **NEW**	Electronic Health Record business case pace of change

Ref:	Current Score		Previous Score	Risk Title: **High risk of Fraud in regards to use of pool cars and fuel cards**	Responsible Executive: Chris Hearn, CFO Comments/ Mitigations
1828	**16**	NEW	NEW	Due to the lack of formal policy/procedures and given the discrepancies identified during a Counter fraud review, the likelihood of fraud occurring is high. However, any financial impact /material loss would be relatively low, hence overall recommendations have been given important/amber ratings as opposed to urgent/red ratings on the Counter Fraud report.	Very limited mitigations in place as there is no policy, no regular audits or check on licences, fuel cards are not aligned to cars, mileage and travel is not always recorded and authorised. However, an action plan is being created with support from the Counter Fraud and Risk Management teams to ensure that robust and appropriate governance processes are in place. It has identified a need for some staff training around good governance processes and what this means for each service and the organisation.
Reporting Committee		Finance and Performance Committee		**BAF objective: PLACE** • We will build sustainable infrastructure to meet the changing needs of the population.	
Ref:	Current Score		Previous Score	Risk Title: **Disparity in the provision of Powered Wheelchairs to Paediatric Patients**	**SYSTEM RISK** Responsible Executive: Chris Hearn, CFO Comments/ Mitigations
1819	**16**	NEW	NEW	Wheelchairs Services (Dorset Healthcare) are responsible for providing powered wheelchairs for children and young people (CYP) who have significant mobility issues (e.g. cerebral palsy GMFCS 4 and 5). However, we are being told that they cannot provide these for CYP if the home is not accessible and the chair will not be used inside the house. This criteria is adult based and does not take into account the developmental needs	This is not a matter DCH have control over. For some large school campuses, we have managed to get charity or education funding to provide powered mobility, but this is ad-hoc and doesn't cover all aspects of the CYP life. Dorset Health Care advised that NHS funded wheelchair services nationally work from the guidelines of powered wheel chair services are in place to maintain the wheelchair service user health within the home to be able to do things such as going to the toilet, bed, getting food etc, to maintain their health in the home. Until guidelines change and funding for other aspect of the individual life, whether education, sports or going out, changes the Dorset

				of CYP to develop independence and have access to education, community facilities and play/leisure.	Wheelchair service must prescribe within the guidelines of the NHS Wheelchair services.
Reporting Committee		Quality Committee		**BAF objective: PLACE** • We will build sustainable infrastructure to meet the changing needs of the population. • We will deliver, safe effective and high-quality personalised care for every individual. • We will listen to our communities, recognise their different needs and help create opportunities for people to improve their own health and wellbeing. **BAF objective: PARTNERSHIP** • We will contribute to a strong, effective Integrated Care System, focussed on meeting the needs of the population. • Through partnership working we will contribute to helping improve the economic, social and environmental wellbeing of local communities	
Ref:	Current Score		Previous Score	Risk Title: **Pace required for implementing National Virtual Ward requirements present clinical safety risks**	**SYSTEM RISK** Responsible Executive: Ruth Gardiner, CIO Comments/ Mitigations
1816	**16**	NEW	NEW	National virtual ward initiative is driving very fast paced procurements and implementation of remote monitoring and other digital developments which the Trust does not have the resource to support in terms of participating in requirements definition, procurement, systems integration and/or overall solution fit.	Review of requirements are being done where possible and clinical safety assessments are being conducted as best we can including reviewing SoPs to mitigate the risks associated with not being able to integrate these new tools with Trust systems.
Reporting Committee		Finance and Performance		**BAF objective: PLACE** • We will utililse digital technology to better integrate with our partners and meet the needs of patients.	
Ref:	Current Score		Previous Score	Risk Title: **Risk of harm to patients that are MFFD remaining in hospital**	**SYSTEM RISK** Responsible Executive: Jo Howarth, CNO Comments/ Mitigations
461	**16**	⇧	15	Patients stay too long in hospital due to internal delays or lack of external care capacity/inefficient process e.g. home with care or community hospital bed. Patients who remain in hospital for longer than they should are at risk of harm - falls or infection	Case examples have been provided to the ICB. PHC have been working with DCH around the reintroduction of Fast Track as this was not an option for some of these patients. There is a gap, and its hoped that the full reintroduction of Fast Track will help and we have been working with DCH around this, including the longer term position in relation to RHFH. However, even with the reintroduction of Fast Track we have identified another gap with frailty patients, and we have highlighted this to the ICB strategic commissioning team.

Reporting Committee		Quality Committee		**BAF objective: PLACE** • We will build sustainable infrastructure to meet the changing needs of the population. • We will deliver, safe effective and high-quality personalised care for every individual. • We will listen to our communities, recognise their different needs and help create opportunities for people to improve their own health and wellbeing. • We will utilise digital technology to better integrate with our partners and meet the need of patients. **BAF objective: PARTNERSHIP** • We will contribute to a strong, effective Integrated Care System, focussed on meeting the needs of the population. • Through partnership working we will contribute to helping improve the economic, social and environmental wellbeing of local communities	
Ref:	Current Score		Previous Score	Risk Title: **External Multiagency Delays Resulting in Delayed Discharge of Complex Paediatric Patients**	**SYSTEM RISK** Responsible Executive: Jo Howarth, CNO Comments/ Mitigations
866	**15**	⟷	15	Increasing amount of children and young people are experiencing extended hospital admissions due to requiring either local authority provision of accommodation / placement, or mental health tier 4 inpatient beds on discharge from Kingfisher Ward.	Weekly escalation though Family Services & Surgical Division updating with progress of patients. Formal escalations when required between multiple agencies involved with patients. Children all discussed at Weekly Integrated Liaison Meetings. 1:1 (or higher ratio staff: patient) support for patients being sought when appropriate for safety. Risk reports entered locally to evidence delays. Risks related to specific high-profile cases escalate on a weekly basis to the Medical Director of DHC. MOU activated and followed where cases require it.
Reporting Committee		Quality Committee		**BAF objective: PLACE** • We will build sustainable infrastructure to meet the changing needs of the population. • We will deliver, safe effective and high-quality personalised care for every individual. **BAF objective: PARTNERSHIP** • We will contribute to a strong, effective Integrated Care System, focussed on meeting the needs of the population. • 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 • Through partnership working we will contribute to helping improve the economic, social and environmental wellbeing of local communities. **BAF objective: PEOPLE** • Learning and development and workforce modernisation	
Ref:	Current Score		Previous Score	Risk Title: **Transition Service for Young People to Improve Health Outcomes**	**SYSTEM RISK** Responsible Executive: Jo Howarth Comments/ Mitigations

1037	**16**		20	There are over 300 transitionable conditions spanning at least 20 services within DCH exclusive to wards and departments. The Transition workforce is insufficient to manage this vast service. Without a comprehensive service, our local young people are at high risk of disengaging with services, risk taking self-management with conditions, non-compliance with treatment, and poor outcomes leading to complications of their condition and potential mortality.	Steering group for transition now formed, led by an ED consultant and the Transition Nurse Specialist. The Chief Medical Officer is the Executive lead for transition. The Trust has developed good regional links through the Burdett Trust, sharing knowledge and ideas. Some Paediatricians liaise with adult counter parts or primary care when they feel a child is ready to transition, however there is no robust pathway to follow for referring and transferring these young people, and therefore no consistency and young people are getting lost to services.
Reporting Committee	Quality Committee	**BAF objective: PLACE** • We will build sustainable infrastructure to meet the changing needs of the population. • We will deliver, safe effective and high-quality personalised care for every individual. • We will listen to our communities, recognise their different needs and help create opportunities for people to improve their own health and wellbeing.			

Risks Scoring 20: **Appendix 3**

Ref:	Current Score		Previous Score	Risk Title: **Patient Transport Provision & Urgent Patient Transfers**	Responsible Executive: Anita Thomas, COO Comments/ Mitigations
456	20	↑	9	Potential delays to treatment and disruption to services arising from difficulties accessing PTS service or urgent patient transfers to other centres due to ambulance or Patient Transport service capacity. RECORDED AS A SYSTEM RISK - CONTRACT MANAGED BY ICB	Contract awarded to two providers, one for admissions and one for discharge. The admission contractors (HTG) are struggling to meet their contact (managed by NHSD), so the discharge support provider are having to facilitate the admission journeys which impact on the discharges. This has been escalated to NHS D as part of the contract performance review. This is raised at various system meetings on a regular basis. Divisional Manager for Integrated and Urgent Care is working with the ICB on the issues raised.
Primary Reporting Committee		Finance and Performance Committee **SYSTEM RISK**		**BAF objective: PLACE** • We will build sustainable infrastructure to meet the changing needs of the population. • We will deliver, safe effective and high-quality personalised care for every individual. • We will listen to our communities, recognise their different needs and help create opportunities for people to improve their own health and wellbeing. **BAF objective: PARTNERSHIP** • We will contribute to a strong, effective Integrated Care System, focussed on meeting the needs of the population. • 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. • 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 • Through partnership working we will contribute to helping improve the economic, social and environmental wellbeing of local communities	
Ref:	Current Score		Previous Score	Risk Title: **Community Paediatric Long Waits for ASD Patients**	Responsible Executive: Anita Thomas, COO Comments/ Mitigations
472	20	↑	15	There is a vacancy within the community paediatric team, which is causing long waits for patients and an increased workload for the two consultants in post. There has also been a significant increase in referrals to the ASD (Autism Spectrum Disorder) service, alongside ongoing commissioning issues for the service.	As of 01/02/24 we have 1,306 ASD patients waiting first seen appointment with the longest waiter at 106 weeks. Community Paediatric Post has been out to advert twice with no shortlistable applicants. Clinical lead has reviewed job description to include Specialists Grade to broaden suitable applicants.

Primary Reporting Committee		Finance and Performance Committee		**BAF objective: PLACE** • We will build sustainable infrastructure to meet the changing needs of the population. • We will deliver, safe effective and high-quality personalised care for every individual. • We will listen to our communities, recognise their different needs and help create opportunities for people to improve their own health and wellbeing. • We will utilise digital technology to better integrate with partners and meet the needs of the population. **BAF objective: PARTNERSHIP** • We will contribute to a strong, effective Integrated Care System, focussed on meeting the needs of the population. • 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. • 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 • Through partnership working we will contribute to helping improve the economic, social and environmental wellbeing of local communities **BAF objective: PEOPLE** • Recruitment and Retention	
Ref:	Current Score		Previous Score	Risk Title: **Electronic Health Record business case pace of change**	Responsible Executive: Ruth Gardiner, CIO Comments/ Mitigations
1814	**20**	↑	**NEW**	Following a requirement by the National Frontline Digitisation (FD) initiative and Regional Finance and Digital teams, Dorset ICS is required to work on a joint Dorset and Somerset Outline Business Case (OBC) for a single electronic health record across acute, community and mental health. Based on the availability of FD funding over the next few years the timeline for completing the OBC is by March 2024. The investment is likely to be in excess of £100m and could be up to £500m across both ICSs with only a small percentage of the capital investment coming from the FD allocation. The required due diligence for a business case of this nature is typically a 6-month process at the very least. Each Trust will be required to approve the joint OBC but given the timelines an insufficient level of due diligence will have been applied to the OBC from a Dorset perspective. This has major financial, reputational, and commercial risks associated with the process we have been required to adopt.	Submission of the OBC for Board approval will be accompanied by the areas of the business case that create the most concern in terms of a lack of due diligence impacting the level of confidence the Board can apply in their decision making.
Primary Reporting Committee		Finance and Performance Committee		**BAF objective: PLACE** • We will utilise digital technology to better integrate with partners and meet the needs of the population.	

Ref:	Current Score		Previous Score	Risk Title: **Theatre Utilisation Below 85%**	Responsible Executive: Anita Thomas, COO Comments/ Mitigations
1749	20	⟺	20	Utilisation for theatres is currently less than the NHS England benchmark of 85%. As a trust for this calendar year to date we are 72.74%, with only 1 x Surgical speciality routinely achieving the 85% target.	Utilisation plan created and shared with the services back in June to give actions in order to improve utilisation. Not currently made an impact , weekly meetings now in place with Divisional Director and performance director to keep focus on theatre utilisation.
Primary Reporting Committee		Finance and Performance Committee		**BAF objective: PLACE** • We will build sustainable infrastructure to meet the changing needs of the population. • We will deliver, safe effective and high-quality personalised care for every individual. • We will listen to our communities, recognise their different needs and help create opportunities for people to improve their own health and wellbeing.	
Ref:	Current Score		Previous Score	Risk Title: **Financial Sustainability 2023/24**	Responsible Executive: Chris Hearn, CFO Comments/ Mitigations
1646	20	⟺	20	The final plan for 2023/24 reflects a breakeven position for the Trust. This includes a CIP of £10.9m (4.2%) and unfunded inflationary pressures of c. £3m, which poses a risk to the financial sustainability strategic objective.	Value Delivery Board has been established focussing on in year and longer-term financial sustainability, and is a formal sub group of the Finance and Performance Committee. System Recovery Group has been established to support system wide recovery.
Primary Reporting Committee		Finance and Performance Committee		**BAF objective: PLACE** • We will build sustainable infrastructure to meet the changing needs of the population. • We will deliver, safe effective and high-quality personalised care for every individual. • We will listen to our communities, recognise their different needs and help create opportunities for people to improve their own health and wellbeing. • We will utilise digital technology to better integrate with partners and meet the needs of the population. **BAF objective: PARTNERSHIP** • We will contribute to a strong, effective Integrated Care System, focussed on meeting the needs of the population. • 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. • 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 **BAF objective: PEOPLE** • Recruitment and Retention • Learning and development and workforce modernisation	
Ref:	Current Score		Previous Score	Risk Title: **Tackling the backlog of elective care**	Responsible Executive: Anita Thomas, COO Comments/ Mitigations
1221	20	⟺	20	Delivery plan for tackling the COVID-19 backlog of elective care with focus on four areas of delivery published 08.02.2022: - Increasing health service capacity - Prioritising diagnosis and treatment	The national planning guidance requested systems to deliver zero patients, waiting over 65 week waits at the end of March 2024. Performance against this trajectory has been tracked via the performance report, which is submitted to FPC and on to board.

			- transforming the way we provide elective care - providing better information and support to patient.	Following the impact of industrial action, NHSE requested a re-forecast of H2, to include performance and financial forecasting. As a result, the 65 week wait trajectory has been amended to 500 patients, at 65+ week waits at the end of March, with zero waiting over 78 weeks. The Trust is currently meeting the revised trajectory. In accordance with the national validation programme, which launched in the summer of 2023, all patients that are over 12 weeks on the waiting list, are contacted every 12 weeks. This contact is to ask the patient if they still want to be on the waiting list or if their condition has changed. Patients with a decision to treat, who request to be removed from the waiting list, are clinically reviewed. Currently, the trust is seeing a 5% removal rate from this work. All patients over 40 weeks, with a decision to treat, have also been contacted to see if they are prepared to travel to another provider, where treatment might be quicker. This is under the national programme and is administered by Dorset ICB. The trust has delivered a £7 million insourcing programme to tackle long waits, this is currently overdelivering, representing a financial risk but has ensured the trust has maintained a zero, 104+ week wait position. Patients continue to be treated in clinical priority first, followed by chronological order. This risk has been scored as 'HIGH' due to the potential impact on patient safety and delay in treatment that could potentially lead to harm. (This is being mitigated by reviewing patients based on clinical need and any changes in presentations). There may be financial implications if there is an increase in litigation if patient harm has been caused due to delays. The Trust continues to work with partners and the ICB where gaps are identified in patient pathways, and for those with complex care needs.
Primary Reporting Committee	Finance and Performance Committee	**BAF objective: PLACE** • We will build sustainable infrastructure to meet the changing needs of the population.		

				• We will deliver, safe effective and high-quality personalised care for every individual. • We will listen to our communities, recognise their different needs and help create opportunities for people to improve their own health and wellbeing. • We will utilise digital technology to better integrate with partners and meet the needs of the population. **BAF objective: PARTNERSHIP** • Through partnership working we will contribute to helping improve the economic, social and environmental wellbeing of local communities • We will contribute to a strong, effective Integrated Care System, focussed on meeting the needs of the population. • 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. • 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 **BAF objective: PEOPLE** • Recruitment and Retention	
Ref:	Current Score		Previous Score	Risk Title: **Ophthalmology Injection Capacity**	Responsible Executive: Anita Thomas, COO Comments/ Mitigations
1786	20	↑	16	Ceasement of insourcing and in house workforce/training will result in patients having their Eylea Injections delayed. As of 22/01/24 - 114 due in January and 102 due in February which will wait until March if no capacity. Overall there are 408 patients on the waiting list	18 weeks funding agreed for a further 5 weekends from 24/25th Feb 2024 to help clear backlog of patients. Nurse Injector capacity in March healthy (17 sessions). Trainee Nurse Injector still requires final approval.
Primary Reporting Committee		Finance and Performance Committee		**BAF objective: PLACE** • We will build sustainable infrastructure to meet the changing needs of the population. • We will deliver, safe effective and high-quality personalised care for every individual. • We will listen to our communities, recognise their different needs and help create opportunities for people to improve their own health and wellbeing. **BAF objective: PEOPLE** • Learning and development and workforce modernisation.	

Corporate Risk Register items scoring 15 or above closed between 01 January 2024 and 29 February 2024.

Ref	Risk Title	Risk Statement	Risk Score at time of closure	Initial risk score	Reporting Committee
1797	SWH Construction Delay	SWH overall Construction delay. New programme issued by TD 12/1, completion and commissioning dates have slipped, postponing the opening past the 12th February. **CLOSED:** **Building signed off and operational.**	**4**	**16**	Finance and Performance
1474	Ophthalmology FOWL Long Waiters	Due to capacity within service we are unable to see patients for their follow ups in the appropriate timeframe. **CLOSED:** **Risk reframed in to four separate care pathway risks.**	**16**	**16**	Finance and Performance
1415	PAS migration	Cyber threat, unsupported database and operating system. Patient information could be intercepted over the network, cyber vulnerabilities may not have patches to resolve. **CLOSED:** **Trust successfully migrated to new hardware / database**	**12**	**15**	Finance and Performance

Report Front Sheet

1. Report Details			
Meeting Title:	Board of Directors, Part 1		
Date of Meeting:	27 March 2024		
Document Title:	**Gender Pay Gap Report (2023)**		
Responsible Director:	Nicola Plumb, Joint Chief People Officer	Date of Executive Approval	7 March 2024 (EH)
Author:	Kirsty Winning, HR Manager Reviewed by Catherine Youers, Head of People Services		
Confidentiality:	No		
Publishable under FOI?	Yes		
Predetermined Report Format?	Yes		

2. Prior Discussion		
Job Title or Meeting Title	**Date**	**Recommendations/Comments**
EDBI Lead	5 March 2024	Comments included.
People and Culture Committee	18 March 2024	Recommended to Board for approval

3. Purpose of the Paper							
To review and approve the Gender Pay Gap report. All UK employers have a legal requirement to publish their gender pay data on an annual basis.							
Note (✓)	✓	*Discuss (✓)*		*Recommend (✓)*		*Approve (✓)*	✓

4. Executive Summary

This report for Dorset County Hospital NHS Foundation Trust reviews the latest data set, which covers the 12-month period ending 31 March 2023.

The gender pay gap calculation is based on the average hourly rate paid to men and women. This calculation makes use of two types of averages: a mean average and a median average. The mean is the average hourly rate and the median is the mid-point hourly rate for men and for women in the workforce. The mean figure is the figure most commonly used.

Our gender pay gap results (based on the hourly pay rates our employees received on 31 March 2023) are as follows:

- Our mean gender pay gap is 21%
- Our median gender pay gap is 5.53%
- Our mean bonus gender pay gap is 5.21%
- Our median bonus gender pay gap is 34.58%
- Our proportion of males within whole Trust receiving a bonus payment is 4.43%
- Our proportion of females within whole Trust receiving a bonus payment is 0.38%
- Our proportion of eligible males receiving a bonus payment is 41%
- Our proportion of eligible females receiving a bonus payment is 24%

Across our entire workforce our mean gender pay gap for 2023 was 21%. This means that the average hourly pay rate for men is 21% higher than for women. This is a 4% reduction to the pay gap of 25% recorded in 2022, and 5% less than that recorded in 2021 (26%), an improving position.

	The steps being taken to close this gap are summarised in the report and include promoting flexible working options, offering networking and peer support for females in the workplace via staff networks, supporting the development of female employees through talent progression opportunities, mentoring, career conversations and leadership development and focusing on female employees in the lower bands to equip them with the skills and confidence to apply for our more senior posts.
5. Action recommended	The Board is recommended to: 1. **APPROVE** the Gender Pay Gap report 2023 for submission & publication on government portal and DCHFT internet.

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

Title of Meeting	**Board of Directors, Part 1**
Date of Meeting	**27 March 2024**
Report Title	**Gender Pay Gap – annual report 2023**
Author	**Kirsty Winning, HR Manager**

1. Introduction

1.1 From 2017 organisations with 250 or more employees must report their gender pay gap (GPG), which is defined as "the difference between the average pay of men and women in an organisation" (Gov.uk). The requirement to report is a legislative requirement contained in the Equality Act 2010 (Gender Pay Gap Information) Regulations 2017. Failure to comply with this responsibility may result in an organisation being the subject of enforcement action by the Equality and Human Rights Commission (EHRC).

1.2 Data is captured on a 'snapshot date' each year which, for the purpose of this report is 31 March 2023.

1.3 The Trust is required to report on six basic calculations:

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

1.4 The data reported is based on:

- gross ordinary pay;
- bonus pay;
- in the relevant pay period;
- by the snapshot date.

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

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

2. The difference between gender pay and equal pay

2.1 It is important to be clear about the difference between gender pay and equal pay. Equal pay ensures that, by law, men and women receive equal pay for work of the same, similar, equivalent or equal value. Gender pay measures the difference between average hourly earnings of men and women across all jobs. The solutions to equal pay and gender pay are different. Closing the gender pay gap is a broader societal as well as organisational issue.

2.2 In considering the data, it is pertinent to note the composition of the Trusts employees by gender, of which 76% of the workforce is made up of female employees. This gender split is a common across NHS organisations and indeed our neighbouring Trusts within the Dorset system, with Dorset HealthCare showing an 83% / 17% split in favour of women, and University Hospitals Dorset with a 73% / 27% split (Dorset Intelligence and Insight Service – DiiS [data as of October 2023]).

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

2.4 The Trust is committed to ensuring equity and fairness. Although we have a gender pay gap due to our disproportionate representation of men and women within the workforce, we are confident that we pay fairly in accordance with the nationally recognised Agenda for Change, Medical & Dental pay and conditions, and our locally recognised Senior Manager and Director pay structures.

2.5 The NHS Job Evaluation Scheme, part of the Agenda for Change NHS pay structure introduced in 2004, was developed as a means of determining pay bands for posts. The key feature in both the design and implementation of this scheme was to ensure equal pay for work of equal value. The scheme has been tested legally and has been found to be equal pay compliant.

3. Methodology

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

4. The Trust's Overall Results

4.1 Across our entire workforce our mean gender pay gap for 2023 is **21%**. This means that the average hourly pay rate for men is 21% higher than for women. This is a 4% reduction to the pay gap of 25% recorded in 2022, and 5% less than that recorded in 2021 (26%). Our overall median gender pay gap is **5.53**%. This means that the mid-point hourly rate for men is 5.53% higher than for women. This is an improvement of 2.47% on 2022's reported 8%, and continues the improving trend against the 9% reported in 2021.

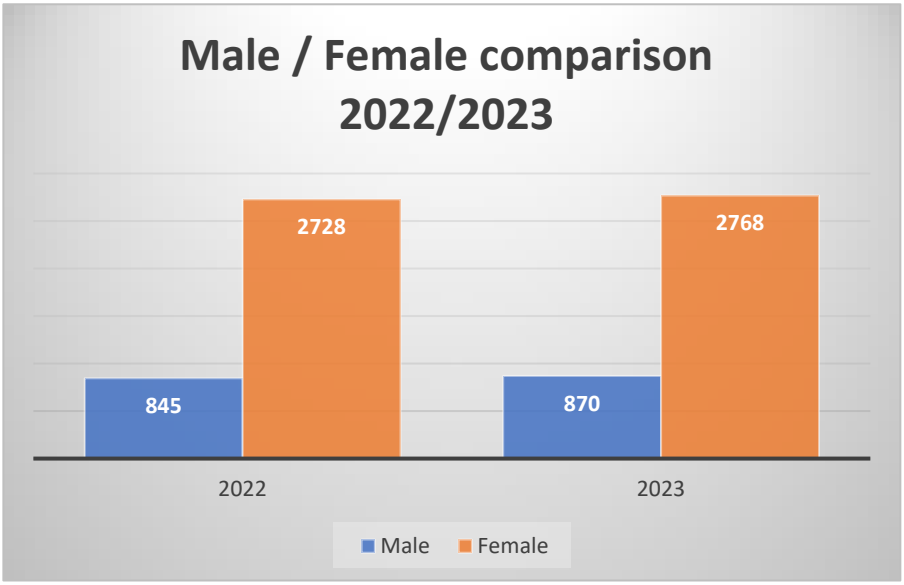
4.2 Our gender pay gap results (based on the hourly pay rates our employees received on 31 March 2023) are as follows:

- Our mean gender pay gap is 21%
- Our median gender pay gap is 5.53%
- Our mean bonus gender pay gap is 5.21%
- Our median bonus gender pay gap is 34.58%
- Our proportion of males within whole Trust receiving a bonus payment is 4.43%
- Our proportion of females within whole Trust receiving a bonus payment is 0.38%
- Our proportion of eligible males receiving a bonus payment is 41%
- Our proportion of eligible females receiving a bonus payment is 24%

5. Gender Pay Gap Analysis

5.1 Male and Female Comparison

5.1.1 There has been a small increase in staff numbers in the reporting year of 65 staff (25 male and 40 female). This represents a reduction of 55% from 143 in 2022 and less than a 1% shift from female to male employees in the workforce.



5.2 Quartile Analysis

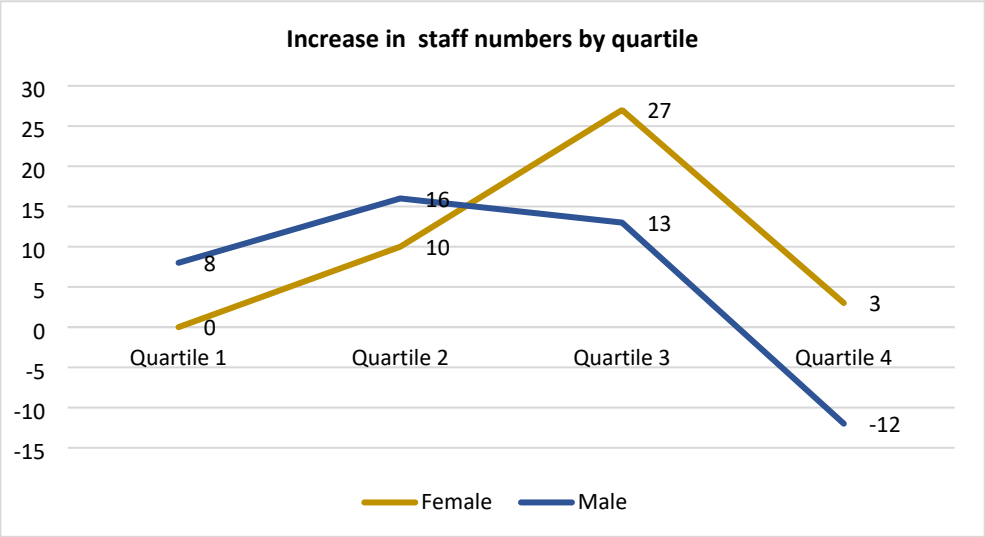
5.21 Quartile information is created by sorting all employees by their hourly rate of pay and then splitting the list into 4 equal parts to create 4 pay quartiles. This therefore means that the quartile bands are fluid and will change annually dependant on the numbers that fall into each pay point and band. The table below shows the proportion of males and females in each of the quartile bands, and with comparison to the 2022 data.

