Board of Directors - Part 1 - 31/07/2024

Wed 31 July 2024, 08:45 - 12:35

THQ Boardroom and MS Teams

Agenda

08:45 - 09:05
20 min

1. Patient Story

09:05 - 09:10
5 min

2. Formalities

- 1a DRAFT Agenda BoD Part 1 V2 31 July 2024 v2.pdf (3 pages)
- 1b Draft Minutes BOD Part 1 29 05 2024 DCS.pdf (12 pages)
- 1c Action Log BoD PART 1 July 2024 DCS.pdf (2 pages)

09:10 - 09:15
5 min

3. Chair's Comments

09:15 - 09:30
15 min

4. CEO Update

- 4a. CEO Board report July24 FINAL DCH v2.pdf (7 pages)
- 4b. NHSE Letter Patient safety and quality..pdf (3 pages)

09:30 - 09:50
20 min

5. Joint Strategy

- 5a. DCH BoD Joint Strategy Report Final.pdf (8 pages)
- 5b. Appendix 1 - Working together improving lives v3.pdf (35 pages)
- 5c. Appendix 2 - Implementation Plan.pdf (3 pages)
- 5d. Appendix 3 - Culture Communications and Engagement Plan.pdf (9 pages)

09:50 - 10:00
10 min

6. Strategic Risks and Corporate Risk Register

- 6a. Strategic Risks - DCH_DHC TB July_August 2024.pdf (23 pages)
- 6b. CRR Draft RAC report June 2024.pdf (43 pages)

10:00 - 10:30
30 min

7. Finance and Performance Committee Report

- Escalation Report FPC June 2024 AT CH.pdf (2 pages)
- Escalation Report FPC July 2024 - ST CH.pdf (2 pages)

7.1. Balanced Scorecard

- 7.1 Balanced Scorecard- An integrated report for the reporting month of June 2024 final.pdf (13 pages)

7.2. Finance Report

- 7.2a. Front Sheet Finance Report FPC Month 3.pdf (3 pages)
- 3b. DCH Finance Report FPC June 2024.pdf (13 pages)

10:30 - 10:45
15 min

Break

10:45 - 11:15
30 min

8. Quality Committee Report

- Escalation Report QC June 2024.pdf (1 pages)
- Escalation Report QC July 2024 - EJ.pdf (2 pages)

8.1. Maternity Update

- 8.1a Front sheet monthly maternity neonatal report Board july 2024.pdf (2 pages)
- 8.1b Board Maternity report July 2024 v0.1.pdf (21 pages)

8.2. Safeguarding Children and Adults Annual Report

- 8.4a. Front Sheet - SG report April 2023-2024.pdf (2 pages)
- 8.4b. Annual Report Safeguarding 2023-2024.pdf (18 pages)
- 5c. Safeguarding Annual Quality Improvement Plan 2024-2025.pdf (8 pages)

8.3. Infection Prevention and Control Annual Report

- 8.5a. Front Sheet IPC Annual Report 2023-2024 Board V1.pdf (3 pages)
- 6b. IPC Annual report 2023-2024 V1.pdf (64 pages)

8.4. Clinical Audit Annual Assurance Report

- 8.6a Clinical Audit Annual Assurance Report Front Sheet July 2024.pdf (2 pages)
- 7b. Annual Clinical Audit Report 2023 2024.pdf (9 pages)
- 7c. Clinical Audit Section DCH Quality Account 2023-24.pdf (22 pages)

11:15 - 11:55
40 min

9. People and Culture Committee Report

- Escalation Report PCC June 2024.pdf (1 pages)
- Escalation Report PCC July 2024 - EH.pdf (1 pages)

9.1. Joint Inclusion and Belonging Strategy

- 9.1a. Front sheet Joint Inclusion and Belonging Strategy 2023-25 Board.pdf (3 pages)
- 9.1b Joint Inclusion and Belonging Strategy 2023-25 FINAL.pdf (30 pages)

9.2. Freedom to Speak Up Update

- 9.2a. FTSU WB Report Q 3 4 Front Sheet May 24.pdf (2 pages)
- 9.2b. FTSU WB Report Q3 Q4 May 23 Final.pdf (4 pages)

9.3. Workforce Health and Wellbeing Review

- 9.3a. PCC Front Sheet HWB Report 170624 FINAL.pdf (2 pages)
- 9.3b. PCC Report HWB June 2024 FINAL.pdf (6 pages)

11:55 - 12:00
5 min

10. Risk and Audit Committee Report

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

12:00 - 12:20
20 min

11. Working Together Committee in Common Report

Escalation Report WTC June 2024 DCS.pdf (2 pages)

11.1. Committee Effectiveness Review and TORs (QC and RAC)

11.1 Committee Effectiveness Review 2023-24 Front Sheet and Report JH.pdf (5 pages)
QC Terms of Reference 2024-25 DRAFT.pdf (5 pages)
RAC Terms of Reference 2024-25 DRAFT.pdf (6 pages)

11.2. Committees in Common Terms of Reference

11.2a Development of Committees in Common - TOR for TB Approval Jul_Aug 2024_.pdf (7 pages)
11.2b Appendix 1 Finance and Performance Committee Dorset County Hospital NHS Foundation Trust Draft for approval TB July 2024.pdf (5 pages)
11.2c Appendix 2 Strategy Transformation and Partnerships Committee Dorset County Hospital NHS Foundation Trust Draft for approval TB July 2024.pdf (5 pages)
11.2d Appendix 3 People and Culture Committee Dorset County Hospital NHS Foundation Trust Draft for approval TB July 2024.pdf (4 pages)

12:20 - 12:25
5 min

12. Charitable Funds Committee Report

12. DCH Charitable Funds Committee - Escalation Report (23.7.24).pdf (2 pages)

12:25 - 12:30
5 min

13. Questions from the Public

12:30 - 12:35
5 min

14. Consent Section

14.1. Medical Revalidation Report

13.1. Front sheet Medical Revalidation Annual Report 2024.pdf (2 pages)
6b. Annex-A-Professional-standards-framework-for-quality-assurance-and-improvement Annual RO report 2023 to 2024.pdf (19 pages)
6c. Annual Report Appendix A April 2023 to Mar 2024.pdf (2 pages)

14.2. Leavers and Retention Report

13.3a. Leaver and Retention Report Front Sheet PCC June 2024 - Final.pdf (3 pages)
5b. Leavers report PCC June 2024 final.pdf (7 pages)
5c. Leavers report PCC June 2024 Appendices final.pdf (6 pages)

14.3. People Plan Annual Progress Review

13.4a. Front Sheet People Plan Progress Report July 2024.pdf (3 pages)
5b. PCC People Plan Review July 2024.pdf (14 pages)

14.4. Working Together Programme Highlight Report

13.5a. Front Sheet Highlight Report - Board July 2024 v0.1.pdf (2 pages)
13.5b. WTPB Monthly Highlight Report July 24 v0.1.pdf (6 pages)

14.5. DCH SubCo Q4 Performance Report

13.6a DCH SubCo Performance report Q4 front sheet.pdf (2 pages)
14.1dii. Performance Report Apr 2024.pdf (6 pages)

14.6. ICB Board Part 1 Minutes

13.7 ICB Board Minutes Part 1 160524 V1 LB Approved.pdf (9 pages)

12:35 - 12:35
0 min

15. 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 **31st July 2024** at **8.45am to 12.35pm** in the **Board Room, Trust Headquarters, Dorset County Hospital, Dorchester** and via **MS Teams.**

The agenda is as set out below.

Yours sincerely

David Clayton-Smith
Trust Chair

AGENDA

1.	**Patient Story** • The Benefits of Creative Health	Presentation	Dawn Dawson Suzy Rushbrook, Caroline Barnes	Note	8.45-9.05
2.	**FORMALITIES** to declare the meeting open.	Verbal	David Clayton-Smith Trust Chair	Note	9.05-9.10
	a) Apologies for Absence:	Verbal	David Clayton-Smith	Note	
	b) Conflicts of Interests	Verbal	David Clayton-Smith	Note	
	c) Minutes of the Meeting dated 29th May 2024	Enclosure	David Clayton-Smith	Approve	
	d) Matters Arising: Action Log	Enclosure	David Clayton-Smith	Approve	
3.	**Chair's Comments**	Verbal	David Clayton-Smith	Note	9.10-9.15
4.	**CEO Update**	Enclosure	Matthew Bryant	Note	9.15-9.30
5.	**Joint Strategy**	Enclosure	Nick Johnson Paul Lewis	Approve	9.30-9.50
6.	**Strategic Risks** (July committees) **and Corporate Risk Register** (June RAC)	Enclosure	Jenny Horrabin Dawn Dawson Mandy Ford	Approve	9.50-10.00
7.	**Finance and Performance Committee Report**	Enclosure	Stephen Tilton	Note	10.00-10.05
7.1.	**Balanced Scorecard**	Enclosure	Anita Thomas Executives	Note	10.05-10.20
7.2.	**Finance Report**	Enclosure	Chris Hearn	Note	10.20-10.30
Coffee Break 10.30-10.45					
8.	**Quality Committee Report**	Enclosure	Claire Lehman	Note	10.45-10.50
8.1.	**Maternity Update** (July QC)	Enclosure	Dawn Dawson Jo Hartley	Note	10.50-11.00
8.2.	**Safeguarding Children and Adults Annual Report**	Enclosure	Dawn Dawson	Note	11.00-11.05

	(June QC)				
8.3.	**Infection Prevention and Control Annual Report** (June QC)	Enclosure	Dawn Dawson	Note	11.05-11.10
8.4.	**Clinical Audit Annual Assurance Report** (June QC and RAC)	Enclosure	Alastair Hutchison	Note	11.10-11.15
9.	**People and Culture Committee Report**	Enclosure	Margaret Blankson	Note	11.15-11.20
9.1.	**Joint Inclusion and Belonging Strategy** (July PCC)	Enclosure	Nicola Plumb Jan Wagner	Approve	11.20-11.35
9.2.	**Freedom to Speak Up Update** (May PCC)	Enclosure	Nicola Plumb Lynn Paterson	Note	11.35-11.45
9.3.	**Workforce Health and Wellbeing Review** (June PCC)	Enclosure	Nicola Plumb	Note	11.45-11.55
10.	**Risk and Audit Committee Report**	Enclosure	Stuart Parsons	Note	11.55-12.00
11.	**Working Together Committee In Common Report**	Enclosure	David Clayton-Smith	Note	12.00-12.05
11.1.	**Committee Effectiveness Review** • Terms of Reference (QC and RAC) (May, June Committees)	Enclosure	Jenny Horrabin	Approve	12.05-12.10
11.2.	**Committees in Common Terms of Reference** • Finance and Performance Committee • People and Culture Committee • Strategy, Transformation and Partnership Committee (July Committees)	Enclosure	Jenny Horrabin	Approve	12.10-12.20
12.	**Charitable Funds Committee Report**	Enclosure	Dave Underwood	Note	12.20-12.25
13.	**Questions from the Public**	Verbal	David Clayton-Smith	Note	12.25-12.30
	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 Abigail.baker@dchft.nhs.uk				
14.	**CONSENT SECTION**				All items 12.30-12.35
	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.				
14.1.	**Medical Revalidation Report** (June PCC)	Enclosure	Alastair Hutchison	Approve	

14.2.	**Leavers and Retention Report** (June PCC)	Enclosure	Nicola Plumb	Note	
14.3.	**People Plan Annual Progress Review** (July PCC)	Enclosure	Nicola Plumb	Note	
14.4.	**Working Together Programme Highlight Report**	Enclosure	Dawn Dawson Nick Johnson	Note	
14.5.	**DCH SubCo Q4 Performance Report**	Enclosure	Nick Johnson	Note	
14.6.	**ICB Board Part 1 Minutes**	Enclosure	David Clayton-Smith	Note	
15.	**Any Other Business** Nil notified	Verbal	David Clayton-Smith	Note	-
16.	**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 25th September 2024** in the **Board Room, Trust Headquarters, Dorset County Hospital, Dorchester** and via **MS Teams.**				

Part 2 Items

- Chair's Update
- CEO's Update
- New Hospital Programme Contract
- Strategic Estates Update
- Cyber Security Update

Consent Items:

- Radiology Out of Hours Reporting Contract
- Lease for Off Site Warehouse
- Premises Assurance Model

Minutes of a public (Part 1) meeting of the Board of Directors of Dorset County Hospital NHS Foundation Trust held at 8.30am on 29th May 2024 at Board Room, Trust Headquarters, Dorset County Hospital and via MS Teams videoconferencing.

Present:		
David Clayton-Smith	DCS	Trust Chair
Margaret Blankson	MB	Non-Executive Director
Matthew Bryant	MBr	Chief Executive
Dawn Dawson	DD	Joint Chief Nursing Officer
Chris Hearn	CH	Joint Chief Finance Officer
Jenny Horrabin	JeH	Joint Director of Corporate Affairs
Jo Howarth	JoH	Director of Nursing (Acute)
Nick Johnson	NJ	Deputy Chief Executive and Joint Chief Strategy, Transformation and Partnership Officer
Eiri Jones	EJ	Non-Executive Director (Deputy Chair)
Claire Lehman	CL	Non-Executive Director
Stuart Parsons	SP	Non-Executive Director
Stephen Tilton	ST	Non-Executive Director
David Underwood	DU	Non-Executive Director
In Attendance:		
Sarah Anton	SA	Corporate Governance Officer
Tom Cooper	TC	Catering Manager (Staff Story)
Julie Doherty	JD	Caldicott Guardian (item BoD24/012)
Jo Hartley	JHa	Head of Midwifery (item BoD24/011 via videoconference)
Trevor Hughes	TH	Head of Corporate Governance
Megan John	MJ	Associate Chief Medical Officer – Clinical Transformation
Kyle Mitchell	KM	Guardian of Safe Working (Item BoD24/018)
Audrey Ryan	AR	Director of Medical Education (For Alastair Hutchison)
Adam Savin	AS	Director of Performance (item BoD24/008 via videoconference)
Members of the Public (attending via videoconference):		
Judy Crabb	JC	Governor (via videoconference)
Kathryn Harrison	KH	Lead Governor (via videoconference)
Jean-Pierre Lambert	JPL	Governor (via videoconference)
Lynn Taylor	LT	Governor (via videoconference)
Apologies:		
Anita Thomas	AT	Chief Operating Officer
Nicola Plumb	NP	Joint Chief People Officer (via videoconference)
Alastair Hutchison	AH	Chief Medical Officer

BoD24/001	**Staff Story**	
Baker Abi 30/07/2024 12:31:14	JoH introduced TC, the trust Catering Manager, who discussed the changes made around the approach to catering and future plans. TC outlined his career in catering and management. TC joined the trust in October 2023 when he undertook a review of current catering provision and noting poor PLACE scores. TC had previously been involved in consulting and turnaround planning and outlined his approach to improvement change. A key focus was to ensure the wellbeing of the diverse team and that staff felt valued, invested in, and connected to the wider trust, building this into	

the management approach. Digital change and improved performance were also at the core of the changes required.

The overall costs to the trust of the catering service had been increasing and revenue was not keeping pace. Opportunities to generate revenue and reduce food waste were being active pursued alongside the introduction of a new tracking system, promoting staff efficiency and reviewing profit.

The recent refurbishment of the Damer's restaurant had doubled capacity and plans were afoot to make the operation cost neutral; increasing opportunities to offer more to the local community and so increase revenue. A key target was not to adversely impact trust staff as a result of the pricing policy which aimed to self-fund catering improvements and the catering service in the longer term. Opportunities to generate revenue via commercial offerings were also under consideration.

Relationships with DHC were also being strengthened to develop a commercial framework and expertise. Looking to the future, each recipe would be reviewed to ensure they were healthy and tasty and opportunities to educate local communities about good nutrition were being maximised.

Food waste was being donated to staff and local food banks with the aim of reducing waste to zero. Menus were going to be more dynamic and seasonal. Working with the ICS, TC advised that early discussions were taking place to develop centralised catering support facilities that would be able to support all NHS provider catering outlets. He noted the importance of getting service spending under control and the work underway with the procurement team to support this and digital development in order to gain accurate spend and sales data.

JoH commended the improvements and noted the use of charitable funds to support refurbishment of the Damer's restaurant and reiterated the ongoing work with dietitians to improve the food offering and to embed the catering service within the trust.

The Board noted the ambitions for the service and heard an anecdote from elsewhere that a hospital restaurant was 'the place to eat Sunday lunch' as it provided great value for money for staff. The restaurant was so popular that staff were required to book tables.

The Board noted the opportunities to work with local farmers, education facilities and employment as an anchor institution and that the trust was already working with Weymouth College to develop apprenticeship schemes.

In response to a question regarding specialist dietary requirements and catering for those with eating disorders, TC advised that there was a need to rationalise the extensive range of prepared elements as these exceeded 500, in order to provide greater nutritional value and strengthen specialist menus. Training was being undertaken with the chefs to educate and develop expertise in these areas.