Quartile	31-03-23 data				31-03-22 data			
	Female	Male	Female %	Male %	Female	Male	Female %	Male %
1	676	224	75%	25%	676	216	79%	21%
2	729	190	79%	21%	719	174	80%	20%
3	743	166	82%	18%	716	153	83%	17%
4	620	290	68%	32%	617	302	67%	33%

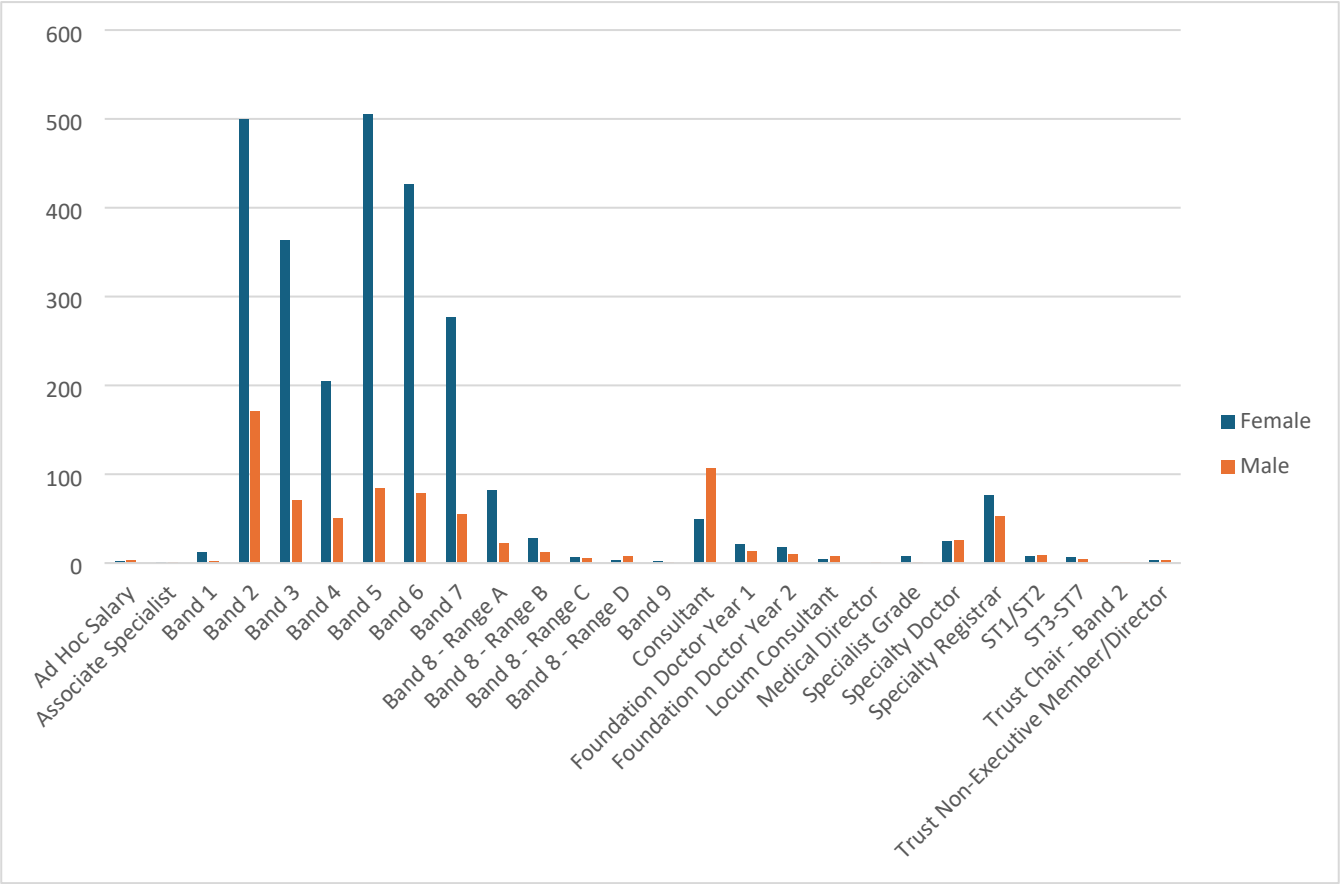
5.2.2 The proportion of male and female employees in the lowest pay quartile is 75% female and 25% male, compared to the proportion of male and female employees in the highest pay quartile which is 68% female and 32% male.

5.2.3 There is a reduction in the percentage of female employees in quartiles one, two and three, however a marginal increase of 1% in females in quartile four (the highest pay quartile).

5.2.4 Reviewing the actual numbers of staff in each quartile the year-on-year comparison shows an increase in males in the lower two quartiles, with increases in quartiles three and four for women. In quartile four there is a reduction in the number of males within this pay bracket.

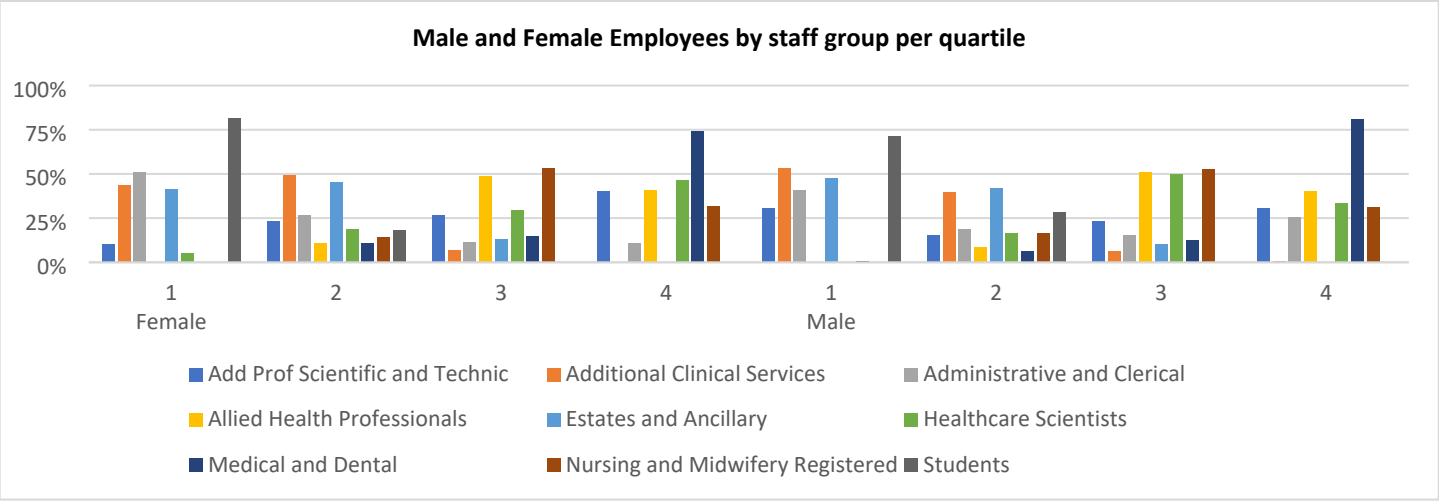


5.2.5 The graph below shows the percentage breakdown of pay bands by gender. Female employees are dominate in all pay bands, except for bands 8C and 8D (although numbers in these are small) and Consultants. In band 9 there are 2 female employees and 1 male.



Male / Female Staff By Pay Band / Medical Grade	Column labels		
	Female	Male	Grand Total
Ad Hoc Salary	2	3	5
Associate Specialist	1	1	2
Band 1	12	2	14
Band 2	499	171	670
Band 3	363	71	434
Band 4	205	50	255
Band 5	505	84	589
Band 6	426	78	504
Band 7	277	55	332
Band 8 - Range A	82	22	104
Band 8 - Range B	28	12	40
Band 8 - Range C	6	5	11
Band 8 - Range D	3	8	11
Band 9	2	1	3
Consultant	49	106	155
Foundation Doctor Year 1	21	13	34
Foundation Doctor Year 2	18	10	28
Locum Consultant	4	7	11
Medical Director		1	1
Specialist Grade	7	1	8
Specialty Doctor	24	25	49
Specialty Registrar	76	52	128
ST1/ST2	7	9	16
ST3-ST7	6	4	10
Trust Chair - Band 2		1	1
Trust Non-Executive Member/Director	3	3	6
Grand Total	2626	795	3421

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



5.2.7 For both male and female staff, students are dominant in the lowest pay quartile. In the 2022 data the student category fell into quartile two. This demonstrates that the pay values in the upper quartiles have increased over the course of the reporting year.

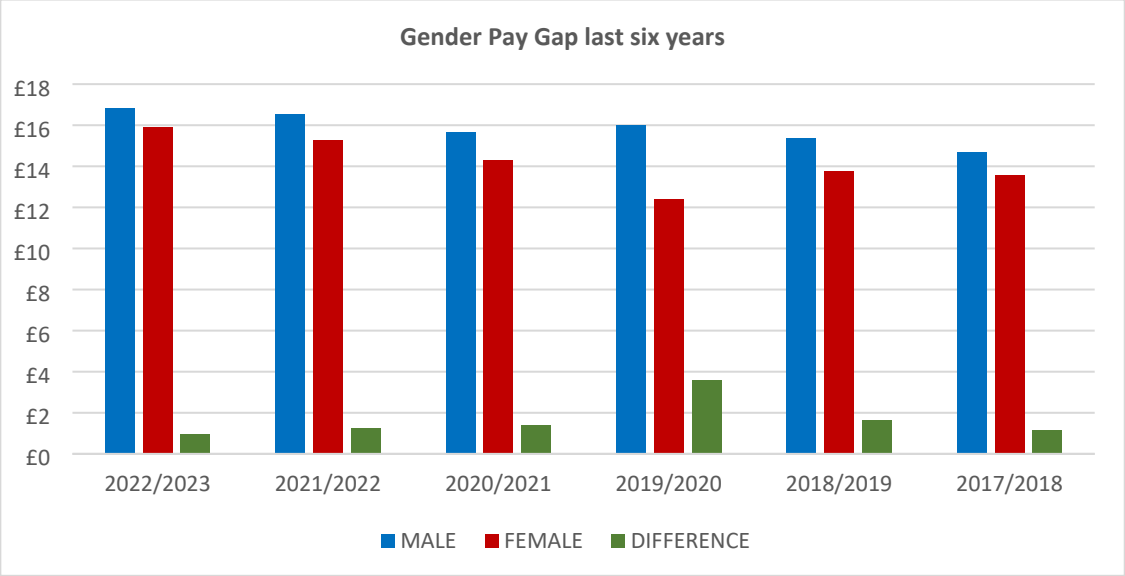
5.2.8 In terms of percentage, female and male data demonstrates Medical and Dental staff remain the highest in the fourth quartile.

5.3 Mean & Median Hourly Rates

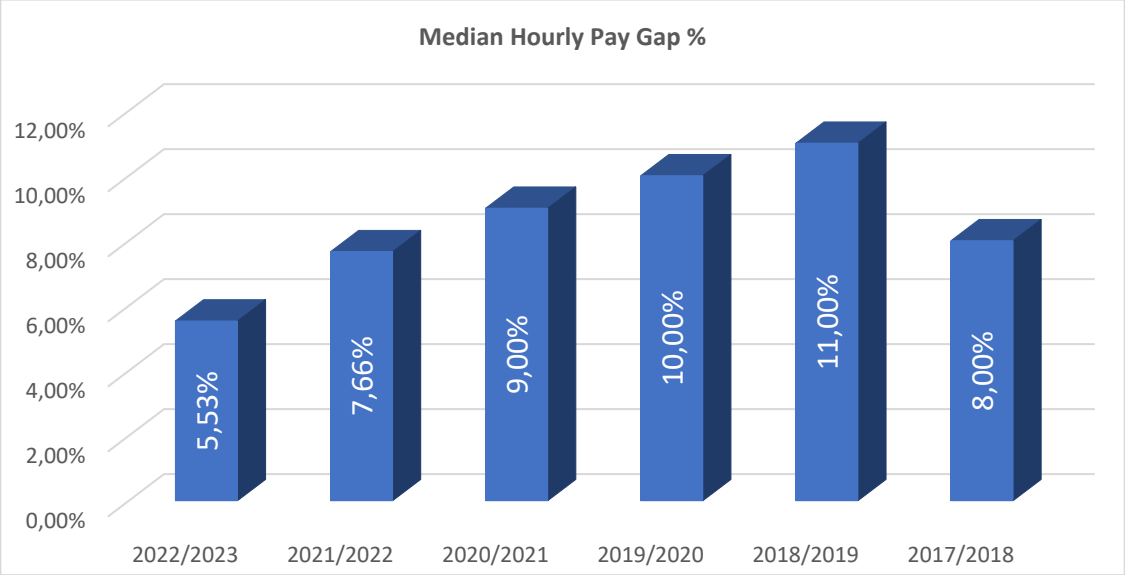
Gender	2022/2023				2021/2022			
	Avg. Hourly Rate	Movement in year	Median Hourly Rate	Movement in year	Avg. Hourly Rate	Movement in year	Median Hourly Rate	Movement in year
Male	£22.46	£0.04	£16.84	£0.32	£22.42	£0.57	£16.52	£0.86
Female	£17.74	£0.84	£15.91	£0.66	£16.90	£0.74	£15.26	£0.98
Difference	£4.71	-£0.80	£0.93	-£0.33	£5.52	-£0.17	£1.27	-£0.10
Pay Gap %	21%		5.53%		25%		8%	

5.3.1 The Trust's mean gender pay gap is 21% in favour of men (women earn 21% less than men) compared to the national average of 14.3% for all employees, or 7.7% for full time employees (Office for National Statistics).

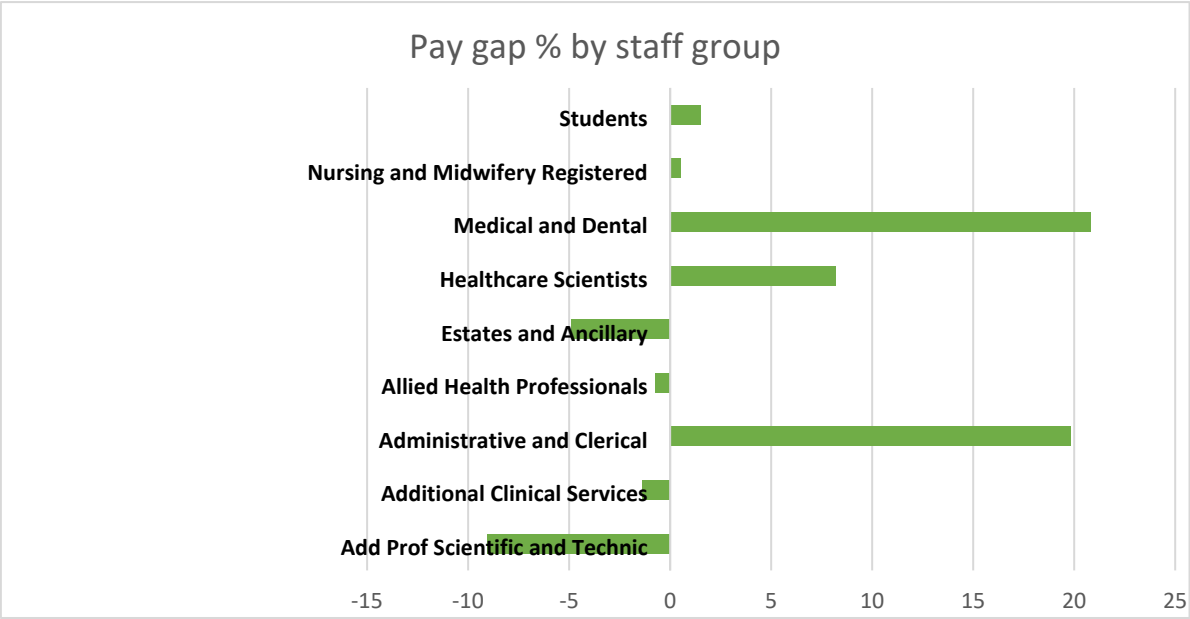
5.3.2 Data for the past six years demonstrates a continuation of the trend in reducing the gender pay gap within the Trust and, bar 2019/20 an increase in the hourly rate of women within the organisation, with the difference in median pay being the lowest since reporting commenced in 2017 at £0.93 per hour.



5.3.3 Analysis of the median gender pay gap identifies that since 2018/19 there is a downward trajectory in terms of the pay gap in median pay.



5.3.4 In order to gain a better understanding of what is creating our gender pay gap we have carried out analysis by staff group. This shows quite a variance across the groups. Ranging from a 20.79% pay gap for Medical & Dental and 19.81% for Administrative and Clerical (which includes managerial roles), to a minus pay gap of -4.9% for Estates and -9.04% for Professional and Technical staff, which is a significant improvement in this staff group from the -0.74% reported in 2022.



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

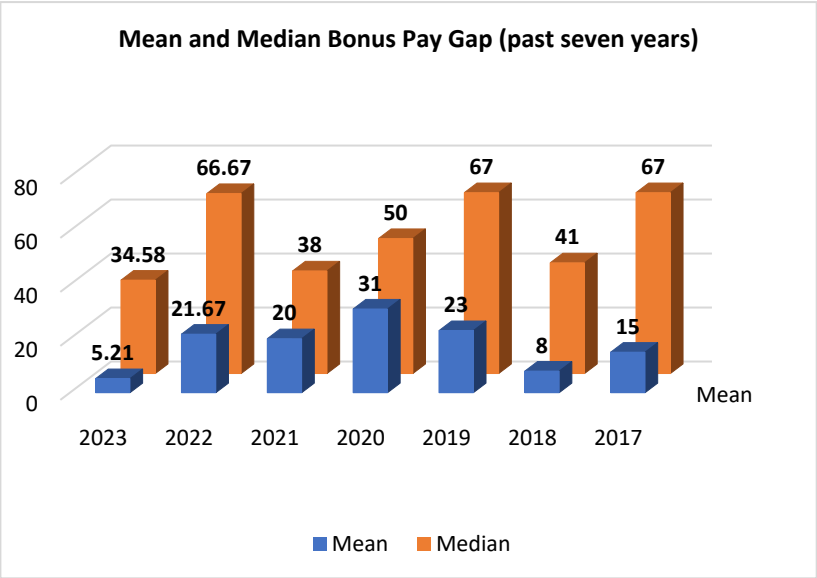
5.4 Bonus Gender Pay Gap Results

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

5.4.2 The table below shows the summary of male and female employees receiving a bonus payment.

Gender	Avg. Pay	Median Pay
Male	11,064.56	9,048.00
Female	10,487.63	5,918.88
Difference	576.93	3,129.12
Pay Gap %	5.21	34.58

5.4.3 As can be seen in the graph below the mean and median pay gap for bonuses has improved significantly and represents the best results that the Trust has seen since reporting commenced.



5.4.4 The number of employees eligible for a bonus is 155. Of that number 49 employees are female and 106 male.

5.4.5 The proportion of female employees eligible for bonus payments (32%) is considerably lower than eligible male employees (68%). This is due to the lower number of female employees progressing to Consultant level. As a Trust we have followed the national guidance by sharing the CEA funds equally across all eligible Consultants.

6. Understanding our Gender Pay Gap

6.1 Whilst female representation in the highest pay quartile looks favourable at 68%, given that female employees make up 76% of the workforce, the 68% representation is a disproportionate number. This is however a 1% improvement on the 2022 result. The 82% female staff in quartile three exceeds the 76% / 24% whole workforce gender split.

6.2 75% of employees in the lower quartile (lowest paid) jobs were female which is a 4% improvement on the 79% reported in 2022, and roughly in line with the gender make-up of the workforce.

6.3 The Trust's median gender pay gap is 5.53% in favour of male employees, with the mean gender pay gap at 21% in favour of males. Compared to the national average of 14.3% for all employees (ONS) the Trust's position appears not aligned with the wider population, however given the unique gender makeup of the healthcare sector a direct comparison would be flawed.

6.4 The disparity between the male and female gender pay gap is not the same as saying females and males are being paid differently for doing the same job. This would be an equal pay issue as explained in section 2.

7. Addressing our Gender Pay Gap / Recommendations

7.1 To address our gender pay gap the Trust would need to either increase the number of male employees in lower grades or increase the number of female employees in the

more senior roles. This however is a challenge in the healthcare sector with the demographic naturally leaning towards females in the professions. That said, in reviewing the data for all grades of medical posts, there are a total of 212 females and 228 males, demonstrating a more even gender split.

7.2 To implement change there is a need to address the barriers for female employees and target the inequalities faced by females in general, as well as those with specific characteristics such as differing ethnicity, age and profession. It remains that there are fewer female employees in senior medical roles, however given the figures for total medical posts, it would be pertinent to expect more females to be appointed to senior roles in the future if we are able to retain those currently in post.

7.3 Barriers that may contribute to the pay gap could be addressed by:

- Continuing to ensure equality of recruitment, including unidentifiable applications for shortlisters.
- Ensuring managers are aware of flexible (smarter) working options and are familiar with their responsibilities and the legal obligation to consider flexible working requests, whilst recognising that in a healthcare setting, there are some roles that cannot be performed at home.
- Promoting flexible working options, including hybrid working and working at home. A legacy of the Covid pandemic is that businesses were forced to be more creative in their approach to work, and this includes DCH. The Trust is actively focussing on Smarter Working and promoting opportunities for staff to work in a way that achieves a positive work life balance.
- Ensuring our Staff Networks continue to offer networking and peer support for females in the workplace.
- Supporting the development of female employees through talent progression opportunities, mentoring, career conversations and leadership development. Giving focus to our female employees in the lower bands to equip them with the skills and confidence to apply for our more senior posts.
- Ensuring the Trust is aligned with the principles of the NHS People Plan which will contribute to our goal to be recognised as an employer of choice and a place to develop a long term clinical and non-clinical career. The Trust is dedicated to raising the profile of the People Plan and as such has been successful in receiving funding for a 12 month People Promise and Retention Manager and People Promise and Retention Specialist Advisor role, working jointly with Dorset HealthCare, and dedicated to ensuring we are actively working with the strands of the national People Promise to deliver a more engaged and diverse workforce that “work(s) together to improve the experience of working in the NHS for everyone” (NHS England).

- Ensuring all recommendations align to our Equality Diversity Inclusion and Belonging strategy.

7.4 The Trust's Widening Participation team are already actively working within our local communities to provide a range of mechanisms which enable underrepresented groups to access opportunities, including:

- Providing pastoral support for our 174 apprentices and managers;
- Providing careers advice and guidance;
- Working with providers to deliver positive learning environments;
- Working within managers to create career pathways to develop our workforce.

8. Recommendations

8.1 The Board is asked to approve the report and authorise the submission of gender pay data to the Government portal by the national deadline of 31 March 2024, and the publication of this report on the Trust's intranet.

9. References

Dorset Intelligence & Insight Service (Diis); Microsoft Power BI; 08 February 2024

Gov.uk; Gender pay gap in the UK: 2023; Gender pay gap in the UK - Office for National Statistics (ons.gov.uk); 07 February 2024

Gov.uk; Statutory guidance – overview; https://www.gov.uk/government/publications/gender-pay-gap-reporting-guidance-for-employers/overview; 09 January 2024

NHS England; Our NHS People Promise; https://www.england.nhs.uk/ournhspeople/online-version/lfaop/our-nhs-people-promise/ ; 27 February 2024

Report Front Sheet

1. Report Details			
Meeting Title:	Board of Directors, Part 1		
Date of Meeting:	27 March 2024		
Document Title:	**Quarterly Guardian Report of Safe Working report: Doctors in Training (Oct 23 – Dec 23)**		
Responsible Director:	Alastair Hutchison, Chief Medical Officer	Date of Executive Approval	06/02/24
Author:	Kyle Mitchell, Guardian of Safe Working		
Confidentiality:	No		
Publishable under FOI?	Yes		
Predetermined Report Format?	Yes		

2. Prior Discussion		
Job Title or Meeting Title	**Date**	**Recommendations/Comments**
People and Culture Committee	19 February 2024	Noted

3. Purpose of the Paper	The production of a quarterly Guardian of Safe Working (GoSW) report to the Board is a requirement of the 2016 Junior Doctor Contract. The report is also shared with the Local Negotiating Committee for Medical and Dental staff.							
	Note (✓)	✓	*Discuss (✓)*		*Recommend (✓)*		*Approve (✓)*	✓
4. Executive Summary	A summary of key issues relating to safe working hours and rota gaps for Junior Doctors in training for quarter 3 (2023/2024). • Junior Doctors, Educational Supervisors and Trust managers continue to engage with the process of delivering an effective Exception Reporting mechanism. • The number of Exception Reports (ER) submitted during this quarter was broadly in line with recent years. • Trauma and Orthopaedics has seen the highest rates of Exception Reporting in this quarter, closely followed by a number of medical specialties. There were approximately equal ER from each division. • Industrial Action (IA) was identified as a direct contributor to 4 ER (7%); it is possible that IA was an indirect contributor to more.							
5. Action recommended	The Board is asked to: 1. **NOTE and APPROVE** the GoSW paper.							

6. Governance and Compliance Obligations			
Legal / Regulatory Link	**Yes**		National contract
Impact on CQC Standards		**No**	

Risk Link		**Yes**		Adhering to requirements of the Junior Doctor Contract 2016
Impact on Social Value			**No**	
Trust Strategy Link		**How does this report link to the Trust's Strategic Objectives?** *Please summarise how your report will impact one (or multiple) of the Trust's Strategic Objectives (positive or negative impact). Please include a summary of key measurable benefits or key performance indicators (KPIs) which demonstrate the impact.*		
Strategic Objectives	People	The guardian of safe working ensures that issues of compliance with safe working hours are addressed by the doctor and the employer or host organisation as appropriate. It provides assurance to the board of the employing organisation that doctors' working hours are safe.		
	Place			
	Partnership			
Dorset Integrated Care System (ICS) Objectives		**Which Dorset ICS Objective does this report link to / support?** *Please summarise how your report contributes to the Dorset ICS key objectives.* *(Please delete as appropriate)*		
Improving population health and healthcare			**No**	
Tackling unequal outcomes and access			**No**	
Enhancing productivity and value for money			**No**	
Helping the NHS to support broader social and economic development			**No**	
Assessments		**Have these assessments been completed?** *If yes, please include the assessment in the appendix to the report..* *If no, please state the reason in the comment box below.* *(Please delete as appropriate)*		
Equality Impact Assessment (EIA)			**No**	
Quality Impact Assessment (QIA)			**No**	

Title of Meeting	**Board of Directors, Part 1**
Date of Meeting	**27 March 2024**
Report Title	**Quarterly Guardian Report of Safe Working report: Doctors in Training (Oct 2023 – Dec 2023)**
Author	**Mr Kyle Mitchell, Guardian of Safe Working (GoSW)**

1. Executive summary

- Junior Doctors, Educational Supervisors and Trust managers continue to engage with the process of delivering an effective Exception Reporting mechanism.
- The number of Exception Reports (ER) submitted during this quarter was broadly in line with recent years (Appendix 2).
- Trauma and Orthopaedics has seen the highest rates of Exception Reporting in this quarter, closely followed by a number of medical specialties. There were approximately equal ER from each division.
- Industrial Action (IA) was identified as a direct contributor to 4 ER (7%); it is possible that IA was an indirect contributor to more.

2. Introduction

All eligible doctors in training at the Trust between July and September 2023 were working under the terms of the 2016 Junior Doctors Contract with 2019 updates; all have the opportunity to submit Exception Reports; and all work schedules complied with contractual commitments under the 2016 Contract. The provision of quarterly report from the Guardian of Safe Working is a contractual requirement outline in the T&CS of the 2016 Contract.

3. High level data

Number of training post (total):	189
Number of doctors in training post (total):	165.7
Annual average vacancy rate among this staff group:	27.7

Exception reports in order of number raised

Exception reports by department				
Specialty	No. exceptions carried over from last report	**No. exceptions raised**	No. exceptions closed	No. exceptions outstanding
Trauma & Orthopaedics	0	**12**	11	1
Renal	0	**9**	9	0
General Medicine	0	**8**	5	3
Obs & Gynea	0	**7**	4	3
Respiratory Medicine	0	**7**	7	0
Geriatric Medicine	0	**6**	6	0
Paediatrics	0	**3**	0	3
Acute Medicine	0	**2**	0	2
Medical Oncology	0	**2**	2	0
General Surgery	0	**2**	2	0
General Practice	0	**1**	1	0
Urology	0	**1**	0	1
ENT	0	**1**	1	0
ED	2	**0**	2	0
Total	2	**61**	50	13

Exception reports by grade				
Grade	No. exceptions carried over from last report	**No. exceptions raised**	No. exceptions closed	No. exceptions outstanding
FY1	0	**12**	5	7
FY2	0	**18**	15	3
CT1	0	**9**	7	2
CT2	0	**7**	5	2
ST1	2	**6**	0	6
ST2	0	**9**	3	6
Total	2	**61**	50	13

4. Work schedule reviews

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

Exception Reports taken to Level 1 Work Schedule Review

Specialty	Grade	Number	Rota
Geriatric Medicine	F1	1	2023 F1 Med 06/12/23-02/04/24
General Practice	F2	1	2023 F2 GP+ Med OC 02/08/2023 - 05/12/2023
Trauma & Orthopaedic Surgery	F2	2	2023 Mixed Grade Surgical 02/08/23-05/12/23

No work schedule reviews remain open, and none were escalated beyond Level 1.