	TC summarised that action was being taken to address long standing issues and noted the opportunities to work with partners such as Dorset Council's farms and MIND and their allotments to develop mutually beneficial reciprocal arrangements, to fostering commercial opportunities to review current leasing options going forward to increase revenue. The Board noted that in line with the national food and drink standards, the nominate Board lead for nutrition was the Chief Nurse and that a nutrition strategy had been previously approved and was reviewed via Quality Committee. DCS thanked TC for his presentation, noting the importance of good nutrition in hospital and the positive ambitions for the catering service. The Board would welcom a future update.	
	Resolved that: the Staff Story be heard and noted.	
BoD24/002	**Formalities**	
	The Chair declared the meeting open and quorate and welcomed governors to the meeting. Apologies for absence were received from Anita Thomas, Alastair Hutchison, and Nicola Plumb.	
BoD24/003	**Conflicts of Interest**	
	There were no conflicts of interest declared in the business to be transacted on the agenda.	
BoD24/004	**Minutes of the Meeting held on the 27th March 2024**	
	The Minutes of the meeting dated 27th March 2024 were approved as an accurate reflection of the meeting noting two minor typographical errors on page 3.	
	Resolved: that the minutes of the meeting held on 27th March 2024 were approved.	
BoD24/005	**Matters Arising: Action Log**	
	The action log was considered, updates received in the meeting were recorded within the log, and approval was given for the removal of completed items.	
	Resolved: that updates to the action log be noted with approval given for the removal of completed items.	
BoD24/006	**Chair's Comments**	
	DCS noted the restrictions resulting from the pre-election period and acknowledged the positive working relationships developing across the system with colleagues. Several important items and statutory reporting requirements were included in the agenda for the meeting.	
	Resolved: that the Chair's comments be noted.	
BoD24/007	**CEO Update**	
	MBr noted the recent council elections and summarised key aspects of his report, bringing the following to the attention of the Board:	

	• The Tobacco and Vapes Bill had not progressed through Parliament due to the general election. • Potential periods of industrial action by junior doctors and ongoing planning to mitigate the impact. • Noting previous Board discussion of the ongoing challenges facing the NHS and planned discussion via agenda items, the safety and quality of care and the environment set for colleagues remained of paramount importance and a top strategic objective for the trust. • The ongoing strategic development of the federated model of joint operation of DCH and DHC, Board working and plans to implement committees in common. • The Working Together flagship schemes were progressing and making a positive difference for patients by removing cross organisational barriers. • The– Joint Investment Committee had endorsed the trust's New Hospital Programme case with progression to the Treasury approval stage in July. It was not clear whether the election would impact this. • The successful visit by the Secretary of State for Health and Social Care to South Walks House and partnership working with community providers. • The new CT scanner had been installed in Weymouth increasing diagnostic capacity and plans to develop a theatre at the site were progressing. • The Staff Survey results would be reported at a future date although improvement in scores were highlighted. • The Board Development session in September would be supported by external Equality, Diversity and Inclusion expert. • The next phase of the charitable appeal had been launched. The Board's thanks were extended to colleagues, governors and patients for their significant efforts and commitment in fundraising. • The trust had received a pastoral care award in respect of internationally recruited nurses. Learning from this approach would be shared with a view to application to overseas medical staff recruitment as part of the trust's ethical recruitment strategy. • Learning from the Children and Young People Flagship would also be shared across the ICS to ensure equity. An update would be returned to a future Board meeting in the Autumn. • The recent visit to both DCH and DHC by the Health Services Safety Investigative Body (HSSIB) who undertaken thematic or significant incident reviews has provided positive feedback about the trusts' progressive thinking and focus on staff culture and safety.	**DD**
	Resolved that the CEO Update be noted.	
BoD24/008	**Balanced Scorecard**	
Baker,Abi 30/07/2024 12:31:14	AS advised of the revised format of the report so as not to duplicate committee reporting and support greater triangulation of the four domains. The paper was in development and metrics from the planning round would be updated the following months. **Quality** DD summarised:	

	• Electronic Discharge Summary data had recovered over previous two months. Delays were a longstanding process issue although lead executives regularly reviewed and sought assurance that there were no harm issues arising. A data and risk review was in place and the outcome would be returned via committee. • A specific review of readmission rates was in train to align to national metrics. • There had been one MRSA bacteraemia Never Event. This was subject to ongoing review. **Performance** • The 62 day Cancer target had returned to percentage of target – 76% achieved. • The elective recovery stretch target was 109% activity. 100% activity had been achieved in April and a new insourcing contract would be in place from May. • Theatre utilisation showed an improved position although the utilisation the target had not been delivered. • Diagnostics performance had improved although the 99% target had not been achieved. • Outpatient metrics had improved with reducing numbers of long waiters. • The four-hour standard urgent and emergency care standard had been achieved. • The number of patients remaining in hospital with No Reason to Reside showed and improved position although the challenging reduction target had not been met. The Finance and Performance Committee would consider the forward view as trajectories were agreed within the plan. Risks and assurances would also be considered and reported at the next meeting. **People** • Essential skills training compliance had improved although had fallen 1% short of target. • Appraisal rates remained below the target and had dipped in month. The year end impact, when high numbers of appraisals fell due, was noted. A shorter appraisal process had been introduced and a 90% target had been set. The importance of objective setting was stressed to support and ensure staff felt connected. The position needed to be recovered by September and the committee sought to understand how this could be sustained. • The sickness absence rate was 3.58% with no concerns identified. • The turnover rate had improved to 9% and the position was commended. • The vacancy rate stood a 3.47%. **Finance** CH noted the next item on the agenda contained the detailed position as at month 1 and advised that sustainability metrics were in development and would be reported going forward.	**FPC**

	The Board commended the new format of the report which had supported and driven some significant improvements.	
	Resolved that: the Balanced Scorecard and System Performance Update be received and noted.	
BoD24/009	**Finance Report**	
	CH presented the month 1 position against the financial plan, highlighting: • The Dorset system had submitted a deficit plan. • The DCH plan was achieve a breakeven position by year end. • The DCH £1.8m deficit position was in line with the phased trajectory and linked to the phased cost improvement programme. The deficit position was driven by operational pressures and the operation of 10 escalation beds. The target was to operate zero escalation beds and active plans were in place. A system trajectory was also in place to reduce the numbers of patients remaining in hospital with No Reason to reside further. Close focus was being maintained on this issue which was being balanced with providing safe care. • A 5% efficiency target had been set and the unidentified scheme gap currently amounted to £3.3m. • Positive reductions in agency spend continued with £658k spend in month. • The cash balance was relatively healthy due to additional income received at the end on the previous financial year and drawn down revenue support from the working capital programme. The Board commended the work to reduce agency spend.	
	Resolved: that the Finance Report be received and noted.	
BoD24/010	**Safe Staffing Annual Review**	
	DD presented the biannual assessment of acute ward staffing requirements and advised that there was no financial request being made of the Board. DD outlined that an evidence-based tool, triangulated with professional judgement and benchmark data informed the assessment of staffing requirements. Maternity services, stroke services and critical care were not included within the assessment as these services had different assessment tools and reporting requirements. The Board heard how competency requirements in specialist areas were a factor affecting staffing requirements and that the trust was developing plans to deliver a dynamic workforce to promote flexibility of employment. The People and Culture and the Quality Committees would monitor the plans. There was currently no staffing assessment tool for other areas such as interventional radiology. Whilst an evidence base and benchmarking data was in place for these areas, a staffing assessment tool was in development nationally. The Board were reminded of previous approval to appoint into the 22% headroom space, enabling safer care, and noted that the self-assessment tool would drive efficiencies and productivity going forward. The additional	

	staffing requirements to support the operation of escalation beds was also noted. The Board noted that the correct national process as set out by the Quality Board had been utilised in the assessment and that clear reporting of the headcount figure would be undertaken. Fortnightly meeting were in place to review the use of agency, headcount and recruitment.	
	Resolved: that the recommendations within the Safe Staffing Annual Review be received and noted	
BoD24/011	**Maternity Update**	
	JHa apologised that not everyone had received the paper and summarised key aspects of the report: • SPC chart presentation of key data • Compliance with the smoking at time of birth target. • Post-partum haemorrhage and 3rd and 4th degree tear incidents below the national average. • 2 incident reports submitted regarding staffing levels. • Safety team had participated in a positive away day. • A review of the Maternity Incentive Scheme (MIS) year 6 requirements and governance arrangements had been completed. • There had been no moderate or baby harm incidents. • An MNSI (replacing HSSIB) report had been received which recommended clinical oversight of escalated concerns and promoting awareness of responsibilities. The actions in response to the report would be presented via Learning Through Incidents Panel. • The risk register had been updated and work to address call bell system issues would commence in June. • Cannula use was now managed. • There had been an increase in the number of complaints received and a focussed report would be taken to the next Quality Committee. Complaints were mainly around communications and the increasing expectation when circumstances and plans change. • There had been a successful NED safety walkabout and no immediate concerns had been identified. Some staff requests to improve working conditions were raised. • Improved shift coverage and training compliance were noted. AR added that there was a change in expectation within the MIS that all consultant anaesthetists should attend a mandatory maternity training day. A compliance target of 70% had been set with recognition that a tailored approach could be applied to non-obstetric consultant anaesthetists. A plan to deliver compliance was in development.	
	Resolved: that the Maternity Update be received and noted.	
BoD24/012	**Learning From Deaths Q4 Report**	
	JD attended for this item and reported that:	

	• The SHMI was within the expected range. Significant triangulation of mortality and quality data provided confidence and assurance of the position. • Concerns remained around clinical coding although risk mitigations were in place. Additional support was being provided by DHC. Temporary agency coders were in place although the provider was no longer within the NHS Framework and may be lost. A transition plan was in place and paper would be presented to DTAG in July. There was a national shortage of clinical coders. • The Board noted a longstanding lag in completing SJRs and the need to ensure a more contemporaneous approach. Divisional teams were reviewing the backlog. The completion of records prior to review contributed to delay and an Artificial Intelligence project was in planning that may support the timeliness of future coding.	
	Resolved: that the Learning From Deaths Q4 Report be approved.	
BoD24/013	**Governance Report**	
	JeH presented the report outlining several in year national governance changes including a new Code of Governance, a new Provider License and the enhanced Fit and Proper Person Test (FPPT) requirements. The report also summarised the conclusions of the Annual Governance Statement and the expected implementation of the new Leadership Competency Framework requirements for all Board members in the autumn. The report aimed to provide assurance of compliance and would be reported in greater detail to the Risk and Audit Committee in June. JeH advised the Board that the trust would be compliant with FPPT requirements by 30th June once DBS checks and outstanding annual Board members attestations had been received. The Board noted the variation in approach to DBS checking for Board members nationally.	
	Resolved: that the Governance Report be received and noted.	
BoD24/014	**Our Dorset Provider Collaborative Report**	
	NJ advised that the Provider Collaborative membership included the GP Alliance and system providers and aimed to promote greater collaboration. Good progress had been made working with UHD and on workforce issues and further work was in train to maximise benefits within procurement processes. Clinical acute networks had been established for Dermatology, Oral Maxillo-facial and Respiratory services to oversee joint performance and network arrangements. The oversight of other collaboratives would follow the establishment of a non-executive oversight group. Whilst progress had been made against ambitious plans, the biggest risks to progress were resource availability and adequate partner engagement.	

	The three trusts were working well and at a senior level acknowledged and recognised the of importance of collaborative working. A further challenge was to secure the work of the collaborative in face of individual organisational / service pressures. DCH was a partner in the collaborative with UHD and DHC and the Board needed to consider the strategic future of acute services from a DCH perspective. The part 2 Board meeting that followed would discuss the issue further.	
	Resolved: that the Our Dorset Provider Collaborative Report be noted.	
BoD24/015	**Social Value Report**	
	SP attended for this item to present a summary of the biannual report. SP highlighted that: • Social Value Programme Group recorded social value activity and had • Contributed to the development of the joint strategy. • The trust's pledge to promote local spend and investment were key social value metrics and were included in the report. Local spend in the previous year was circa £7m with 50% of catering suppliers being in Dorset. • Employment and widening participation included the Health Care Support Worker Scholarship Programme with 100% retention rate. • The apprenticeship target had been exceeded. • Spouses of nurses recruited from overseas had been supported to secure local employment with 13/23 now employed by the trust. • The employment fayre in March had been attended by around 200 people. The Young Volunteer Programme was in place and offered three key ways in which young people could support the trust. • Investment in capital projects – Tilbury Douglas, the trust's construction developer, led in the social value field and their social value return on investment report on South Walks House was included and amounted to circa 12% of the project value. Work had commenced on data relating to the New Hospitals Programme. The board noted the range of social value activity undertaken by the trust and commended the report. Presentations to divisional management teams, general communications and the social value report provided feedback and information about social value activity to teams. Social value was also discussed at staff induction. The Board noted that ICS partner social value engagement remained a challenge and that the Integrated Care Partnership would be best placed to support greater engagement and to demonstrate the work partners were undertaking. NJ to progress outside meeting.	
	Resolved: that the Social Value Report be noted.	

BoD24/016	Board Subcommittee Escalation Reports	
	The following subcommittee Escalation Reports were taken as read. Committee Chairs drew attention to the following key points: **Quality Committee** • Noted the change in committee chair during the period. • Ongoing issues with the ICB commissioned renal patient transport service. Escalated to ICB via the Chief Nursing Officer. • Transfer of clinical policies on SharePoint resulting in challenges in clinical access to these. • Call bells in maternity services being replaced imminently. • Further to the Fuller inquiry, a self-assessment of mortuary service compliance had been undertaken. • Earlier discussion regarding Electronic Discharge Summaries by Board was noted. • Clinical governance review and further review of JAG in 6 months. • Challenges in getting Oliver McGowen face to face training in place were noted. • Detailed discussion of the coding issue – the coding informing the SHMI score had been completed at the cost of the current year's activity. The longevity of the issue was remarked, and the plan was to be presented to DTAG.The Board noted the improvements in the depth of coding. **Finance and Performance Committee** • 2024/25 planning submission – thanks were extended to teams for their tenacity and commitment to developing the plan. • EHR OBC to be discussed in part 2. Noted that prior scrutiny and discussion by the Finance and Performance Committee had not been possible prior to Part 2 discussion. • The cyber security risk was discussed and noted the need for greater visibility of the risk by the Board. • the trust delivered a break-even position at the end of 2923/24 – a significant achievement. • The reduction in agency expenditure was noted. **People and Culture Committee** • Recruitment and vacancy rates had improved. • The number of late papers received by committee was noted. • Divisional dashboards were in use and providing greater interrogation of the data and improved reporting. • Education and Training Report noted that two apprenticeship coders were in training. • A pastoral care award relating to overseas nurses had been received. • There had been a reduction in mandatory training compliance. • There were national issues regarding dementia training provision. • Concerns were raised about the lack of clarity surrounding continuous professional development training funding. • Anxiety, stress and depression remained a persistent causation of staff absence. A report was to be returned to the June committee.	

	• A recruitment audit had returned and positive report demonstrating that several issues had seen improvements. **Charitable Funds Committee** • The charity had generated £640k of income in year, a marginal increase on the previous year. • The majority of funds were now being placed in unrestricted funds. • The Capital appeal had been launched and noted the significant staff contributions. Several significant pledges had also been received. • The committee had not been quorate on one occasion and a review of the terms of reference would be undertaken. **Working Together Committee in Common** • Developing a joint strategy, shared executive posts and the federated model of operation. • The ambition to evolve the Working Together Committee into a transformation and partnership committee. • Several business cases had been agreed and implementation plans were now in place.	**JeH**
	Resolved that: Board subcommittee Escalation Reports be received and noted.	
BoD24/017	**Questions from the Public**	
	LT feedback that her travel agent had provided extremely positive and unsolicited feedback about the hospital and maternity services. KH noted the praise for those staff participating in the DCH 100 event and also commended the work of the charity team who had supported the event. KH requested whether further information could be returned to the Council of Governors about the ICB's role and function within the system.	**MBr**
	CONSENT SECTION	
	The following items were taken without discussion. No questions had been previously raised by Board members prior to the meeting.	
BoD24/018	**Guardian of Safe Working Annual Report**	
	KM acknowledged in his final report, the positive working relationships in operation and mutual respect amongst colleagues within the trust. He noted that junior doctors remained under considerable strain and noted the good working relationship with management and leadership teams. Dermatology and oncology were areas of particular concern. Jill McCormick would be taking on the Guardian role going forward and would be an ample successor. The Board heard the areas of concern and additional support needs and thanked Kyle Mitchell for his contribution as the Guardian of Safe Working.	
	Resolved: that the Guardian of Safe Working Annual Report be approved.	

BoD24/019	**Communications Activity Update**	
	Resolved: that the Communications Activity Update be received and noted.	
BoD24/020	**ICB Part 1 Board Minutes**	
	Resolved: that the ICB Part 1 Board Minutes be received and noted.	
BoD24/021	**Any Other Business**	
	The Board noted that with Junior Doctors would take further industrial action in June and that plans to minimise the impact were in place. MBr extended the Board's thanks to JoH for her significant contributions to the Board and the trust in her role as Executive Interim Chief Nurse over the preceding 18 months and looked forward to continuing to work with her in her role as Deputy Director of Nursing (Acute). The Board also offered their best wishes to TH who would be retiring in July.	
BoD24/022	**Date and Time of Next Meeting**	
	The next part one (public) Board of Directors' meeting of Dorset County Hospital NHS Foundation Trust will take place at **8.30am** on **Wednesday 31st July 2024** in the **Board Room, Trust Headquarters, Dorset County Hospital, Dorchester** and via **MS Teams.**	

Action Log – Board of Directors Part 1

Presented on: 31st July 2024

Minute	Item	Action	Owner	Timescale	Outcome	Remove? Y/N
Meeting dated: 29th May 2024						
BoD24/007	**CEO Update**	An update and learning from the Children and Young People Flagship to be returned to the Board.	**DD**	Autumn 2024	Not due	**N**
BoD24/016	**Board Subcommittee Escalation Reports**	A review of the Charitable Funds Committee Terms of Reference to be undertaken	**JeH**	September 2024	Not due	**N**
BoD24/017	**Questions from the Public**	Further information about the ICB's role and function within the system to be returned to the Council of Governors.	**MBr**	August 2024	ICB Chair to attend August COG	**Y**
Meeting dated: 27th March 2024						
BoD23/184	**Corporate Risk Register**	Risk 1819 to be reviewed; a suggestion that Finance and Performance Committee should be the responsible committee.	**JH AT**	June 2024	Update to be provided in meeting	
BoD23/184	**Corporate Risk Register**	Risk 1814 (relating to the Electronic Health Record) to be reviewed	**NJ**	June 2024	Risk has been closed as the OBC was submitted to DHC, UHD and DCH boards in May 2024, and now submitted to SW Region for a fundamental criteria review (FTR).	**Y**
Actions from Committees…(Include Date)						
Actions to Committees…(Include Date)						

BoD24/008 May 2024	**Balanced Scorecard**	FPC to monitor and assure delivery of the challenging 109% Elective recovery Targets and consider forward trajectories as these are agreed within the plan.	FPC	September 2024	Included in June's FPC Performance Report	**Yes**

Report Front Sheet

1. Report Details			
Meeting Title:	Board of Directors		
Date of Meeting:	Wednesday 31 July 2024		
Document Title:	CEO Report		
Responsible Director:	Matthew Bryant, CEO	Date of Executive Approval	24.07.24
Author:	Jonquil Williams, Joint Corporate Affairs Business Manger		
Confidentiality:	No		
Publishable under FOI?	Yes		
Predetermined Report Format?	No		

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

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

4. Key Issues

Strategic update – national topics of interest

- Following the General Election we are starting to see the first steps being taken by the newly-formed Labour government under Prime Minister Sir Keir Starmer.
- On 27 May 2024, NHS England announced the roll-out of Martha's Rule in 143 hospitals across England. All Dorset's acute hospitals - Dorset County, Royal Bournemouth and Poole - have been selected
- The final report by Sir Brian Langstaff KC into the infected blood inquiry was published on 20 May 2024.
- On 3 June 2024, pathology laboratory Synnovis, which processes blood tests on behalf of several NHS organisations mainly in south-east London, suffered a ransomware cyber attack.

NHS Dorset

- Public Health Dorset currently operates under a shared service agreement between BCP Council and Dorset Council, providing key public health services across both areas.
- A recent Ofsted and CQC inspection found that children and young people in Dorset who have special educational needs and disabilities (SEND) have typically positive experiences and outcomes.

Dorset County Hospital

- On 26 June 2024 the Trust received a letter from NHS England entitled: 'Action required: Maintaining focus and oversight on quality of care and experience in pressurised services'.

	• We were delighted to be notified that the Secretary of State for Health and Social Care has approved Dorset County Hospital's business case for the new Emergency Department and Critical Care Unit. • A sensory courtyard garden is being created at Dorset County Hospital (DCH) thanks to a £45,204 grant from the Greener Communities Fund
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			
Strategic Objectives – Place			
Strategic Objectives – Partnership			
Dorset Integrated Care System (ICS) goals	**Which Dorset ICS goal does this report link to / support?** Please summarise how your report contributes to the Dorset ICS key goals. (Please delete as appropriate)		
Improving population health and healthcare	**Yes**	**No**	If yes - please state how your report contributes to improving population health and health care
Tackling unequal outcomes and access	**Yes**	**No**	If yes - please state how your report contributes to tackling unequal outcomes and access
Enhancing productivity and value for money	**Yes**	**No**	If yes - please state how your report contributes to enhancing productivity and value for money
Helping the NHS to support broader social and economic development	**Yes**	**No**	If yes - please state how your report contributes to supporting broader social and economic development
Assessments	**Have these assessments been completed?** If yes, please include the assessment in the appendix to the report.. If no, please state the reason in the comment box below. (Please delete as appropriate)		
Equality Impact Assessment (EIA)	**Yes**	**No**	
Quality Impact Assessment (QIA)	**Yes**	**No**	

1. Background

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

2. National Strategic Update

2.1 New Government and Secretary of State

Following the General Election we are starting to see the first steps being taken by the newly-formed Labour government under Prime Minister Sir Keir Starmer. The new Secretary of State for Health and Social Care, Wes Streeting, has made some strong statements about the challenges facing the NHS and how he plans to address them.

At the heart of this will be a focus on speeding up changes to the model of care with a strong emphasis on prevention, digital technology, out of hospital care and joint working between community services, mental health, secondary care and primary care. This is also at the centre of the work we've been doing in Dorset so we are well-placed to respond to this and make a positive difference for our communities.

There will also be a focus on waiting times, which we are already working hard to address, and there is likely to be a 10 year reform plan for the NHS. We await further detail on the government's plans and will consider its impact for us as it emerges.

2.2 Martha's Rule sites selected

On 27 May 2024, NHS England announced the roll-out of Martha's Rule in 143 hospitals across England. All Dorset's acute hospitals - Dorset County, Royal Bournemouth and Poole - have been selected to be part of this major patient safety initiative to implement and test Martha's Rule over the coming year.

Martha's Rule will provide a consistent and understandable way for patients and families to seek an urgent review if their or their loved one's condition deteriorates and they are concerned this is not being responded to. NHS England is working with Martha's parents to develop materials to ensure that all patients, families and colleagues understand what the rule means for them and can act on it.

2.3 Report from the infected blood inquiry

The final report by Sir Brian Langstaff KC into the infected blood inquiry was published on 20 May 2024. The independent public statutory enquiry was established to examine the circumstances in which patients were given infected blood and/or infected blood products. It identified that between 1970 and the early 1990s more than 30,000 NHS patients were given blood transfusions, or treatments which used blood products, contaminated with hepatitis C or HIV. The Prime Minster has issued an apology on behalf of successive Governments and the entire British state and Amanda Pritchard, NHS Chief Executive, has issued a public apology on behalf of the NHS in England.

The infected blood and blood products that have been the subject of this inquiry were withdrawn in 1991. Since then comprehensive systems have been put in place to ensure the safety of both donors and recipients of blood and blood-derived products. This includes the establishment of NHS Blood and Transplant in 2005 which distributes blood and blood products to NHS hospitals and follows strict guidelines and testing to protect both donors and patients.

The two key learning points from the inquiry are:

- The need to truly listen to patients when they raise concerns and, where necessary, investigate those concerns objectively
- The need for robust clinical governance processes that identify poor clinical behaviour and decision-making.

2.4 The Synnovis cyber incident

On 3 June 2024, pathology laboratory Synnovis, which processes blood tests on behalf of several NHS organisations mainly in south-east London, suffered a ransomware cyber attack. On 20 June criminals behind the attack published data files and Synnovis are working at pace to identify the full scale and nature of the data released and patient impacted.

This reinforces the need for us to ensure our digital systems are secure and can protect us from the potentially serious impacts of a cyber attack of this kind.

3. Local Strategic Update

3.1 Public health in Dorset

Public Health Dorset currently operates under a shared service agreement between BCP Council and Dorset Council, providing key public health services across both areas.

The local authorities are exploring how we deliver our public health function differently and it has been agreed that the shared public health service will separate from April 2025.

Some of our public health services may continue to be delivered in partnership and some services may be delivered separately by each council. Both councils are currently working through what this looks like in practice and how services may be affected.

Planning after April 2025 will be the responsibility of the newly formed public health services in each council area. We will be engaging with both councils to ensure that we continue to work effectively together to improve the health and wellbeing of all the communities we serve.

3.2 SEND inspection – Dorset Council

A recent Ofsted and CQC inspection found that children and young people in Dorset who have special educational needs and disabilities (SEND) have typically positive experiences and outcomes.

The local area partnership inspection took place over three weeks in March and involved staff from Dorset Council, NHS organisations and education settings as well as many families.

The inspectors reviewed hundreds of pieces of information, many of which were prepared by colleagues at short notice. They spoke to young people and their families as well as practitioners working in children's services, health care and in education settings. The final report is available online.

4. Working in Partnership

4.1 Joint strategy

Following an extended period of engagement with a range of stakeholders and further refinement, our joint strategy is now ready for Board approval. The strategy sets out how we will work together, and in partnership with the wider health and care system, to improve lives in our local communities.

Our vision is for healthier lives, empowered citizens, thriving communities.

Our mission is to work in partnership to provide high quality, compassionate services and to nurture an environment where people can be their best.

These are supported by four high level strategic objectives focussing on:

- **Care:** we provide safe, compassionate care
- **Communities:** we help build strong communities where people live well and are healthier
- **Colleagues:** we are empowered, skilled, caring colleagues who can thrive at work
- **Sustainability:** our services are sustainable environmentally and financially and we make best use of resources

Enabling plans are being developed and a programme of communication and engagement on the strategy internally and externally will begin in the autumn.

4.2 Working Together programme

We continue to develop our approach to working in a federated way, identifying opportunities to improve outcomes and experience for local communities by collaborating more, and working together in partnership with others.

Progress and plans highlighted at the Working Together Programme Board include:

- **Digital**: a renewed focus in the coming months on enabling better digital collaboration between colleagues across the two trusts. This will support the wider system working on digital.
- **Frailty flagship**: this has a goal to reduce unplanned hospital admission for people over 70 and data is starting to show that numbers are reducing in the Dorset County Hospital catchment area.
- **Children and young people parity of esteem flagship**: this project aims to improve the experience of children and young people presenting with mental health issues at the emergency department. It has had significant service user involvement and has been given the green light to progress to the next stage.
- **Joint appointments**: We have appointed a joint director of estates and are in the process of appointing a joint chief information officer. Again this allows us to strengthen the work we are doing with other partners by being able to represent our diverse services with a single voice working strategically.

5. Dorset County Hospital

5.1 Maintaining focus and oversight on quality of care and experience in pressurised services

On 26 June 2024 the Trust received a letter from NHS England entitled: 'Action required: Maintaining focus and oversight on quality of care and experience in pressurised services'. The letter, included at Appendix 1, asks every Board across the NHS to assure themselves that they are working with system partners to do all they can to:

- provide alternatives to emergency department attendance and admission, especially for those frail older people who are better served with a community response in their usual place of residence
- maximise in-hospital flow with appropriate streaming, senior decision-making and board and ward rounds regularly throughout the day, and timely discharge, regardless of the pathway a patient is leaving hospital or a community bedded facility on

The letter sets out a series of areas where specific assurance is required. We are reviewing our arrangements against these areas and assurance will be provided through the Quality Committee and to Board.

5.2 Performance

Flow within the hospital has continued to be a risk at Dorset County Hospital which has been caused by an increase in demand at the front door and decrease in availability of beds in the system. The Industrial Action that took place between 27 June to 2 July impacted our elective delivery and the increase in demand for cancer diagnosis has impacted our cancer performance trajectories.

5.3 New Hospital Programme project jumps next approval hurdle

We were delighted to be notified that the Secretary of State for Health and Social Care has approved Dorset County Hospital's business case for the new Emergency Department and Critical Care Unit and has written to the Chief Secretary at HM Treasury. We are now waiting for formal notification from the Treasury, which is the final approval hurdle before the project can begin in earnest.

5.4 Temporary helipad site receives funding

Air ambulances will find it easier to land at night in Dorchester, thanks to new and improved lighting from the HELP Appeal - the only charity in the country dedicated to funding hospital helipads.

Dorset County Hospital's helipad has temporarily moved to the Army Reserve Centre on Poundbury Road to allow enabling works and construction of the new Emergency Department and Critical Care Unit to take place.

The site, just a short distance from DCH, is already used by military helicopters and includes a large field with easy access for crews to transfer patients to an ambulance and be taken to the hospital, less than three minutes away.

The HELP Appeal donated £13,500 to DCH and Dorset and Somerset Air Ambulance (DSAA) for new and improved lighting which will make it easier for pilots to identify the landing site and arrive and depart safely.

5.5 Dorset County Hospital receives funding for a sensory garden

A sensory courtyard garden is being created at Dorset County Hospital (DCH) thanks to a £45,204 grant from the Greener Communities Fund. DCH's sustainability team applied for the funding to turn a disused courtyard opposite Special Care Dentistry into a sensory courtyard garden for patients, staff and visitors to use.

The Greener Communities Fund supports the creation or improvement of green spaces to benefit the health and wellbeing of people with limited access to green space.

To:
- Integrated care board:
  - chairs
  - chief executives
  - chief operating officers
  - medical directors
  - chief nurses/directors of nursing
- Integrated care partnership chairs
- NHS trust:
  - chairs
  - chief executives
  - chief operating officers
  - medical directors
  - chief nurses/directors of nursing
- Regional directors

NHS England
Wellington House
133-155 Waterloo Road
London
SE1 8UG

26 June 2024

CC:
- Local authority chief executives

Dear colleagues,

Action required: Maintaining focus and oversight on quality of care and experience in pressurised services

Thank you for everything that you and your teams continue to do to provide patients, the public and people who use our services with the best possible care during the period of sustained pressure that colleagues in all health and social care services are experiencing.

Despite the hard work of colleagues, and everything they are achieving in the face of these challenges, we would all recognise that on more occasions than we would like, the care and experience patients receive does not meet the high standards that the public have a right to expect, and that we all aspire to provide.

However busy and pressurised health and care systems are, people in our care – as well as their families and carers – deserve at all times to be treated with kindness, dignity and respect. This week's Channel 4 Dispatches documentary, filmed in the Emergency Department at Royal Shrewsbury Hospital, was a stark example of what it means for patients when this is not the case. While Urgent and Emergency Care (UEC) is facing real pressures as a result of increasing demand, lack of flow and gaps in health and social care capacity,

Publication reference: PRN01417

the documentary highlighted examples of how the service some patients are experiencing is not acceptable.

We are therefore asking every Board across the NHS to assure themselves that they are working with system partners to do all they can to:

- provide alternatives to emergency department attendance and admission, especially for those frail older people who are better served with a community response in their usual place of residence
- maximise in-hospital flow with appropriate streaming, senior decision-making and board and ward rounds regularly throughout the day, and timely discharge, regardless of the pathway a patient is leaving hospital or a community bedded facility on

These interventions are clearly set out in the UEC recovery plan year 2 document, and it is evident from the data that those systems with fewer patients spending over 12 hours in an emergency department are doing a combination of all of them, consistently, with direct executive ownership.

In addition, wherever a patient is receiving care, there are fundamental standards of quality which must be adhered to. Corridor care, or care outside of a normal cubical environment, must not be considered the norm – it should only be in periods of escalation and with Board level oversight at trust and system level, based on an assessment of and joined up approach to managing risk to patients across the system (through the OPEL framework). Where it is deemed a necessity – whether in ED, acute wards or other care environments - it must be provided in the safest and most effective manner possible, for the shortest period of time possible, with patient dignity and respect being maintained throughout and clarity for all staff on how to escalate concerns on patient and staff wellbeing.

While these pressures are most visible in EDs and acute services, they are also wider issues which need whole-system responses, including local authorities, social care and primary and community services. There is therefore a shared responsibility to ensure that quality (patient safety, experience, and outcomes) is central to the system-level approach to managing and responding to significant operational pressures.

In achieving this, Board members across ICS partners should individually and jointly assure themselves that:

- their organisations and systems are implementing the actions set out in the UEC Recovery Plan year 2 letter
- basic standards of care, based on the CQC's fundamental standards, are in place in all care settings
- services across the whole system are supporting flow out of ED and out of hospital, including making full and appropriate use of the Better Care Fund
- executive teams and Boards have visibility of the Seven Day Hospital Services audit results, as set out in the relevant Board Assurance Framework guidance
- there is consistent, visible, executive leadership across the UEC pathway and appropriate escalation protocols in place every day of the week at both trust and system level

- regular non-executive director safety walkabouts take place where patients are asked about their experiences in real time and these are relayed back to the Board

In line with the NHS operating framework, regional COOs, chief nurses and chief medical directors will continue working with ICB colleagues across systems (CMO, CNO, COO/CDOs) and trusts to support a planned approach to clinical and operational assessment of system pressures and risks, ensuring an integrated approach to any tactical response and balancing clinical risk across the system. This collaboration should include provider CEOs, system executives, local authority, and third sector partners where applicable.

Where any organisation is challenged we will work with you to use the improvement resources at our disposal, including clinical and operational subject matter expertise from the highest performing organisations, GIRFT, ECIST and Recovery Support. We also have a joint improvement team with the Department for Health and Social Care for complex discharge led by Lesley Watts, CEO of Chelsea and Westminster. If you are unclear how to ask for help in any of these areas, please do so via your regional COO in the first instance.

We recognise that all colleagues across health and social care are working extremely hard in very difficult circumstances, and that UEC is not the only pathway in which this is the case. However, there are interventions and standards that do make a difference and can address much of the variation in quality and waiting times across the country, and it is incumbent on us all to do everything we can to ensure that the poor quality of care we saw on Monday evening is not happening in our own organisations and systems.

Yours sincerely,

Sarah-Jane Marsh

National Director of Integrated Urgent and Emergency Care and Deputy Chief Operating Officer

NHS England

Dr Emily Lawson DBE

Chief Operating Officer

NHS England

Professor Sir Stephen Powis

National Medical Director

NHS England

Dame Ruth May

Chief Nursing Officer

England

Report Front Sheet

1. Report Details			
Meeting Title:	Board of Directors		
Date of Meeting:	29 May 2024		
Document Title:	Working Together, Improving Lives, Joint Strategy 2024 - 2029		
Responsible Director:	Nick Johnson - Deputy Chief Executive, Joint Chief Strategy, Transformation and Partnerships Officer	Date of Executive Approval	8 Jul 2024
Authors:	Paul Lewis, Sally Northeast, Ciara Darley and Harad Burn		
Confidentiality:	*If Confidential please state rationale:*		
Publishable under FOI?	Yes		
Predetermined Report Format?	**No**		

2. Prior Discussion		
Job Title or Meeting Title	**Date**	**Recommendations/Comments**
Board Development Session	6 Mar / 1 May	Supportive and recommended refinement
Working Together Programme Board	24 May 24	Approved
Joint SLG	29 April / 18 Jul	Supportive
Joint Executive Management team	21 May / 8 Jul	Supportive

3. Purpose of the Paper	**To approve the Vision, Mission, Objectives and outcomes of the Working Together, Improving Lives, Joint Strategy 2024 – 2029.** **To discuss and comment on the implementation plan**						
	Note (✓)		*Discuss (✓)*	✓	*Recommend (✓)*		*Approve (✓)*	✓
4. Key Issues	This report contains the Joint Strategy; Working Together, Improving Lives for both Dorset County and Dorset HealthCare 2024-29, which is submitted for approval by this committee. The Joint Strategy document is at Appendix 1. The report itself details key parts of the strategy, the development process, how engagement was a core to the effort, the close alignment to the Dorset ICS. The report also describes the strategy launch and how it will be delivered through the Enabling plans, One Transformation Approach and the Joint Improvement Framework. The implementation plan is at Appendix 2.						
5. Action recommended	The Board of Directors is recommended to: 1. **APPROVE** the Vision, Mission, Objectives and metrics the Working Together, Improving lives, Joint Strategy 2024 – 2029 2. **Comment** on the implementation and Culture, Communications and Engagement Plans						

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

Risk Link		**Yes**	**~~No~~**	The Joint Strategic Objectives will update and inform the Board Assurance Framework
Impact on Social Value		**Yes**	**~~No~~**	The Joint Strategy has Social Value as part of its principles
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	Updates these objectives		
	Place			
	Partnership			
Dorset Integrated Care System (ICS) goals		**Which Dorset ICS goals does this report link to / support?** *Please summarise how your report contributes to the Dorset ICS key goals.* *(Please delete as appropriate)*		
Improving population health and healthcare		**Yes**	**~~No~~**	The new joint strategy enables mental health, community and acute services across Dorset to work together to improve lives, with a focus on population heath and prevention
Tackling unequal outcomes and access		**Yes**	**~~No~~**	Reducing inequalities is part of the Joint Strategy principles
Enhancing productivity and value for money		**Yes**	**~~No~~**	Productivity and value for money is a core part of the Joint Strategy and is one of the 4 Strategy Objectives
Helping the NHS to support broader social and economic development		**Yes**	**~~No~~**	Yes, this is covered in the principle of Social Value
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**	

Our joint strategy - Working together, Improving lives 2024 – 2029

EXECUTIVE SUMMARY

The joint strategy sets the strategic direction for Dorset County Hospital and Dorset HealthCare for the next five years. It's an ambitious plan that creates a shared vision, mission and objectives for both Trusts working together in a federation.

The work to refresh the joint strategy began in October 2023. We followed a development roadmap, adhering to agreed principles while allowing the flexibility that an iterative approach requires. This process included understanding why a refresh was necessary, defining the strategic framework and its scope, engaging stakeholders, and ultimately establishing a new vision, mission, strategic objectives and metrics.

Throughout the development process we prioritised engaging, listening, and incorporating feedback. The joint strategy brings together contributions from stakeholders, reflecting the evolving needs of the communities we serve and our own ambitions. the strategy aligns with the Dorset Integrated Care Partnership's strategy and Joint Forward Plan.

The strategy underscores our commitment to working with all partners to improve population health, reduce inequalities, positively contribute to local communities, and enhance sustainability. Our unique contribution will see mental and physical health, community and acute services working closely together, integrating care and reducing duplication.

Our vision is for **healthier lives, empowered citizens, thriving communities**. Our mission sets out how we will achieve the vision. Our mission is **to work in partnership to provide high quality, compassionate services and to nurture an environment where people can be their best**

To deliver the mission we have developed four strategic objectives:

- **Care - we provide safe, compassionate care**
- **Communities - we help build strong communities where people live well and are healthier**
- **Colleagues - we are empowered, skilled, caring colleagues who can thrive at work**
- **Sustainability - our services are sustainable environmentally and financially and we make best use of resources**

Subject to approval, the next steps will be implementation. This includes finalising the metrics to track progress, launching the strategy formally, finalising the governance arrangements and moving to delivery through the One Transformation Approach and the Joint Improvement Framework.

The Joint Strategy document is at Appendix 1 and the supporting implementation plan is at Appendix 2.

INTRODUCTION

This joint strategy represents the shared ambition of Dorset County Hospital and Dorset HealthCare to transform healthcare delivery and improve the health and wellbeing of local

communities. As federated NHS trusts, we aim to combine our strengths to improve integration and collaboration between physical and mental health, community and acute services, improving care and experience for those we serve. Our strategy is aligned with national NHS priorities and the Dorset Integrated Care Partnership (ICP) goals and ambitions. It ensures we address the evolving needs of our population while fostering a supportive and inclusive environment for staff.

VISION & MISSION

The proposed vision is **for healthier lives, empowered citizens, thriving communities**

The proposed mission is **to work in partnership to provide high quality, compassionate services and to nurture an environment where people can be their best**

STRATEGIC OBJECTIVES

To deliver the mission we have developed four strategic objectives:

- **Care - we provide safe, compassionate care**
- **Communities - we help build strong communities where people live well and are healthier**
- **Colleagues - we are empowered, skilled, caring colleagues who can thrive at work**
- **Sustainability - our services are sustainable environmentally and financially and we make best use of resources**

DEVELOPMENT PROCESS

The joint strategy developed using a structured approach combined with significant stakeholder engagement, feedback, and refinement. This resulted in a vision, mission and objectives that reflect our stakeholder contributions.

The strategy development was informed by the Dorset ICP strategy, the Joint Forward Plan, the ambitions of both trusts for the future and a focus on responding to the evolving needs of the communities we serve. The graphic below shows how the joint strategy aligns with the Dorset Integrated Care System plans.