5. Immediate Safety Concerns.

No Exception Reports submitted during this quarter were escalated as representing immediate safety concerns.

6. Vacancies

Appendix 1 is updated to include all vacancies among the medical training grades during the previous quarter reported for each month, split by specialty and grade.

7. Fines

There were no fines levied during this period.

8. Other issues arising

Regular and quorate Junior Doctors Forums continue to meet on a scheduled basis in line with contractual requirements.

Industrial Action continued into this quarter with the inevitable associated challenge for doctors of all grades and for the hospital management structures. The exception reporting mechanism was not designed to detect nor highlight the impact of IA on junior doctors. Scrutiny of individual ER, and comparison across years (Appendix 2), suggest that IA has not dramatically increased extra-contractual working for junior doctors, either before/ after IA, or for junior doctors not participating in IA.

9. Summary

Junior Doctors continue to work over and above their contracted hours due to clinical demand and the Exception Reporting mechanism allows this to be logged and time granted in lieu. The number of ER submitted suggests that most clinical areas achieve an approximate match between junior doctor workforce and clinical demand, and any mismatch appears approximately equal across clinical areas.

10. Recommendation

The Guardian asks the Board to note this report and to consider it to provide an assurance of compliance with the safeguarding aspects of the 2016 Junior Doctors Contract.

APPENDICES

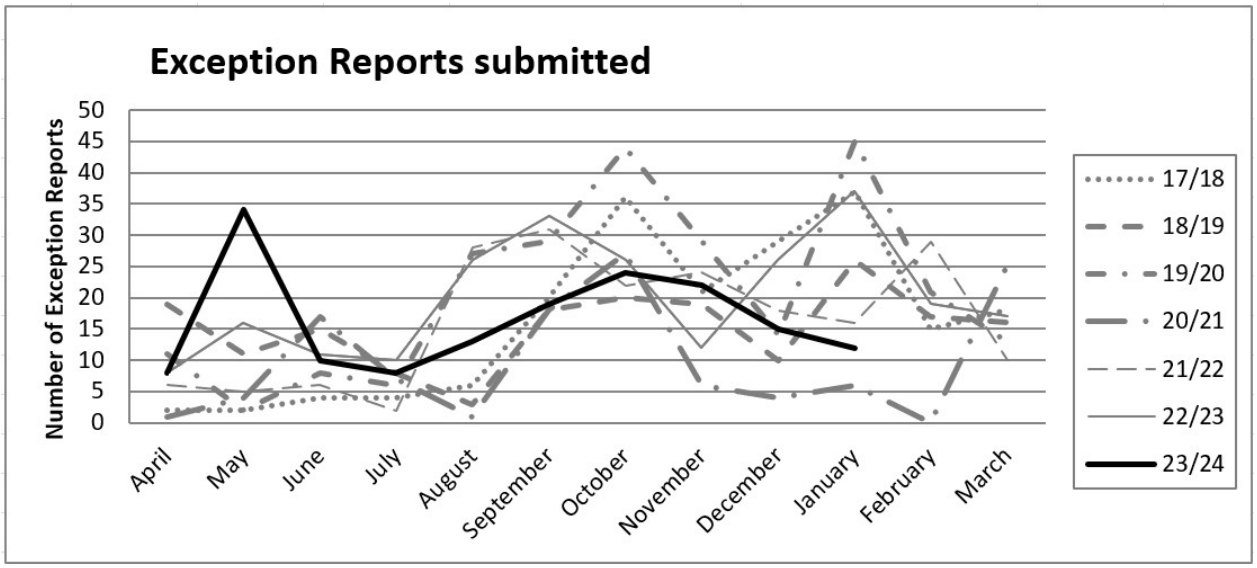
QUARTERLY GUARDIAN REPORT ON SAFE WORKING HOURS: DOCTORS IN TRAINING

OCT 23 – DEC 23

Appendix 1 – Trainee Vacancies within the Trust

Department	Grade	Rotation Dates	Oct 23	Nov 23	Dec 23	Average Q3
Paediatrics	ST3	Sept	0	0	0	0.0
Paediatrics	ST4+	Sept	0.2	0.2	0.2	0.2
O&G	ST1	Oct	0	0	0	0.0
O&G	ST3+	Oct	1.4	1.4	1.4	1.4
ED	ST3+	Sept and Feb	0.7	0	0	0.2
Surgery	CT1	Aug	0	0	0	0.0
Surgery	CT2	Aug	0	0	0	0.0
Surgery	ST3+	Oct	0	0	0	0.0
Orthopaedics	ST3+	Sept	1	1	1	1.0
Anaesthetics	CT1/2	Aug	0.2	0.2	0.2	0.2
Anaesthetics	ST3+	Aug and Feb	2	2	1.9	2.0
Clinical Radiology	ST1/2	Aug	0.2	0.2	0.2	0.2
Medicine	CT1/2	Aug	2.9	3.7	3.7	3.4
Medicine COE	ST3+	March	0.2	0.2	0.2	0.2
Medicine Diab/Endo	ST3+	Aug	1	1	1	1.0
Medicine Gastro	ST3+	Sept	0	0	0	0.0
Medicine Resp	ST3+	Aug	0.2	0.2	0.2	0.2
Medicine Cardio	ST3+	Feb	0.2	0.2	0.2	0.2
Medicine Renal	ST3+	Aug	0	0	0	0.0
Haematology	ST3+	Sept	0.4	0.4	0.4	0.4
Med/Surg	FY1	Aug	3	3	2	2.7
Med/Surg	FY2	Aug	0.8	0.8	3.4	1.7
GPVTS	ST1	Aug & Feb	9	8.2	8.2	8.5
GPVTS	ST2	Aug & Feb	0.6	1.4	1.4	1.1
GPVTS	ST3	Aug & Feb	2	2	2.5	2.2
Orthodontics	ST3+	March	1	1	1	1.0
Ophthalmology	ST3+	Aug	0	0	0	0.0
Total			27	27.1	29.1	27.7

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



Report Front Sheet

1. Report Details			
Meeting Title:	Board of Directors, Part 1		
Date of Meeting:	27 March 2024		
Document Title:	**2023 Staff Survey Results**		
Responsible Director:	Nicola Plumb, Joint Chief People Officer	Date of Executive Approval	6 March 2024 (EH)
Author:	Julie Barber, Head of Organisational Development		
Confidentiality:	No		
Publishable under FOI?	Yes		
Predetermined Report Format?	Yes		

2. Prior Discussion		
Job Title or Meeting Title	**Date**	**Recommendations/Comments**
Joint Executive Team Meeting	12 March 2024	
People and Culture Committee	18 March 2024	Noted

3. Purpose of the Paper	The purpose of the paper is to provide a high-level summary of the 2023 NHS Staff Survey results. The full results are also shared.							
	Note (✓)	x	*Discuss (✓)*	x	*Recommend (✓)*		*Approve (✓)*	

4. Key Issues

The 2023 NHS Staff Survey was conducted between October and December last year. Our response rate was 41%, which was a slight drop from last year, but we achieved a small increase in the number of staff responding (1,421). The median response rate for our benchmarking group (Acute and Acute & Community Trusts) was 45%.

A response rate of 40% or more is considered good and gives an accurate indication of what our staff are thinking. It also means we can consider statistical significance and make robust conclusions about the data. Around a fifth of our scores have improved in a way that is considered statistically significant.

Since 2021, the questions in the NHS Staff Survey have been aligned to the People Promise and are made up of 7 People Promise elements and 2 themes (Staff Engagement & Morale). This means that for many questions, we only have comparison data over 3 years rather than 5 years so may not be able to identify longer-term trends.

Due to a national issue with the quality of data, the Survey Coordination Centre are unable to report on some results for the 2023 survey. The People Promise element of 'We are safe and healthy' cannot be reported on due to issues with the two-sets of sub-scores for 'Negative experiences' and 'Health and safety climate'. More detail can be found here: https://www.nhsstaffsurveys.com/survey-documents/

Our scores have improved in all 6 of the reportable People Promise elements and the 2 themes, and all are above the NHS average. An overview of the People Promise elements and themes is shown at Appendix A.

The Employee Engagement index continues to have a score out of 10. Following

	a decline in scores over the last 2 years, our score has risen to 7.07 this year. A growing body of evidence links staff engagement to patient outcomes. The theme of Morale has also increased from last year, to 6.00. Our results give an indication of how DCH is continuing to improve the experiences of staff, demonstrating we are a Trust which is responding well to current challenges. Ongoing work in the areas of inclusion, speaking up, staff health and wellbeing and leadership and management development will help to further improve the staff experience at DCH.
5. Action recommended	The Board is asked to **note** and **discuss** the Report.

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

2023 STAFF SURVEY RESULTS

Executive Summary

The purpose of the paper is to provide a high-level summary of the 2023 NHS Staff Survey results, to showcase both positive and negative trajectories and to highlight work ongoing within the Trust which will impact on areas explored within the Survey.

The 2023 NHS Staff Survey was conducted between October and December last year. A response rate of 41% was achieved (1,421 employees). The median response rate for our benchmarking group (Acute and Acute & Community Trusts) was 45%.

Since 2021, the questions in the NHS Staff Survey have been aligned to the People Promise and are made up of 7 People Promise elements and 2 themes (Staff Engagement & Morale). This means that for many questions, we only have comparison data over 3 years rather than 5 years so may not be able to identify longer-term trends.

Due to a national issue with the quality of data, the Survey Coordination Centre are unable to report on some results for the 2023 survey. The People Promise element of 'We are safe and healthy' cannot be reported on due to issues with the two-sets of sub-scores for 'Negative experiences' and 'Health and safety climate'. More detail can be found here: https://www.nhsstaffsurveys.com/survey-documents/

Our scores have improved in all 6 of the reportable People Promise elements and the 2 themes, and all are above the NHS average. An overview of the People Promise elements and themes is shown at **Appendix A.**

The Employee Engagement index continues to have a score out of 10. Following a decline in scores over the last 2 years, our score has risen to 7.07 this year. A growing body of evidence links staff engagement to patient outcomes. The theme of Morale has also increased from last year, to 6.00, which is considered statistically significant.

We continue to utilise the results to identify positive outcomes, areas to improve and any trends worthy of note. At a local level, divisional leaders will be cascading results and team leads will facilitate 'time to talk' conversations with their teams to co-design, embed and own local action plans. This year, deeper dives into team results will be aided by the implementation of the TED Team Support Tool being implemented during April and May.

Our programmes of work are being reviewed in light of staff survey and People Pulse results alongside local intelligence collaborations which will help drive improvements to our staff development offers and targeted support initiatives.

This paper follows the publication of the results on 7 March 2024 and serves as a supplement to the detailed survey report.

The PCC is asked to note and discuss the contents of the Report.

1. Introduction

The 2023 NHS Staff Survey was conducted between October and December last year. A response rate of 41% was achieved (1421 employees). The median response rate for our benchmarking group (Acute and Acute & Community Trusts) was 45%. Given this response rate, it is important that the survey results are used alongside all other sources of staff feedback including the quarterly People Pulse results, freedom to speak up data, local intelligence meetings and the experiences of staff collated via departmental visits.

Each year we utilise the results to identify positive outcomes, areas to improve any trends worthy of note. For some questions we have up to five years of trend data, providing a much more reliable indication of whether the most recent results represent a change from the norm rather than only comparing the most recent results with the previous year. However, for many questions, we only have comparison data over 3 years.

2. Overview of Survey Results

2.1 Overview of People Promise elements and themes

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

Due to a national issue with the quality of data, the Survey Coordination Centre are unable to report on some results for the 2023 survey. The People Promise element of 'We are safe and healthy' cannot be reported on due to issues with the two-sets of sub-scores for 'Negative experiences' and 'Health and safety climate'. More detail can be found here: https://www.nhsstaffsurveys.com/survey-documents/

Our scores have improved in all 6 of the reportable People Promise elements and the 2 themes, and all are above the NHS average. An overview of the People Promise elements and themes is shown at **Appendix A.**

The Employee Engagement index continues to have a score out of 10. Following a decline in scores over the last 2 years, our score has risen to 7.07 this year. A growing body of evidence links staff engagement to patient outcomes. The theme of Morale has also increased from last year, to 6.00.

2.2 Staff Engagement/Employee Engagement Index (EEI) score

There has been an increase in the overall staff engagement score this year, to **7.07**. Whilst this increase is not considered a statistically significant change, our survey provider pointed out that a score of 7 or over is excellent.

The staff engagement score is calculated from the scores of 9 questions relating to 3 themes: motivation, involvement and advocacy. There has been a positive increase in all but one of the 9 questions, that being 'able to make suggestions to improve the work of the team/department'.

The downward movement on this question is minimal and the result is significantly higher than the national average in any event.

The theme of advocacy is considered particularly important as it is scrutinised by the CQC in terms of the NHS staff, friends and family test questions, with 23c and 25d providing a recommendation for the organization. These scores for these two questions have improved in a noticeable way and both are substantially above the national average.

Theme	Questions/Statements	2023 Score %	2022 Score %	2021 Score %	National Average 2023 %
Motivation	Q2a: Often/always look forward to going to work	**57.39**	**54.69**	**57.46**	**55.00**
	Q2b: Often/always enthusiastic about my job	**72.35**	**71.40**	**73.09**	**69.39**
	Q2c: Time often/always passes quickly when I am working	**72.65**	**72.43**	**75.48**	**72.33**
Involvement	Q3c: Frequent opportunities for me to show initiative in my role	**79.76**	**77.23**	**77.23**	**73.66**
	Q3d: Able to make suggestions to improve the work of my team/department	**74.34**	**74.65**	**74.96**	**71.43**
	Q3f: Able to make improvement happen in my area of work	**60.55**	**57.99**	**58.74**	**56.35**
Advocacy	Q23a: Care of patients/service users is my organisations top priority	**77.70**	**75.82**	**78.67**	**74.83**
	Q23c: I would recommend my organization as a place to work	**66.31**	**60.88**	**66.32**	**60.52**
	Q23d: If a friend/relative needed treatment I would be happy with the standard of care provided by this organisation	**71.71**	**65.79**	**74.55**	**63.32**
Overall score for Engagement		**7.07**	**6.95**	Higher 2023 result is **NOT considered a statistically significant change**	

2.2.1 Staff Engagement trajectory 2015-2023

Year	Dorset County Hospital	Best within benchmark group	Average within benchmark group
2015	7.0	7.6	7.0
2016	7.0	7.4	7.0
2017	7.1	7.4	7.0
2018	7.2	7.6	7.0
2019	7.2	7.6	7.0
2020	7.2	7.6	7.0
2021	7.1	7.4	6.8
2022	7.0	7.3	6.8
2023	7.1	7.3	6.9

Our Staff Engagement scores over the last 9 years indicate that this year we have turned a corner, but we need to focus on that area to maintain momentum. The benchmark group was in decline but also shows the 0.1 improvement. The exemplar group is showing a decline and indicates we are as close to exemplar as we are to the benchmark group, so the gap has reduced between our score and the best score, further evidence we are heading in the right direction.

2.3 Morale

There has been an increase in the overall score for morale this year, to 6.00. *This increase demonstrates a statistically significant change*, and our survey provider pointed out that a score of over 6 is excellent, so we are just on the cusp of this.

Morale is broken down into 3 themes, with 13 questions evidencing the areas of: thinking about leaving, work pressure and stressors. Whilst the scores showed some downward trajectories, the positive movements have contributed to the overall improved result.

Stress index questions not only feed morale but also sickness absence ultimately, so we need to keep an eye on these areas.

Question 26c indicate a group of our most disengaged staff who state they will leave the organisation as soon as they can find another job. This score is high across the NHS at 15%, so although we are better than average and our score has decreased since last year, this is another area for us to focus on improving.

Theme	Question/Statement	2023 Score %	2022 Score %	2021 Score %	National Average 2023 %
Thinking about leaving	Q26a: I often think about leaving this organisation	**28.12**	**29.93**	**28.47**	**28.89**
	Q26b: I will probably look for a job at a new organization in the next 12 months	**18.01**	**22.11**	**19.79**	**20.74**
	Q26c: as soon as I can find another job, I will leave this organisation	**13.05**	**15.12**	**12.79**	**15.32**
Work pressure	Q3g: I am able to meet all the conflicting demands on my time at work	**44.34**	**40.33**	**40.88**	**46.63**
	Q3h: I have adequate materials, supplies and equipment to do my work	**57.03**	**53.49**	**55.72**	**56.88**
	Q3i: There are enough staff at this organization for me to do my job properly	**29.64**	**21.92**	**22.86**	**31.75**
Stressors	Q3a: I always know what my work responsibilities are	**86.24**	**86.42**	**88.32**	**86.63**
	Q3e: I am involved in deciding on changes introduced that affect my work area/team/department	**56.30**	**54.32**	**55.54**	**51.60**
	Q5a: I have unrealistic time pressures	**23.86**	**22.41**	**21.40**	**25.08**
	Q5b: I have a choice in deciding how to do my work	**56.72**	**58.26**	**56.70**	**52.55**

	Q5c: Relationships at work are strained	**46.71**	**44.88**	**42.70**	**45.96**
	Q7c: I receive the respect I deserve from my colleagues at work	**69.52**	**72.09**	**70.90**	**70.96**
	Q9a: My immediate manager encourages me at work	**72.47**	**71.70**	**74.10**	**71.45**
Overall score for Morale		**6.00**	**5.78**	Higher 2023 result **is considered a statistically significant change**	

3. People Promise elements and sub-scores

Out of the 6 reportable People Promise elements, whilst all have improved this year, three are indicated as being a statistically significant change. Details are shown at **Appendix B**.

A summary of the sub-scores is shown at **Appendix C**.

Three new questions have been included in the element 'We are safe and healthy' so there is no comparable data from previous years and answers have not contributed to sub-scores. Two questions are about unwanted sexual behaviour. This is not identifying a new issue but shows our score for staff/colleagues as 0.6% above average and 3.09% short of the best result across the NHS, so another area to target during 2024-25. Work is already underway in this area; the Trust has signed the national Sexual Safety charter and is collating more detailed feedback from staff in a separate anonymous survey.

4. Questions not linked to People Promise elements or themes

Question 16c interrogates discrimination on grounds of the protected characteristics.

Question	Category	Scores
16c1	Ethnic background	DCH – 35.44%, is **lower** than Benchmark – 51.88%
16c2	Gender	DCH – 21.62%, is **higher** than Benchmark - 19.22%
16c3	Religion	DCH – 2.50%, is **lower** than Benchmark 4.47%
16c4	Sexual orientation	DCH – 1.19%, **lower** than Benchmark 4.00%
16c5	Disability	DCH – 11.80%, **higher** than Benchmark 9.01%
16c6	Age	DCH – 18.15%, **higher** than Benchmark 17.15%
16c7	Other	DCH – 30.68%, **higher** than Benchmark 24.27% A*s this category sits outside the protected characteristics, we will need to investigate further to find out what is behind this statistic.*

Colleagues in a range of sectors are now much more aware of discrimination and what discriminatory behaviour looks like. At DCH, our work programmes such as Dignity and Respect at Work and our Inclusive and Compassionate Leadership Programmes will have helped staff recognise these behaviours.

The breakdown for Q.16 (apart from c7 mentioned above) cites levels of discriminatory behaviour relating to the protected characteristics covered by the Equality Act 2010. Our EDIB Workplan includes initiatives to target discrimination in all its forms and advocates zero tolerance.

5. Bank Staff

669 surveys were sent to Bank Staff which yielded 132 responses, so a response rate of 19.7%. Some significant differences were noted in comparison to substantive staff. Examples are shown below.

5.1 Areas where Bank Staff reported more positively (with statistical significance)

- I look forward to going to work (+ 12.7%)
- I often/always find my work emotionally exhausting (-11.3%)
- I achieve a good balance between my work life and home life (+22.1%)
- I never/rarely have unrealistic time pressures (+14.8%)

5.2 Areas where Bank Staff reported more negatively (with statistical significance)

- My immediate manager is interested in listening to me when I describe the challenges I face (-11.3%)
- I am involved in deciding on changes introduced that affect my work (-29.5%)
- I am able to make improvements happen at work (-22.5%)
- I feel supported to develop my potential (-15.4%)

5.3 Next steps

Bank Staff report most negatively on ‘having a voice that counts’, but other areas will also need to be addressed. Bank Staff seem to suffer from less stress and pressure than substantive staff so some lessons could be learned from their experiences. Bank Staff will be fully included in the analysis process when results are disseminated to divisions and teams. The disparities will be owned and investigated at local level with oversight from the Bank Engagement Lead, so any learning can be shared.

6. WRES

In comparison with the 2022 scores, there are improvements for BME staff in 3 out of 4 questions. There has been a significant and encouraging reduction in BME staff experiencing harassment, bullying or abuse from patients/relatives and staff. However, the percentage of BME staff who have reported discrimination from a manager/team leader has increased.

Cases of harassment, bullying, abuse and discrimination are all unacceptably high for all colleagues and will continue to be an area of focus.

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

Question – WRES data DCH	BME 2023	BME 2022	BME 2021	WHITE 2023	WHITE 2022	WHITE 2021
% of staff experiencing harassment, bullying or abuse from **patients or relatives** in last 12 months	**22.01**	**29.76**	**34.0**	**18.01**	**25.04**	**24.55**
% of staff experiencing harassment, bullying or abuse from **staff** in last 12 months	**25.84**	**32.35**	**29.05**	**22.57**	**24.94**	**26.00**
% of staff who feel the organisation provides equal opportunities for career progression or promotion	**59.31**	**47.02**	**55.03**	**58.09**	**60.74**	**62.59**
% of staff who experienced discrimination at work from manager/team leader or colleague in last 12 months	**17.96**	**16.57**	**18.67**	**7.76**	**6.13**	**5.56**

7. Workforce Disability Equality Standard (WDES)

When comparing scores to the previous year, improvements are seen on 7 questions and declines on 2. Non-disabled staff show improvements across all 7 questions and whilst this is good news, these scores highlight that our disabled staff continue to have a less positive experience across the board. The reduction in the number of staff experiencing bullying and harassment from patients/relatives, managers, and other colleagues is encouraging but we recognise there is still more work to do in these areas.

The continued rise in both disabled and non-disabled staff reporting incidences helps to identify where action needs to be targeted. Equal opportunities for career progression and reasonable adjustments have seen a declining trend over 3 years and needs further investigation. Work is already underway in conjunction with the Without Limits staff network to strengthen the policy, training and processes relating to reasonable adjustments.

Question – WDES data DCH	Disabled 2023	Disabled 2022	Disabled 2021	Non-Disabled 2023	Non-Disabled 2022	Non-Disabled 2021
% of staff experiencing harassment, bullying or abuse from **patients or relatives** in last 12 months	**22.77**	**28.77**	**32.38**	**17.11**	**24.51**	**23.45**
% of staff experiencing harassment, bullying or abuse from **managers** in last 12 months	**14.51**	**15.97**	**17.20**	**7.53**	**9.90**	**9.25**
% of staff experiencing harassment, bullying or abuse from **other colleagues** in last 12 months	**24.21**	**28.81**	**26.47**	**18.04**	**18.90**	**20.37**
% of staff who reported last experience of harassment, bullying or abuse	**53.57**	**52.00**	**50.83**	**51.57**	**42.77**	**44.23**
% of staff who feel the organisation provides equal opportunities for career progression or promotion	**55.26**	**59.10**	**60.69**	**59.34**	**58.59**	**61.72**
% of staff who felt pressure from their manager to come into work when not feeling well enough	**24.51**	**28.63**	**27.78**	**18.00**	**18.11**	**19.60**
% of staff who are satisfied with the extent the organisation values their work	**36.81**	**36.49**	**39.84**	**48.42**	**46.43**	**47.00**
% of staff who say their employer has made reasonable adjustments to enable them to carry out their work	**70.33**	**71.92**	**74.1**	**N/A**	**N/A**	**N/A**
Staff Engagement Score	**6.71**	**6.59**	**6.85**	**7.19**	**7.06**	**7.18**

8. Approach to acting on results

8.1 There is more work to do in analysing and understanding what the results of the survey are telling us. There are some disparities between different service areas and these will need to be unpicked at a local level, in line with the expectation that survey results are owned in teams and services.

8.2 Local level results will be made available to services and teams to help them develop local initiatives to improve staff experience.

8.3 DCH will be implementing the TED Team Support Tool during April and May to support team development. The tool is aligned to the People Promise elements and will help with deeper dives into Staff Survey results at team level.

8.4 The survey results will also be used in preparation for the People Promise examplar programme that both DCH and DHC are participating in. This programme will take account of all the initiatives we have implemented to support staff experience and continue the dialogue with staff about how we can work together to improve engagement and retention at DCH.

8.5 A summary of the trust-wide and local initiatives will be used to inform the CQC pre-inspection report

8.6 Once the qualitative feedback is available, it will be triangulated through our local intelligence processes to illustrate more fully what this means for DCH.

9. Conclusion

9.1 The full staff survey report was made available online on 7th March at www.nhsstaffsurveys.com. This paper sought to provide a headline analysis of Dorset County Hospital's results.

9.2 The results give us the opportunity to respond to the needs of our staff. Combined with the insights we have from other sources, they put us in a positive position to continue our work to improve staff experience.

9.3 Improvements or declines in scores are generally relatively small but they still allow us to identify areas of good practice and areas for improvement.

9.4 Across the People Promise elements and themes we have improved in all areas, and our scores are above the NHS average for our sector.

9.5 In the sub-score groupings, out of a reportable total of 13, only 2 had lower scores than the previous year: (1) Diversity & Equality and (2) Inclusion. Whilst not ignoring improvements to better our positive scores, these two areas will benefit from activities outlined in our EDIB Action Plan.

9.6 The survey results indicate that the experiences of disabled staff and those from minority ethnic groups are less positive than other groups of staff. Whilst we recognise there is more to do, we must also celebrate the significant progress that has been made,

particularly in the reduced numbers of staff experiencing harassment, bullying or abuse from patients or relatives in last 12 months, and for disabled staff an improvement in manager behaviours.

9.7 We will now use these results to continue our honest dialogue with all colleagues to understand their lived experience, assess what more we can do to support staff and work together to improve our working lives.

10. Recommendation

The Board is recommended to:

1. **NOTE** and **DISCUSS** the report.