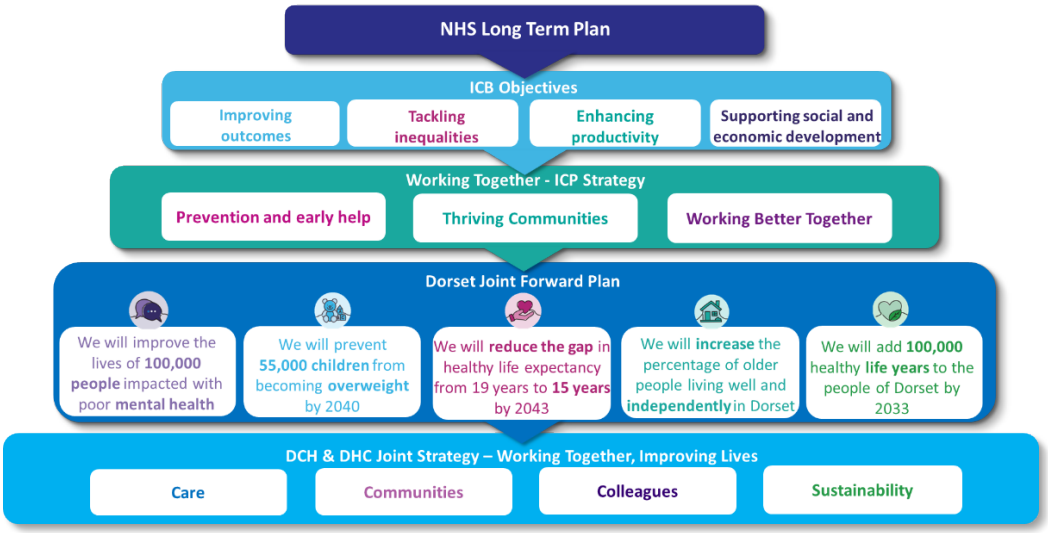


Figure 1 - System Alignment

The roadmap below shows the main steps taken to develop the strategy. While progress was broadly linear, there was significant refinement and iterations along the way based on feedback, better understanding and reflection. Development started in October 2023 and is set to complete in August 2024, when launch and implementation will commence.

We worked with stakeholders to develop a set of guiding principles to support the development and implementation of the strategy – they are set out on page 17 of the strategy.

Extensive engagement with stakeholders has helped inform and shape the joint strategy. The key themes we heard were; enhancing partnership working to improve support and care, future proofing and sustainability, environmentally, financially and digitally, supporting our staff to improve and to deliver the aims of the strategy.

The key words we heard were Compassion, Kindness, Together, Integrated, Quality, Respect, Empowering, Excellence, Community, Thriving.

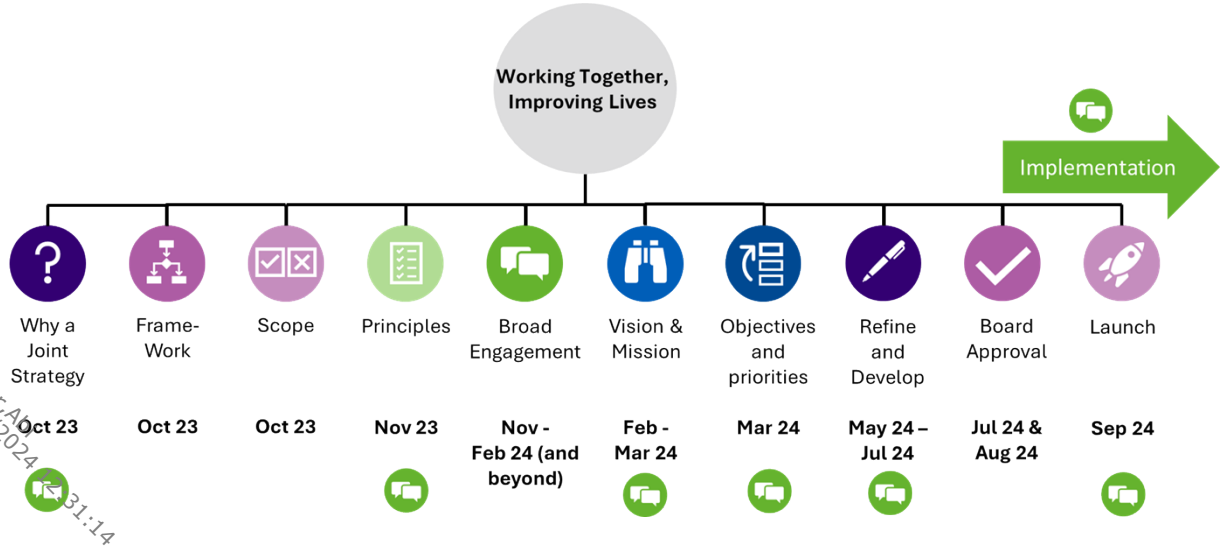


Figure 2 – High level development timeline

IMPLEMENTATION

The joint strategy outlines the future direction for both Trusts over the next five years and will be delivered through the Clinical & Quality, Digital, People, Finance, and Infrastructure plans. This will be supported by the development of a single transformation approach and the Joint Improvement Framework.

This strategy represents an exciting new direction for both Trusts. We will be different. There will be a greater emphasis on communities, population health, and enhanced collaboration and integration of mental and physical health services across community and acute settings. Staff are at the heart of this transformation, and their engagement is essential to achieving our goals. By fostering good engagement, we aim to increase staff commitment, ensuring their working lives become more fulfilling and rewarding.

Clinical and Quality Plan

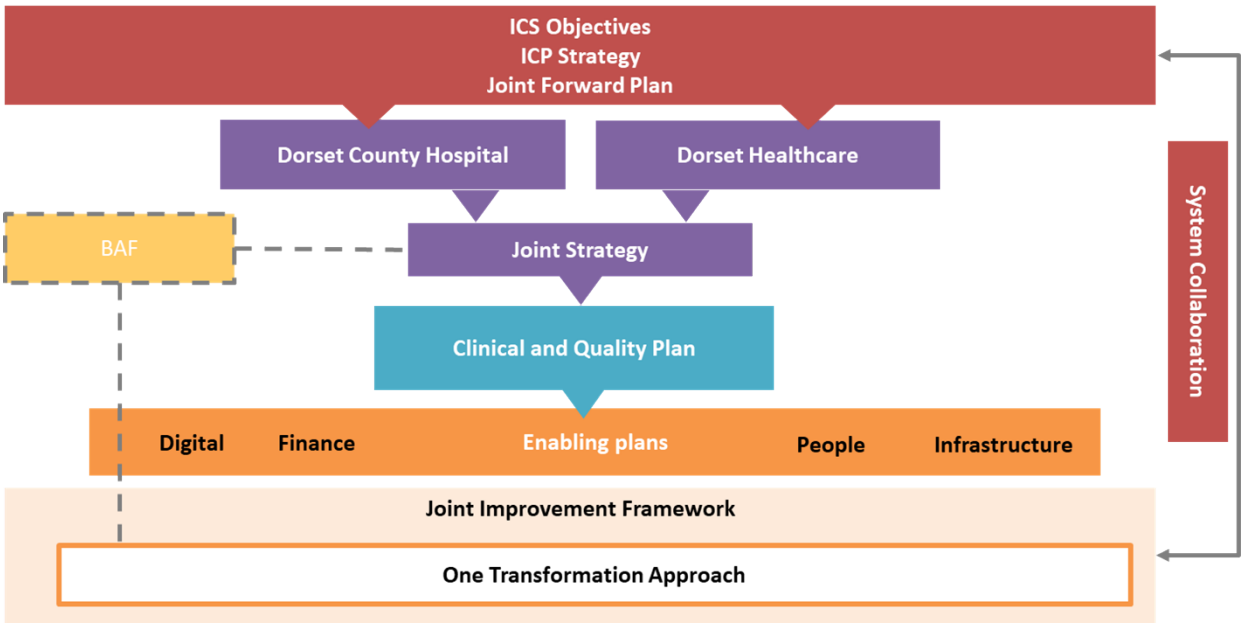
Building on the joint strategy, the Clinical and Quality Plan will detail our clinical and quality goals. Specifically, it will outline how we aim to better integrate mental and physical health, community and acute services to improve the experience and outcomes for patients. The plan will focus on providing high quality, safe, and compassionate care, ensuring people are equal partners in their care. It will emphasise building strong communities where people live well and enjoy healthier lives, with a strong focus on prevention of ill health.

Enabling Plans

Digital, finance, workforce, and infrastructure plans are being developed to coordinate efforts and ensure a more focused approach on what truly matters.

Board Assurance Framework

The refreshed Board Assurance Framework is in development to ensure a smooth transition, enabling the Trusts to monitor and report on strategic risks and controls.



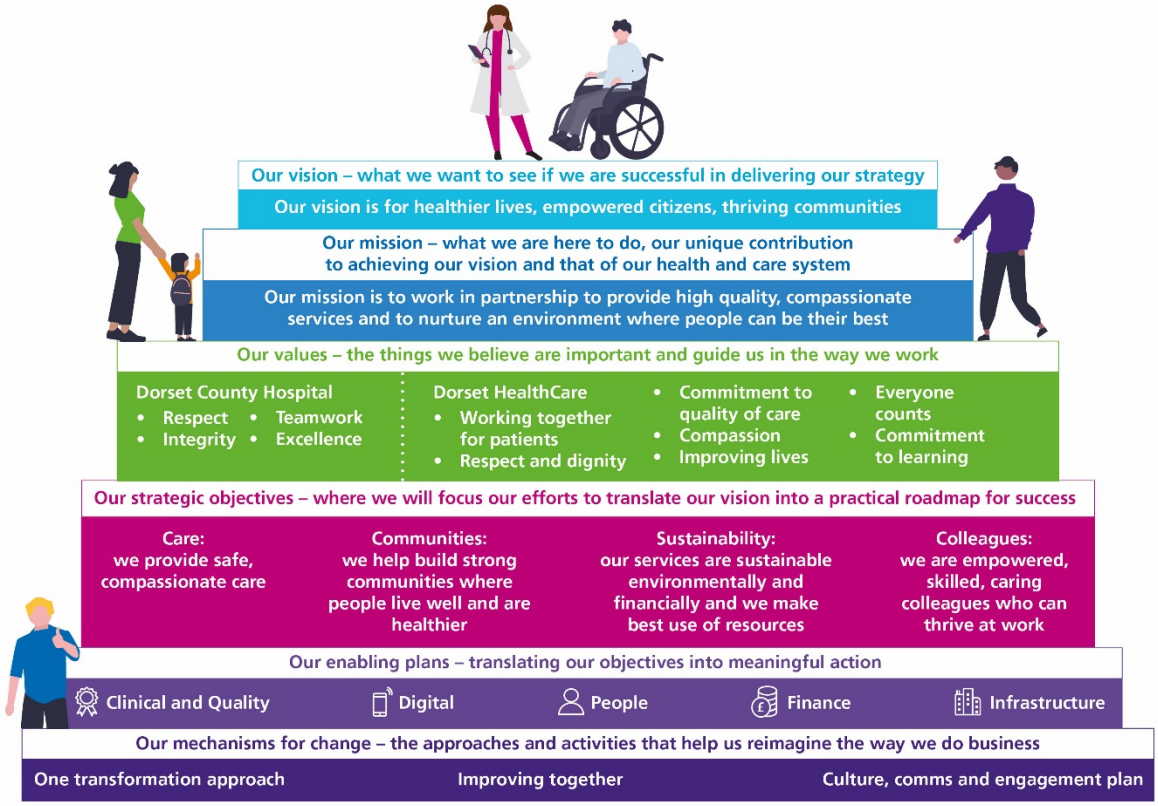
Culture, communications and engagement

The publication of the strategy is our opportunity to reinvigorate our two organisations under our new vision, mission and objectives. From the autumn we will run a comprehensive cultural development programme with colleagues which will enable everyone to make the connection between the strategy and their role. This will include a reshaped programme of organisational development and staff engagement including updates to our induction, recognition and reward programmes. This will be supported by communications activity, which is set out at a high level in the culture, communications and engagement plan at appendix 3.

CONCLUSION

- Our joint strategy - Working Together, Improving Lives 2024 – 2029 - has followed an agreed development process.
- Engagement, development, and refinement following agreed principles have been hallmarks of the development.
- The vision, mission, objectives and outcomes reflect feedback, system alignment, our own ambitions and the evolving needs of the communities we serve.
- The implementation plan brings the joint strategy to life and sets out the main components of the One Transformation Approach and the Joint Improvement Framework

The Joint Strategy is summarised in the graphic below.



RECOMMENDATIONS

The Board of Directors is recommended to:

1. Approve the Vision, Mission, Objectives and Outcomes for the Working Together, Improving lives, Joint Strategy 2024 – 2029
2. Comment on the implementation and Culture, Communications and Engagement Plans

Authors:
Ciara Darley – Senior Programme Manager
Harad Burn – Graduate Management
Paul Lewis – Deputy Director Strategy, Transformation & Partnerships
Sally Northeast - Associate Director of Communications and Public Engagement DHC

Date: 24 July 2024

Appendices
Appendix 1 – Joint Strategy Working Together, Improving Lives 2024 - 2029
Appendix 2 – Implementation Plan
Appendix 3 – Culture, Communications and Engagement Plan

Working together, improving lives

Dorset County Hospital and Dorset HealthCare

Foreword – Chief Executive and Chair

We are delighted to share our first joint strategy for Dorset County Hospital and Dorset HealthCare. As federated NHS trusts working closely with our Dorset health and care system partners, we are setting out clear intentions and ambitions that we can achieve together.

We need to transform our services and the way we work to better meet the needs of Dorset people and communities now and for the future. Our ambition is to change out of hospital services across the whole health and care system. We need to do this to meet the challenges we face, along with the wider NHS, and to improve access to healthcare for local people.

Working closely with citizens and communities and putting their voice at the heart of all we do is vital to our success. We are looking to transform the way people manage their own health – empowered, supportive communities and innovative digital solutions will be two key elements to this change.

Our strategy is aligned to the national priorities for the NHS, as well as the ambitions set out in the Dorset Integrated Care Partnership's strategy Working Better Together. We believe strongly in the power of partnership and that we can achieve more together as two trusts, playing our part alongside partners in the wider health and care system.

Our vision, mission and objectives clearly reflect our renewed focus on improving population health, working in partnership, making the very best use of our resources and supporting, developing and retaining our people.

Central to this strategy is our commitment to inclusion and belonging and to ensuring that we address the inequalities we know exist in health outcomes for some communities and groups.

We also recognise that as large organisations we can make a positive contribution to society, supporting our communities and our economy to thrive by adding social value.

Our objectives will guide us in achieving the strategic outcomes we set, underpinned by robust delivery plans and a structured approach to transforming and improving our services.

Thank you to everyone who gave their views as we developed this strategy. We will continue to evolve our approach and will keep the conversation going to ensure local people are at the heart of all we do.

Matthew Bryant
Chief Executive

David Clayton-Smith
Chair

Table of contents

Dorset County Hospital and Dorset HealthCare

Working together, improving lives

Joint strategy 2024-29

NHS

Our vision is for healthier lives, empowered citizens, thriving communities.

Our mission is to work in partnership to provide high quality, compassionate services and to nurture an environment where people can be their best.

Our strategic objectives

Care

We provide safe, compassionate care.

- Improved access to the right care, at the right time, in the right place
- People are equal partners in their care and have a positive experience
- Patients and service users are always safe in our care

Communities

We help build strong communities where people live well and are healthier.

- Improved population health and wellbeing through joined up working across health and care
- People staying well through prevention, detection and early intervention, with more control over their own health
- People and communities involved in shaping health and care services

Colleagues

We are empowered, skilled, caring colleagues who can thrive at work.

- Colleagues are positive about their experience at work
- All colleagues feel they belong and are included
- A sustainable workforce with the right skills now and for the future

Sustainability

Our services are sustainable environmentally and financially and we make best use of resources.

- Releasing time to care through improved processes, skill mix and digitally enhanced technology
- Sustainable models that optimise use of the available resources
- Using our size, scale and reach to make a positive difference to the economic and social wellbeing of Dorset
- Minimise our negative impact on public health and the environment

Our values

Dorset County Hospital

- Respect
- Integrity
- Teamwork
- Excellence

Dorset HealthCare

- Working together for patients
- Respect and dignity
- Commitment to quality of care
- Compassion
- Improving lives
- Everyone counts
- Commitment to learning

1. Our communities

Population health

The GP registered population in Dorset as a whole is 831,631. Data from Public Health Dorset (November 2023) sets out specific information about the communities served by Dorset Council and Bournemouth, Christchurch and Poole (BCP) Council.

Dorset Council area

The Dorset Council area is home to just over 379,000 people.

Population growth in last 10 years **4%**

Residents >65 **30%**

People are generally healthier and live for longer than the national average.

Life expectancy

Women 84.6 years (82.6 nationally)

Men 80.6 years (78.6 nationally)

Health inequalities in life expectancy between the most and least deprived areas show the difference is 5.2 years for men and 4.6 years for women.

BCP Council area

BCP is home to just over 400,000 people.

Population growth in last 10 years **5.6%**

Residents >65 **22%**

Inward migration of young people thanks to its three universities.

Like Dorset, people in the BCP area are generally healthier and live longer than the national average.

Life expectancy

Women 83.3 years (82.6 nationally)

Men 79.7 years (78.6 nationally)

Health inequalities in life expectancy between the most and least deprived areas show the difference is 6.9 years for men and 6.4 years for women.

For young people the levels of childhood obesity are lower than England as a whole but hospital admissions for self-harm are worse than England. For adults, the percentage of people experiencing depression is in line with England, as is the percentage of those who are overweight or obese, though this is still over 60% and has changed little over time. While mortality rates are lower than (Dorset) or similar to (BCP) England, a significant number of registered patients have hypertension and for many this co-exists with depression, diabetes and kidney disease.

2. Our Dorset – partners working together

We are part of the Our Dorset Integrated Care Partnership (ICP), which includes the county's NHS organisations, our two councils, our police and fire services and our partners in the voluntary and community sector.

Building on long-standing, strong and successful partnerships in Dorset, our ICP makes decisions and works together to improve the health and wellbeing of the people living here.

The integrated care partnership:

- is collectively responsible for budgets, staffing and delivering the best care for people in Dorset
- gives consistent advice and proactive support so people can stay well, particularly those who are vulnerable or at higher risk of developing serious or long-term health conditions
- joins up care and treatment when needed
- improves access to services so everyone is given the right care in the right place at the right time
- works at a local level with communities on how services are delivered.

Our Dorset Provider Collaborative (ODPC)

In Dorset we have set up a single strategic provider collaborative which is governed by a leadership board. This is in addition to some service-specific provider collaboratives.

The goals of the ODPC are:

- 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 ODPC uses co-production principles to work with communities, colleagues, health and care providers and wider partners to support these goals and to help deliver the Integrated Care Partnership strategy.

Collective decisions are made through the ODPC Leadership Board on behalf of the member organisations.

The partner organisations of Dorset ODPC are:

- Dorset County Hospital NHS Foundation Trust
- Dorset HealthCare University NHS Foundation Trust
- University Hospitals Dorset NHS Foundation Trust
- Dorset General Practice Alliance (DGPA)

Membership of the ODPC and representation on its leadership board has been extended beyond the partnership organisations. It includes representatives from Wessex Local Medical Committee, South Western Ambulance Service NHS Foundation Trust (SWASFT) and NHS Dorset.

The ODPC has identified three initial areas of focus:

- clinical acute networks
- shared services
- workforce and agency.

The ODPC also oversees a number of existing programmes where collaborative work was already happening.

3. Our trusts and our federation

Dorset County Hospital and Dorset HealthCare are two foundation trusts working in a federated way to better meet the needs of our population and contribute to the collective objectives of Dorset's integrated care partnership.

Dorset County Hospital

Dorset County Hospital (DCH) provides a range of clinical services for over 300,000 people who live mainly in west, mid- and north Dorset in both rural and urban communities.

DCH employs around 3,500 members of staff, working across various locations including the main hospital in Dorchester, GP surgeries, schools, residential homes, people's own homes and in the five community hospitals in Weymouth, Portland, Bridport, Blandford Forum and Sherborne.

The hospital itself has approximately 378 beds including 32 maternity, 14 paediatrics and 12 critical care. There are seven main operating theatres and two day surgery theatres.

Increasing demand is putting pressure on the emergency department (ED), which treats twice as many people as it was built for. Demand is expected to increase and much-needed government investment has allowed work to begin on building a new ED and critical care unit.

The Outpatient Assessment Centre in the centre of Dorchester runs outpatient clinics, diagnostic appointments and day case local anaesthetic procedures. This allows patients to be seen for multiple appointments in one visit and frees up valuable space on the main hospital site.