Name and Title of Author: Julie Barber, Head of Organisational Development
5 March 2024

Appendix A: People Promise Elements & Themes: Overview

Appendix B: People Promise Elements: Significance Testing

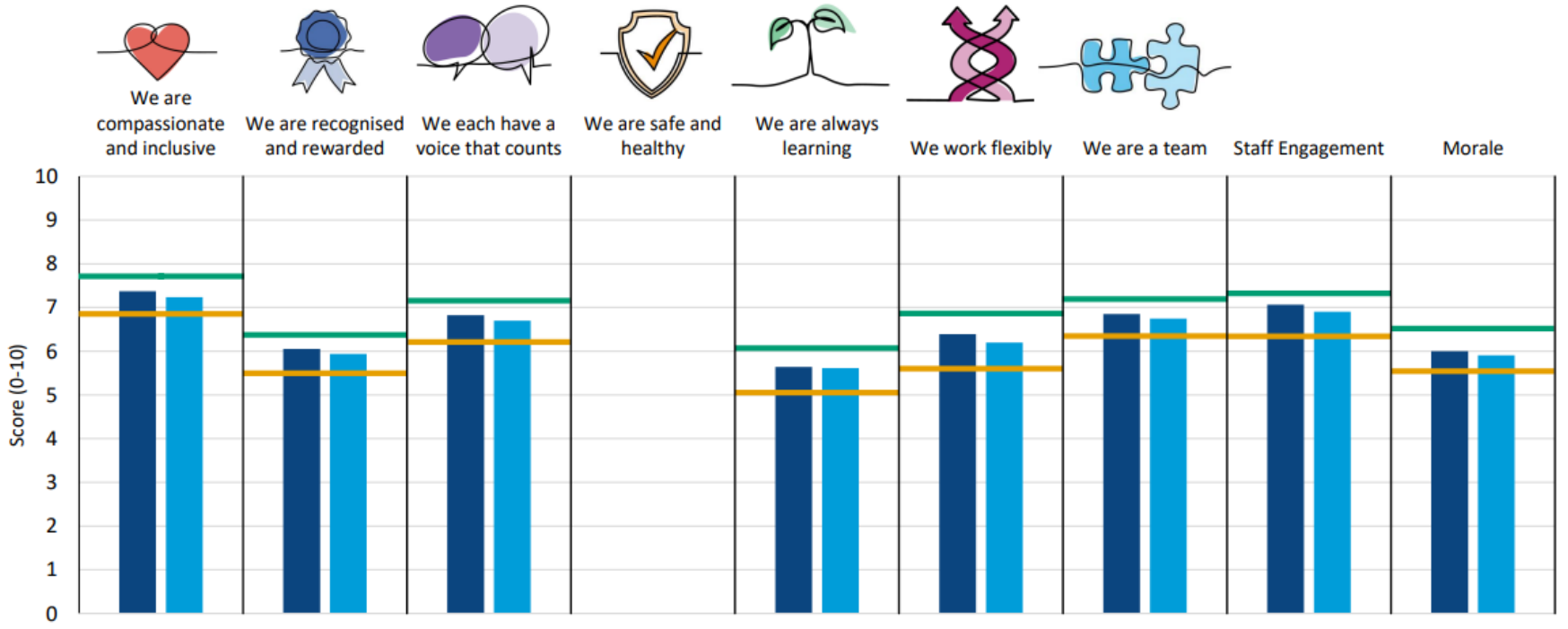
Appendix C: Summary of People Promise elements and sub-scores

APPENDIX A

People Promise elements and themes: Overview

Survey Coordination Centre NHS

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



	We are compassionate and inclusive	We are recognised and rewarded	We each have a voice that counts	We are safe and healthy	We are always learning	We work flexibly	We are a team	Staff Engagement	Morale
Your org	7.37	6.05	6.82	-	5.64	6.39	6.85	7.07	6.00
Best result	7.71	6.37	7.16	-	6.07	6.87	7.19	7.32	6.52
Average result	7.24	5.94	6.70	-	5.61	6.20	6.75	6.91	5.91
Worst result	6.85	5.50	6.21	-	5.05	5.60	6.35	6.34	5.54
Responses	1418	1420	1401	-	1354	1412	1420	1418	1419

Note. 2023 results for 'We are safe and healthy' have not been reported due to an issue with the data. Please see https://www.nhsstaffsurveys.com/survey-documents/ for more details.

Appendix B: Significance testing – 2022 vs 2023

Survey Coordination Centre NHS

Statistical significance helps quantify whether a result is likely due to chance or to some factor of interest. The table below presents the results of significance testing conducted on the theme scores calculated in both 2022 and 2023*. For more details please see the technical document.

People Promise elements	2022 score	2022 respondents	2023 score	2023 respondents	Statistically significant change?
We are compassionate and inclusive	7.33	1403	7.37	1418	Not significant
We are recognised and rewarded	5.89	1396	6.05	1420	Significantly higher
We each have a voice that counts	6.80	1391	6.82	1401	Not significant
We are safe and healthy	5.86	1399	-	-	-
We are always learning	5.45	1336	5.64	1354	Significantly higher
We work flexibly	6.22	1392	6.39	1412	Significantly higher
We are a team	6.80	1397	6.85	1420	Not significant
Themes					
Staff Engagement	6.95	1402	7.07	1418	Not significant
Morale	5.78	1402	6.00	1419	Significantly higher

Note. 2023 results for 'We are safe and healthy' have not been reported due to an issue with the data. Please see https://www.nhsstaffsurveys.com/survey-documents/ for more details.

People Promise Elements & Subscores Summary

People Promise element 1: We are Compassionate & Inclusive
Our overall score of 7.37 is 0.04 improvement on last year against a benchmark of 7.24. This element has 4 sub-scores.

Compassionate culture
This section includes 5 questions, all of which have improved, giving a score of 7.23 compared to 7.06 last year.

Compassionate leadership
This section includes 4 questions, all of which have improved, giving a score of 7.12 compared to 7.05 last year.

Diversity and equality
This section includes 4 questions, 3 of which have declined and 1 has improved, giving a score of 8.21 compared to 8.27 last year.

Inclusion
This section includes 4 questions, all of which have declined, giving a score of 6.93 compared to 6.95 last year.

People Promise element 2: We are recognised and rewarded
This promise covers tangible elements such as pay and intangible elements such as how valued people feel. Our organisational score for this element is 6.05, compared to 5.89 last year & *represents a significantly higher score*. **This element has 5 questions but no sub-scores**. 3 questions improved and 2 declined. Satisfaction with pay (Q4c) improved by 8%, no doubt linked to last year's agreed pay rise.

People Promise element 3: We each have a voice that counts
Our overall score of 6.82 is 0.02 improvement from last year against a benchmark of 6.70. This element has 2 sub-scores.

Autonomy and control
This section includes 7 questions, 4 of which have declined and 3 have improved, giving a score of 7.13 compared to 7.12 last year.

Raising concerns
This section includes 4 questions, 3 of which have improved and 1 declined, giving a score of 6.52 compared to 6.48 last year.

People Promise element 4: We are safe and healthy
This element overall cannot be reported on due to a national issue with data.

Health and safety climate
This section cannot be reported on due to an issue with data.

Burnout
This section includes 7 questions, all of which have improved, giving a score of 5.02 compared to 4.78 last year.

Negative experiences
This section cannot be reported on due to an issue with data.

Other questions – three questions which are new for 2023 survey:
Three new questions have been included in this section, so there is no comparable data from previous years and answers have not contributed to sub-scores.

Two questions (1*7a & 17b) are about unwanted sexual behaviour in the workplace. Q17a (from patients/service users) – DCH score is 7.26% against a benchmark of 7.73% and Q17b (staff/colleagues) – DCH score is 4.53%, higher than the benchmark of 3.82%.*

Q.22 is about access to nutritious and affordable food whilst working (our score is 59.36% against a benchmark of 53.77%)

People Promise element 5: We are always learning
Our overall score of 5.64 is 0.19 improvement on last year against a benchmark of 5.61. This element has 2 sub-scores. *Our increased score this year is considered to be a statistically significant change.*

Development
This section includes 5 questions, 1 of which has declined but 4 have improved, giving a score of 6.65 compared to 6.54 last year.

Appraisals
This section includes 4 questions, all of which have improved, giving a score of 4.62 compared to 4.35 last year.

People Promise element 6: We work flexibly
Our overall score of 6.39 is 0.17 improvement on last year against a benchmark of 6.20. This element has 2 sub-scores. *Our increased score this year is considered to be a statistically significant change.*

Support for work-life balance
This section includes 3 questions, all of which have improved, giving a score of 6.34 compared to 6.21 last year.

Flexible working
This section only has one question, about opportunities for flexible working patterns. The score has increased from 6.22 last year to 6.43 this year, against a benchmark of 6.15.

People Promise element 7: We are a team
Our overall score of 6.85 is 0.05 increase on last year, against a benchmark of 6.75. This element has 2 sub-scores.

Team working
This section has 8 questions, 2 have improved and 6 declined, but this still gives us an increased score this year, at 6.76 compared to 6.72 as the declining scores were smaller than the increased ones. Positive experiences on discussing team effectiveness and freedom for how the team does its work tipped the balance.

Line management
This section has 4 questions and they all improved, giving a score of 6.94 compared to last year at 6.88. The highest improvements were in managers taking a positive interest in staff health & wellbeing and asking for staff opinions before making decisions.

Report Front Sheet

1. Report Details			
Meeting Title:	Board of Directors, Part 1		
Date of Meeting:	27th March 2024		
Document Title:	Executive Walkaround Update		
Responsible Director:	Jo Howarth, Interim Chief Nursing Officer	Date of Executive Approval	13/12/23
Author:	Emma Hoyle Deputy Chief Nursing Officer		
Confidentiality:	No		
Publishable under FOI?	Yes		
Predetermined Report Format?	No		

2. Prior Discussion		
Job Title or Meeting Title	**Date**	**Recommendations/Comments**
Quality Committee	19 December 2023	Noted

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

3. Executive Summary

The Executive Well-led Walkaround has been reinstated in the Summer 2023 and is carried out by an Executive Director and either a Non-Executive Director or Deputy Director.
Bi-monthly summary of themes and findings to be shared with Quality Committee
Process incorporates 15 step challenge (first impressions), Staff engagement, Well Organized and Well Led
Areas Visited October and November 2023

- Evershot Ward
- Dermatology/Medical and Surgical Outpatients
- SSD
- Portering
- Renal Dialysis

Themes identified

First Impression

Areas very welcoming and staff engaged with process and pleased to have an opportunity to discuss issues with the team
Areas noted as clean and tidy.
Some advice offered regarding storage of equipment

Safe

Up to date ward board and signage, evidence of cleaning and safety checklists
Immediate resolution of a fire door obstruction

Caring and Involving

Good staff patient interaction, good adherence to privacy and dignity
Clarity required re interactions between clinicians and patients as difficult to observe

	Well Organized and Calm Clean organized environments Signage present but noted paper unlaminated signs – recommendations to remove made at time. Noted areas for estates to attend to e.g., ceiling tiles. Curtaining around patients needed additional hooks. ***Well Led*** Morning huddle, good evidence of teamwork and leadership Need to strengthen staff understanding of governance and how to escalate concerns.
4. Action recommended	The Board is recommended to: 1. **NOTE** the report. 2. **RECEIVE** assurance on actions to address any performance issues. 3. **AGREE** the key points, risks & concerns to be reported to the Board.

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

Report Front Sheet

1. Report Details			
Meeting Title:	Board of Directors, Part 1		
Date of Meeting:	27th March 2024		
Document Title:	Going Concern Review		
Responsible Director:	Chris Hearn, Chief Financial Officer	Date of Executive Approval	08/03/2024
Author:	James Claypole, Deputy Financial Controller		
Confidentiality:	No		
Publishable under FOI?	Yes		
Predetermined Report Format?	No		

2. Prior Discussion		
Job Title or Meeting Title	**Date**	**Recommendations/Comments**
Risk and Audit Committee	19 March 2024	Recommended for approval

3. Purpose of the Paper	For approval to prepare Trust Annual Accounts on a going concern basis.							
	Note (✓)		*Discuss (✓)*		*Recommend (✓)*		*Approve (✓)*	✓
4. Key Issues	Each year the Trust is required to carry out an assessment of whether it is appropriate to prepare its accounts on a going concern basis. • Forecasting breakeven position for 2023-24 with closing bank balance of £7.7m. • Draft plan for 2024-25 forecasts a deficit of £11.5m, with NHSE revenue support and repayment of working capital totalling £15.7m required to ensure sufficient cash levels. • The provision of healthcare services is still required for the Trust resulting in ongoing support from Department of Health and Social Care and assurance of going concern status.							
5. Action recommended	The Board is recommended to: 1. Review the draft assessment of going concern and 2. Approve the assessment.							

6. Governance and Compliance Obligations			
Legal / Regulatory Link	**Yes**	**No**	To comply with the terms of the Trust's authorisation
Impact on CQC Standards	**Yes**	**No**	
Risk Link	**Yes**	**No**	
Impact on Social Value	**Yes**	**No**	

Trust Strategy Link		**How does this report link to the Trust's Strategic Objectives?** *Please summarise how your report will impact one (or multiple) of the Trust's Strategic Objectives (positive or negative impact). Please include a summary of key measurable benefits or key performance indicators (KPIs) which demonstrate the impact.*		
Strategic Objectives	People			
	Place	To ensure the financial sustainability of the Trust it requires a realistic assessment of whether the going concern basis is appropriate.		
	Partnership			
Dorset Integrated Care 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**	

GOING CONCERN BASIS FOR ACCOUNTS PREPARATION

1. INTRODUCTION

1.1 The annual report and accounts of the Trust will be approved after consideration by the Board of Directors and signed by the Chief Executive as Accounting Officer. The completed report is submitted to NHSE and later formally laid before Parliament.

1.2 All Foundation Trusts are required to prepare their annual accounts in accordance with accounting standards and company law, and must also be compliant with the additional requirements contained in the Department of Health and Social Care Group Accounting Manual 2023-24 (GAM).

1.3 The financial statements should be prepared on a going concern basis unless informed by the relevant national body or DHSC sponsor of the intention for dissolution without transfer of services or function to another entity.

1.4 This includes the concept of the accounts being prepared on the basis that the entity is a going concern and is expected to continue its business operations for the foreseeable future. A key consideration of going concern is that the Trust has sufficient cash resources to meet its obligations as they fall due. In the context of going concern, foreseeable future is deemed to mean at least 12 months from the expected date of signing of the accounts. eg Q1, 2025-26.

1.5 The purpose of this paper is to provide information and assurance to the Trust Board that the Trust can consider itself a going concern. The Trust Board are asked to review and confirm that they consider the Trust to be a going concern.

2. REQUIREMENTS

2.1 Executives must decide each year whether it is appropriate for the Trust to prepare its accounts on the going concern basis, considering best estimates of future activity and cash flows. For 2024-25 the Trust continues to be commissioned to provide Healthcare services by NHS England and continues as a Provider within the Dorset Integrated Care System.

2.2 The Department of Health and Social Care Group Accounting Manual 2023-24 (GAM) reminds NHS Foundation Trusts; “The anticipated continuation of the provision of a service in the future, as evidenced by inclusion of financial provision for that service in published documents, is normally sufficient evidence of going concern.”

2.3 The Trust should include a statement on whether or not the financial statements have been prepared on a going concern basis and the reasons for this decision, with supporting assumptions or qualifications as necessary (*Code of Governance C.1.2*).

2.4 Where there is a material uncertainty over the going concern basis (for instance, continuing operational stability depends on finance or income that has not yet been approved), or where the going concern basis is not appropriate, the executives will need to disclose the relevant circumstances and should discuss the basis of accounting and the disclosures to be made with their auditors.

3. TRUST ASSESSMENT

3.1 The Trust Board assessed the going concern basis for the 2022-23 annual accounts and concluded that the Trust accounts should be prepared on the going concern basis.

3.2 The Trust's financial and cash flow forecasts are monitored on a monthly basis by NHSE.

3.3 The latest available financial outturn indicates that the net Income and Expenditure outcome for 2023-24 is a breakeven position and closing cash position of £7.7m.

3.4 At draft plan stage, the Trust has currently forecast a deficit of £11.5m for 2024-25 with a borrowing requirement of £15.7m which is available from NHSE.

3.5 The Trust's forecast cash position for 2022-23 to 2024-25 is as follows:

	Actual 2022-23	Forecast Outturn 2023-24	Plan 2024-25
Surplus (Deficit) from Operations	**(905)**	**3,507**	**(6,162)**
Non-cash or non-operating income and expense	11,196	356	33
Net cash inflow/(outflow) from operating activities	**10,291**	**3,863**	**(6,129)**
Investing activities	(26,005)	(24,711)	(26,803)
Net cash inflow/(outflow) from investing activities	**(15,714)**	**(20,848)**	**(32,932)**
Financing activities	8,677	9,613	27,928
Net cash inflow/(outflow) from financing activities	**(7,037)**	**(11,235)**	**(5,004)**
Opening cash and cash equivalents less bank overdraft	25,951	18,914	7,679
Net cash increase / (decrease)	(7,037)	(11,235)	(5,004)
Closing cash and cash equivalents less bank overdraft	**18,914**	**7,679**	**2,675**

3.6 The Trust is actively reviewing and managing the deteriorating cash position linked to increased income and expenditure pressures and timing of receipts. Work linked to improving and recovering the Trust's cash sustainability is ongoing with active engagement amongst Dorset System partners.

3.7 The Trust has an outstanding capital loan of £4.6 million from the Foundation Trust Finance Facility (FTFF), which is due to be repaid in March 2026.

3.8 The Trust will have contracts with its local commissioners with services being commissioned in the same manner as in previous years.

3.9 The Trust has no plans to discontinue any operations, transfer services and significantly amend its structure.

4. CONCLUSION

4.1 The latest available financial forecast indicates that the Income & Expenditure outcome for 2023-24 will be a deficit position of breakeven and the closing cash position of £7.7m.

4.2 A first draft financial plan for 2024-25 is showing a deficit of £11.5m, work is ongoing with the Dorset System and the Regional team to understand this deficit and improve future financial outcomes for the Trust and the Dorset System.

4.3 The Cash flow forecast shows the need for interim revenue Public Dividend Capital during 2024-25 to maintain liquidity, if the plan remains the same there will be a further requirement for interim revenue Public Dividend Capital in the 1st quarter of 2025-26.

4.4 The Trust will have contracts with national and local commissioners for 2024-25 and the Board of Directors have made no decisions to discontinue any operations, transfer services or significantly re-structure the organisation.

4.5 The regulator (NHSE) have not issued any communications that impact on our going concern assessment.

4.6 Given the continued requirements for the Healthcare services and available revenue support, it is concluded that the Foundation Trust has no material uncertainty with its financial sustainability on profitability and liquidity.

4.7 The Trust therefore meets the requirements of Department of Health and Social Care Group Accounting Manual 2023-24 as there is evidence of provision of a service in the future, and therefore it is appropriate that it prepares its accounts on a going concern basis and includes a statement to this effect in its Annual Report and Accounts.

5. GOING CONCERN – STATEMENT FOR THE 2023-24 ANNUAL REPORT AND ACCOUNTS

5.1 Based on the above conclusion, it is proposed to include the following statement in the Annual Report and as a note in the Annual Accounts, as required by the Department of Health and Social Care Group Accounting Manual (GAM) 2023-24:

"International Accounting Standard 1 requires the board to assess, as part of the accounts preparation process, the Trust's ability to continue as a going concern. In the context of non-trading entities in the public sector, the anticipated continuation of the provision of a service in the future is normally sufficient evidence of going concern. The financial statements should be prepared on a going concern basis unless there are plans for, or no realistic alternative other than, the dissolution of the Trust without the transfer of its services to another entity within the public sector.

After making enquiries, the directors have a reasonable expectation that the services provided by the NHS foundation trust will continue to be provided by the public sector for the going concern period, being 12 months from the date of signing this Annual Report.

In preparing the financial statements, the Board of Directors have considered the Trust's overall financial position against the requirements of IAS1.

The Trust is reporting a breakeven position for the year ended 31 March 2024 with a closing cash position of £(forecast of £7.7 million). The Trust anticipates an operating deficit of (first draft - £11.5 million) in 2024-25 and a closing cash position of (first draft - £2.7 million), this will include the need to apply for financial support through interim revenue public dividend capital anticipated to be to the value of (first draft - £15.7 million).

The executives have adopted the going concern basis in preparing the accounts, following the definition of going concern in the public sector adopted by HM Treasury's Financial Reporting Manual.

6. ACTION REQUIRED BY THE AUDIT COMMITTEE

6.1 The committee is requested to:

a) receive this report on the going concern assessment undertaken;

b) note the impact on the going concern position of the Trust;

c) consider whether the committee accepts and agrees with the conclusion presented in the report;

d) if so, recommend Board approval for the annual accounts for the year ended 31 March 2024 to be prepared on a going concern basis.

Chris Hearn
Chief Financial Officer
March 2024

INTEGRITY | RESPECT | TEAMWORK | EXCELLENCE

NHS
Dorset County Hospital
NHS Foundation Trust

Escalation Report

Committee: Quality Committee

Date of Meeting: 20th February 2024

Presented by: Eiri Jones

Significant risks / issues for escalation to Board for action	• Ongoing review of an optometrist who is no longer employed by the Trust • Work underway to resolve the dialysis transport issues; some improvement already seen • Positive transformation workstreams and partnership approach

Key issues / matters discussed at the Committee	The committee received, discussed and noted the following reports:
	• Quality Report noting:
	  ○ Various core metrics remain under trajectory, including healthcare acquired infections.
	  ○ Increase in falls; 50% of incidents were patients who fell more than once. Good discussion around this topic.
	  ○ Plans to show the quality dashboard live in future meetings
	• Divisional Update from Trauma and Orthopaedics noting a query from the CQC regarding national joint registry mortality data. The data had been reviewed and corrected with the national joint registry confirming that the Trust is not an outlier.
	• Maternity Safety Report noting
	  ○ Key metrics shared at the meeting by showing the live dashboard
	  ○ Assurance sought around training compliance
	  ○ Further assurance awaited in response to a Thirlwall inquiry action
	  ○ A meeting to be arranged between the maternity safety champions, and system and regional maternity teams.
	• Learning from Deaths Report noting the SHMI had been in range for eight of the last nine months.
	• Managing External Inspections Standard Operating Procedure
	• Transformation Update and QI Progress Report
	• Escalation Reports from the following subgroups, generating assurance questions from committee members
	  ○ Clinical Effectiveness Committee
	  ○ Patient Safety Committee
	  ○ Infection Prevention and Control Committee
	  ○ Research Steering Group
	  ○ Patient Experience and Public Engagement Committee

Decisions made by the Committee	• Learning from Deaths Report
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

Committee: Quality Committee

Date of Meeting: 19th March 2024

Presented by: Eiri Jones

Significant risks / issues for escalation to Board for action	• A steady or improving state in relation to quality metrics. Where there were areas of concern the committee was provided with assurance that actions to improve the position were underway. • Broadly positive CQC Maternity Survey results • MBRRACE data for 2022 published in March 2024 indicated that the Trust's stabilised and adjusted neonatal mortality rate excluding deaths due to congenital abnormalities was more than 5% higher than the average for similar Trusts. Work was underway to review this including a five-year review of neonatal mortality.

Key issues / matters discussed at the Committee	The committee received, discussed and noted the following reports:
	• Quality Report noting a thorough discussion and presentation of the live dashboard. This was noted to be particularly useful in showing the link from ward to board.
	• Maternity Reports generating good discussion and specific questions where further assurance was required. Reports presented were:
	  ○ Maternity Safety Report
	  ○ MBRRACE data for 2022, published March 2024
	  ○ ATAIN quarter 3 report – noting a positive position below the national target
	  ○ CQC Maternity Survey Results
	• The Trust Equity and Equality Quality Impact Assessment policy and use of the Dorset system tool was noted.
	• The National Audit Programme Update was noted.
	• Quality Priorities 2024/25 were reviewed and the continuation of the current priorities was supported.
	• The following Escalation reports were received and noted:
	  ○ Medicines Committee
	  ○ Safeguarding Committee
	  ○ Clinical Effectiveness Committee work plan.
	• The committee effectiveness review process was noted.
	• The ICB Quality committee minutes were noted.

Decisions made by the Committee	• Nil
Implications for the Corporate Risk Register or the Board Assurance Framework (BAF)	• The Board Assurance Framework and Corporate Risk Register were noted and felt to be reflective of the current risks. • An increasing risk to the Corporate Risk Register was noted relating to renal transport. This has been escalated to the ICB via Performance and Quality routes. Continued monitoring of patient safety incidents via the Quality Report will remain

Items / issues for referral to other Committees	• Nil

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NHS
Dorset County Hospital
NHS Foundation Trust

Escalation Report

Executive / Committee: Finance and Performance Committee

Date of Meeting: Monday 19th February 2024

Presented by: Stephen Tilton

Significant risks / issues for escalation to Committee / Board for action	• Concern with regard to the OMF position and timeline for the service across DCH and UHD. • Increase in waiting lists and times, in particular Gynaecology.
Key issues / matters discussed at the Committee	The meeting considered the following: • Divisional Reports from **Family Services and Surgical Division** ○ Noted an improvement in theatre utilisation but concern in DM01 deteriorating. ○ CIP delivery was raised as a concern **Urgent and Integrated Care Division and Somerset Stroke Services Update** ○ Concern with regard to cardiology and the potential risk of significant harm to patients. **Somerset Stroke Services update** ○ Committee was updated that Somerset have agreed the change in the provision of stroke services. HASU at Yeovil will close, date yet to be decided. • **Performance Report noting:** ○ Data illustrating non-elective demand in the system was presented and similar work underway for elective demand. ○ Theatre utilisation has improved to 73% however still off target from the national target of 85%. ○ Impact on elective recovery by industrial action was illustrated and it was noted that the Trust will not be providing in-sourcing for elective activity above tariff. • **Finance Report noting:** ○ Year to date deficit of £9.8m. ○ There is an efficiency shortfall partly due to under collection and impact of industrial action. ○ Agency spend is £30k off plan, there has been improvements in spend since the change of cap in January. ○ Positive cash position of £3.5m • **Draft Budget and Operational Plan 2024/25** ○ Interim planning assumptions received which are linking to internal processes. Final guidance yet to be published. ○ Committee delegated authority for the high level flash submission. ○ Assumption of no further industrial action and assume covid demands remain at similar levels. ○ Will start 2425 at a breakeven position. • Patient Flow Board Quarterly Review ○ Collaboration opportunities with Dorset Healthcare and the Working Together programme

	○ Dorset Council have funded positions which are working alongside the Trust in the Discharge lounge. ○ Need to ensure partners are committed to supporting long term following MADE events. • Escalation reports from: **CPSUG** ○ Noted that all capital schemes are prioritised and the committee and board will be sighted on capital programme for next year. **Value Delivery Board** ○ Noted to improve the escalation report to highlight the risk associated with delivered CIP.
Decisions made by the Committee	• Draft Budget and Operational Plan 2024/25 recommended for approval
Implications for the Corporate Risk Register or the Board Assurance Framework (BAF)	• Nil new
Items / issues for referral to other Committees	• Escalation of cardiology patient safety risk to Quality committee

INTEGRITY | RESPECT | TEAMWORK | EXCELLENCE

NHS
Dorset County Hospital
NHS Foundation Trust

Escalation Report

Executive / Committee: Finance and Performance Committee

Date of Meeting: Monday 18th March 2024

Presented by: Stephen Tilton

Significant risks / issues for escalation to Committee / Board for action	• The achievability of 2024/25 financial plan and risk associated with CIP target raised as a concern
Key issues / matters discussed at the Committee	**Performance report** • Long waits are performing better than trajectory with reduction in 65 and 78 week waits, 0 planned for 78 week by end of May. Faster to diagnosis standards 77% against 75% target. It was noted DCH are a positive outlier in Wessex. • 62 day backlog has come down due to a validation of letters. • Improved diagnostic performance and this has been noted at tiering meeting. • ED performance remains static but still above 76%. • PIFU and Theatre Utilisation remain static, and it was noted both areas performing better than peers. • Areas of concern noted. Demand for non-elective activity has been consistent all year and continues to increase. • Elective demand increase analysis (completed by the ICB) confirms post code drift and most of the increase comes from the East. 54% elective growth has come from Bournemouth and Poole primary care network. • NCTR has increased and seen a 3-month increase. All 3 areas of concern impact elective and non-elective activity and performance outputs and main drivers for what is holding performance back. **Finance update** • M11 ended month £8.9m deficit. • On going improvements in agency, vacancy percentage has improved as well as the system agency rate reduction which has seen in month spend just over £800k, it was noted for first time below plan. • Cost improvement has achieved just over £4m. • The trust final proposed position is to end with a £7.5m deficit, which if achieved will be bridged by the Dorset ICB to break even. The risk associated was noted and raised as a concern by the committee. **Operational Planning 2024/25** • Following the £76m flash submission there has been system and regional work to reduce and this has bought the target to a £44m deficit submission with DCH submitting £8.5m deficit. Cost improvement is a particular challenging area and CIP target is set at 4% which is £11.3m. • All systems (nationally) pushed to review CIP targets, Dorset ICB submitting 5% with the additional 1% risk sitting in ICB pending iterations moving through planning process. • A risk of a shortfall of cash in Q1 and in line with timescales the trust has requested for Q1 draw down.

Decisions made by the Committee	• Draft Budget and Operational Plan 2024/25 recommended for approval at Extra-ordinary board on 18th March 2024 • Cash request from NHSE recommended for approval by the board. • DCH estates strategy recommended for approval by the board. • Pathology Services (Lot 5) Managed service for Molecular Diagnostics for Southern Counties Pathology (SCP) recommended for approval by the board. • Electronic Health record case note scanning contract extension recommended for approval by the board.
Implications for the Corporate Risk Register or the Board Assurance Framework (BAF)	• Finance risk to be reviewed in light of current position.
Items / issues for referral to other Committees	• Impact of pausing digital programmes on patient safety to be raised at Quality committee.

Escalation Report

Executive / Committee: People and Culture Committee

Date of Meeting: Monday 19th February 2024

Presented by: Margaret Blankson (Chair)

Significant risks / issues for escalation to Board for action	• Reduction in agency spend, vacancy rates and sickness absence. Increase in apprenticeships and appraisals. • Guardian of Safe Working Report to be shared at Board

Key issues / other matters discussed by the Committee	The committee considered the following items:
	• People and Performance Report and Dashboard noting broadly positive metrics.
	• Divisional Reports from
	  ○ Urgent and Integrated Care Division including a pharmacy deep dive. This was seen to be a good model for divisional reports.
	  ○ Family Services and Surgical Division
	• Bank and Agency Usage and Expenditure Report noting positive improvements and a period of stability owing to the work of the People Directorate and across the Trust. Work still to be done to look at the structural causes of bank and agency usage.
	• Update on Locally Employed Doctors
	• Guardian of Safe Working Report
	• There were no subgroup Escalation Reports
	• Helpful questions from governors relating to engaging with local housing developments and noting transport issues.

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

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NHS
Dorset County Hospital
NHS Foundation Trust

Escalation Report

Executive / Committee: People and Culture Committee

Date of Meeting: Monday 18th March 2024

Presented by: Margaret Blankson (Chair)

Significant risks / issues for escalation to Board for action	• The Gender Pay Report was approved and is recommended to the Board for national submission and publication. • The Board Assurance Framework was noted and would be discussed at the Board. • The Staff Survey results were discussed and would be further discussed at the Board. Of note were some positive, statistically significant results, and some results that indicated further work was needed by the Trust.

Key issues / other matters discussed by the Committee	The committee considered the following items:
	• People and Performance Report and Dashboard noting:
	  ○ Reduction in agency spend, vacancy rate, and turnover.
	  ○ Successful Healthcare Support Worker recruitment event with more than 20 full time equivalent workers recruited.
	  ○ Increasing waiting time for staff accessing onsite and phone counselling, now a four week-wait. This was being closely monitored.
	• Divisional Reports from
	  ○ Family and Surgical Services Divisional report was deferred.
	  ○ Informatics / Business Intelligence (including Coding update) noting the increasing requirements of the services which support with the functioning of clinical systems.
	  ○ Estates and Facilities noting positive trajectory with a number of key performance indicators. Shortage of and difficulty attracting trade professionals to the Trust, which was similarly experienced by other trusts.
	• There were no Escalation Reports from working groups reporting to the committee.
	• The committee effectiveness review process was noted.
	• The ICB people and Culture Committee Minutes were noted.

Decisions made by the Committee	• The Gender Pay Report was approved.
Implications for the Corporate Risk Register or the Board Assurance Framework (BAF)	• Nil new
Items / issues for referral to other Committees	• None

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NHS
Dorset County Hospital
NHS Foundation Trust

Escalation Report

Committee: Risk and Audit Committee

Date of Meeting: 19th March 2023

Presented by: Stuart Parsons

Significant risks / issues for escalation to Board for action	• The Board Assurance Framework and Corporate Risk register were approved. • There were no material changes or significant impact arising from changes to Accounting Policies and Areas of Estimation within the Annual Accounts. • The Annual Accounts will be prepared on a going concern basis. • The Annual Internal Audit Work Plan was approved and is recommended to the Board. • The External Audit Plan and fees were approved. • The Managing External Inspections Standard Operating Procedure was approved.

Key issues / other matters discussed by the Committee	The committee considered the following items:
	• Review of accounting policies and areas of estimation.
	• Going Concern Report
	• Internal Audit Progress Report noting:
	  ○ The Cost Improvement Audit returned **moderate** assurance on process design and **moderate** assurance for effectiveness.
	  ○ The Recruitment audit returned **significant** assurance for process design and **moderate** assurance for effectiveness.
	• The Anticrime Report and self-assessment were received, noting all areas were on track to deliver compliance with the standards.
	• The External Audit Progress report was received.
	• The Gifts and Hospitality Register report was noted.
	• The committee effectiveness review process was noted.
	• The ICB Audit Committee Minutes were noted.

Decisions made by the Committee	• The Board Assurance Framework and Corporate Risk register were approved. • The Annual Internal Audit Work Plan was approved. • The Anticrime Work Plan was approved. • The External Audit Plan and fees were approved. • The Managing External Inspections Standard Operating Procedure was approved. • The Charitable Funds Consolidation review was noted and the committee approved the non-consolidated status within the Trust Annual Report.
Implications for the Corporate Risk Register or the Board Assurance Framework (BAF)	• The Board Assurance Framework and Corporate Risk register were approved. Committees were asked to place review of risks higher on their respective agendas. Further discussions were to be had regarding system level risks, not owned by the trust, that impacted other partners within the system

Items / issues for referral to other Committees	• Other committees to prioritise the BAF and Corporate Risk Register on their agendas and to review mitigations.

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NHS
Dorset County Hospital
NHS Foundation Trust

Escalation Report

Executive / Committee: Charitable Funds Committee

Date of Meeting: 20 March 2024

Presented by: Dave Underwood

Significant risks / issues for escalation to Committee / Board for action	• **Chemotherapy Appeal major donor request for refund of donation (£30K+ £7.5K Gift Aid)** due to significant delays to Fortuneswell Unit redevelopment. Charitable Funds Committee decision 'in principle' to refund donation if required. Head of Charity is liaising with donor who has agreed to receive the latest Chemotherapy Unit project progress update and will then consider if they still wish their donation to be returned. Head of Charity will inform Charity Chair of final decision accordingly.
Key issues / matters discussed at the Committee	**DCHC Charitable Funds Committee (20.3.24)** • **DCH Charity Finance/Income 23/24** reports (M11 Feb 2024) received. Total income to date as of end Feb £491,910. Unrestricted funds were £347,420, providing a surplus of £127,420 against the reserves target of £220,000. Income to date for March is £57,615. Year-end income total forecast to be around £550,000. • **Capital Appeal (ED/CrCU)** report received. £394K income/pledges to date as of Feb 2024. Kate Adie CBE DL has agreed to be Appeal Patron. Major donor engagement event to be held at Athelhampton House on 2nd May 2024. Promotion ongoing 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	• **Chemotherapy Appeal major donor request for refund of donation (£30K+ £7.5K Gift Aid)** due to significant delays to Fortuneswell Unit redevelopment. Charitable Funds Committee decision 'in principle' to refund donation if required. Head of Charity is liaising with donor who has agreed to receive the latest Chemotherapy Unit project progress update and will then consider if they still wish their donation to be returned. Head of Charity will inform Charity Chair of final decision accordingly.
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: Monday 5th February 2024

Presented by: David Clayton-Smith (Joint Chair)

Significant risks / issues for escalation to Committee / Board for action	• The Benefits Realisation: Metrics and Outcome Measures was approved by the committee. • The Prioritisation Framework was approved by the committee. • Discussions around the evolution of the committee to encompass a broader transformational remit. • A full discussion regarding the Joint Chief Nursing Officer proposal, with the committee endorsing the recommendation.

Key issues / matters discussed at the Committee	The committee in common considered the following items:
	• Working Together Monthly Highlight Report noting:
	  ○ Consideration being given to moving flagship four (admission avoidance) to the Integrated Neighbourhood Team Programme, pending assurance that the programme was robust enough to support the flagship.
	  ○ Limited capacity in the digital workstream due to the significant focus on EPR implementation
	• Benefits Realisation: Metrics and Outcome Measures
	• Prioritisation Framework: to support decision making for areas of focus for 2024/25
	• Governance review progress
	• Evolution of the committee in common
	• Strategy: updated position

Decisions made by the Committee	• The Benefits Realisation: Metrics and Outcome Measures was approved by the committee. • The Prioritisation Framework was approved by the committee. • The Joint Chief Nursing Officer proposal was endorsed by the committee
Implications for the Corporate Risk Register or the Board Assurance Framework (BAF)	•
Items / issues for referral to other committees	• Nil

Learning from Deaths Report Q3 2023/24

1. Report Details			
Meeting Title:	Board of Directors		
Date of Meeting:	27 March 2024		
Document Title:	Learning from Deaths Q3 2023/24		
Responsible Director:	Prof Alastair Hutchison	Date of Executive Approval	
Author:	Dr Julie Doherty / Prof Alastair Hutchison		
Confidentiality:	No		
Publishable under FOI?	Yes		
Predetermined Report Format?	No. However formatted in line with SW Regional guidance. Breadth of data presented is recognised as an exemplar within SW Region.		

2. Prior Discussion		
Job Title or Meeting Title	**Date**	**Recommendations/Comments**
Hospital Mortality Group	February 2024	
Quality Committee	February 2024	

3. Purpose of the Paper	To inform the Quality Committee of the learning occurring from deaths being reported, investigated and appropriate findings disseminated throughout the Trust. To also outline additional measures put in place to assure the Trust that unnecessary deaths are not occurring at DCH despite a previously elevated SHMI. Presentation of the Learning from Deaths report at Quality Committee and Trust Board is a mandatory obligation for all Trusts.						
	Note (✓)		*Discuss (✓)*		*Recommend*	*Approve (✓)*	
4. Key Issues	The latest published SHMI data (5 months in arrears) for DCH was within the 'Expected Range' for the rolling 12 months to September 2023 (see page 7). No other local or national indicators suggest excess unexpected deaths are occurring at DCH, but the SW Region Chief Medical Officer visited DCH on 06/Dec/2023 to review our latest data and to discuss our processes with a wide cross-section of staff involved in Mortality Review. He was assured that we understand our data and have appropriate triangulation of local, regional and national data in place. We do have re-emerging concerns that our SHMI will be adversely affected by the lack of resources within the clinical coding dept which is resulting in a significant backlog.						
5. Action recommended	The Quality Committee is recommended to: 1. **DISCUSS and NOTE** the findings of the report 2. **DISCUSS** the additional scrutiny occurring 3. **APPROVE** the report and escalate to Trust Board						

6. Governance and Compliance Obligations			
Legal / Regulatory Link	**Yes**		Learning from the care provided to patients who die is a key part of clinical governance and quality improvement work (CQC 2016). Publication on a quarterly basis is a regulatory requirement.
Impact on CQC Standards	**Yes**		An elevated SHMI will raise concerns with NHS E&I and the CQC. The previous reduction in SHMI and improvements in coding are acknowledged, and the overall trend in DCH's SHMI is favourable.
Risk Link	**Yes**		• Reputational risk due to higher than expected SHMI • Poor data quality can result in poor engagement from clinicians, impairing the Trust's ability to undertake quality improvement • **Clinical coding data quality is essential to the Trust's ability to assess quality of care. There is currently a high level of uncoded activity relating to resources within the clinical coding dept** and a national preference from coders for remote working – negatively impacted by DCH's backlog in scanned

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

CONTENTS

1.0 DIVISIONAL LEARNING FROM DEATHS REPORTS

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

1.1 Family Services and Surgical Division Report - Quarter 3 2023/24 Report

Structured Judgement Review Results:

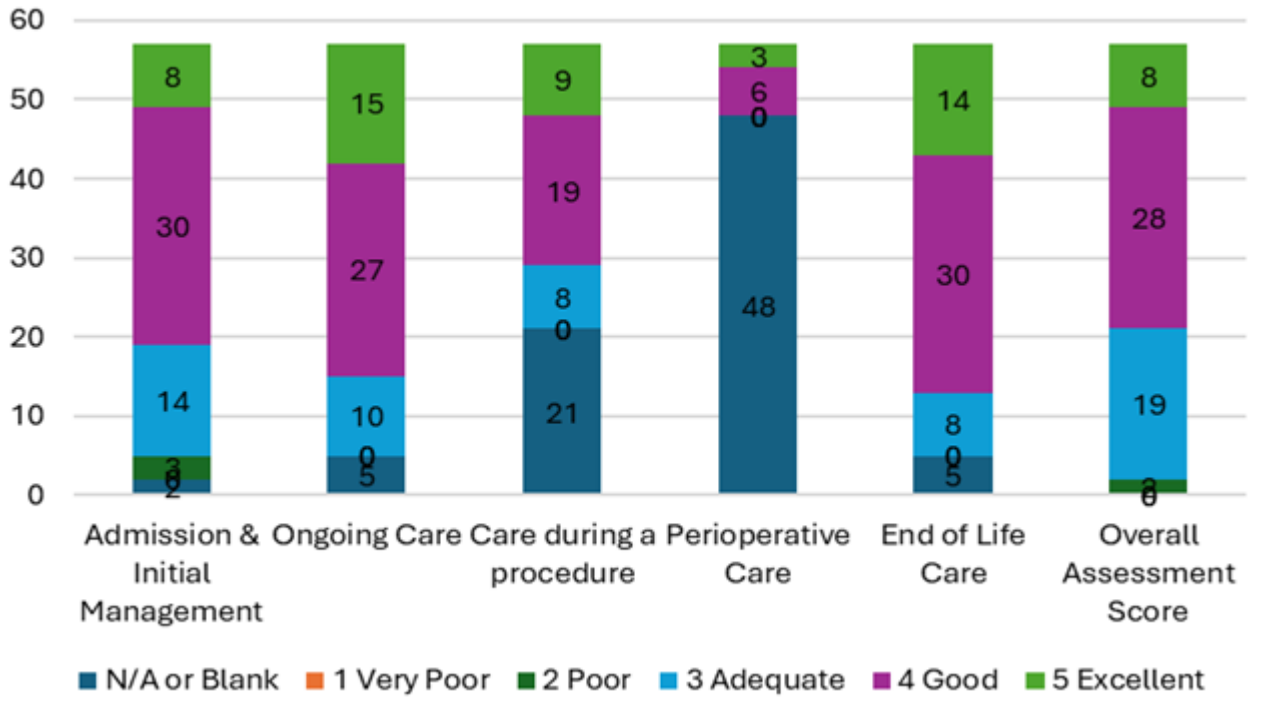
The Family Services & Surgery Division had 45 deaths in quarter 3, of which 40 that require SJR's to be completed. Within quarter 3 57 SJR's have been completed from this quarter and previous months.

Outstanding SJR's:

The Division have completed a number of SJR's from previous quarters. The backlog of outstanding SJR's (over 2 months) for the Division as at 31/01/2024 is 15:

Feedback from SJR's Completed in Quarter 3:

Phase Score	Admission & Initial Management	Ongoing Care	Care during a procedure	Perioperative Care	End of Life Care	Overall Assessment Score
N/A or Blank	2	5	21	48	5	0
1 Very Poor	0	0	0	0	0	0
2 Poor	3	0	0	0	0	2
3 Adequate	14	10	8	0	8	19
4 Good	30	27	19	6	30	28
5 Excellent	8	15	9	3	14	8



Overall Quality of Patient Record:

Blank	Score 1 Very poor	Score 2 Poor	Score 3 Adequate	Score 4 Good	Score 5 Excellent
0	0	3	17	30	7

- Admission clerking poor but excellent documentation of initial discussion with family.

- Excellent record keeping but no LocSSIP for Bronchoscopy.
- Findings on examination absent from record in initial clerking. However, documented in previous ED clerking by Consultant who organised abdo CT scan.
- Generally good patient record but some legibility issues.
- Notes all loose and in wrong order. Difficult to navigate.
- Notes on DPR, all one folder of 108 pages. Some entries illegible due to poor handwriting.
- Very good including dictated communication with family.
- Need Patient Sticker or handwritten details as well as date and signature and name of clinician writing – included in newsletter for feedback & learning.

Quality Manager continues to monitor when the Mortuary/Clinical Coding have released the records to obtain them before they go to the scanning team to try and mitigate being scanned to DPR before the SJR has been completed.

Avoidability of Death Judgement Score:

Score 1 Definitely avoidable	Score 2 Strong evidence of avoidability	Score 3 Probably avoidable (more than 50:50)	Score 4 Possibly avoidable but not very likely (less than 50:50)	Score 5 Slight evidence of avoidability	Score 6 Definitely not avoidable
0	0	0	0	11	46

1.2 Division of Urgent & Integrated Care – Quarter 3 Report 2023/24

In quarter 3 there were 153 deaths, 38 SJR's were requested from these deaths, and 35 SJR's were completed during this period (completed SJR's not necessarily from this quarter).

	Q3			Q4			Q1			Q2			Q3			
	Oct	Nov	Dec	Jan-23	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Total YTD
Deaths	57	62	73	71	61	69	61	60	57	65	58	60	49	41	63	907
Deaths requiring SJR'S from Month	10	10	8	7	9	11	10	10	14	15	14	18	11	14	13	174
*Completed SJR'S	3	10	5	1	8	14	5	12	16	2	14	17	20	12	3	142

* Completed SJR'S not necessarily from that month's deaths

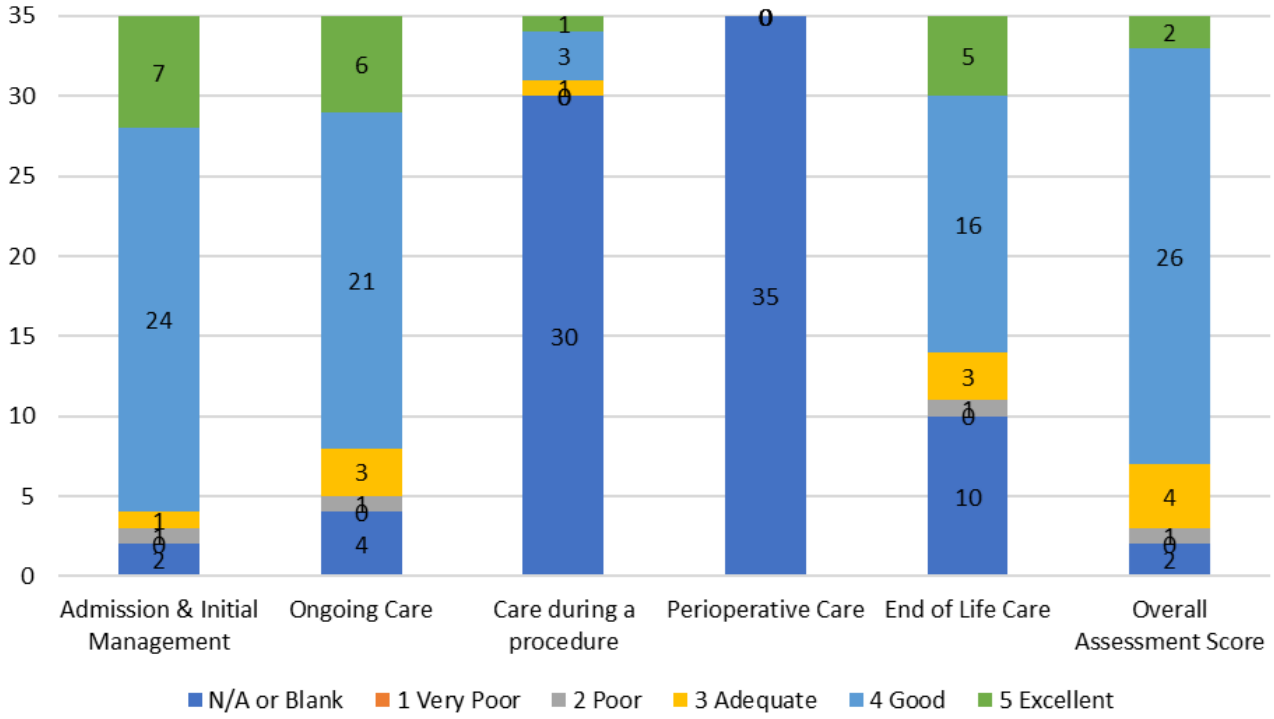
Outstanding SJRs for the Division as at 09/02/2024 is 43 including outstanding nosocomial reviews:

July	August	September	October	November
3	5	15	11	14

Quarter 3 Results

Phase score from 35 completed SJR's in Quarter 3:

Phase Score	Admission & Initial Management	Ongoing Care	Care during a procedure	Perioperative Care	End of Life Care	Overall Assessment Score
N/A or Blank	2	4	30	35	10	2
1 Very Poor	0	0	0	0	0	0
2 Poor	1	1	0	0	1	1
3 Adequate	1	3	1	0	3	4
4 Good	24	21	3	0	16	26
5 Excellent	7	6	1	0	5	2



Overall Quality of Patient Record:

Blank	Score 1 Very poor	Score 2 Poor	Score 3 Adequate	Score 4 Good	Score 5 Excellent
2	0	4	6	16	7

- Good documentation and joint record for all health staff.
- Clear and regular documentation.
- 1. AAND form signed by SHO, not consultant, 2. TEP signed by same SHO, 3. No documentation (that I can see) of discussion re TEP and AAND, 4. Handwriting in places hard to read and not consistent use of bleep numbers (surgical reg entry is not signed).
- Good notes especially good documentation by med reg.
- Notes on DPR, one folder of 212 pages, not necessarily in chronological order.
- Notes on DPR. Only documents cardiac arrest form and ambulance record.
- Notes were available both electronically and paper, although difficult to locate the inpatient daily reviews.
- Very good daily notes. Clear plans and discussions.

Avoidability of Death Judgement Score:

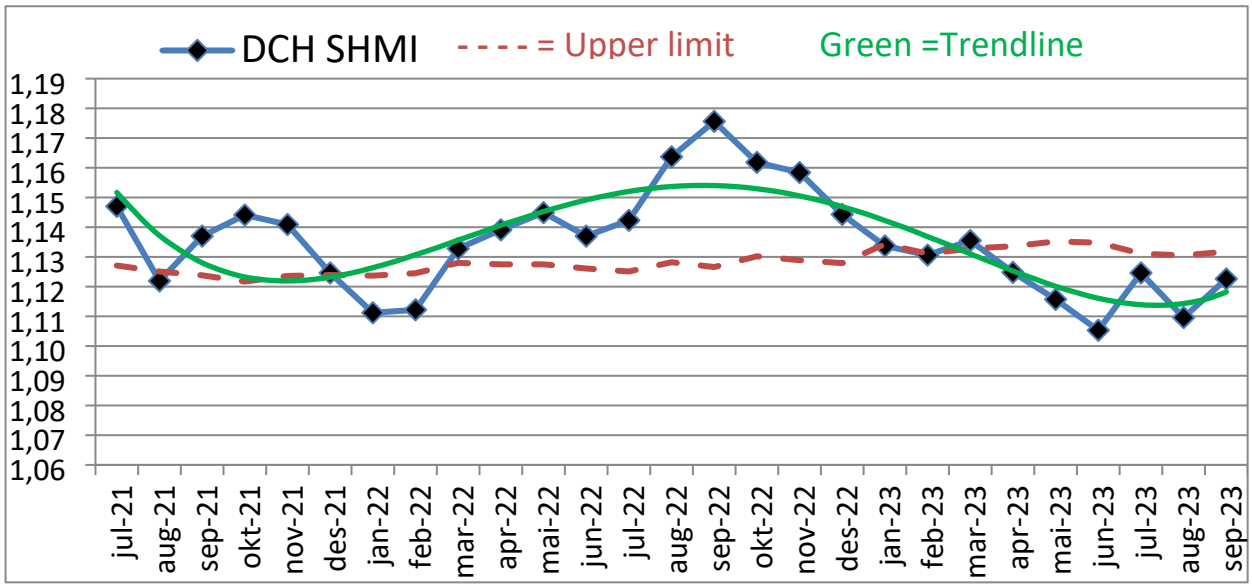
Score 1 Definitely avoidable	Score 2 Strong evidence of avoidability	Score 3 Probably avoidable (more than 50:50)	Score 4 Possibly avoidable but not very likely (less than 50:50)	Score 5 Slight evidence of avoidability	Score 6 Definitely not avoidable
0	0	0	1	2	32

2.0 NATIONAL MORTALITY METRICS AND CODING ISSUES

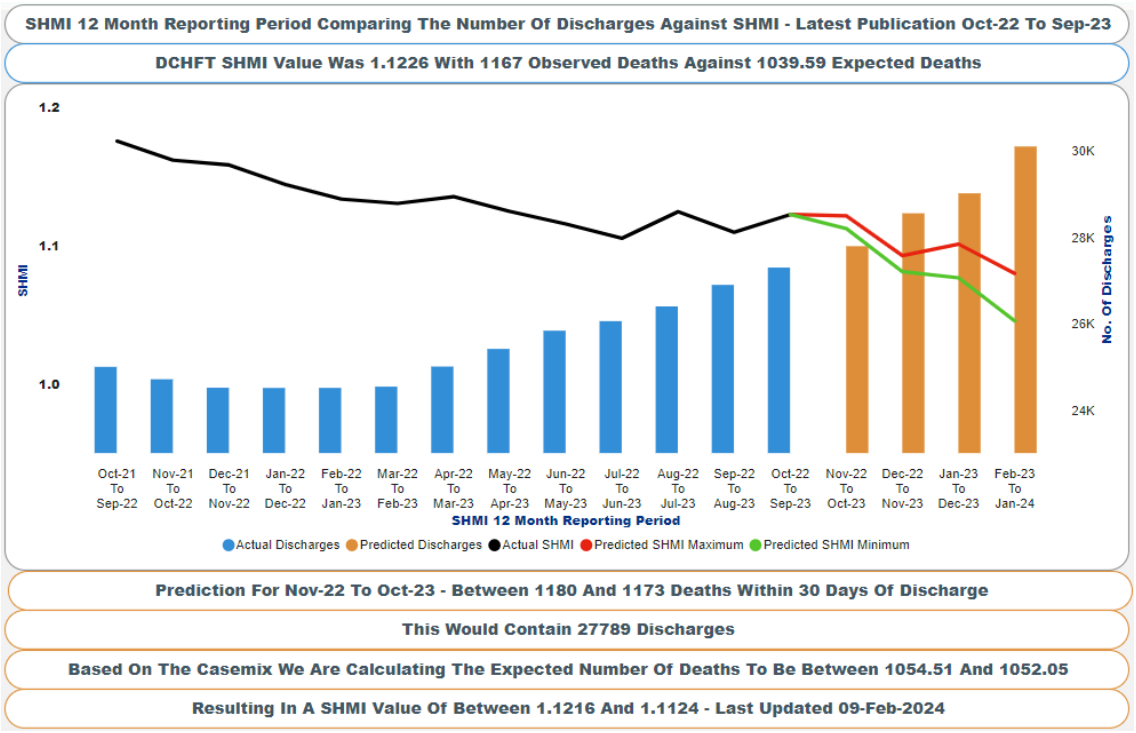
2.1 Summary Hospital-level Mortality Indicator (SHMI)

SHMI is published by NHS Digital for a 12-month rolling period, and 5 months in arrears. It takes into account all diagnostic groups, in-hospital deaths, and deaths occurring within 30 days of discharge. It is calculated by comparing the number of observed (actual) deaths in a rolling 12-month period to the expected deaths (predicted from coding of all admissions).

The latest SHMI publication from NHS England is for the period October 2022 to September 2023. The Trust's figure is 1.1226, which is within the expected range using NHS England's control limits. The DCH internal prediction is that SHMI will remain at around this level next month and then fall gradually over the following three months to around 1.0700, however this depends on the coding department being able to submit the annual HES return on time. We are aware that our data continues to be adversely influenced by short staffing/difficulty recruiting to two posts in the Coding Department, and a possible under-reporting of 'sepsis' in the written medical record.