Dorset HealthCare

Dorset HealthCare (DHC) provides community and inpatient physical and mental health services for over 830,000 people across Dorset and beyond. It employs around 7,000 staff with a wide range of expertise and specialisms. They deliver healthcare at over 300 sites, including mental health inpatient hospitals, community hospitals, GP surgeries, village halls, schools, care homes and people's own homes.

Community physical health services include 12 community hospitals, minor injuries units, district nurses, health visitors, school nursing, end of life care, sexual health services, safeguarding children, diabetes education, audiology, speech and language therapy, dermatology, podiatry, orthopaedic services, wheelchair services, anti-coagulation services, pulmonary rehab and stroke services.

DHC is the provider of NHS mental health services for Dorset, with some services also delivered in Southampton. Services include inpatient hospitals, Child and Adolescent Metal Health (CAMHS), eating disorders support, homeless support, Steps2Wellbeing (talking and psychological therapies), perinatal services, Armed Forces support, learning disabilities support, retreats and community front rooms.

Demand for all services has been increasing, particularly post-pandemic, and the Trust has been successful in winning funding through the New Hospital Programme to increase mental health provision in the county. Work on our children and young people's psychiatric intensive care unit in Bournemouth and improvements to adult mental health facilities at the main St Ann's campus in Poole began in 2024. We also opened a new eating disorders unit in 2023 which was co-designed with people who use our services.

The federation of our two trusts

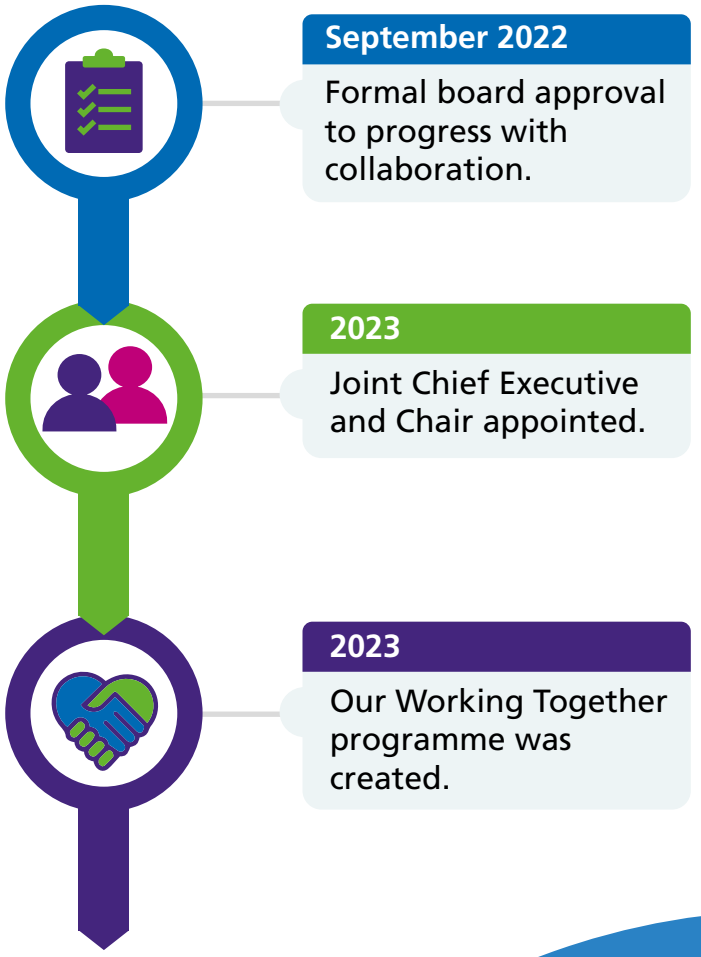
In 2022 our two trusts explored the potential benefits of sharing a Chief Executive and Board Chair. The two Boards agreed to create this new leadership model to help simplify decision-making, increase integration and improve quality and outcomes for the people we serve.

We appointed a joint Chief Executive of both trusts in April 2023 and a joint Chair in May 2023. They are now leading our organisations in developing a clear common purpose and innovative solutions for our current challenges with a focus on:

- preventing ill-health
- tackling health inequalities
- integrating physical and mental health more effectively
- joining up workforce planning and development.

Our Working Together programme was created to make the most of the closer relationship between the two trusts with a focus on:

- improving our patients' experience through more joined up care between teams
- improving population health through better patient pathways, improved outcomes, working together for our shared service users, sharing good practice
- providing new personal and team development opportunities for staff
- improving efficiency through better decision-making, mutually supportive transformation agendas and strategic planning, reduced duplication, and improved use of resources.



The programme has made progress on four flagship clinical programmes and has also collated a range of case studies where services across the trusts are already working together to achieve better outcomes for patients.

In 2024 the trusts agreed to work together through a federated model. While this is not a formal merger it does give us a framework to work more closely and is an established model being used elsewhere in the country. In a federation of NHS trusts:

- we retain individual sovereignty – we are separately accountable to NHSE and regulated by the CQC, with individual Trust Boards holding the executive to account
- we have a shared common purpose, set out in this strategy
- our teams work together to support new models of integrated care
- we are developing a shared culture
- we have a shared executive team with other joint posts where this makes sense
- we have some shared governance arrangements
- we have some shared corporate services
- we have a legally binding agreement between us.

We actively encourage colleagues and teams to explore all opportunities to work more collaboratively and will support them to do this through a comprehensive programme of engagement and cultural development.

Working together, improving lives

Serving all Dorset communities

We recognise that our two trusts serve different communities with Dorset HealthCare as a whole-county provider and Dorset County Hospital serving the west of the county.

The way we work in the east of the county will be a little different and our relationship with University Hospitals Dorset (UHD) is critical. The Our Dorset Provider Collaborative is a key vehicle for this work with the three trusts working together, and with primary care and other partners, to join up services wherever possible. Dorset HealthCare will also continue to develop new ways of working with UHD and more joined-up services for communities in the east of Dorset. Work to establish integrated community and neighbourhood teams will involve all the provider trusts and enable a tailored, local focus on what's needed in different parts of the county.

As key players in the integrated care system, we are committed to working constructively with all partners to ensure that all our communities can access the services they need. We must work together to tackle key issues, particularly where they lead to inequalities in health outcomes for different communities and groups.

These disparities are often systematic and preventable, resulting from the environments in which we are raised, reside and work. All these factors impact our chances of achieving mental and physical wellbeing and we have a clear duty to take action together to address them.

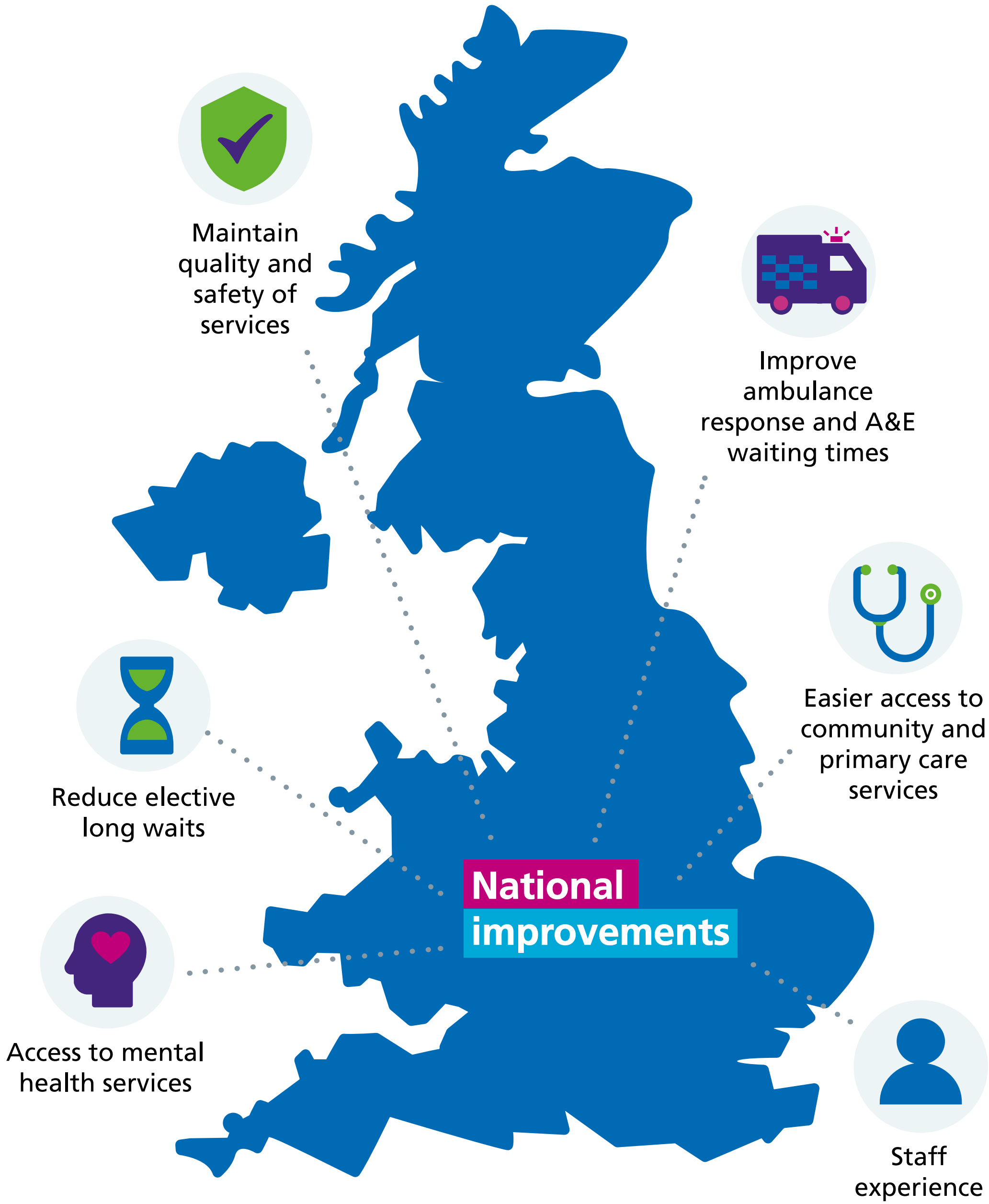
4. Strategic context

The national picture

The overall priority for the NHS nationally for 2024/25 continues to be the recovery of core services and improving productivity following the COVID-19 pandemic. To improve patient outcomes and experience NHS organisations must continue to:

- maintain our collective focus on the overall quality and safety of our services, particularly maternity and neonatal services, and reduce inequalities
- improve ambulance response and A&E waiting times by supporting admissions avoidance and hospital discharge and increasing acute bed and ambulance service capacity
- reduce elective long waits and improve performance against the core cancer and diagnostic standards
- make it easier for people to access community and primary care services, particularly general practice and dentistry
- improve access to mental health services so that more people of all ages receive the treatment they need
- improve staff experience, retention and attendance

Integrated care boards, trusts and primary care providers need to work together to plan and deliver a balanced net system financial position in collaboration with other integrated care system partners.



The Dorset picture

Dorset Integrated Care Partnership's strategy Working Better Together sets out the vision and priorities for all partners delivering health and care support in Dorset. Our strategic objectives align with this strategy to contribute to these over-arching ambitions for our communities.

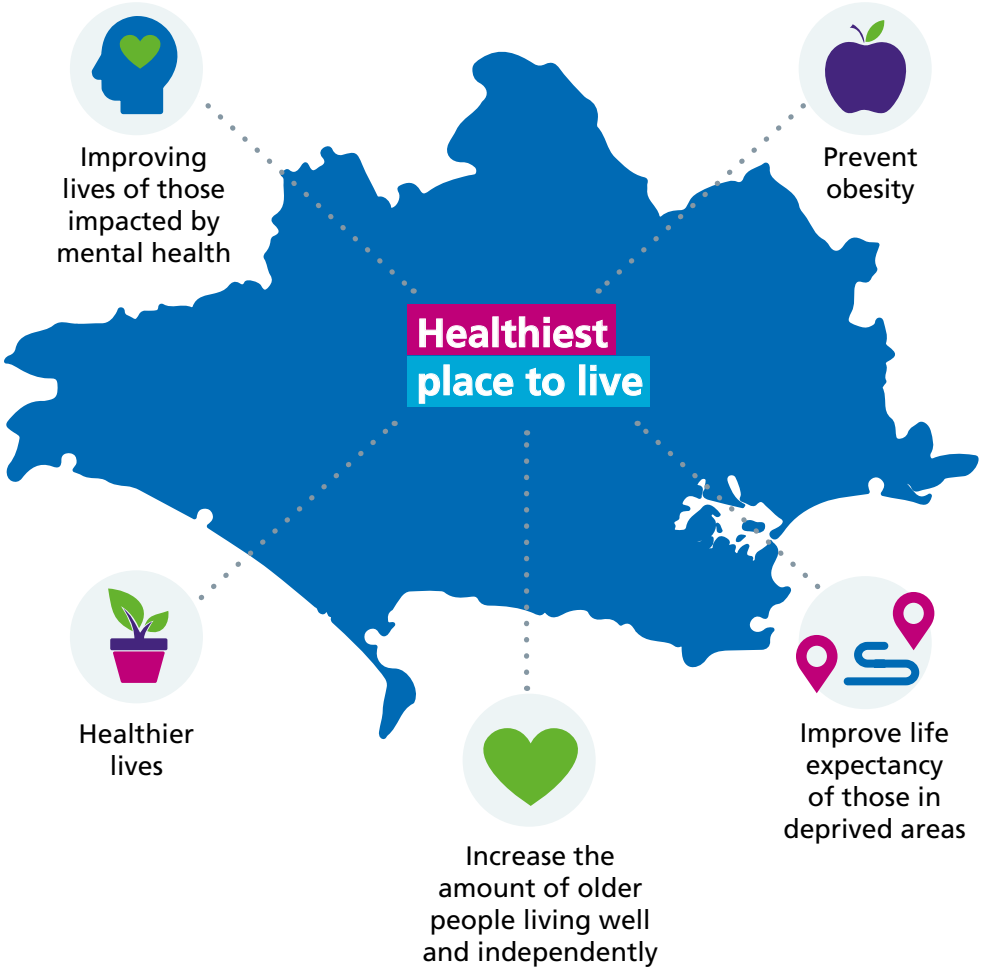
The vision of the Dorset Integrated Care Partnership is to work together to deliver the best possible improvements in health and wellbeing.

Its key priorities are:

1. prevention and early help
2. thriving communities
3. working better together.

The joint forward plan, Making Dorset the healthiest place to live, sets out how we will deliver the strategy and focuses on five outcomes:

1. we will improve the lives of 100,000 people impacted by poor mental health
2. we will prevent 55,000 children from becoming overweight by 2040
3. we will reduce the gap in life expectancy between most and least deprived areas from 19 years to 15 years by 2043
4. we will increase the percentage of older people living well and independently in Dorset
5. we will add 100,000 healthy life years to the people of Dorset by 2033.



Why we have developed a joint strategy

In line with the national picture, both trusts have faced ongoing challenges in recovering services from the impacts of the pandemic. Access to cancer treatment, elective care, community health services and social care have been significantly affected over the last five years and there is increased demand for mental health services.

As our federation develops, our joint strategy gives us a shared direction and purpose, as set out by our joint vision and mission, as we work to improve the health and wellbeing of our communities. It describes our unique contribution to the communities we serve while working together with our partners.

This joint strategy provides:

- **For our patients, service users, carers, and communities**: a clear description of how we will improve and develop services shaped around local needs
- **For our staff**: an understanding of the key priorities which will guide the way we plan and deliver care together
- **For our system partners**: a description of our contribution to the partnership working that will support the health and wellbeing of our communities

5. Key principles

We worked with stakeholders to co-produce a set of guiding principles which are embedded in the strategy to guide us now and into the future.

- We provide high quality, safe and effective care
- We work with our partners to improve health and reduce inequalities
- We make a positive contribution to the communities we serve. Dorset County Hospital has started its social value journey and both trusts will work to ensure that, as anchor institutions, we consider the best ways to make a positive contribution in our communities
- Patients, service users, carers and communities are at the heart of everything we do and are an equal partner in the way we plan and deliver care. We work to the principles of the ICS's approach to working with people and communities
- Our greatest asset is our staff and their positive working relationships with each other and with partners and the people we serve
- We maximise the value of our collective resources and live within our means
- Collaboration is the accepted way we work
- We are continuously improving

6. How we shaped this strategy

In developing this strategy we engaged with staff from both trusts, patient and carer representatives, partner organisations and the public to understand what is important to them.

This was done across a three-month period through face-to-face and online meetings and an online survey. We received a varied range of views and will continue to test out our approach as we develop our plans for the future.

We themed the views we received to identify the topics that are most important to those who took part in the engagement. The main themes emerging from the engagement were:

Patients, carers and public

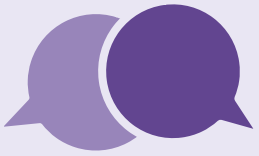
- Being seen, treated and discharged quickly
- Being flexible in how we deliver care
- Good communication and being listened to
- Good information and signposting
- Having a good experience of care
- Working with partners to join up health and care
- Finding innovative solutions and making the best use of digital
- Reducing bureaucracy
- Sharing and recognising skills

Staff

- Improved outcomes and experience for patients
- Patient safety and quality
- Reduced inequality and variation
- Co-design with communities so people are in control of their own health and wellbeing
- Making better use of resources and being financially sustainable for the future
- Support for staff in a compassionate and empowered culture
- Improved workforce supply
- Better partnership working

Key words from engagement

- Compassion
- Kindness
- Together
- Integrated
- Quality
- Respect
- Empowering
- Excellence
- Community
- Thriving



7. Our vision and mission

Our vision is for healthier lives, empowered citizens, thriving communities

Or vision shows how we would like things to be if we are successful in delivering our strategy. It demonstrates our commitment to helping improve the health of the population, with people being in control of their own health and all of us playing our part to help our communities thrive.