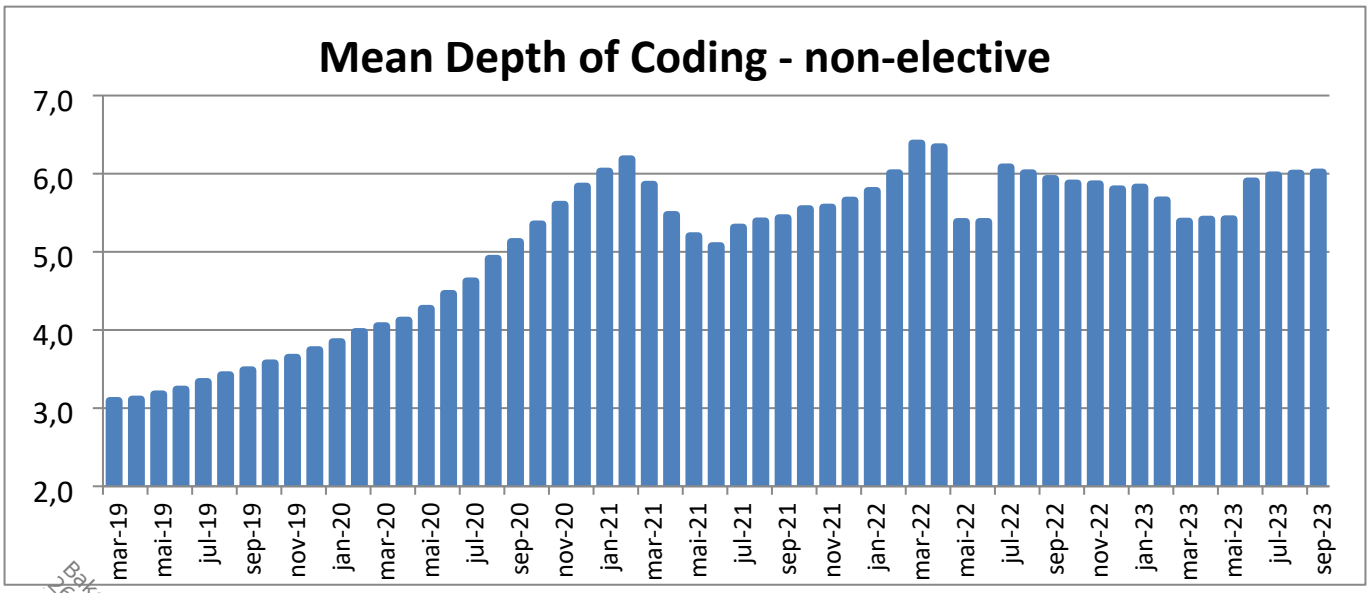


The graph below shows the expected trend in SHMI for the coming 4 months:



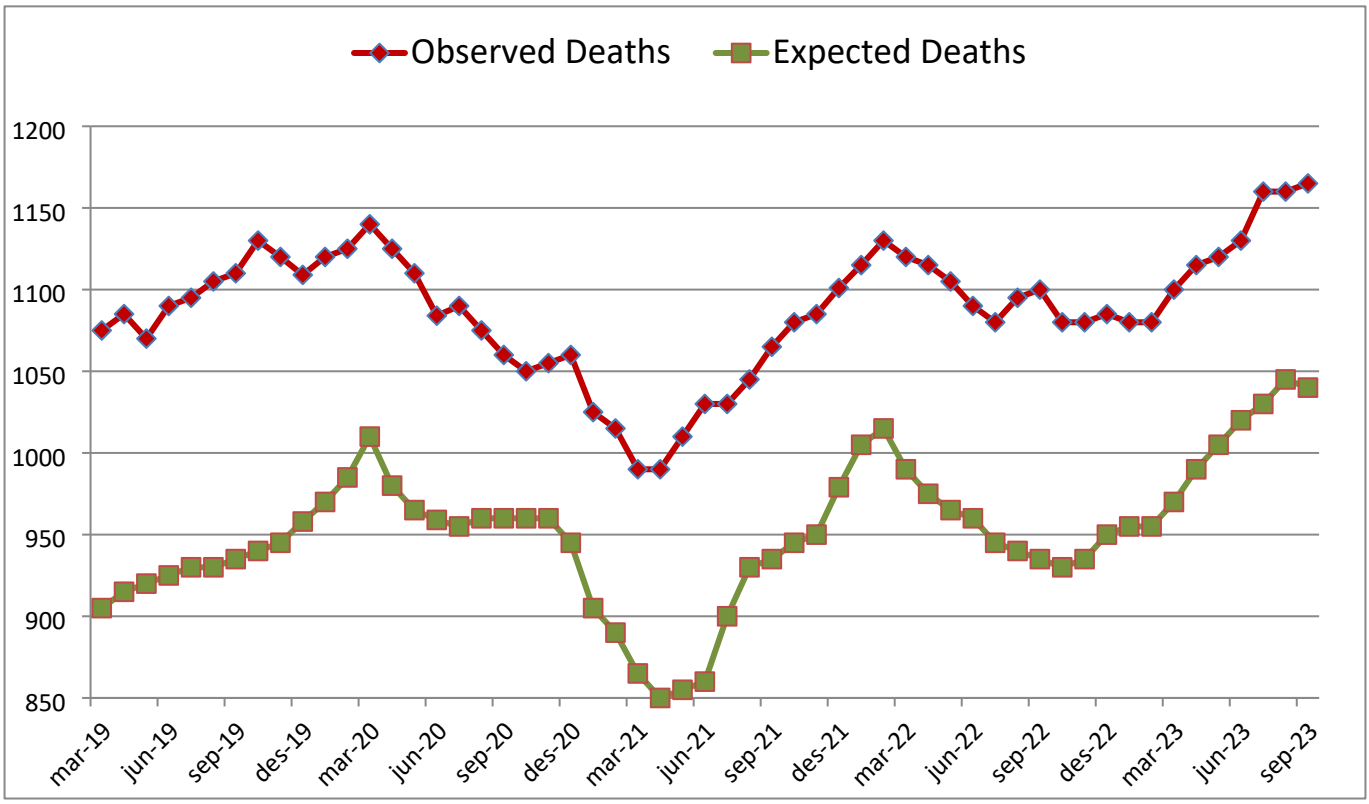
2.2 Depth of coding: NHS Digital states "*As well as information on the main condition the patient is in hospital for (the primary diagnosis), the SHMI data contain up to 19 secondary diagnosis codes for other conditions the patient is suffering from. This information is used to calculate the expected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

DCH's depth of coding had been improving steadily up to March 2022 (see graph below), but subsequent months showed a tendency to decrease. The latest figures show excellent performance but at the cost of an increasing backlog. However Dorset Healthcare have been able to provide an additional 20 hours/week of coding time which will help significantly.



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

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



3.0 OTHER NATIONAL AUDITS/INDICATORS OF CARE

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

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

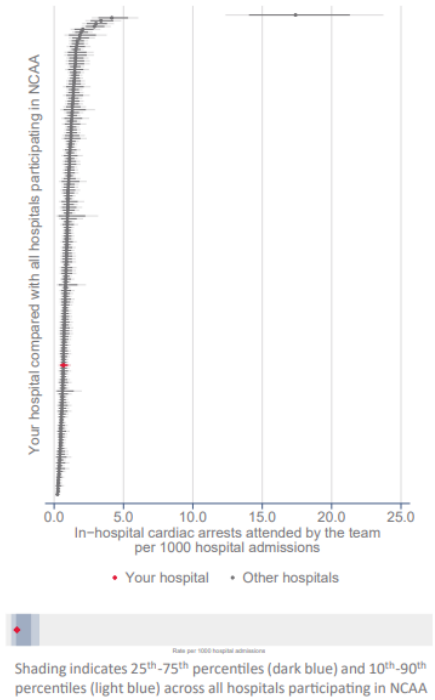
In light of various issues related to maternity units and excess deaths of both children and mothers, NHS Digital has now published the first iterations of a "National Maternity Dashboard". This data is also contained within the monthly Quality report.

3.1 NCAA Cardiac Arrest data

The national Cardiac Arrest audit for DCH including data from April 2023 to Sept 2023 (quarters 1+ 2) was published on 17/01/24. Frequent cardiac arrest calls suggest unanticipated deteriorations in a patient's condition, whereas fewer calls suggest higher standards of ward care, although this is unproven.

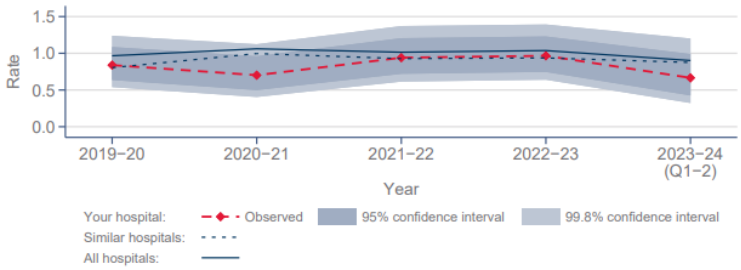
The graph below (left) represents the number of in-hospital cardiac arrest calls attended by the team per 1,000 admissions for all adult, acute care hospitals in the NCA Audit. DCH is indicated in red, and lower on the chart is better. The table to the right gives more detail by quarter year, and the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

Rate of cardiac arrests per 1000 hospital admissions



Shading indicates 25th-75th percentiles (dark blue) and 10th-90th percentiles (light blue) across all hospitals participating in NCAA

	Hospital admissions	Eligible team visits	Rate per 1000 hospital admissions	95% confidence interval	99.8% confidence interval
Quarter 1	17988	12	0.67	(0.34, 1.17)	(0.22, 1.50)
Quarter 2	18100	12	0.66	(0.34, 1.16)	(0.22, 1.49)
Quarter 3					
Quarter 4					
Year to date	36088	24	0.67	(0.43, 0.99)	(0.32, 1.20)



Definition

- Hospital admissions: Total includes elective, non-elective, day cases, babies born in your hospital and neonates
- Eligible team visits: All reported in-hospital cardiac arrests attended by the team
- Observed rate: The total number of cardiac arrests attended by the team divided by the total number of admissions to your hospital multiplied by 1000 to give a rate per 1000 hospital admissions
- Confidence interval: Reflects the degree of uncertainty surrounding your observed rate, given the total number of admissions to your hospital

Dorset County Hospital
NCAA Report: 1 April 2023 to 30 September 2023

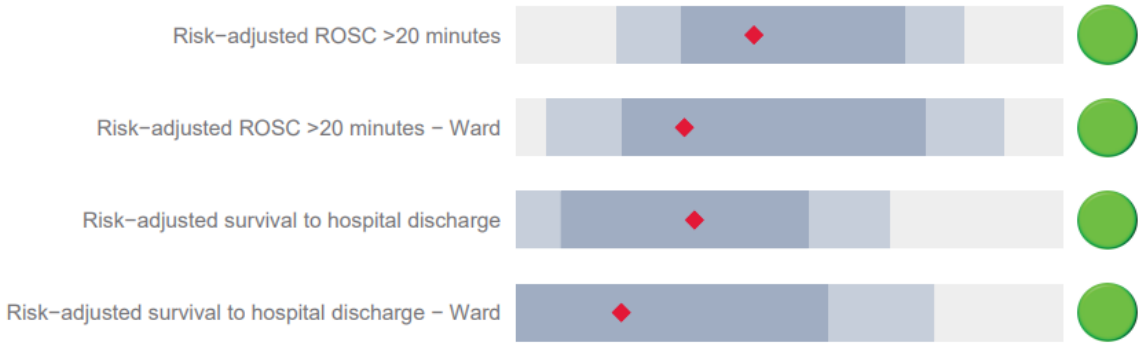
4

Date of report: 15/01/2024
©Resuscitation Council (UK) & ICNARC

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

a) Time to 'Return of Spontaneous Circulation' (a measure of resuscitation effectiveness) and
b) Survival to Discharge.
These and all other measures in the report get a 'green' indicator for the most recently reported Quarter 2 (published 17/01/24).

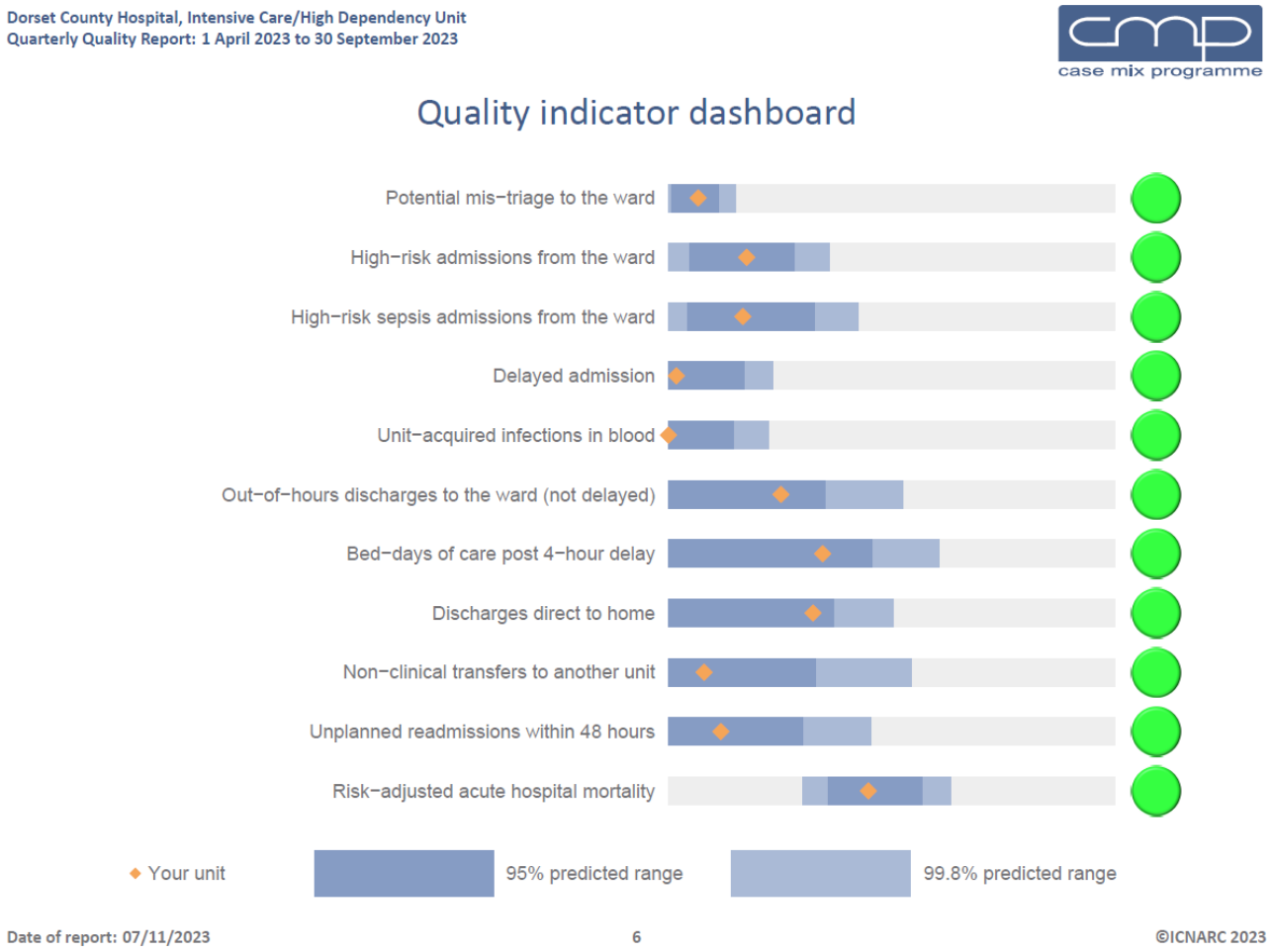
Risk-adjusted outcomes: Dashboard



3.2 National Adult Community Acquired Pneumonia Audit latest data – last published Nov 2019 (see below), and not undertaken for either 2019/20 or 2020/21. Data collection restarted in Spring 2022 but it is unclear whether this has completed.

3.3 ICNARC Intensive Care survival data for financial year 2023/24 Q1+2; published 07/11/23; n = 313 patients.

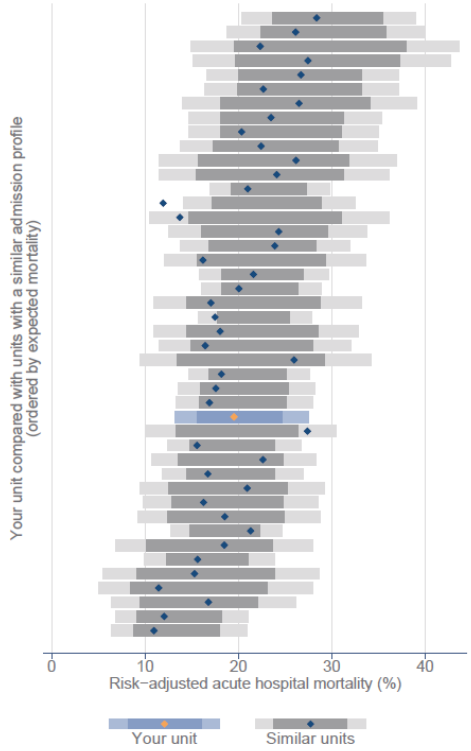
There are no amber or red indicators in this quarter's chart where previously there were delays in being able to discharge patients from ICU, with some delays being long enough that the patient was discharged direct to home. This is a welcome improvement. A Q3 update to this data is expected to be published within the next 2 weeks.



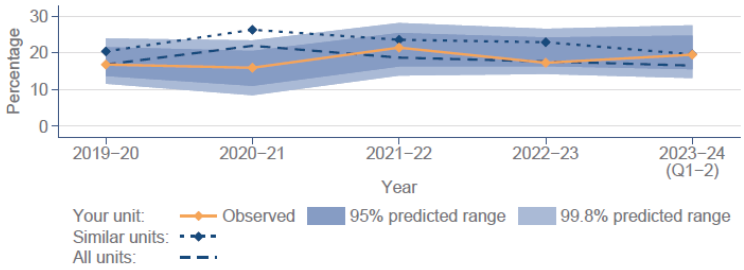
The charts below show the "risk-adjusted acute hospital mortality" following admission to the DCH Critical Care Unit in Q1+2 2023/24. They compare observed and expected death rates in a similar fashion to SHMI, with expected deaths of 60 but actual deaths of 58 for the half year.

case mix programme

Risk-adjusted acute hospital mortality



	Eligible n	Complete n (%)		Observed n (%)	Expected %	95% predicted range	99.8% predicted range	
Quarter 1	148	147 (99.3)	●	29 (19.7)	22.0	(15.1, 28.5)	(11.7, 32.7)	●
Quarter 2	153	150 (98.0)	●	29 (19.3)	18.5	(12.1, 24.6)	(9.0, 28.5)	●
Quarter 3								
Quarter 4								
Year to date	301	297 (98.7)	●	58 (19.5)	20.2	(15.6, 24.7)	(13.2, 27.5)	●



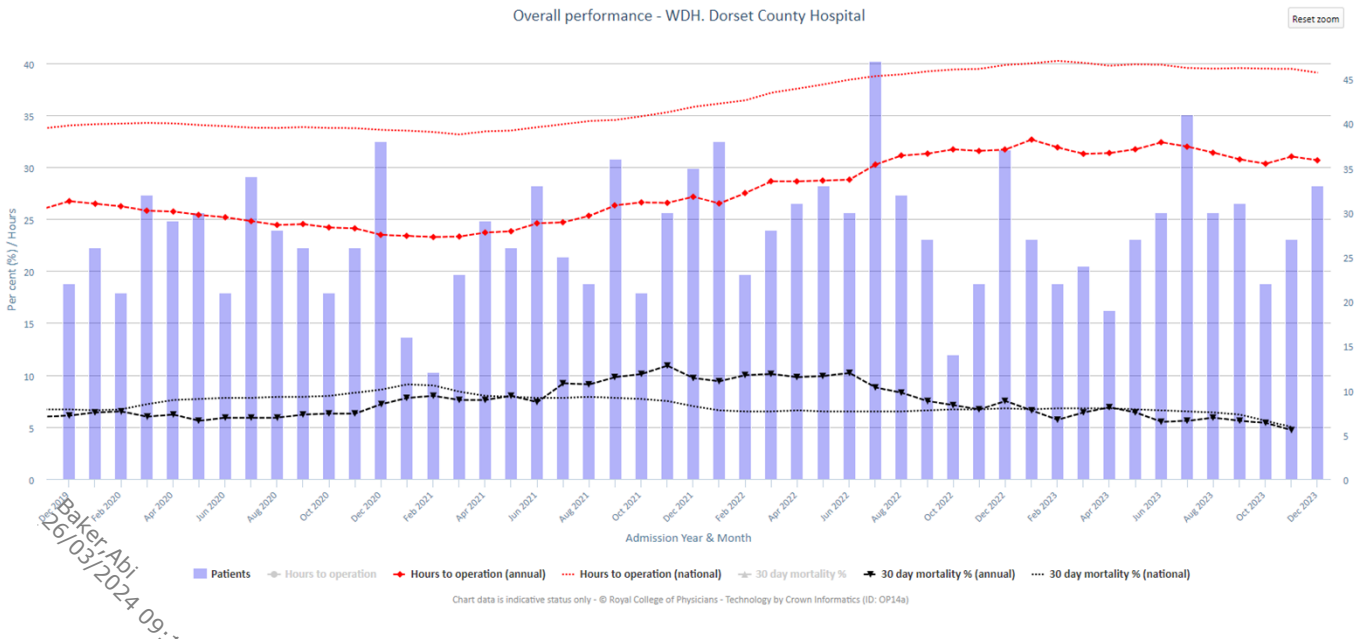
Definition

- Eligible: All critical care unit admissions, excluding readmissions, patients dead on admission and those admitted to facilitate organ donation
- Complete: The number and percentage of eligible admissions with sufficient data to calculate an ICNARC$_{H-2023}$ model risk prediction and complete status at discharge from acute hospital
- Observed percentage: The number and percentage of complete eligible admissions that died before ultimate discharge from acute hospital
- Expected percentage: The expected percentage of acute hospital deaths, calculated as the mean predicted risk of death from the ICNARC$_{H-2023}$ model, among complete eligible admissions to your unit
- Predicted range: We expect a unit's observed percentage to lie within the 95% predicted range 19 times out of 20 and within the 99.8% predicted range 998 times out of 1000

These results are well within the expected range.

3.4 National Hip Fracture database to Dec 2023

30 day mortality remains at or below the national average for 8 consecutive months.



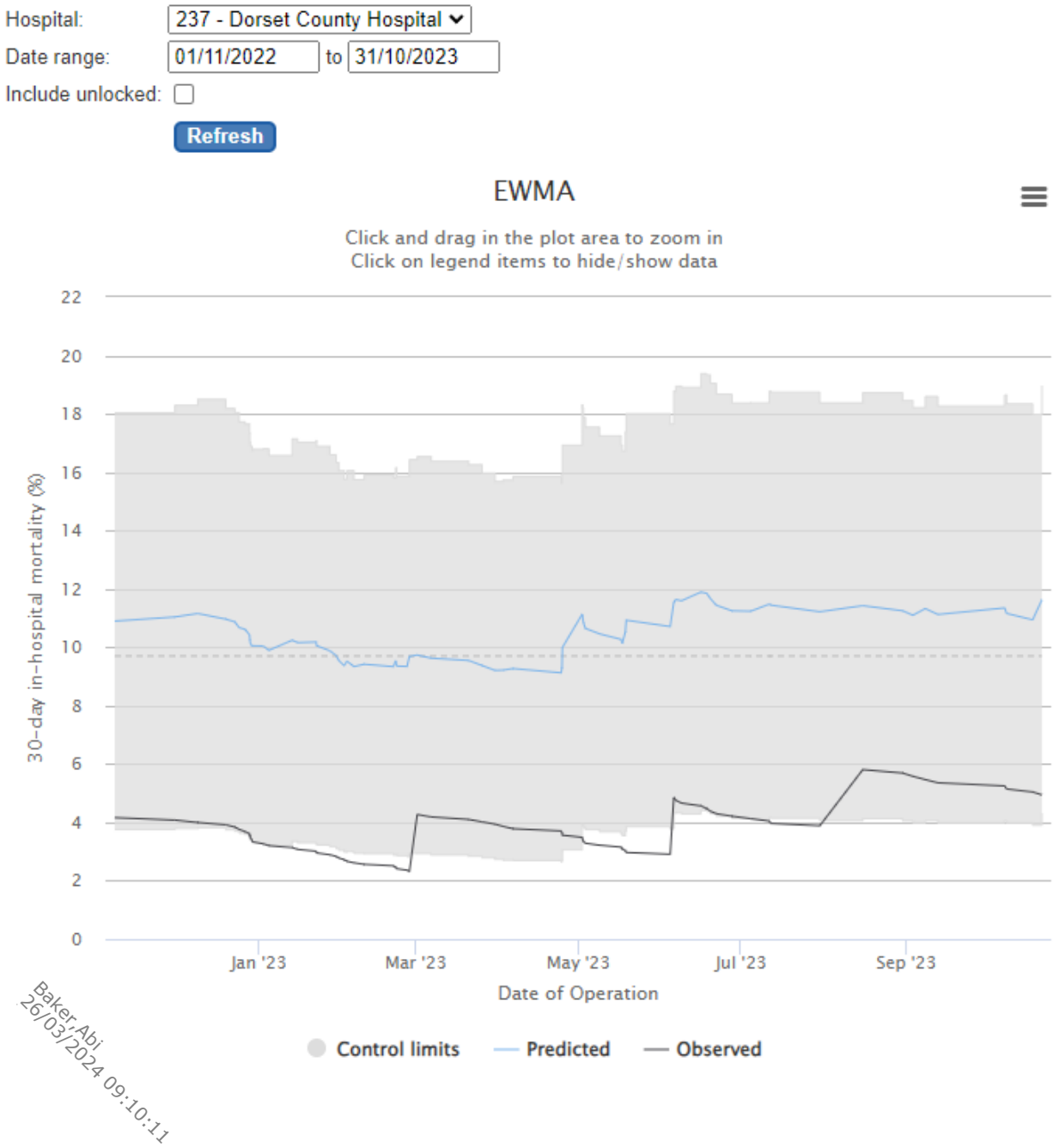
'Hours to operation' remains significantly better than the national average with mortality just below the national average.

3.5 National Emergency Laparotomy Audit

Patients admitted to hospital because of an acute abdominal problem will usually undergo an urgent abdominal CT scan in order to arrive at a diagnosis. They may then need a general anaesthetic and an 'emergency laparotomy' (open abdominal surgical exploration) to resolve the underlying problem. These are high risk procedures since time to optimise the patient's condition may not be available if deterioration is occurring.

A Exponentially Weighted Moving Average chart can be used to display near real-time in-hospital mortality within a single hospital . The chart below displays the expected range of mortality given the hospitals casemix, and the hospital's actual mortality. EWMAs can be used as a warning system for early detection of concerning changes in mortality rates. The light blue line is the 'expected mortality' percentage, the dotted line is the national average, the black line is the 'observed (actual DCH) mortality percentage, and the grey area denotes the upper and lower control limits.

The mortality percentage for DCH is approximately one third of the expected mortality and on occasions is below the lower control limit suggesting that DCH's results are 'statistically significantly' better than expected for this 12 month period.



3.6 Getting it Right First Time; reviews in Qtr 3

GIRFT are now responsible for, and primarily focusing on, recovery of waiting lists in 6 High Volume, Low Complexity (HVLC) specialties – ophthalmology, ENT, gynaecology, general surgery, urology and orthopaedics. However, this has no direct bearing on Learning from Deaths.

23.10.23 GIRFT HVLC Visit
09.11.23 ODN Surgery in Children Service Review
27.11.23 Diabetic Foot Peer Review.

Action plans for the above reviews are scheduled to be presented at the Clinical Effectiveness Committee

3.7 Trauma Audit and Research Network

DCH is a designated Major Trauma Unit (TU) providing care for most injured patients, and has an active, effective trauma Quality Improvement programme. It submits data on a regular basis to TARN which then enables comparison with other TUs. No new data has been published for the past 12 months as a result of a cyber attack and we are awaiting the recreation of the website.

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

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

In previous Learning from Deaths reports we have used data from Dr Foster but this is always several months in arrears. The latest Dr Foster data non-elective readmissions relates to the 12 months to July 2023 and shows a readmission rate of 13.1% which is below the national average of 14.0%. However internal DiiS Power BI data shows that for the 9 months to 31 December 2023 the non-elective readmission rate is 16.8% but we have no national comparator.

Original Discharge Date	Number of Discharges	Number of Emergency Re-Admissions within 30 Days	% of Emergency Re-Admissions within 30 Days of the Patient Original Discharge	Number of Emergency Re-admission within 7 Days	% of Emergency Re-admissions within 7 Days of the Patient Original Discharge
April - 2023	1731	268	15.48%	153	8.84%
May - 2023	1881	308	16.37%	169	8.98%
June - 2023	1810	303	16.74%	171	9.45%
July - 2023	1709	285	16.68%	160	9.36%
August - 2023	1840	319	17.34%	177	9.62%
September - 2023	1804	309	17.13%	177	9.81%
October - 2023	1851	285	15.40%	147	7.94%
November - 2023	1986	333	16.77%	168	8.46%
December - 2023	1922	368	19.15%	192	9.99%
Total	**16534**	**2778**	**16.80%**	**1514**	**9.16%**

3.9 National Child Mortality Database

The National Child Mortality Database (NCMD) was launched on 1 April 2019 and collates data collected by Child Death Overview Panels (CDOPs) in England from reviews of all children who die at any time after birth and before their 18th birthday.

NCMD have released data for 2023, which covers child deaths notified and reviewed up until 31 March 2023. Child death data release 2023 | National Child Mortality Database (ncmd.info)

MBRRACE data (latest report 2021) MBRRACE-UK: Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK | MBRRACE-UK | NPEU (ox.ac.uk)

No new data since Q2 LfD report.

3.10 National Perinatal Mortality Review tool

No cases for December 2023.

November 2023: There are no published reviews for Dorset County Hospital NHS Foundation Trust in the period from 30/5/2023 to 30/11/2023

There has been one case within the Maternity Incentive Scheme reporting period. All timescales were met. The case was reviewed at the DCH/UHD joint PMRT review panel and care graded as A and A – no care issues identified that affected the outcome.