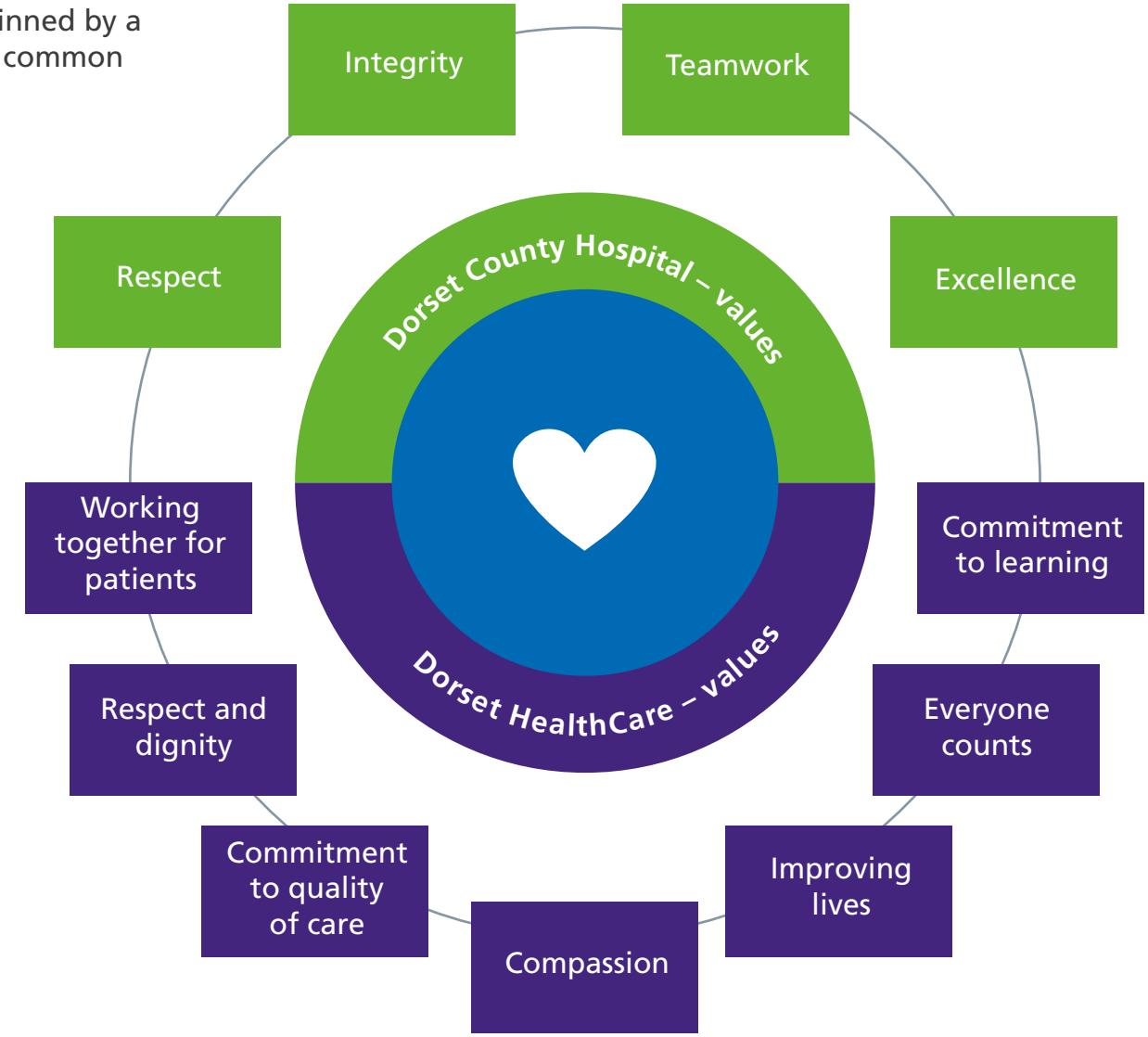
Our mission is to work in partnership to provide high quality, compassionate services and to nurture an environment where people can be their best

Our mission represents what we are here to do, our unique contribution as two federated trusts to achieving our vision and the wider ambitions of our health and care system. It shows that our two trusts will work together and with others to achieve the best possible outcomes for Dorset communities. It highlights the importance of supporting and empowering colleagues to provide the best possible care.

Healthier lives
Empowered citizens
Thriving communities

8. Our values and behaviours

Our two trusts each have their own values, underpinned by a set of behaviours, and we will look to build on the common themes to develop shared values for the future.



9. Our strategic objectives

Our strategic objectives show where we will focus our efforts to translate our vision into a practical roadmap for success for the next five years. They provide clarity and direction and support us to make decisions and prioritise resources. By monitoring our progress against these objectives, we can celebrate our successes and quickly identify areas that need improvement.

CARE – we provide compassionate, safe, person-centred care

COMMUNITIES – we help build strong communities where people live well and are healthier

COLLEAGUES – we are empowered, skilled, caring colleagues who can thrive at work

SUSTAINABILITY – our services are sustainable environmentally and financially and we make best use of resources

Objective 1: CARE – we provide compassionate, safe, person-centred care

CARE

What we heard

People told us they want a good experience of care and to be seen, treated and discharged quickly. It is important to them that we continue to focus on patient safety, quality and improving outcomes. They also want good information and effective signposting to support them on their care journey and to manage their own health.

What will success look like?

We will provide the safest and most person-centred care we can for everyone using our services. That means that when people need care, they can access it easily, in the right setting and with the most appropriate professional. People receive streamlined care, which is co-ordinated in a way that puts individuals at the centre of their care, responding to all of their physical and mental health needs. This leads to improved experiences of care and better outcomes. Everyone should feel they are an equal partner in their own care and that they are treated with respect and kindness, every time.

What we want to achieve	How we will measure progress
Improved access to the right care, at the right time, in the right place	• Patient reported and clinical outcome measures • Waiting times for access to, and discharge from, services • Number of out of area placements • Care provided locally or care provided out of hospital
People are equal partners in their care and have a positive experience	• Patient experience feedback and complaints • Empowerment level metrics
Patients and service users are always safe in our care	• No avoidable harm across all our mental and physical health services

Objective 2: COMMUNITIES – we help build strong communities where people live well and are healthier

COMMUNITIES

What we heard

People want their care to be joined up and seamlessly delivered, which could be achieved through better partnership working. They want to be involved in shaping and co-designing health services so that they can be more in control of their own health and wellbeing. They are looking for more flexible approaches to delivering care and a focus on reducing inequality and variation in care.

What will success look like?

We are committed to working together in collaboration with people and communities, our healthcare and other partners to help build healthier communities for everyone. We know we can make a difference by shaping our services to meet the needs of the communities we serve. We will improve and develop pathways between mental and physical health services and community and acute services. Our work will focus on empowering people to be well and stay healthy with a clear focus on preventing ill health. We will seek to tackle inequalities in outcomes and access and make the care we provide fairer for all those that need it.

What we want to achieve	How we will measure progress
Improved population health and wellbeing through joined up working across health and care	• Health and inequality metrics • Variation in service provision, access and experience
People staying well through prevention, detection and early intervention, with more control over their own health	• Population activation measures (to be developed) • Population health data • Unplanned health and care interventions or % of population living well / independently
People and communities involved in shaping health and care services	• Number of people and communities involved in the co-design and co-production of their local health and care services

Objective 3: COLLEAGUES – we are empowered, skilled, caring colleagues who can thrive at work

COLLEAGUES

What we heard

Colleagues want to feel supported by a compassionate and empowered culture. They want us to have the right staff with the right skills and for knowledge and expertise to be shared and recognised. They would like to see reduced bureaucracy and better partnership working to ensure we are effective.

What will success look like?

We know when staff feel content, valued and empowered there are improved outcomes and experience for people using our services. We view diversity as a strength to be encouraged and celebrated. We will support our staff to realise their potential, providing learning and development opportunities, creating a psychologically safe environment and a culture of continuous improvement.

What we want to achieve	How we will measure progress
Colleagues are positive about their experience at work	• Colleagues recommending our trusts as a place to work • Team effectiveness assessment? • Cultural measure
All colleagues feel they belong and are included	• Relevant NHS staff survey metrics
A sustainable workforce with the right skills now and for the future	• Colleagues accessing learning and development • Turnover • Planned versus actual workforce • Creation of new and innovative roles?

Objective 4: SUSTAINABILITY – our services are sustainable environmentally and financially and we make best use of resources

SUSTAINABILITY

What we heard

People told us it was a priority for us make the best use of our resources to ensure we are financially sustainable for the future. They are keen for us to find innovative solutions and make the best use of the opportunities offered by digital technology. They felt we should carefully consider our impact on our environment and also the positive contribution we can make, as organisations, to local communities.

What will success look like?

To provide the best care we can, we need to use our resources wisely, now and for the future. We will live within our means, be as productive as we can be, eliminate waste and spend wisely to get the best value. We are committed to positively contributing to the social and economic health of our local communities and will spend locally whenever we can to boost the local economy. We will reduce the carbon we use and positively contribute to the local environment wherever we can.

What we want to achieve	How we will measure progress
Releasing time to care through improved processes, skill mix and digitally enhanced technology	• New / redesigned posts? • Productivity and effectiveness metrics • Digital plan metrics
Sustainable models of care that optimise use of the available resources	• Dorset per capita spend on health and care • Financial balance • Number of resilient services
Using our size, scale and reach to make a positive difference to the economic and social wellbeing of Dorset	• Progress against our social value pledge
We minimise our negative impact on public health and the environment	• Green plan metrics

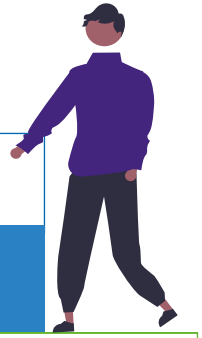
10. Strategic summary

Our vision – what we want to see if we are successful in delivering our strategy

Our vision is for healthier lives, empowered citizens, thriving communities

Our mission – what we are here to do, our unique contribution to achieving our vision and that of our health and care system

Our mission is to work in partnership to provide high quality, compassionate services and to nurture an environment where people can be their best



Our values – the things we believe are important and guide us in the way we work

Dorset County Hospital

- Respect
- Teamwork
- Integrity
- Excellence

Dorset HealthCare

- Working together for patients
- Respect and dignity
- Commitment to quality of care
- Compassion
- Improving lives
- Everyone counts
- Commitment to learning

Our strategic objectives – where we will focus our efforts to translate our vision into a practical roadmap for success

Care: we provide safe, compassionate care

Communities: we help build strong communities where people live well and are healthier

Sustainability: our services are sustainable environmentally and financially and we make best use of resources

Colleagues: we are empowered, skilled, caring colleagues who can thrive at work

Our enabling plans – translating our objectives into meaningful action

Clinical and Quality | Digital | People | Finance | Infrastructure

Our mechanisms for change – the approaches and activities that help us reimagine the way we do business

One transformation approach | Improving together | Culture, comms and engagement plan

11. How we will implement our strategy

The joint strategy sets out the agreed future direction for both trusts over the next five years. It is ambitious and recognises the additional change associated with collaboration.

We need to create the right climate and put the right tools in place to be successful. We will do this through:

Our five enabling plans

These will outline the contribution of these functional areas to achieving our objectives. They will include detailed actions, activities and expected outcomes, providing a meaningful link between the strategy and the work that is carried out by teams.

Our enabling strategies cover:

- Clinical and quality – including collaboration and integration across mental and physical health, community and acute services and addressing health inequalities
- Digital – including inter-operability between our trusts to support collaboration
- People – including workforce, colleague engagement, diversity and inclusion
- Finance – including financial sustainability and social value
- Infrastructure – including estates and environmental plans.

Our one transformation approach

This helps us think about things in a different way, reimagining how things could be to improve outcomes and experience. It guides us in:

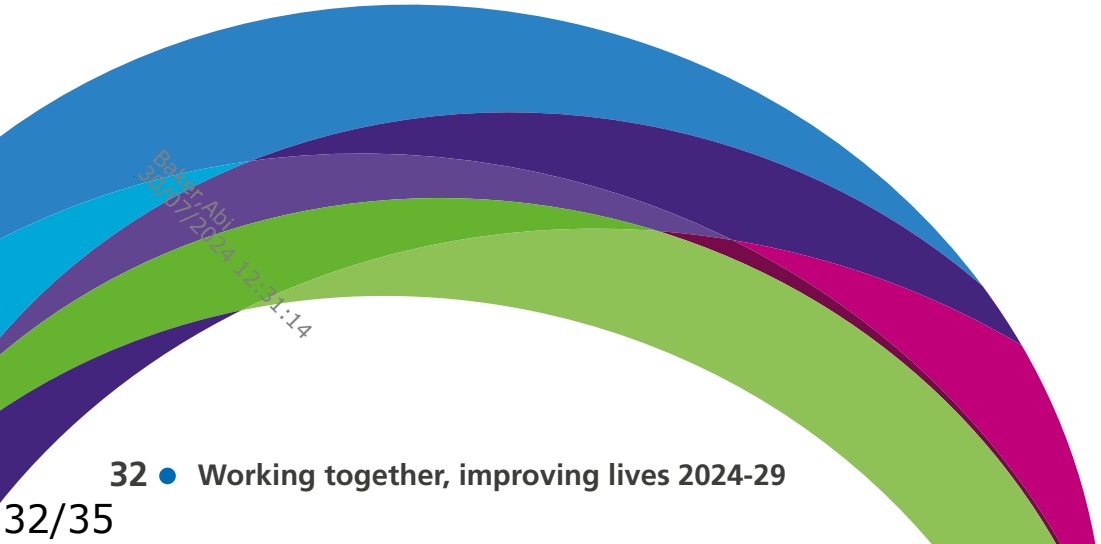
- moving to a system that focuses on prevention, avoiding illness and helping people stay independent
- developing a collective view of the future, working with colleagues, patients, service users, communities and partners
- working systematically through what we need to have place to realise our ambitions
- prioritising the programmes of work which will make the most difference for our communities and support us in achieving our vision.

Improving together – our approach to improvement

Our joint improvement framework, improving together, describes how we will improve to make sustainable, meaningful change happen by creating a thriving shared improvement culture.

We will do this together by:

- creating momentum through clear communications and simple advice
- equipping people with the right skills and tools
- providing a clear and agreed methodology to data-driven decision-making and meaningful evaluation.
- embedding improvement in all that we do, making it a golden thread across all our services
- valuing everyone's contribution so that we co-design and co-develop solutions with lived experience at the heart of all we do.



Culture, communications and engagement plan

Our supporting communications and engagement plan sets out how we will ensure that our vision, mission and objectives are understood by our many audiences. There will be a rolling programme of activity to engage with people in the ways they prefer and maintain an ongoing dialogue as our plans progress. This will include a comprehensive cultural development programme to embed the principles of the strategy across our trusts.

The plan's over-arching objectives are to ensure that:

- colleagues at both trusts understand how the joint strategy influences what they do and actively contribute to its successful delivery
- wider stakeholders, including local people, understand how we are working in partnership to improve lives and how they can be involved.

12. How we will monitor this strategy

Each year we will work to an implementation plan setting out the priority actions – drawn from operational plans, the enabling plans and the transformation and improvement programmes – which will map across to our strategic objectives. More specific measures will enable us to track success against areas of activity. We will also track specifically against the things that people have told us are important to them to check we are responding and making progress in those areas.

A dashboard, updated quarterly, will allow the Boards to monitor progress and the redeveloped Board Assurance Framework (BAF) will ensure that risks to achieving the strategy are regularly monitored through respective organisational audit committees.

Get involved

We are keen to continue the conversation that will help us our services for the future. If you would l like to share your views please contact dhc.dch.workingtogether@nhs.net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Dorset County Hospital and Dorset HealthCare

Working Together

Dorset County Hospital NHS Foundation Trust
Dorset HealthCare University NHS Foundation Trust

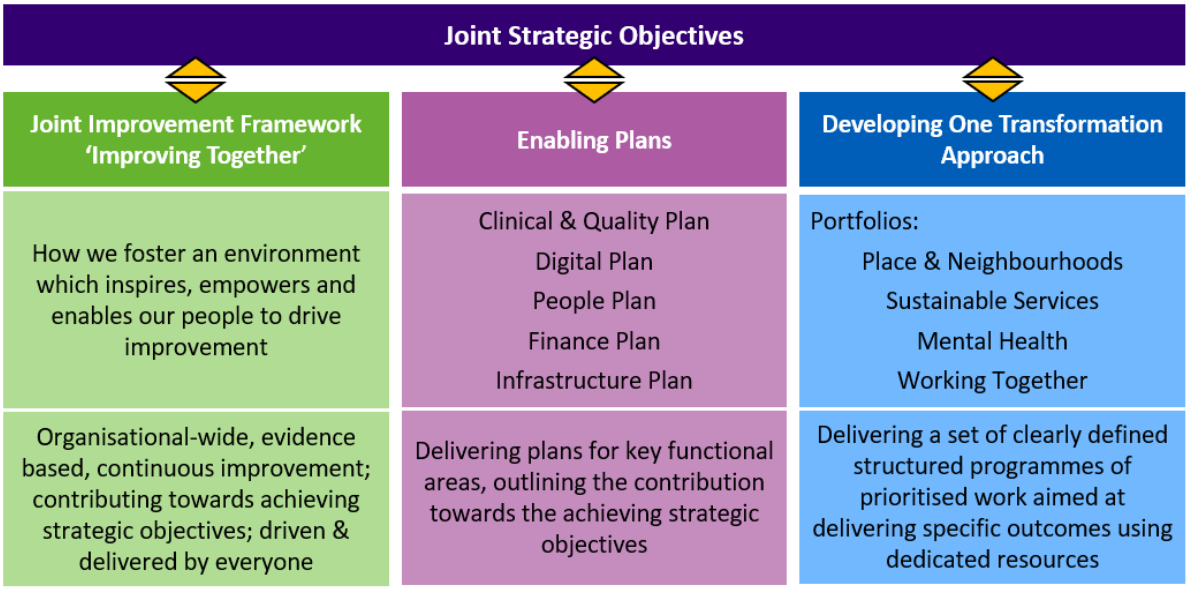
Appendix 2

DRAFT Joint Strategy Implementation Plan

OVERVIEW

Strategy implementation is about transforming plans into actions to achieve the ambitions and objectives of our "Working Together, Improving Lives" strategy. To do this, we need to re-engage with our colleagues, discuss the revised strategic direction and support people to understand what it means for them. After developing the strategy, we will decide on our yearly priorities, balancing transformational activities, quality improvements, and day-to-day operations within the limits of our finances and resources.

There are 3 main delivery components: The Joint Improvement Framework, a number of joint enabling plans and the development of a single transformation approach. These complementary approaches are shown below.



LAUNCH AND IMPLMENTATION

Following approval of the Joint Strategy, more detailed implementation planning can commence. This will capture:

- Culture, Communications and Engagement
- Continued development of the key metrics and creation of an interactive strategy dashboard
- Governance and reporting, supported by transformation portfolios
- Development of the Board Assurance Framework

Culture, Communications and Engagement

A crucial part of the success of the strategy will be how well it is communicated and embedded within the organisations, and it is recognised that this will take time. Subject to approval of the plan in July and August, the strategy will launch in September 2024. Even before this, work is ongoing to develop our visual identity. A communications campaign has been drafted to ensure that the strategy and plan can be effectively communicated to staff and stakeholders to enable accessibility and further engagement.

Engagement with Organisational Development Colleagues will commence to further support the roll out of engagement and implementation activities.

Metrics

Part of the year one deliverables will be to ensure that the measures identified to evidence the successful implementation of the strategy are robust and accessible. In some cases, this may mean introducing some proxy measures to support a rounded understanding of the outcome we aim to achieve. An interactive strategy dashboard will bring these measures together, to support teams across the organisations to understand our progress towards achieving each strategic objective.

Governance and Reporting

Further supporting the organisation to access and influence strategy progress will be robust governance and reporting, which will need to be clearly communicated and aligned to new joint governance processes set out as part of our federation. This will include consideration of the newly formed committees in common, delivery through portfolios as outlined within the one transformation approach which will bring all broad scale change together via the Joint Transformation Improvement Board, and establishing the links to work which is happening more broadly across both organisations. The latter being supported by the Joint Improvement Framework.

The Board Assurance Framework

Work is already underway to develop a refreshed outline Board Assurance Framework. The intention is that whilst there will be a set of joint strategic risks, there will be a separate Board Assurance Framework for each Trust as the score (likelihood and consequence) and the controls, assurance and actions may be different across the two trusts. Once the Joint Strategy and joint strategic risks have been approved by each Board the full Board Assurance Framework will be developed and populated.

ENABLING PLANS

Clinical and Quality Plan

Building on the joint strategy, the Clinical and Quality Plan will detail our clinical and quality goals. Specifically, it will outline how we aim to better integrate mental and physical health, community and acute services to improve the experience and outcomes for patients. The plan will focus on providing high quality, safe, and compassionate care, ensuring people are equal partners in their care. It will emphasise building strong communities where people live well and enjoy healthier lives, with a strong focus on prevention of ill health.

Enabling Plans

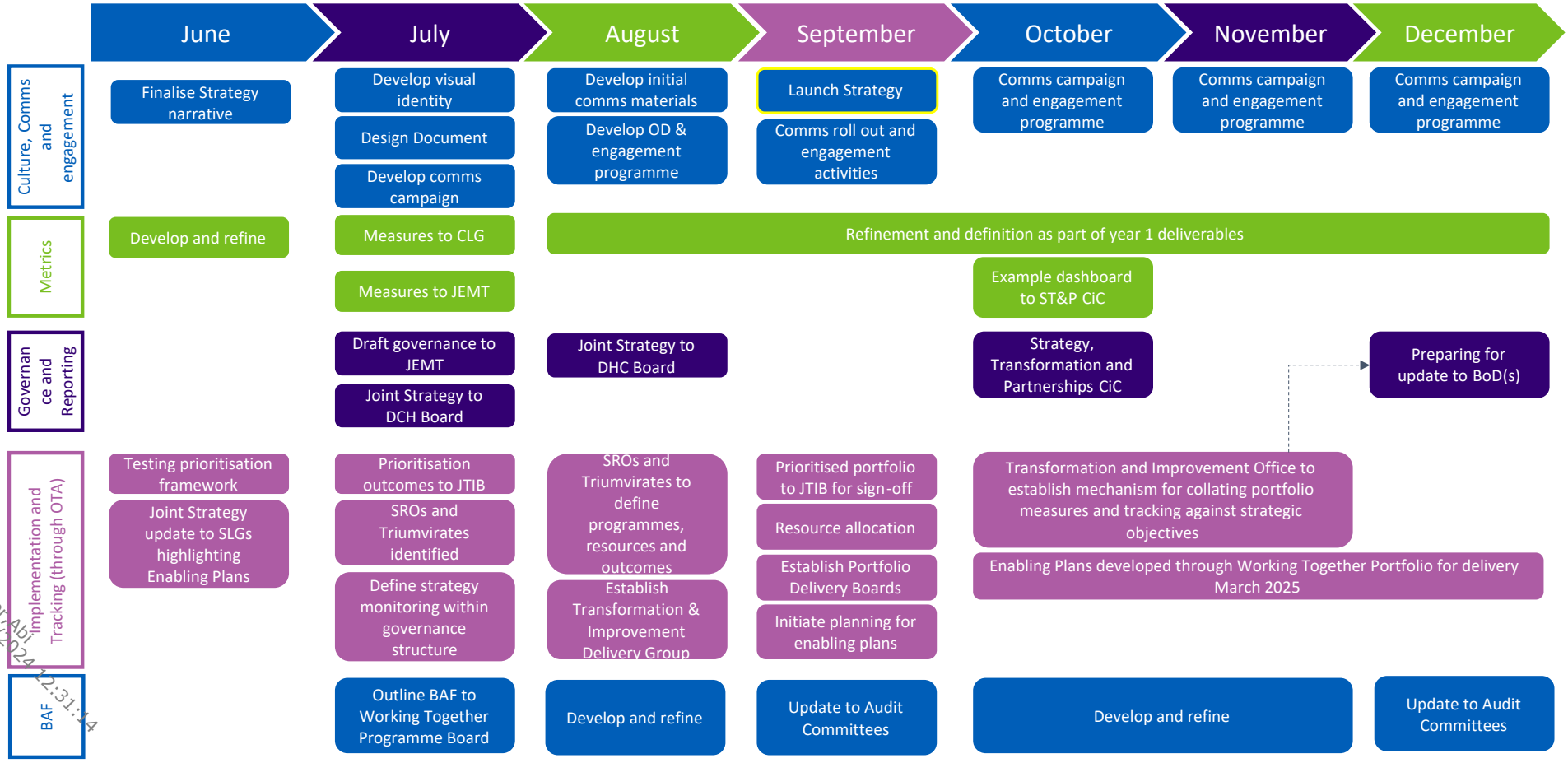
Digital, finance, workforce, and infrastructure plans are being developed to coordinate efforts and ensure a more focused approach on what truly matters.

DRAFT IMPLEMENTATION PLANS

The draft implementation roadmap has been added below.

Working Together

Dorset County Hospital NHS Foundation Trust Dorset HealthCare University NHS Foundation Trust



DCH-DHC joint strategy culture, communications and engagement plan

2024-5

Working Together programme

Dorset County Hospital NHS Foundation Trust
Dorset HealthCare University NHS Foundation Trust

Plan on a page

Operational Objective: Set out our future direction of travel to support staff to deliver against our over-arching objectives and enable stakeholders and the public to understand our role in improving health outcomes for people in Dorset.

Communications Objective: Colleagues at both trusts understand how the joint strategy influences what they do and actively contribute to its successful delivery. Wider stakeholders (including local people) understand how we are working to improve lives.

Approach: The main workstreams for this plan are shown below

Audience	What	How	When	Measures
Internal	Embed the principles of the joint strategy across both organisations by proactively engaging colleagues in the ways they prefer	Cultural/OD programme	From Sept 24	Engagement levels, feedback
Internal and external	Develop and embed a clear shared brand and visual identity, creating a range of assets that clearly demonstrate our joint approach	Communications campaign plan	From Aug 24	Recognition and awareness levels
Internal and external	Deliver a communications campaign to launch the strategy, support the OD programme and regularly share information on progress with all stakeholders	Brand development plan	From Sept 24	Feedback, awareness levels
Internal and external	Establish engagement mechanisms to ensure work to deliver the strategy is constantly informed by a range of views and perspectives	Participation and engagement plan	From Sept 24	Participation and involvement levels

Roles, responsibilities and risks

Exec SRO	Nick Johnson	**Plan delivery**	Trust comms teams	**Risks this plan seeks to mitigate**	• Disengaged or concerned colleagues who don't understand and/or are not involved in the change • Concern from partners about impact of change on relationships
C&E strategic lead	Sally Northeast	**Oversight group**	WTPB/ JEMT		

Key messages

1. Dorset County Hospital and Dorset HealthCare now have a shared strategy which takes over from our previous individual strategies.
2. The strategy sets out clear intentions and ambitions that we can achieve together as federated NHS trusts, working closely with our Dorset health and care system partners.
3. We're doing this to better meet the needs of Dorset people and communities now and for the future.
4. We now have a shared vision and mission
5. Our shared objectives are:

Our vision is for healthier lives, empowered citizens, thriving communities - now and for the future.

Our mission is to work in partnership to provide high quality, person-centred services, and to create and grow an environment where colleagues can be their best.

CARE
We provide compassionate, safe, person-centred care

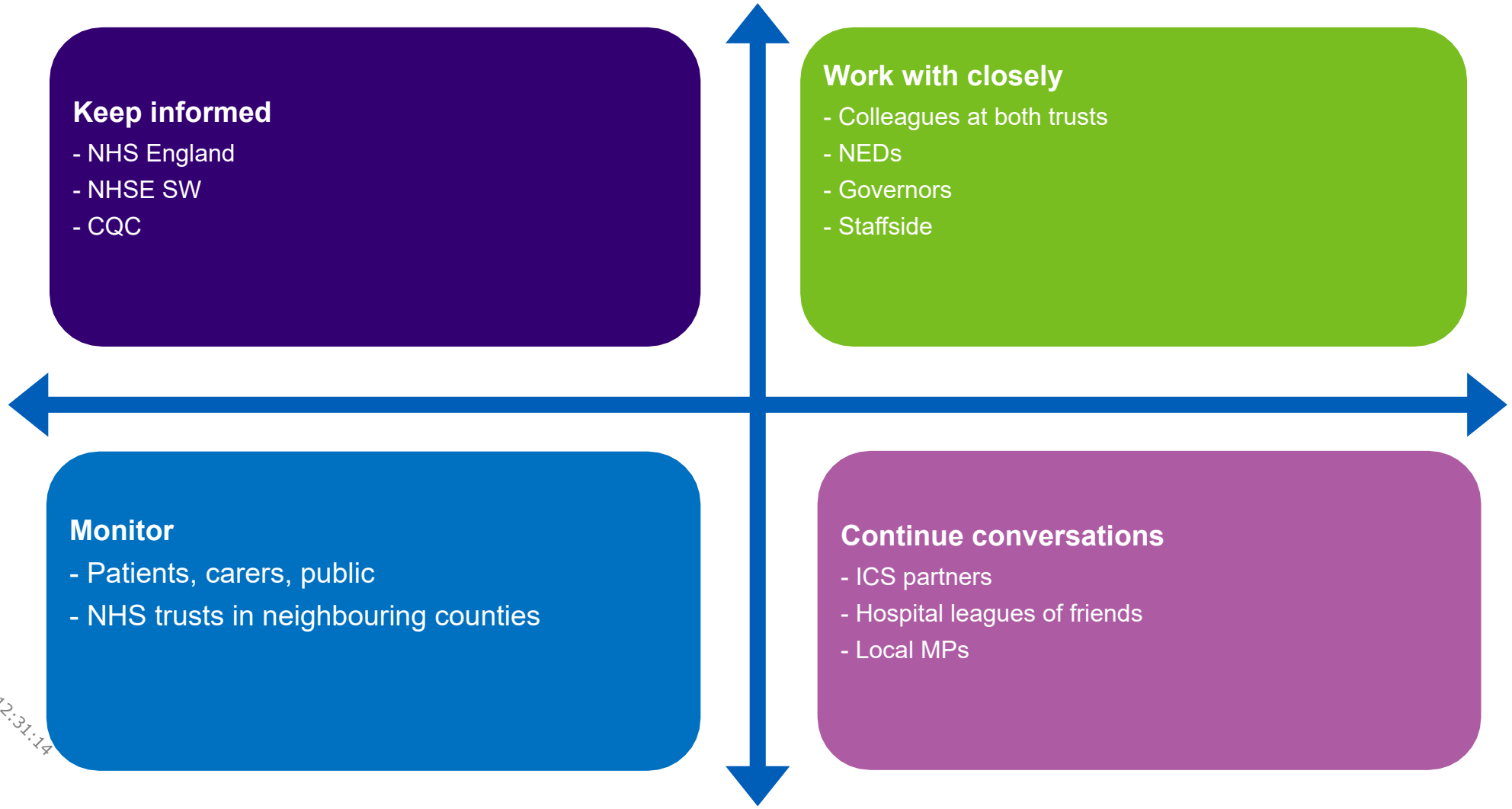
COMMUNITIES
We help build strong communities where people live well and are healthier

COLLEAGUES
We are empowered, skilled, caring colleagues who can thrive at work

SUSTAINABILITY
Our services are sustainable environmentally and financially and we make best use of resources

6. Everyone can be involved in shaping and delivering our plans – colleagues, local people and communities, partners. This is a team effort – please get involved.

Stakeholder matrix



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Embed the strategy - OD programme

Activity	Audience	Frequency	When	Who	Notes
Director-led sessions - in person and online	Staff	Weekly?	From Sept 24	Directors, OD	Existing and bespoke meetings
Create toolkits for teams	Staff	One off	Aug 24	OD, comms	
Embed in leadership programme	Staff		From Sept 24	OD	
Embed in induction	Staff		From Sept 24	L&D	
Embed in recognition programmes	Staff		From Sept 24	OD	
Embed in learning and development offer	Staff		From Sept 24	L&D, OD	
Engagement with and through staff networks and HWB champions	Staff		From Sept 24	OD, EDI	

Create and roll out the brand

Activity	Audience	When	Who	Notes
Create design concept and visual identity guidance	All	Aug 24	Comms	First application on the joint strategy
Design strategy	All	Jul 24	Comms	For Boards
Create summary/Easy Read version of strategy	All	Jul/Aug 24	Comms/ JW	
Create branded templates – Powerpoint, Word etc	All	From Jul 24	Comms	
Create hard copy and digital assets	All	From Aug 24	Comms	Including posters, pop-ups, displays, digital plaques. Slide deck
Create set of videos featuring staff, including launch video with execs	All	From Aug 24	Comms	
Audit use of old brands and develop replacement plan	All	From Aug 24	Comms, estates, IT, ops teams	NB significant piece of work which will take some time to complete

Communications campaign - internal

Activity	Audience	Frequency	When	Who	Notes
Regular feature in CEO bulletin	Staff	Weekly	From Aug 24	SN, MB	
Revamp intranet hub and keep updated	Staff	As needed	Aug 24 & ongoing	Comms	Updated at least monthly
Team Brief featured topic at both Trusts	Staff	Monthly	Sept, Dec 24, Feb, Apr 25	SN, NJ, MB	Focus on different objectives every other month
Present at key groups & meetings eg SLGs, Leadership Forums, CLG etc	Staff	Monthly	From Sept 24	Execs	Plot diary of meetings - comms
Operational cascade	Staff	As needed	Ongoing	Man-agers	Slide deck provided
Trust weekly bulletins	Staff	As needed	Ongoing	Comms	
DCH and DHC CEO Board reports	All	Bi-monthly	Jul/Aug 24 & ongoing	JW, MB, SN	

Communications campaign - external

Activity	Audience	Frequency	When	Who	Notes
Update information on public websites	External	One off	Aug 24	Comms	Keep updated as needed
Present at key groups who informed the development of the strategy eg EbEs, PEG	External	One off?	From Sep 24	Senior leaders	May want to go back with progress updates regularly
Updates in ICP CEO report	Partners	Bi-monthly	Sep, Nov 24, Jan, Mar 25	JW, MB, SN	
Social media – ongoing campaign	External	Regular	From Sep 24	Comms	Using new comms assets
Present at key partner forums eg councils, NHS partners, GPA, VCSE	External	One off?	From Sep 24	Senior leaders	May want to go back with progress updates regularly
E-newsletter to external stakeholders	Partners	Bi-monthly	From Oct 24	Comms	

Keep engaging

Activity	Audience	When	Who	Notes
Develop programme/toolkit to ensure involvement of patients, carers, experts by experience, PEGs	Patients, carers, experts by experience, PEGs	From Sept 24	Part/eng leads	
Workshops/presentations with key partners – ICB, UHD, GP Alliance, VCSE Assembly – to seek views	Partners	From Sept 24	Part/eng leads	

DCH Trust Board – 31 July 2024
DHC Trust Board – 7 August 2024
Strategic Risks and Development of DCH and DHC Board Assurance Framework

Author	Jenny Horrabin - Joint Director of Corporate Affairs
Lead Director	Jenny Horrabin – Joint Director of Corporate Affairs
Purpose of Report	To seek approval for Joint Strategic Risks

Executive Summary

The Joint Strategy 'Working together, improving lives' is being presented to Board for approval at the DCH and DHC Boards on 31 July 2024 and 7 August 2024 respectively. Alongside the development of the Joint Strategy work on developing the Joint Principal Risks to achieving the Joint Strategic Objectives has continued to avoid any unnecessary delay. Below are the key steps to arriving at the final draft set of strategic risks for both DCH and DHC:

- Two Joint Board Development Sessions have been held (March and May 2024) to review our approach to risk management. This has included a review of the strategic risks and the risk appetite.
- The output from the session held in May 2024 was reviewed by the Joint Executive Management Team and developed into a more focussed set of strategic risks.
- Those risks have then been reviewed and consolidated into a set of draft strategic risks that have been mapped to Executive Leads, Committees and Strategic Objectives. (**Table 1**).
- The existing risks from the DCH and DHC Board Assurance Frameworks were reviewed and mapped across to the new Joint Strategic Risks (**Table 2a – DCH and Table 2b – DHC**)
- The draft strategic risks were reviewed by the Joint Executive Management Team (JEMT) on 18 June 2024 and the risks were scored. The scoring matrix is included at **Table 3.**
- The risks were reviewed by the responsible Committees in DCH and DHC during July 2024 and the feedback from the Committee has been incorporated into the final set of strategic risks presented to Board for approval.
- The Audit Committee has reviewed the proposed strategic risks and received assurance on the process. However, due to timing the DCH Risk and Audit Committee has not met and therefore has not had this oversight of the process. The Chair of the Audit Committee and the Joint Director of Corporate Affairs are meeting to agree the timing of this.
- There were no changes of substance arising from the Committee reviews. The majority of amendments were typographical.
- The Joint Director of Corporate Affairs is meeting with the DCHG and DHC Chairs of Audit to review the BAF template.
- The full BAF will be reported to the September Committees and September/October Boards.

There was feedback from the DCH Finance and Performance Committee regarding the need to be clear on where oversight of the risks related to the implementation of digital capabilities, which might straddle more than one Committee. It was agreed that this would be worked

through in our reporting and that each risks would be assigned to a single Committee to ensure clear ownership, but recognising that many risks had implications beyond a single Committee. The intention is that whilst there will be a set of joint strategic risks, there will be a separate Board Assurance Framework for each Trust as the score (likelihood and consequence) and the controls, assurance and actions may be different across the two trusts. Once the Joint Strategy and Joint Strategic Risks have been approved by each Board the full Board Assurance Framework will be developed and populated. There will be a separate BAF for each Trust – with separate controls, assurance and actions. Further work is required to develop a joint risk appetite, building on the work undertaken at the joint Board Development Workshops.	
Recommendation	The Board is requested to: • Approve the strategic risks • Endorse the process and timeline outlined for the development of the Board Assurance Framework • Note that further work will be undertaken on the development of a joint risk appetite

DCH Trust Board – 31 July 2024 Date TBC
DHC Trust Board – 7 August 2024
Strategic Risks and Development of DCH and DHC Board Assurance Framework

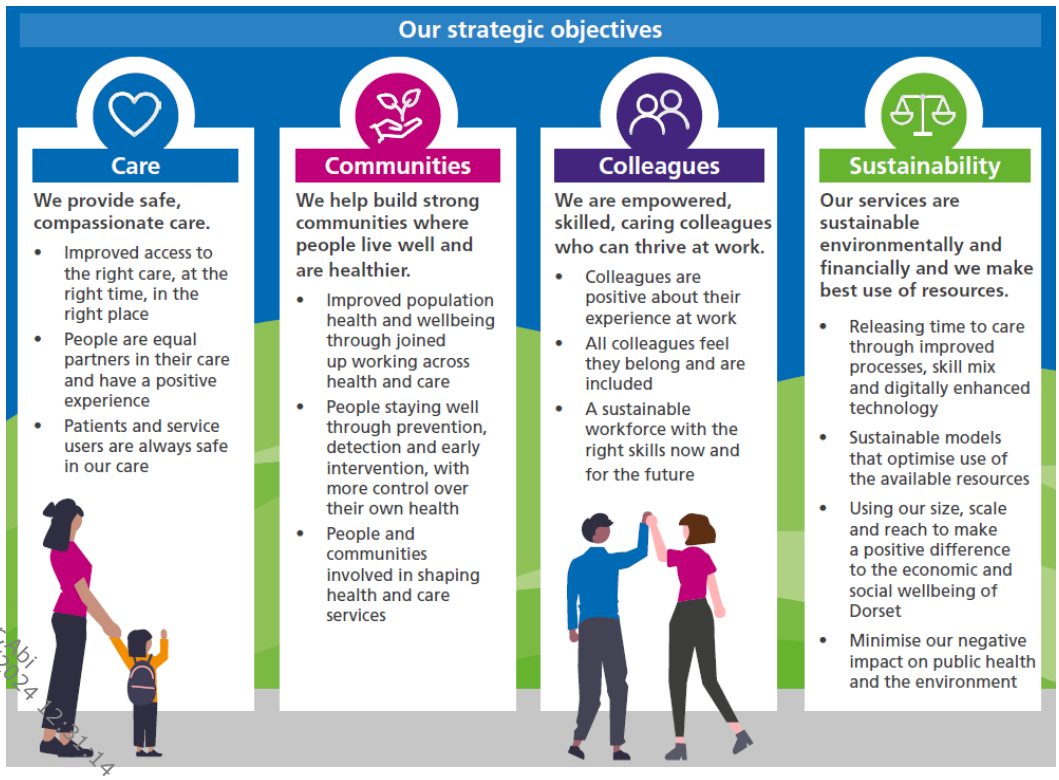
1. Introduction

The Board Assurance Framework, together with the Corporate Risk Registers (Clinical and Non-Clinical) and local risk registers provide the framework for the management of risks across the Trust.

A critical role of the board is to focus on the risks that may compromise the achievement of the Trust's strategic objectives. In order to be confident that the system of internal control is robust, the board must be able to provide evidence that it has systematically identified its strategic objectives and managed the principal risks to achieving them. The BAF is the tool that enables the board to undertake this duty.