4.0 QUALITY IMPROVEMENT ARISING FROM SJRs & HMG

The following themes have been identified from SJRs / discussions at HMG and are being translated into quality improvement projects:

a) An ED audit is being planned to review the quality of documentation of care within AGYLE in order to improve clerking & communication generated from the auto populated ED discharge letter.

5.0 MORBIDITY and MORTALITY MEETINGS

Morbidity and mortality meetings are continuing across the Trust, with minutes collated by Divisional Quality Managers. Dates of these meetings are reported to and reviewed by the Divisional Clinical Governance meetings. Following M&M meetings any learning and actions identified from the cases discussed are highlighted and information collated on an overview slide which is shared at their monthly Care Group meeting and the Divisional Business & Quality Governance meeting. Records of action plans and learning identified are available across departments.

Quality of clerking remains a recurring theme for improvement. Improving clerking, admission diagnosis and discharge summaries will also support clinical coding.

Examples of learning from M&M:

Anesthetics: Important reminder of drug checks and knowledge of alternative drugs when supply issues

Paediatrics: Difficult IV access pathway in progress; Reminder to check documentation of clerking / management plans if someone writes on your behalf.

6.0 LEARNING FROM CORONER'S INQUESTS Q3

DCH has been notified of 16 new Coroner's inquests being opened in the period 01 October 2023 – 31 December 2023.

11 inquests were held during Quarter 3. 7 inquests were heard as Documentary hearings, not requiring DCH attendance. 1 required the clinician to attend Court in person. 3 required attendance remotely from the DCH 'virtual courtroom' (in THQ) using Microsoft Teams. The Risk Team no longer have a dedicated Virtual Court Room, due to office re-configuration. 2 pre-Inquest review hearings were held.

We currently have 44 open Inquests. The Coroner has reviewed all outstanding cases to decide whether any can be heard as documentary hearings. No Regulation 28 (Preventive Future Death Notices) have been given during this quarter.

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

Learning Identified: Urology to discuss appropriateness of an early discharge. Wider learning around the need for clinicians to ensure that the family are aware that a DNAR (Do Not Attempt to Resuscitate) has been put in place. To encourage earlier discussions with family, to ensure they are aware of early signs of deterioration.
DCH has a task group working on making improvements to pathways for Treatment Escalation Plans (TEP) and DNAR recommendations.

7.0 LEARNING FROM CLAIMS Q3

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

Claims pattern Quarter 3 FY 23/24.

New potential claims	11
Disclosed patient records	30 (15 claims, 15 disclosures to the coroner)
Formal claims	14 clinical negligence, 0 employee claim
Settled claims	3 clinical negligence, 0 employee claims
Closed - no damages	21 clinical negligence, 0 employee claims

8.0 SUMMARY

The latest SHMI publication from NHS England is for the period October 2022 to September 2023. The Trust's figure is 1.1226, which is within the expected range using NHS England's control limits.

The DCH internal prediction is that SHMI will remain at around this level next month and then fall gradually over the following three months to around 1.0700 - however this depends on the coding department being able to submit the annual HES return on time. We are aware that our data continues to be adversely influenced by resource challenges within the Coding Department and a possible under-reporting of 'sepsis' in the written medical record. An impact on SHMI is expected in due course. The clinical coding risk is rated as high on the risk register. The team are presenting an SBAR to the executive team with options for risk mitigation.

No other metrics of in-patient care suggest that excess mortality is occurring at DCH. Nevertheless, the Hospital Mortality Group remains vigilant and will continue to scrutinise and interrogate all available data to confirm or refute this statement on a month by month basis. At the same time internal processes around the completion and recording of SJRs, M&M meetings, Medical Examiners and Learning from Deaths are now well embedded and working effectively within the Divisional and Care Group Teams.

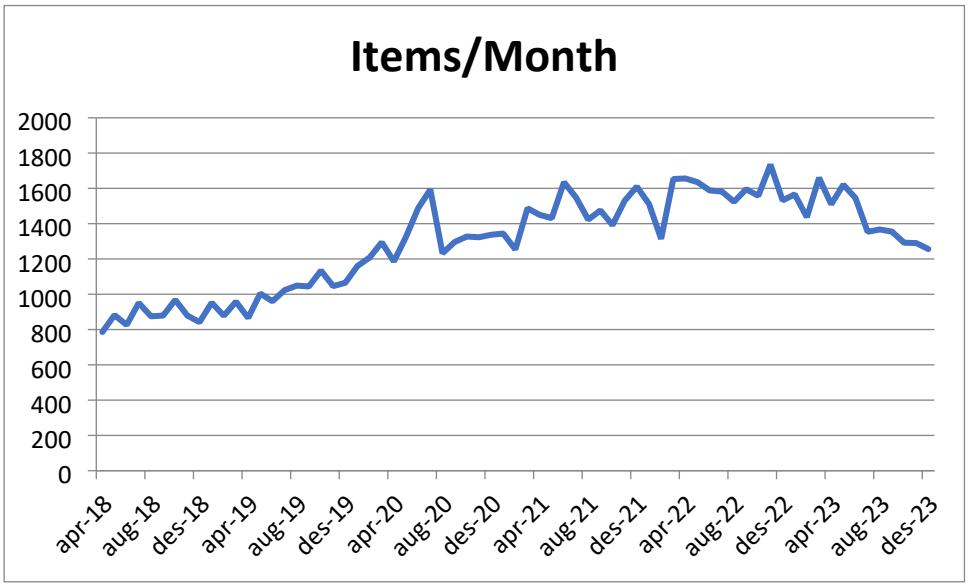
Performance Report

Andrew Harris
Superintendent Pharmacist
January 2024

Key Performance Indicators (KPIs)

	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23
Total Number of Customers per Month	205	215	196	143	135	116	126	138	133
Total Items Dispensed	1510	1621	1545	1354	1367	1355	1292	1290	1256
Average Items/day	83.9	81.1	70.2	64.5	62.1	64.5	58.7	58.6	66.1
No. of same day Prescriptions	291	342	333	181	273	179	158	210	196
No. of Advance Prescriptions	469	521	463	492	383	466	516	434	429

Activity levels from April 2018 to current:



Fortuneswell Pharmacy has returned to cancer only related activity which is reflected in the reduced activity from August 2020, though cancer related activity is now climbing.
A review of dispensing activity was undertaken in June 2023 in conjunction with the Chief Pharmacist and Lead Cancer Nurse to identify activity that could be relocated elsewhere (main hospital pharmacy or community pharmacy) to manage the increasing workload.

All contractual KPIs year to date are green, with two exceptions:
On Wednesday 19th July, pharmacy were unable to provide a responsible pharmacist for the full day to cover annual leave. No responsible pharmacist was signed in for the period 10:00-12:30.
In August, the performance on day in advance prescriptions dropped to 86.99%. This again is primarily related to leave, with the dispenser being sick for one week, followed by the superintendent being on annual leave for 2 weeks. In both cases, cover from the Trust pharmacy did not cover the full working hours of the absent staff member.

Performance measure	Key Performance Indicator	Target performance	Green	Amber	Red	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep–23	Oct-23	Nov-23	Dec-23
Rate of dispensing errors detected post issue	Number of errors made per total volume of prescriptions dispensed that have LEFT the department	<2.0%	<1.0%	1.0-2.0%	>2.0%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Near Miss Monitoring	Number of errors made per total volume of prescriptions dispensed that have NOT LEFT the department	<2.0%				0.93%	0.80%	0.97%	0.81%	1.02%	0.59%	1.55%	1.16%	0.96%
Availability of service	Responsible Pharmacist Availability	0	0 to 45 mins	45 to 90 mins	> 90 mins	0	0	0	150 mins	15 mins	0	0	0	0
Availability of medicines	The % of prescription items dispensed in full at the first time of presentation excluding manufacturer can't supply	98%	100% - 98%	97.9% - 96%	< 95.9%	99.60%	99.44%	99.35%	99.63%	99.12%	99.48%	99.69%	99.46%	99.60%
MHRA Recall Assurance	100% of all SABs alerts, MHRA and Company-Led recalls are managed in accordance with Class status	100%				100%	100%	100%	100%	100%	100%	100%	100%	100%
All Mosaiq advance prescription preparedthe day in advance of collection	The completion time should bethe day in advance of collection/ delivery to chemotherapy nurses.	>90%	100% - 90%	89.9% - 80%	<80%	95.9%	91.6%	92.0%	98.0%	86.9%	97.0%	99.0%	96.5%	98.6%
The waiting time for dispensing prescriptions, during a monthly period shall be: (i) 30 minutes or less in respect of 95% of all prescriptions; and (ii) 20 minutes or less in respect of 80% of all prescriptions	The time taken for a patient to wait for their prescription from the time they present it to the Pharmacy.	(i) 30 minutes or less in respect of 95% of all prescriptions (ii) 20 minutes or less in respect of 80% of all prescriptions	For (i) Greater than or equal to 95% For (ii) Greater than or equal to 80%	For (i) 80% - 94.9% For (ii) 65% - 79.9%	For (i) Less than 80% For (ii) Less than 65%	(i) 99.5% (ii) 98.1%	(i) 99.1% (ii) 95.9%	(i) 99.5% (ii) 97.2%	(i) 99.1% (ii) 99.1%	(i) 97.1% (ii) 97.1%	(i) 99.1% (ii) 97.2%	(i) 98.9% (ii) 95.9	(i) 97.9% (ii) 95.8%	(i) 100% (ii) 98.4%

Index of customer satisfaction	The patient overall satisfaction level		100% of Customers to be offered Customer Feedback Survey Monthly Reporting on KPIs to record; Total Number of Customers per Month Completion / Uptake Rate (%)			100 %	100 %	100 %	100 %	100 %	100 %	100 %	100 %	100 %
Number of complaints	The number of upheld complaints		1 or fewer complaints per quarter	2 or fewer complaints per quarter	Over 2 complaints per quarter	0	0	0	0	0	0	0	0	0
Number of non-agreed non-formulary items supplied	Number of items that appear on total non-formulary supply report	0%	0% - 0.049%	0.05% - 0.099%	> 0.1%	0	0	0	0	0	0	0	0	0
Controlled drug management	Correct procedure against SOPs followed at all times	100%	No Tolerance			100 %	100 %	100 %	100 %	100 %	100 %	100 %	100 %	100 %
Provision of financial, clinical and management information	financial, clinical and management information to be provided within 5 working days following the end of the previous month	100%	100% - 99%	98.9% - 97.5%	< 97.5 %	100 %	100 %	100 %	100 %	100 %	100 %	100 %	100 %	100 %
Waste/Expiry management *	Waste Costs below £200 per month - Stock waste to be managed	<£200	<£200			£14.84	£0.01	£0.00	£18.29	£0.00	£0.00	£0.00	£35.45	£0.14

	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23
Month End Stock Value £k (i/c VAT)	301	300	298	288	282	280	271	266	263

Incidents
No dispensing errors have left Fortuneswell Pharmacy in financial year 2023/24

Complaints
Nil

Keys Risks

- The original business was for a dedicated Cancer Services Outpatient Pharmacy with an estimated dispensing activity of ~700 items per month. Activity has steadily increased over the two year period and is now 1,400 per month, double the anticipated level of activity in the original business case. There is now a risk the Outpatient Pharmacy would no longer meet the General Pharmaceutical Council (GPhC) premises standards if re-inspected.
- Significant level of vacancies within the DCH Clinical Pharmacy Service impacting on ability of Superintendent Pharmacist to take Annual Leave. This also poses a potential for service disruption (reduced opening hours) in the absence of the superintendent pharmacist (both planned and unplanned).
- HM Treasury commenced a consultation in August 2020 on "VAT and the Public Sector: Reform to VAT refund rules". This has significant implications for the Public sector including the NHS which if the recommendation is implemented, would permit full refunds of the VAT incurred on all goods and services during the course of non-

business activities (full refund model). This represents a significant risk to the long term sustainability of the subsidiary company.

Working Together

Dorset County Hospital NHS Foundation Trust Dorset HealthCare University NHS Foundation Trust

Working Together Programme

OPTIONS APPRAISAL - FUTURE ORGANISATIONAL FORM

DCH Board of Directors, Part I – 27 March 2024
DHC Board of Directors, Part I – 03 April 2024

Author	Sally O'Donnell
SROs	Dawn Dawson, Nick Johnson

Prior Discussion

Job Title or Meeting Title	Date	Recommendations/Comments
Working Together Programme committee in common	14 December 2023	Recommended for approval
DCH Board of Directors Part 2	31 January 2024	Approved
DHC Board of Directors Part 2	07 February 2024	Approved

Executive Summary

An evaluation of four options for the future collaboration arrangements between the two Trusts has been undertaken as follows:

Option 1: Unwind – revert back to two separate organisations

Option 2: Working Together Programme (WTP) as per current position

Option 3: Federated Model - with shared executive and back office teams, joint strategies, but retention of separate Boards and statutory responsibility

Option 4: Merger – a single new statutory organisation replacing DCH/DHC

The options appraisal has been

- developed by the Working Together Programme Board
- considered at two Joint Executive Management Team meetings in December, when the approach to evaluating the options was agreed, and the preferred Option 3, the federated model, was recommended as the best strategic fit for the foreseeable future
- endorsed by the Committee in Common at its meeting on 14 December 2023, who recommended, subject to a decision by both Trust Boards, that we work towards a federated model, with further work being undertaken to develop that model.

Characteristics of the federated model include:

- each Trust retains individual sovereignty, accountable to NHSE and regulated by CQC
- shared executive team
- shared culture and sense of governance

- shared back office services, where this adds value and makes sense - joint strategies, - individual Boards hold Trusts to account - joint structures support new models of care Each Trust could retain separate identity, or the federation could have a single shared identity, eg a logo or form of words, but each Trust might then refresh its individual vision, values and identity to support this. This, and other details of the model would be developed in the next step, subject to the Board decision.	
Recommendation	The Board of Directors has previously approved this options appraisal. It is presented to this public Board meeting for transparency.

Working Together

Dorset County Hospital NHS Foundation Trust

Dorset HealthCare University NHS Foundation Trust

Committee in Common
14 December 2023

Future of Working Together
Options Appraisal

Executive SROs	Dawn Dawson and Nick Johnson
Author	Sally O'Donnell
Purpose of Report	This paper evaluates the options for future operational arrangements between Dorset County Hospital NHS Foundation Trust (DCH) and Dorset HealthCare University NHS Foundation Trust (DHC). The Working Together Programme Board at their meeting on 21 November 2023, supported the options appraisal process proposed in this paper. Executives received a presentation on 28 November, which was updated following their feedback. On 5 December 2023 the joint Executive Management Team reached a consensus to recommend to this committee that the two organisations should continue to work together within a federation model.
Decision required	The Committee in Common are asked to endorse this recommendation

1 EXECUTIVE SUMMARY

1.1 The Working Together Programme has been established for over a year. This paper evaluates the options for operational arrangements between Dorset County Hospital NHS Foundation Trust (DCH) and Dorset HealthCare University NHS Foundation Trust (DHC) going forward. Executives from both Trusts have contributed to the evaluation.

1.2 The report considers four options:

Option 1: Unwind – revert back to two separate organisations

Option 2: Working Together Programme (WTP) as per current position

Option 3: Federated Model - with shared executive and back office teams, joint strategies, but retention of separate identity, Boards and statutory responsibility

Option 4: Merger – a single new statutory organisation replacing DCH/DHC

1.3 Executives from the Trusts have evaluated the options, and at their joint meeting on 5 December, agreed to recommend that the Trusts continue to work together, moving towards a federated model.

2 BACKGROUND

2.1 By 2022, the pandemic had demonstrated what could be achieved by bringing services together and expediting innovation to improve care. NHS England[1] had noted the growing body of evidence pointing to the benefits of integrated care. A strong commitment to collaboration already existed in Dorset. In addition, DCH and DHC both had a substantive CEO vacancy and Chair appointments due.

2.2 Within this context, recognising a potential opportunity:

- March 2022, the Boards agreed to explore ways in which they might work more closely together and commissioned Deloitte to assist with this.
- September 2022, they agreed to share a Chief Executive and Board Chair.
- Quarter 1, 2023/24, the joint CEO and Chair were in post, and workstreams to deliver the benefits were established.
- Quarter 2, 2023/4, an external review was undertaken and in September 2023, the Working Together Programme also undertook a 12-month review, which included feedback from stakeholders. Both identified the need to clarify the future model for collaboration.

2.3 Throughout, the key drivers for change have been:

- To improve population health
- To improve our patients' experience of healthcare
- To deliver sustainable healthcare

2.4 This paper takes into account these key drivers, the twelve-month review and feedback from key stakeholders and examines the options for continuing to work together.

3 STRATEGIC CASE

3.1 In August 2021, NHSE published guidance on the 'critical role provider collaboratives would play in helping systems deliver better care'. Through collaboratives, NHSE identified that providers were delivering significant benefits for patients, that development of shared rotas, digital capabilities, and innovative workforce models were improving the resilience of services, and the consolidation of back-office functions was realising millions of pounds of substantial savings that could be reinvested to improve patient care.

3.2 In 2022, working with both the two Trusts, Deloitte identified that people's health needs are increasingly complex and can't be resolved in mental health or physical health

[1] NHSE August 2021: Working Together at Scale

silos, or acute, community or primary care silos. Therefore, services need to integrate and wrap around the individual.

3.3 Deloitte set out the evidence base for collaboration in the NHS:

- **Promoting better population level health outcomes** – by enabling the NHS and partners to move downstream from treating ill-health to promoting better health
- **Reducing health inequalities** – including reducing variation and standardising service
- **Reducing clinical variation and improving quality of care through joined up service delivery** – ie better integrated care, consistency, reduced confusion, delay and gaps in service delivery
- **Broadening the service offer to local people** – by taking a joined up approach to services, resources and delivery, collaboration can increase the range of services available to patients
- **Increasing resilience of local services** – making services more sustainable, increasing availability of services, that on their own Trusts may not be able to provide consistently.

3.4 Deloitte noted the history of collaboration between the two Trusts (along with other organisations in Dorset) and how they were already working together in delivery of services eg Stroke, Musculo Skeletal, Urgent Care, Research and Development.

3.5 Following engagement with clinicians, staff, public and other key stakeholders, Deloitte made a compelling strategic case for strong partnership, brought together under single leaders, that was supported by both Boards in September 2022.

3.6 National and local context leads to the alignment of DCH and DHC strategic directions. Across the NHS, patients face long waiting times; recruitment and staff retention are increasingly challenging; resources are stretched. Locally, the Dorset Integrated Care System (ICS) has clear objectives that NHS providers have signed up to. The Dorset Integrated Care Partnership has published its strategy. The Dorset Integrated Care Board has also recently published its Joint Forward Plan. DCH and DHC will work with NHS partners to support this plan.

3.7 Both Trusts face similar performance challenges in ever more constrained economic circumstances. It could be argued that to not collaborate could increase the risk of unmanaged demand, patient care being disjointed and inefficient, safety of patients with physical and mental health needs being compromised, increased workforce shortages and the Trusts being financially unsustainable.

4 CURRENT SITUATION

4.1 The organisations have commenced a programme of collaborative working under the WTP. Matthew Bryant commenced as Chief Executive of both trusts in April 2023 and David Clayton-Smith as Chair in May 2023 and they have been leading the two organisations in developing a clear common purpose and innovative solutions for the current challenges. The 12-month review of the WTP noted the following achievements:

- Governance arrangements in place include:
  - Memorandum of Understanding and Data Sharing Agreement
  - WTP Board oversees and directs the programme's clinical transformation flagship programmes; showcase teams that are already working together; and holds enabling services to account in supporting the delivery of the WTP
  - WTP Committee in Common meets bimonthly
  - joint executive team meetings have been established
  - joint Board workshops and joint Senior Leadership meetings
- Four clinically led flagship transformation programmes have been established to design new models of care to significantly improve care pathways for:
  - Frailty
  - Diabetes
  - Children and Young People Mental and Physical Health Parity
  - Admission avoidance
- Clinical case studies are show-casing what can be achieved when teams bridge organisational boundaries to improve patient pathways, whilst also identifying the blocks that, if removed, would make this easier for other teams to follow.
- An enabling programme comprising non-clinical services has been established to support delivery of the flagship proposals.
- A review of executive roles has been undertaken to assist the forward plan for an executive structure that will support the two organisations to work together. In the meantime, recruitment is underway for a joint Director of Corporate Affairs and some interim roles operate across both organisations, i.e. Chief People Officer, Estates Director.
- The IT firewall has been updated to allow accounts and mailboxes at DCH to move into the cloud to begin the process of improving sharing of access to Outlook.

4.2 In the first twelve months, since the Boards agreed to work together, our case studies and early work have already demonstrated that working together can

- **improve patient experience**; for example, we have heard how a patient in the chronic pain service has personally benefited from a more integrated approach; MSK patients no longer have a series of appointments but can be seen by a range of professionals in one visit; patients with a learning disability and their carers are feeling more supported when they have an acute appointment or admission.
- **reduce waiting lists**; for example, the pulmonary rehab team have shared data showing reductions in the number of patients waiting for assessment, from 650 in June 2022 to 350 in August 2023.
- **shorten lengths or stay**; the stroke/neuro joint project has shown a reduction in acute length of stay and in-patient rehabilitation.
- **reduce costs**: savings are already being achieved in 2023/24 through shared CEO and Chair appointments, interim Chief People Officer, and Director of Estates as well as savings identified through procurement, eg audiology devices and equipment.
- **improve experience for staff**; for example, MSK staff feel their input into redesign of services has been valued and that they are able to better explain x-ray results to their patients through learning achieved by working alongside orthopaedic colleagues; in our case studies, the feedback has been very positive

about working together, sharing expertise and learning, increasing the breadth of knowledge in the team and supporting each other.

4.3 The 12-month review challenged the Trusts to consider whether the WTP is currently sufficiently ambitious in its approach to tackling key risks to both organisations, in terms of their capacity to deliver sustainable, safe, quality healthcare, within the context of unprecedented demand, workforce challenges and financial constraints.

4.4 Arising from the 12-month review, a forward plan has been developed and endorsed by the WTP Board. This plan is ambitious, moving from the current achievements delivered by the programme to a form that does even more together under shared leadership, to maximise the benefits of working together, whilst continuing to preserve the identity of the two organisations.

5 OPTIONS TO BE ASSESSED

5.1 During the review process various engagement opportunities including feedback from staff, stakeholders, Board members, the Senior Leadership Group, and Governors, have indicated four potential options for consideration for the future. These are described as:

Option 1: Unwind ie revert to two separate organisations with separate Chair and CEO

Option 2: Working Together Programme as per current position

Option 3: Federated Model - with shared executive and back office teams, joint strategies, but retention of separate identity, Boards and statutory responsibility

Option 4: Merger – a single new statutory organisation replacing DCH/DHC. This would have a new identity.

6 OPTIONS EVALUATION

6.1 Table 1 provides a SWOT analysis of the 4 options.

6.2 Table 2 assesses the relative costs and financial benefits of each option.

6.3 Table 3 scores each of the options against a set of weighted criteria

6.4 Back in 2014, following recognition that the variation in the quality of health and adult social care was unacceptable, the Dalton Report *Examining new options and opportunities for providers of NHS care* said ‘There are no ‘right’ or ‘wrong’ organisational forms – what matters is what works.

Table1: The Options

Options	Key Features	SWOT Analysis		Comments
Option 1 Unwind – revert back to two separate organisations	· Each Trust retains individual sovereignty, accountable to NHSE and regulated by the CQC · Appointment of CEO and Chair per Trust · Separate governance arrangements · Shared ICB objectives	**Strengths** Reduction in meetings related to working together One organisation's weaker financial position will not impact on the other Retain individual organisational identities Able to prioritise organisational objectives Able to work together without having to create a formal shared identity (brand)	**Weaknesses** Missed opportunity to deliver recognised benefits to patient care from increased integration Potential distraction during CEO/Chair appointments process. Reduced focus on integrated working Lost opportunity to work together in delivery of ICB priorities and seamlessness of care Loss of savings through joint appointments and shared costs	Could unwinding the two organisations potentially trigger a further acute services review?
		Opportunities Potential to reduce duplication of effort in transformation of services Able to continue working together as ICS partners	**Threats** Sustainability of one or both organisations Risk to reputation Potential impact on population health and health inequality, with failure to adequately transform patient pathways, leading to increase in demand	

Option 2 Working Together Programme continues	· Each Trust retains individual sovereignty, accountable to NHSE and regulated by the CQC · Joint CEO/Joint Chair · Some joint senior positions	**Strengths** Positive impact on seamless care delivery, workforce and resources, as demonstrated over past 12 months No liabilities or legal commitments Easy to set up Flexible Aligned decision-making	**Weaknesses** Insufficient change to impact on key organisational risks relating to quality, workforce and financial sustainability Lack of clarity to staff, patients and other stakeholders about organisational identity Programme not embedded in Business as Usual Minimal obligation between organisations, in terms of input/effort	Is there an argument that this could bring the west into sharper focus and detract from essential development in the east. Would this arrangement impact on the two acute organisations working together effectively?
		Opportunities Continue to manage under programme management approach with agreed projects continuing to align the organisations and deliver the benefits of integration to patient care	**Threats** Potential lost opportunity to progress joint strategies and the 12-month forward plan of the WTP. DHC staff working in the east of the county and other stakeholders in the east may not support the approach	

<table>
<tr>
<td rowspan="2">Option 3
Federated Model</td>
<td rowspan="2">· Each Trust retains individual sovereignty, accountable to NHSE and regulated by the CQC
· Each Trust can retain separate identity, although
Federation can have a single identity
· shared executive team
· shared culture and sense of governance
· shared back office services
· joint strategies,
· individual Boards hold Trusts to account
· joint structures to support new models of care</td>
<td>Strengths
Maximises the benefits of integration without the distraction/cost of a merger.
Legally binding agreement eg on managing financial flows, making decisions, jointly, sharing staff and other facilities
Trusts work together to deliver ICB priorities
Shared focus on key organisational risks
Flexible recruitment/ development opportunities to address workforce constraints; staff can move across the federation
Shared culture supports effective, long-term collaboration
Stronger sense of ‘joint’ identity</td>
<td>Weaknesses
Lack of clarity to staff, patients and other stakeholders about organisational identity
Could this be seen by staff and stakeholders as a further step towards eventual merger?
The federation will be as strong as the weakest partner
Lack of focus on risks peculiar to each of the organisations e.g. A&E waits, Mental Health out of county placements
Can create challenges in the collective management of teams and services spanning both organisations
Each Trust remains a legal entity and as such, an individual data controller[2]</td>
<td rowspan="2">NHS Trusts are free to enter into a Federation under s56 H&C Act 2022 – which provided for providers/ system partners to work together with new options for joint decisions.
Federated Trusts need formal shared identity – is this the right way forward?
Arrangements must fall short of merger by default</td>
</tr>
<tr>
<td>Opportunities
Potential to reduce costs through shared back office services and joint exec posts
Increase organisational resilience
Bring WTP into Business as Usual model
Build on economies of scale
Trusts can design collaboration model to meet the need, promoting openness, trust, risk and responsibility sharing
Contractual obligation between organisations, in terms of input/effort
Federation can focus on areas likely to have most benefit eg shared back office or a</td>
<td>Threats
DHC staff working in the east of the county and other stakeholders in the east may not support the approach
Would this impact the acute to acute relationships?
Is there an argument that a better model would be a fully federated model across the system or two (one east and one west to match place based direction of travel?)</td>
</tr>
</table>

[2] Data Protection Act 1998, common law confidentiality requirements and the Health and Social Care (Safety and Quality) Act 2015

		clinical focus eg virtual wards.		
Option 4 Merger – a single new statutory organisation replacing DCH/DHC	New organisation replaces DCH and DHC	**Strengths** Reduction in number of NHS Trusts in Dorset Potential to positively impact on relationship with UHD for the benefit of system-working Contractual obligation between both organisations, in terms of input/effort Removes cumbersome boundaries to integrated/flexible working Reduction in bureaucracy Single data controller	**Weaknesses** Short and medium-term significant distraction during merger process High cost of merger process which will require SOC / FBC approval from the CMA[3] and oversight of significant dedicated project team.	Although mergers can be successful: 2015: University of Bristol found that in 102 mergers, productivity remained the same, waiting times increased and financial deficits increased. Kings Fund[4] found • avr cost >£150m per merger; • lack of evidence that mergers lead to more sustainable organisations; • not always sufficient management capacity to deliver. NB successful SOC for merger of 4 Trusts providing community and mental health services in H&IoW
		Opportunities Potential to reduce costs through shared back office services and joint executive appointments Potential to increase organisational resilience Potential in the long term to deliver improved decision-making, seamless care, financial savings.	**Threats** Merged organisation may fail to deliver due to distraction and cost of process Risk of negative impact on quality, safety and organisational reputation (as experienced during previous DHC merger) May result in increased turnover of staff which would result in loss of experience to both organisations. This would be going in a direction which has consistently been denied by senior leaders over a 12 – 18 month period	

[3] Competition and Markets Authority
[4] Kings Fund Report: Foundation Trust and NHS Trust Mergers 2015

6.5 Whilst improving our patients' experience of healthcare and improving population health have remained the priorities for the Working Together Programme, in reaching a decision about future organisational format the relative costs/financial benefits of each of the options is an important consideration. Table 2 illustrates the financial assessment in relative terms.

Table 2: Financial Assessment

Option	Cost	Financial benefit
Unwind	£££	0
Working Together Programme	£	££
Federated Model	£	£££
Merger	££££	££££

6.6 Table 3 provides scored criteria for the evaluation of the options.

6.7 These criteria and scores have been considered by the executive team, and whilst there was some inevitable variation in scoring, relative scores were supported

6.8 Option 3, the federated model, scored highest in the evaluation process. The key characteristics being as follows:

- each Trust retains individual sovereignty, accountable to NHSE and regulated by the CQC
- each Trust can retain separate identity, although the Federation can have a single identity
- shared executive team
- shared culture and sense of governance
- shared back office services
- joint strategies,
- individual Boards hold Trusts to account
- joint structures support new models of care

6.9 Following discussion, the joint executive team agreed that this was the best strategic fit for the organisations for the foreseeable future.

Table 3: Scoring the Options

Evaluation Criteria (next 3-5 years)	Weight	Option 1		Option 2		Option 3		Option 4		Notes
	1-3	Score (1-5)	Weighted total	Score (1-5)	Weighted total	Score (1-5)	Weighted total	Score (1-5)	Weighted total	
Impact on quality and safety of care	3	2	6	3	9	5	15	2	6	Opt4, lower than Opt3 - short-term distraction & longer-term diluted focus on specific areas due to loss of statutory board focus
Impact on patient experience	3	2	6	3	9	5	15	2	6	Opt4, lower than Opt3 - short-term distraction & longer-term diluted focus on specific areas due to loss of statutory board focus
Impact on ICB priorities	2	2	4	3	6	4	8	3	6	Opt1 is step back from aims and priorities; Opt2 aligned; Opt3 increases ability to influence & drive forward, Opt4 creates distraction from ICB priorities
Impact on support from Partners for collaboration	2	3	6	4	8	4	8	3	6	Partners likely to prefer current programme or federated model rather than going back to separation or merger and impact that will have
Reduction in unwarranted variation in outcomes and access	2	2	4	3	6	4	8	2	4	Opt 3 creates capacity while retaining connections and localities. Opt 4 creates distraction and scale of single trust will create greater distance from communities and localisation
Reduction in health inequalities	2	2	4	3	6	4	8	2	4	Similar to above rationale
Information sharing supports seamless service delivery	2	1	2	3	6	4	8	5	10	No barriers to info sharing in merger
Impact on improving workforce recruitment and retention	2	2	4	2	4	4	8	4	8	Op 2,3 and 4 all providing opportunity to consolidate recruitment approaches and improve environment. Op4 risk of disconnect for staff from org, but also easy for staff to move/train etc under one org structure
Impact on efficient use of resources	2	1	2	2	4	4	8	4	8	Opt 3 and 4 both allow more effective deployment of resources, op 4 greater opp but off-set by opportunity cost of org change.
Impact on key organisational risks	2	2	4	3	6	4	8	3	6	Closer working provides best opp to address org risk. Balance to be found between collab work and specific org risks. Op 4, org change will create greatest distraction from addressing org risks

Evaluation Criteria (next 3-5 years)	Weight	Option 1		Option 2		Option 3		Option 4		Notes
	1-3	Score (1-5)	Weighted total	Score (1-5)	Weighted total	Score (1-5)	Weighted total	Score (1-5)	Weighted total	
Strategic fit, including 5 pillars, Place	2	1	2	3	6	5	10	3	6	Collaboration aligned to ICP and ICB strategies. Op3 increases collab without distraction of Op 4 which will force inward focus
Ability to support other partnerships incl primary care/out of hospital, acute	2	1	2	3	6	5	10	3	6	Op 3 increases strength to lead and influence partnerships and maintain flexibility to pursue multiple partnerships e.g. acute, primary care etc
Deliverability of option	2	3	6	5	10	4	8	2	4	Op 2 easiest, effectively what we are doing, Op3 an evolution of current position. Op 1 and 4 biggest structural changes required. Op 4, greatest amount of energy and capacity required.
Total		24	**52**	40	**86**	56	**122**	38	**80**	

Options:

1: Unwind – revert back to two separate organisations
2: Working Together programme approach continues
3: Federated Model - with joint executive, joint strategies, shared services, but retention of Boards and statutory responsibility
4: Merger – a single new statutory organisation replacing DCH/DHC

Score: 1 (negative/least impact) ⟷ 5 (positive impact)

7 RECOMMENDATION

7.1 Option 3, the federated model, with characteristics as described in section 6 above, is the collaboration model recommended by the joint executive team.

8 ACTION REQUIRED

8.1 The Committee in Common are asked to endorse this recommendation.

Report Front Sheet

1. Report Details			
Meeting Title:	**Board of Directors, Part 1**		
Date of Meeting:	**27 March 2024**		
Document Title:	**Register of Interests and Register of Gifts and Hospitality**		
Responsible Director:	**Jenny Horrabin, Director of Corporate Affairs**	Date of Executive Approval	
Author:	**Trevor Hughes, Head of Corporate Governance**		
Confidentiality:	Not confidential		
Publishable under FOI?	Yes		
Predetermined Report Format?	No		

2. Prior Discussion		
Job Title or Meeting Title	**Date**	**Recommendations/Comments**
Risk and Audit Committee	18 March 2024	Noted

3. Purpose of the Paper	To receive and note for information and assurance.							
	Note (✓)	✓	*Discuss (✓)*		*Recommend (✓)*		*Approve (✓)*	

4. Key Issues

The Trust is obliged to comply with national guidance published in 2016/17 regarding declarations of interests and the need to maintain a register of gifts and hospitality received by staff.

Declarations of Interest Report

All staff are required to notify any interests that they hold. In particular, decision making staff are required to declare any interests on an annual basis. Decision making staff are defined as those staff that are:

- Executive directors or equivalent decision makers responsible for spending tax-payers money
- Members of advisory groups
- Banded 8a or above
- Administrative or clinical staff with the power to enter into contracts or commission goods and service.

For the financial year 2023/24, declarations were received from 294 (129 in 2022/23) staff out of the 462 (423 in 2022/23) who are required, under the criteria above, to make a declaration. This includes members of the Board of Directors. Of the 294 staff that made a declaration, 64 staff (18 in 2022/23) declared an interest and 230 (118 in 2022/23) had nothing to declare. This represents a significant improvement in compliance from 2022/23.

Staff who are required to make a declaration have received an email from the Electronic Staff Record (ESR) system asking them to make or review their declaration, and a message has been published in the weekly Staff Bulletin. A reminder email will be sent from ESR directly to those individuals concerned and a general reminder will also be published in the Weekly Bulletin.

	A summary of the declarations held on ESR is attached as appendix one. **Gifts and Hospitality Report** Revisions to the Conflicts of Interest (standards of Business Conduct) for Trust Employees Policy were approved in July 2021. The policy makes clear the requirement for any gifts or hospitality received by staff to be notified via line management arrangements to the Corporate Governance team who will maintain the central record. There were two declarations made for the receipt of gifts or hospitality during the financial year 2023/24 relating to the costs of training data analytic staff (c.£5,000) and flights and accommodation (c. £2,000) to enable training in recently purchased intensive care equipment. The small number of sponsored events attended such as meetings, training and conferences is in part due to the limited capacity of staff due to operational pressures to attend. The Corporate Governance team will continue to promote the declaration of gifts and hospitality in the coming months to ensure greater compliance with the Conflicts of Interest (standards of Business Conduct) for Trust Employees Policy for the financial year 2024/25.
5. Action recommended	The Board is asked to: **NOTE** the note the report, significant improvement in the number of staff recording their interests and the continuing action to promote staff awareness of the need to submit declarations of interests and gifts or hospitality received.

6. Governance and Compliance Obligations				
Legal / Regulatory Link		**Yes**		Failure to comply with the guidance may result in actions being enforced on the Trust. Compliance with guidance on the receipt of gifts and hospitality and protects decision makers and those with responsibility for authorising public body expenditure.
Impact on CQC Standards		**Yes**		An effective governance process for the management of staff interests and the receipt of gifts and hospitality supports compliance with the Trust's provider license and registration with the CQC.
Risk Link		**Yes**		Effective management of declared interests supports risk mitigation and compliance with the Trust's Standing Financial Instructions.
Impact on Social Value			**No**	If yes, please summarise how your report contributes to the Trust's Social Value Pledge
Trust Strategy Link		**How does this report link to the Trust's Strategic Objectives?** *Please summarise how your report will impact one (or multiple) of the Trust's Strategic Objectives (positive or negative impact). Please include a summary of key measurable benefits or key performance indicators (KPIs) which demonstrate the impact.*		
Strategic Objectives	People			
	Place			
	Partnership			
Dorset Integrated Care System (ICS) goals		**Which Dorset ICS goals does this report link to / support?** *Please summarise how your report contributes to the Dorset ICS key goals.* *(Please delete as appropriate)*		

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

Minutes of the meeting of the Part 1 Public ICB (ICB) Board of NHS Dorset
Thursday 11 January 2024 at 10am
Board Room at Vespasian House, Barrack Road, Dorchester, DT1 1TS
and via MS Team

Members Present:		
	Jenni Douglas-Todd (JDT)	ICB Chair
	Rhiannon Beaumont-Wood (RBW)	ICB Non-Executive Member
	John Beswick (JB)	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)	ICB Non-Executive Member
	David Freeman (DF)	Acting ICB Chief Executive Officer
	Leesa Harwood (LH)	ICB Non-Executive Member
	Paul Johnson (PJ)	ICB Chief Medical Officer
	Rob Morgan (RM)	ICB Chief Finance Officer
	Paula Shobbrook (for Siobhan Harrington)	Deputy Chief Executive University Hospitals Dorset NHS Foundation Trust
	Debbie Simmons (DSi) (virtual)	ICB Chief Nursing Officer
	Vikki Slade (VS) (virtual) (part)	Leader BCP Council and ICB Local Authority Partner Member (East)
	Kay Taylor (KT)	ICB Non-Executive Member
	Dan Worsley (DW)	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)	Interim Chair, Dorset VCSE Board
	Kate Calvert (KC)	Acting ICB Chief Commissioning Officer
	Dawn Harvey (DH)	ICB Chief People Officer
	Matt Prosser (MP) (virtual) (part)	Chief Executive, Dorset Council
	Ben Sharland (BS)	Primary Care Participant
	Jon Sloper (JS)	Interim Programme Director, VCS Assembly
	Stephen Slough (SS)	ICB Chief Digital Information Officer
	Dean Spencer (DSp)	ICB Chief Operating Officer
In attendance:		
	Liz Beardsall (LBe)	ICB Head of Corporate Governance
	Jane Ellis (JE)	ICB Chief of Staff
	Dr Kate Goyder (KG) (for item ICBB24/005) (virtual)	Paediatric Consultant, University Hospitals Dorset NHS Foundation Trust
	Jillian Kay (JK) (virtual)	Corporate Director for Wellbeing, Bournemouth, Christchurch and Poole Council
	Steph Lower (SL) (minutes)	ICB Deputy Head of Corporate Governance
	Josie Roberts (for item ICBB24/005) (virtual)	Clinical Lead, University Hospitals Dorset NHS Foundation Trust
	Sue Whitney (for item ICBB24/005) (virtual)	Operational Manager (UHD)
Public:		

	1 members of the public was present in the room. The meeting was also available via livestream.	
Apologies:		
	Cecilia Bufton (CB)	Integrated Care Partnership Chair
	Sam Crowe (SC)	Director of Public Health for Dorset and Bournemouth, Christchurch and Poole (BCP) Councils (participant)
	Graham Farrant (GF)	Chief Executive, Bournemouth, Christchurch and Poole Council
	Spencer Flower (SF)	Leader Dorset Council and ICB Local Authority Partner Member (West)
	Siobhan Harrington (SH)	Chief Executive University Hospitals Dorset NHS Foundation Trust and ICB NHS Provider Trust Partner Member (member)
	Patricia Miller (PM)	ICB Chief Executive (member)
	Andrew Rosser (AR)	Chief Finance Officer, South Western Ambulance Service Foundation Trust (participant)
	Forbes Watson (FW)	GP Alliance Chair, Primary Care Partner Member

ICBB24/001 Welcome, apologies and quorum

The Chair declared the meeting open and quorate. There were apologies from Cecilia Bufton, Sam Crowe, Graham Farrant, Spencer Flower, Siobhan Harrington, Patricia Miller, Andrew Rosser and Forbes Watson.

ICBB24/002 Conflicts of Interest

The following interests were declared:-

- John Beswick - agenda item 02 – Board Story (paediatric virtual ward). JB was an executive and Board member of Great Ormond Street Hospital children's hospital where children were referred from other hospitals. This was already declared on the Register of interests and there was no conflict of interest with this item or action required.
- Jonathon Carr-Brown – agenda item 10 – Improving Patient Access to Emergency Care. JCB stated he held a senior role in a self-care company (Healthily) that used artificial intelligence to signpost people and explain what they needed to know. The company did not contract with the NHS sector so there was no conflict of interest with this item or action required. This was already declared on the Register of Interests.

ICBB24/003 Minutes of the Part One Meeting held on 2 November 2023

The minutes of the Part One meeting held on 2 November 2023 were agreed as a true and accurate record.

V Slade joined the meeting.

Resolved: the minutes of the meeting held on 2 November 2023 were approved.

ICBB24/004 Action Log

The action log was considered, and approval was given for the removal of completed items. It was noted that all items were complete apart from ICBB23/183 as the action relating to the inclusion of further Primary Care information was due to be incorporated in early 2024. It was agreed this action could be marked for removal.

Action: SL

In relation to action ICB23/179 Freedom to Speak Up, there was a keenness to receive updates in relation to the learning from the CQC inspection (due to be published in late March) and the recent staff survey. These would be included on the Board Work Plan accordingly.

Action: SL

Resolved: the action log was received, updates noted, and approval was given for the removal of completed actions.

Standing Items

ICBB24/005 Board Story: virtual wards

The Deputy Chief Executive Officer, UHD introduced the paediatrics virtual ward story video.

Key issues to note included:-

- The paediatrics virtual ward was part of a national NHS-funded project.
- The virtual ward focus was on the group of children who required more care than parents would be able to offer but were safe to be treated within their home environment.
- Virtual ward benefits included early discharge from hospital and a reduction in unnecessary visits and/or admission to hospital, along with enabling families where possible to be able to carry on with their normal lives.
- Since commencement, the service had seen 239 individual patients and 1,165 bed days had been saved.
- Examples of conditions treated through the paediatric virtual ward include bronchiolitis, gastroenteritis and wheeze.
- The positive feedback in terms of the care received.

The Chair asked that the Virtual Ward Wrapped poster be circulated to the Board.

Action : SL

Although recognising the paediatric virtual ward model of care was specific, the learning and insights from implementing the model were being shared to assist in paving the way for other parts of the virtual ward initiative to progress.

In terms of next steps, work was being taken forward with primary care which was a key enabler to preventing hospital admissions. The ICB Chief Medical Officer would meet with Dr Kate Goyder outside of the meeting to discuss further.

Action: PJ

Effective local engagement regarding the service was key to ensuring the virtual ward was able to treat the right patients.

The Board noted that a holistic assessment was undertaken for every patient including their environment.

ICBB24/006 Acting Chief Executive Officer's Report

The Acting ICB Chief Executive Officer (CEO) introduced the Acting CEO's Report.

Key issues to note:-

- The unprecedented year of NHS industrial action which had had a significant scale of impact for Dorset. There was acknowledgement of the hard work undertaken by all during such periods.
- The reprioritisation of the ICB's operational targets and financial position following the NHS England national letter.
- The progress being made with the Joint Forward Plan in terms of delivery.
- The successful recent public market-place engagement events undertaken.
- The positive ongoing conversations with the Portland community regarding their healthcare services.

L Bate joined the meeting

There was a national challenge in terms of NHS staff vaccine uptake but Dorset was performing comparatively well in the South West/nationally. The overall challenges for NHS staff were recognised and work would continue in terms of engaging with staff including increasing vaccine uptake.

Regarding the Electronic Patient Record (EPR) business case, discussions were taking place regarding the governance structure which would include partnering up with the Somerset ICS system. NHS Dorset had stepped back from its early- stage lead role with the Dorset providers now progressing the work. The ICB Board would be required to sign off any resourcing requirements etc. and this would enable sight of the evolution of the work. Work was underway to develop the options appraisal for the Outline Business Case and the Board noted the focus on ensuring the programme aligned with primary care.

There was a query regarding whether the current operating/resource model was right and whether the symptoms or root cause were being addressed. Recognising the current significant challenges, there would be a need to address the symptoms at present however there was a need not to lose sight of how to make the changes necessary to enable sustainable delivery of services. Work was progressing in terms of the individual priority focuses e.g. the integrated neighbourhood team programme.

M Prosser left the meeting

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

ICBB24/007 Quality Report

The ICB Chief Nursing Officer introduced the Quality Report which had been previously scrutinised by the Quality, Experience and Safety Committee.

Key points to note:-

- In terms of the follow-on waiting lists (FOWL) backlog, a system deep dive would be undertaken to explore whether there had been any clinical harm identified to patients in light of the ongoing industrial action. Dorset County Hospital had already commenced an initial focus on ophthalmology patients and once completed, the findings would be shared to inform the approach for wider partners. The Chief Nursing Officer was on a national group and would link with the group to ascertain what other systems were doing in terms of solutions.
- No criteria to reside continues to be a challenge and a key area of focus.
- The Dorset Medicines Safety Officers had commenced a task and finish group to investigate improvements with medicines prescribed on hospital discharge.

Action: DS

Resolved: the Board noted the Quality Report.

ICBB24/008 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 month 8.

Key points to note:-

- The ICS was reporting a year-to-date deficit of £41.6M which was a deterioration from month 7. The main drivers included Personal Health Commissioning (PHC), inflation, elective activity performance and agency spend.
- In terms of agency costs, although the Dorset system was over the cap set by NHS England, improvement was being seen and use of some of the more high-cost agencies had ceased.
- Operational pressures relating to industrial action were a significant financial performance challenge. An additional £9.3M funding had been received which had been shared between both acute providers.
- Further discussion would take place in Part 2 in terms of the end of year financial position and what would be achievable.

The agency spend challenges were multi-faceted. There was an underlying issue in terms of staff shortages and the inability to recruit nationally, particularly in rural areas such as Dorset. It was noted that reducing the rate card would help financially but would not resolve the issue itself. Work continued to address the issues both in the shorter and longer term.

Concern was raised regarding the continued increase in PHC costs which was a longstanding issue. This was a national issue and was being driven by the numbers, acuity and price increases. A PHC financial recovery group had been set up to explore what could be done. A further discussion would be held in Part 2.

Regarding inflationary pressures, the biggest movement continued to be driven by energy prices. The Board noted Dorset was signed up to receive the best prices. Work was being taken forward to see if Dorset could access any of the regional contingency funding. This issue would be picked up in more detail at the Productivity and Performance Committee.

Action: DW/RM

Resolved: the Board noted the Dorset ICS Finance Update.

ICBB24/009 System Performance Report

The ICB Chief Operating Officer introduced the System Performance Report.

Key issues to note:-

- There had been an increase in the number of targets met from 6 to 10 with improvement seen in 17 other areas.
- A number of standards were off track with several attributable to industrial action.
- There were a number of key focuses for the remainder of the year including the delivery of safe services, maintaining elective activity, reducing waiting lists and maintaining /improving cancer care.

- Work continued in relation to adult virtual wards, having reached half way towards the levels anticipated.
- No criteria to reside remained of concern. A number of multi-agency discharge events had been held to assist capacity and increase flow, with particular success within the mental health area, however sustainability was key.
- Access to A&E remained a concern with Dorset ICS (combined) under-performing against the 4-hour standard of 76% of patients waiting less than 4 hours to be seen.

The Urgent and Emergency Care Delivery Group was looking at ambitions for the forthcoming year in terms of achieving the step changes required to help tackle the broader issues such as population health, inequalities and value for money.

A further discussion would be held in Part 2 in terms of performance delivery.

Resolved: the Board noted the System Performance Report.

ICBB24/010 Committee Escalation Reports

The Board Committee Chairs presented the committee escalation reports from the December meetings which included an additional Risk and Audit Committee report from the November meeting. All issues discussed were included in the previously circulated reports and key issues for noting included:-

- People, Engagement and Culture Committee – future system People Performance report and dashboard reports would be by exception. The NHS Dorset People Performance Plan was more outcome focused. Recognition of the achievement of the winter communications and engagement plan without any budget. There had been rich feedback following the culture of system working deep dive however this had been compromised by the low response rate. Board colleagues were asked to socialise the report within their organisations to help improve future response rates. The temporary workforce discussion would be brought back for a further discussion.
- Prevention, Equity and Outcomes Committee – this was the inaugural meeting and provided an opportunity to discuss how the committee would be different and would relate to other committees including overlaps. The committee considered its revised Work Plan with an emphasis on prevention and equity through an 'outcomes' lens.
- Productivity and Performance Committee – there was a detailed finance and performance discussion including the H2 position. There were a number of deep dives including medicines, cancer and mental health. The committee had sought to re-escalate the PHC position to the ICB Board and this would be picked up under Part 2.
- Quality, Safety and Experience Committee – the committee took assurance around the Quality report with selected highlighted areas and approved the two remaining Patient Safety Incident Response Plans for Dorset County Hospital NHS Foundation Trust (DCH) and University Hospitals Dorset NHS Foundation Trust (UHD). An update was received on the Dorset Local Maternity and Neonatal System in terms of the key quality and safety issues. The committee received a baseline assessment on approaches to quality improvement across NHS Dorset and was supportive of a future development session.
- Risk and Audit Committee – there had been two meetings since the last Board. There had been a focus on the risk register noting the risks were being managed rather than remaining static. Development of the Board Assurance Framework had been a key focus of the two meetings culminating in a workshop to be held in Part 2 of this meeting. The committee had received an update on the planned replacement of the Finance Ledger (ISFE2) and would look at the development of that programme.
- Strategic Objectives Committee – this was the inaugural meeting and provided an opportunity to discuss the future focus of the committee to enable it to be effective.

There was also discussion in relation to overlaps with the other committees. A key issue would be how to assess the value added and what metrics to be used to ensure effective progress was being made.

Resolved: the Board noted the Committee Escalation Reports.

Items for Decision

ICBB24/011 Committee Terms of Reference and Work Plans

The Head of Corporate Governance introduced the Committee Terms of Reference (TORs) and Work Plans.

Following the committee refresh, the Board approved the revised ToR and Work Plans at it November meeting noting the two new committees and the Risk and Audit Committee would review their respective ToRs and Work Plans at their December meetings and bring any amendments back to the Board for approval.

The proposed changes were as highlighted in the report. In addition, for the Strategic Objectives Committee, there had been a line added in relation to reporting into the Integrated Care Partnership, the addition to the membership of the Chief Commissioning Officer and the inclusion of a mechanism to ensure a seamless transition from the transformation phase to business as usual.

Further work was being undertaken on the Prevention, Equity and Outcomes Committee Work Plan. The Committee would consider this at its February meeting and any further changes would be brought back to the Board for approval.

In relation to the Strategic Outcomes Committee Work Plan, there was a significant amount of research and innovation work going on across individual organisations so there was a need to ensure a co-ordinated holistic approach to ensure research and innovation were adding to the ICS agenda. This could be looked at as a higher education work piece and it was suggested a conversation take place outside of the meeting.

Action: NB/JA

Resolved: the Board approved the recommendations set out in the Committee Terms of Reference and Work Plans subject to the action set out above.

Items for Noting/Assurance/Discussion

ICBB24/012 Patient Safety Incident Response Framework Plans (PSIRF)

The ICB Chief Nursing Officer introduced the Patient Safety Incident Response Framework Plans for the remaining two organisations – DCH and UHD.

The Plans had been approved at their respective trust Boards and the December ICB Quality, Experience and Safety Committee and were compliant with the relevant legislation.

Resolved: the Board noted the Patient Safety Incident Response Plans for DCHFT and UHD.

ICBB24/013 Improving patient access to emergency care across Dorset

The Manager, Dorset Healthwatch introduced the Improving patient access to emergency care across Dorset report.

Healthwatch Dorset had been asked by NHS Dorset to evaluate residents' understanding of the different healthcare settings available and how easily accessible they were.

The Board noted there was less feedback from young people and the local male population.

The findings were broadly grouped into two key themes – a need for improved communication between units, patients and NHS111 and a need to better align demand and capacity across the different urgent care and same day response offers. Specific areas of feedback included public difficulty in understanding the language/signposting and messaging, however there was positive feedback regarding treatment provided.

The findings had shaped six recommendations for improvement as set out in the report. There were a number of longer-term issues that would be addressed through the Urgent Care Delivery Board.

Caution was expressed in relation to the timescale for recommendation 4 in terms of the provision of a more consistent offer across MIUs and UTCs with evenly distributed staffing to enable the same level of care/opening hours. This was an important ambition however units were currently fragile.

A contributory challenge was changing people's behaviour to avoid individuals seeking reassurance from their 'safest space' and more work could be done in this area. People needed high quality prompt information signposting and consideration needed to be given as to how to ensure a consistent response wherever the patient accessed the system.

Action: DS

It was suggested a further evaluation be undertaken in due course in terms of 'you said, we did' to see if experiences of accessing emergency care across Dorset had improved.

There was commitment from all to improve patient experience and ensure services continued to develop to wrap around the needs of the population.

The Chair thanked Dorset Healthwatch for the insightful report.

Resolved: the Board noted the Improving patient access to emergency care across Dorset report.

ICBB24/014 ICB Customer Care Bi-Annual Report

The Chief Nursing Officer introduced the ICB Customer Care Bi-Annual Report.

Key points to note were:-

- Communication remained the key area for improvement.
- Work was progressing in relation to exploring how complaints could be approached differently as a system to improve patient experience and system learning.

Following a query regarding assurance that issues previously raised had been stopped, it was noted the Board report was pitched at a strategic high level however provider reports included patient experiences, improvement work and how any themes were being addressed. This was also discussed in more detail at the ICB's Quality, Experience and Safety Committee.

Resolved: the Board noted the ICB Customer Care Bi-Annual Report.

Items for Consent
There were no items for consent.

ICBB24/015 Questions from the Public
There were no questions received from members of the public.

ICBB24/016 Any Other Business
In relation to the Bibby Stockholm barge, a forthcoming visit from the Home Affairs Select Committee was planned. The ICB's Chief Medical Officer would attend on behalf of the local health sector. It had been determined elements of the living environment could exacerbate the mental health and wellbeing of those individuals on board and an enhanced offer of support had been put in place.

ICBB24/017 Key Messages and review of the Part 1 meeting

The Head of Corporate Governance summarised the key messages from the meeting as:-

- The success of the UHD paediatric virtual ward highlighted in the Board story was welcomed.
- Good work continued to manage the challenges in relation to the industrial action.
- The continued work to mitigate the quality, financial and operational challenges.
- The improvements in the UHD maternity services noting the joint/collaborative working.
- The clear commitment to the six actions set out in the 'Improving Access to Emergency Care' Healthwatch Dorset report and the importance of closing the loop on the actions.

The Board reflected on:

- The need for reporting strategic progress either within the CEO report or as a standalone item.
- The balance between Board and Committee reporting detail. However, it was recognised Board reports were pitched at a high level therefore caution was given in terms of slimming down the information provided. It was suggested consideration be given to expanding what was presented to committees.
- The Board welcomed the meeting focus on the Dorset population and the need to look through a well-being lens rather than ill-health.
- Tackling the symptoms versus the root cause and the need for more prevention discussions through the Development Sessions.
- Constructive challenge to the regional NHS team on the best use of the system's resources.

The Chair thanked everyone including the public, for their attendance.

ICBB24/018 Date and Time of Next Meeting
The next meeting of the ICB Board would be held on Thursday 7 March 2024 at 10am, at the offices of Bournemouth, Christchurch and Poole Council. Further details would follow.

ICBB24/019 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: 7 March 2024