2. Review of Strategic Risks

A Joint Strategy, 'Working together, improving lives' has been developed across Dorset Healthcare University NHS Foundation Trust (DHC) and Dorset County Hospital NHS Foundation Trust (DCH) during 2023/24 and the early parts of 2024/25. The Boards of both DHC and DCH have been fully engaged in this process and it is planned that this will be presented to both Boards in July / August 2024 for formal approval. The original intention was to present this to both Boards in May / June 2024, but this was delayed due to reporting restrictions arising due to the general election. The Strategic Objectives from the Joint Strategy (subject to formal approval) are:



The Joint Strategy is being presented to Board for approval at the DCH and DHC Boards on 31 July 2024 and 7 August 2024 respectively. Alongside the development of the Joint Strategy work on developing the Joint Principal Risks to achieving the Joint Strategic Objectives has continued to avoid any unnecessary delay. Below are the key steps to arriving at the final draft set of strategic risks for both DCH and DHC:

- Two Joint Board Development Sessions have been held (March and May 2024) to review our approach to risk management. This has included a review of the strategic risks and the risk appetite.
- The output from the session held in May 2024 was reviewed by the Joint Executive Management Team and developed into a more focussed set of strategic risks.
- Those risks have then been reviewed and consolidated into a set of draft strategic risks that have been mapped to Executive Leads, Committees and Strategic Objectives. (**Table 1**).
- The existing risks from the DCH and DHC Board Assurance Frameworks were reviewed and mapped across to the new Joint Strategic Risks (**Table 2a – DCH and Table 2b – DHC**)
- The draft strategic risks were reviewed by the Joint Executive Management Team (JEMT) on 18 June 2024 and the risks were scored. The scoring matrix is included at **Table 3.**
- The risks were reviewed by the responsible Committees in DCH and DHC during July 2024 and the feedback from the Committee has been incorporated into the final set of strategic risks presented to Board for approval.
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- The Joint Director of Corporate Affairs is meeting with the DCHG and DHC Chairs of Audit to review the BAF template.
- The full BAF will be reported to the September Committees and September/October Boards.

The intention is that whilst there will be a set of joint strategic risks, there will be a separate Board Assurance Framework for each Trust as the score (likelihood and consequence) and the controls, assurance and actions may be different across the two trusts.

3. Next Steps – Development of the Board Assurance Framework

Once the Joint Strategy and joint strategic risks have been approved by each Board the full Board Assurance Framework will be developed and populated. As noted above there will be a separate BAF for each Trust – with separate controls, assurance and actions.

It is anticipated the following Committees in Common will commence from September 2024 and therefore the risks have been assigned to the new Committee:

- Finance and Performance
- Strategy, Transformation and Partnerships
- People and Culture

The timing of Committees and Audit Committees will be reviewed to ensure that the review of the individual risks by assigned Committees takes place prior to the Audit Committee review wherever possible. The BAF will be presented to the respective boards in September / October 2024.

4. Recommendations

The Board is requested to:

- Approve the strategic risks
- Endorse the process and timeline outlined for the development of the Board Assurance Framework
- Note that further work will be undertaken on the development of a joint risk appetite

NHS
Dorset HealthCare University
NHS Foundation Trust

NHS
Dorset County Hospital
NHS Foundation Trust

Table 1 – Consolidated / Redefined Risks - Final Draft

Board Assurance Framework - Strategic Risk Overview - Final Draft June 24	Strategic Priorities				Responsibility		DCH	DHC	
Strategic Risks	Communities	Care	Colleagues	Sustainable	Committee (and CIC when established)	Executive	July-24 C x L	July-24 C x L	Mapping to Board Development Session
SR1: Culture If we do not achieve a culture of compassion and empowerment and engagement, we will not have a motivated workforce with the required capacity and skills to improve patient outcomes and deliver safe care.		X	X		**DCH - People and Culture** **CIC - People and Culture**	Chief People Officer	**5x3 = 15**	**5x2 = 10**	Culture & Wellbeing Capacity Professionalism
SR2: Workforce Capacity If we are not able to recruit and retain the required number of staff with the right skills we will not be able to deliver high quality		X	X		**DCH - People and Culture** **CIC - People and Culture**	Chief People Officer	**5x3 = 15**	**5x4 = 20**	Capability and Skills

Board Assurance Framework - Strategic Risk Overview - Final Draft June 24	Strategic Priorities				Responsibility		DCH	DHC	
Strategic Risks	Communities	Care	Colleagues	Sustainable	Committee (and CIC when established)	Executive	July-24 C x L	July-24 C x L	Mapping to Board Development Session
and safe sustainable services within our resources									
SR3: Capacity and Demand If we do not meet current and expected demand and achieve local and national measures and targets within available resources we may face regulatory action and patients outcomes will be adversely affected	**X**	**X**		**X**	**DCH - Finance and Performance** **CIC - Finance & Performance**	Chief Operating Officer	**4x4= 16**	**4x4 = 16**	Capacity Governance and compliance

NHS Dorset HealthCare University NHS Foundation Trust

NHS Dorset County Hospital NHS Foundation Trust

Board Assurance Framework - Strategic Risk Overview - Final Draft June 24	Strategic Priorities				Responsibility		DCH	DHC	
Strategic Risks	Communities	Care	Colleagues	Sustainable	Committee (and CIC when established)	Executive	July-24 C x L	July-24 C x L	Mapping to Board Development Session
SR4: Collaboration If we do not have effective and positive partnerships within the ICS then we will not be able to shape decisions and deliver the transformation required.	X			X	**DHC - Finance and Transformation** **CIC - Strategy, Transformation & Partnerships**	Chief Strategy Officer	**4x3= 12**	**4x3= 12**	Collaboration, Engagement and Partnership Governance and compliance
SR5: Transformation and Improvement If we do not seek and respond to the views of our communities to co-produce and continuously improve and transform our services, we will not contribute to the reduction of health inequalities within our communities.	X	X		X	**DHC - Finance and Transformation** **CIC - Strategy, Transformation & Partnerships**	Chief Strategy Officer	**4x4 = 16**	**4x4= 16**	Continuous improvement and Innovation

Board Assurance Framework - Strategic Risk Overview - Final Draft June 24	Strategic Priorities				Responsibility		DCH	DHC	
Strategic Risks	Communities	Care	Colleagues	Sustainable	Committee (and CIC when established)	Executive	July-24 C x L	July-24 C x L	Mapping to Board Development Session
SR6: Digital Infrastructure If we do not advance our digital and technological capabilities, including achieving our EHR ambitions, we will not deliver the innovative and sustainable services and the delivery of safe services could be compromised.	X			X	**DHC - Finance and Transformation** **DCH - Finance and Performance** **CIC - Strategy, Transformation & Partnerships)**	Chief Strategy Officer	**5x5 = 25**	**5x4= 20**	Digital Infrastructure and Technology
SR7: Cyber security If we do not take sufficient steps to ensure our cyber security arrangements are maintained and up to date then we are at increased risk of a cyber security incidents		X		X	**DHC - Finance and Transformation** **DCH - Finance and Performance** **CIC - Strategy, Transformation & Partnerships)**	Chief Strategy Officer	**3x5= 15**	**3x4= 12**	New

NHS
Dorset HealthCare University
NHS Foundation Trust

NHS
Dorset County Hospital
NHS Foundation Trust

Board Assurance Framework - Strategic Risk Overview - Final Draft June 24	Strategic Priorities				Responsibility		DCH	DHC	
Strategic Risks	Communities	Care	Colleagues	Sustainable	Committee (and CIC when established)	Executive	July-24 C x L	July-24 C x L	Mapping to Board Development Session
SR8: Estates If we do not have an estate that is fit for purpose and economically and environmentally viable we will be unable to provide the right places for our staff to deliver high quality services to the communities that we serve		X	X	X	**DHC - Finance and Transformation** **DCH - Finance and Performance** **CIC - Finance & Performance**	Chief Finance Officer	**4x4 = 16**	**4x4= 16**	Estates
SR9: Finance If we do not deliver on our financial plans, including the required level of savings, then and this will adversely impact our ability to provide safe sustainable services, and will impact upon the overall ICS position				X	**DHC - Finance and Transformation** **DCH - Finance and Performance** **CIC - Finance & Performance**	Chief Finance Officer	**4x4 = 16**	**4x4= 16**	Finance Governance and Compliance

Board Assurance Framework - Strategic Risk Overview - Final Draft June 24	Strategic Priorities				Responsibility		DCH	DHC	
Strategic Risks	Communities	Care	Colleagues	Sustainable	Committee (and CIC when established)	Executive	July-24 C x L	July-24 C x L	Mapping to Board Development Session
SR10: Safety and Quality of Services If we are not able to deliver the fundamental standards of care in all of our services we will not be providing consistently safe, effective and compassionate care		**X**			**DCH - Quality Governance** **DHC - Quality**	Chief Nursing Officer	**4 X 4 = 16**	**4 X 4 = 16**	Governance and compliance Capability and Skills Capacity

Table 2 – Mapping to 2023/24 BAF Risks

2A. Dorset County Hospital

DCH 2023/24 Risks	Mapped to 24/25 Refreshed Strategic Risks	Proposed Action
1. We do not develop a compassionate, inclusive and open culture in the Trust within which staff feel involved, empowered, that they belong and that they are at their best	SR1 Culture	Close 23/24 risk - mapped across
2. We are unable to recruit and retain sufficient staff to deliver the Trust's strategy and ambitions	SR2 Workforce Capacity	Close 23/24 risk - mapped across
3. We are unable to support the development of a sustainable workforce to meet future needs	SR2 Workforce Capacity	Close 23/24 risk - mapped across
4. 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%	SR3 Capacity and Demand	Close 23/24 risk - mapped across
5. 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.	Not mapped - not a strategic risk	Move to Corporate Risk Register

DCH 2023/24 Risks	Mapped to 24/25 Refreshed Strategic Risks	Proposed Action
6. 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	SR3 Capacity and Demand	Close 23/24 risk - mapped across
7. 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.	Not mapped - not a strategic risk	Move to Corporate Risk Register
8. 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.	Not mapped - not a strategic risk	Move to Corporate Risk Register
9. 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	SR1 - Culture SR2 - Workforce Capacity	Close 23/24 risk - mapped across
10. 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	Not mapped - not a strategic risk	Closed
11. 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	SR8 -Estates SR9 - Finance	Close 23/24 risk - mapped across

DCH 2023/24 Risks	Mapped to 24/25 Refreshed Strategic Risks	Proposed Action
environmental, social and economic well-being of our communities, populations and people.		
12. 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	SR6 Digital Infrastructure	Close 23/24 risk - mapped across
13. 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.	SR7 Cyber Security	Close 23/24 risk - mapped across
14. 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.	SR7 Cyber Security	Close 23/24 risk - mapped across
15.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.	SR4 Collaboration SR5 Transformation and Improvement	Close 23/24 risk - mapped across
16. 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	SR5 Transformation and Improvement	Close 23/24 risk - mapped across

DCH 2023/24 Risks	Mapped to 24/25 Refreshed Strategic Risks	Proposed Action
17. 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	SR2 Workforce Capacity	Close 23/24 risk – mapped across
18. Recovery of waiting lists plus increasing workload within the hospital may impair our ability to contribute effectively to the objectives of the ICS	SR3 Capacity and Demand	Close 23/24 risk - mapped across
19. 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	SR9 Finance	Close 23/24 risk - mapped across
20. 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.	SR9 Finance	Close 23/24 risk - mapped across
21. 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	SR4 Collaboration	Close 23/24 risk - mapped across
22. 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	SR4 Collaboration	Close 23/24 risk - mapped across
23. 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	SR4 Collaboration	Close 23/24 risk - mapped across

DCH 2023/24 Risks	Mapped to 24/25 Refreshed Strategic Risks	Proposed Action
not be possible and appropriate and measured solutions which improve sustainability and reduce variation will not be implemented		
24. 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	SR5 Transformation and Improvement	Close 23/24 risk - mapped across
25. 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	SR5 Transformation and Improvement	Close 23/24 risk - mapped across

2B. Dorset HealthCare – Mapping of Risks

DHC 2023/24 Risks	Mapped to 24/25 Refreshed Strategic Risks	Proposed Action
1A. We do not have the capacity to meet demand for services and provide timely access to treatment and care.	SR3 - Capacity and demand	Close 23/24 risk - mapped across
1B. We do not consistently provide the quality of care or services that meet the needs and expectations of our local population	SR10 - Quality and Safety	Close 23/24 risk - mapped across
2A. We do not achieve the appropriate alignment between the objectives of the integrated care system and those of the Trust	SR4 - Collaboration	Close 23/24 risk - mapped across
2B. We are unable to achieve an appropriate balance between preventative and community care and urgent and inpatient care	SR5 - Transformation and Improvement	Close 23/24 risk - mapped across
3A. We do not deliver a breakeven financial position	SR9 - Finance	Close 23/24 risk - mapped across
3B. We do not secure the necessary funding to improve the use and allow enhancement of the Trust's physical and digital infrastructure	SR9 - Finance SR6 - Digital Infrastructure	Close 23/24 risk - mapped across
4A. We are unable to recruit and retain sufficient staff to deliver the Trust's strategy and ambitions	SR2 - Workforce Capacity	Close 23/24 risk - mapped across

4B. We do not establish a compassionate, inclusive and open culture in the Trust within which staff feel involved, empowered and can innovate	SR1 - Culture	Close 23/24 risk - mapped across
4C. We are unable to support the development of a sustainable workforce to meet future needs	SR1 - Culture SR2 - Workforce Capacity	Close 23/24 risk - mapped across

Table 3 – Risk Scoring Matrix

		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

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

Consequence Score

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	Uncertain delivery of key objective/service due to lack of staff Unsafe staffing level or competence (>5 days) Loss of key staff	Non-delivery of key objective/service due to lack of staff Ongoing unsafe staffing levels or competence Loss of several key staff

			Poor staff attendance for mandatory/key training	Very low staff morale No staff attending mandatory/ key training	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

1. Report Details			
Meeting Title:	Board of Directors, Part 1		
Date of Meeting:	31 July 2024		
Document Title:	Corporate Risk Register		
Responsible Director:	Jo Howarth Director of Nursing and Quality (Acute Services)	Date of Executive Approval	Approved by Dawn Dawson 13/06/2024
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	18/6/24	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. Awaiting the review of the Risk Appetite statement following the Joint Strategy meeting with Dorset Healthcare. Once agreed, this will be reflected within the report.							
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, Part 1
Corporate Risk Register as at 31 May 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.

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 TO RISK REGISTER 01 March 2024 to 31 May 2024 scoring 15 or above. (these will not be repeated in Appendix 3)

Date information	Initial Risk Score at time of addition	Risk Register Reference	Risk Title	Risk Description	Primary Reporting Committee
Date risk added to register. 03/04/2024 Next review date: 15/05/2024 Overdue at time of writing report. Proposed date for risk to be managed: 02/08/2024	20 (Major (4) x Certain (5))	1854	24 Beds - Overall Refurbishment Completion Delay	If there is a delay in the construction programme, this creates a risk in ability to deliver and realise the benefits from the scheme proposal. Discussions to take place in April between the Trust and Contractor regarding partial handover of internal works - due to complete 04/07/24- prior to full completion of external works to allow clinical operations to begin and help realise initially proposed benefits. MITIGATION: Now working towards revised construction programme with completion dated 02.08.24. *Referred back to reporter for update.*	Finance and Performance Responsible Executive: Anita Thomas BAF reference: Place
Date risk added to register. 03/05/2024 Next review date: 02/06/2024 Overdue at time of writing report. Proposed date for risk to be managed: 31/03/2025 Baker,Abi 30/07/2024 12:31:14	20 (Major (4) x Certain (5))	1833	Risk to Clinical Coding due to current agency staff not being on NHS Approved Framework	Temporary staffing have stated the current utilisation of agency clinical coders has to cease after 1st July 2024 as Pharma Direct, the agency company, are not on the NHS Approved Framework. There are currently 3 WTE clinical coders employed through this agency and 2 temporary clinical coders employed until June 2024 and August 2024. Not being able to utilise agency coders will result in increase in backlog of uncoded hospital spells and pressure on clinical coding manager and existing staff. Having such a large backlog increases the risk of not achieving coding deadlines (6 weeks post discharge for elective admissions and 3 months post discharge for non-elective admissions). Timeliness of clinical coding, as is quality and depth of it, has a major impact on elective recovery, key performance indicators for the Trust including	Finance and Performance Responsible Executive: Ruth Gardiner BAF reference: Place

Date information	Initial Risk Score at time of addition	Risk Register Reference	Risk Title	Risk Description	Primary Reporting Committee
				clinical coding completeness targets, ICB measure, population health measurement, SHMI, Model Health System productivity measures as well as many other local and national performance targets. MITIGATION: • Add Pharma Direct to the NHS Approved Framework • Utilise an agency company that is on the NHS Approve Framework • Recruit clinical coders. • Consider exemption specialities specified under section 7.5 of Agency Rules published February 2024. *Referred back to reporter for update*	
Date risk added to register. 24/05/2024 Next review date: 31/05/2024 Overdue at time of writing report Proposed date for risk to be managed: 31/08/2024 Baker,Abi 30/07/2024 12:31:14	16 (Major (4) x Likely (4))	1896	Fire Team Response to emergencies	The fire team are at a significant risk when responding to an incident due to a lack of formal training being provided. The Trust Emergency Planning Procedure will immediately be compromised should there be a confirmed fire due to the fire team response not following procedures. MITIGATION: • Email sent to advise the fire teams of the correct procedures to follow as an interim measure. • A formal training package is now being developed for the fire teams for delivery over the next 2 weeks. • A further door opening training package will be developed for all staff in departments who carry out the initial alarm investigation prior to the arrival of the fire team. *Referred back to reporter for update*	Finance and Performance Responsible Executive: Chris Hearn BAF reference: Place
Date risk added to register. 20/05/2024 Next review date:	16 (Major (4) x Likely (4))	1893	Transport for Renal patients	Renal patients are either failing to get to or failing to be collected from the renal units at DCH, RBH and Yeovil due to hospital transport issues. This has led to patients refusing to attend for their	Finance and Performance Responsible Executive: Anita Thomas

Date information	Initial Risk Score at time of addition	Risk Register Reference	Risk Title	Risk Description	Primary Reporting Committee
28/06/2024 Proposed date for risk to be managed: 31/12/2024				treatment, cutting treatment short or being in the department for a lengthy amount of time awaiting collection. MITIGATION: • Escalated to ICB as the commissioners of the service and the contract holders. • Regular meetings between provider and ICB. • Taxis being used on occasion. • Dialysis times being adjusted *No update as not yet due for review.* *System Risks shared with the ICB 03.06.2024*	**SYSTEM RISK:** CONTRACT MANAGED BY ICB BAF reference: Place BAF Reference: Partnership
Date risk added to register. 01/04/2024 Next review date: 28/06/2024 Proposed date for risk to be managed: 31/03/2025	16 (Major (4) x Likely (4))	1886	Financial Sustainability 2024/25	Failure to remain in budgets and to make the cost improvements required to reach breakeven point. MITIGATION: • Budget meetings • Monitored at FPC *No update as not yet due for review.*	Finance and Performance Responsible Executive: Chris Hearn BAF reference: Place
Date risk added to register. 01/05/2024 Next review date: 01/06/2024 Overdue at time of writing report Proposed date for risk to be managed: 31/03/2025	16 (Major (4) x Likely (4))	1881	Neonatal Nursing staffing	Current neonatal nursing establishment not compliant with safe levels of staffing according with BAPM and Neonatal Nursing workforce Calculator. Regular bank and overtime hours required each month to cover the unit with 2 RN and 1 HCA. Often agency is used too, when no other option is available. Establishment not sufficient to cover 3 members of staff on duty at all times. And no establishment at all available for supernumerary shift lead co-ordinator (as per National Service specification). MITIGATION: • Business planning request sent to Divisional director and chief nursing officer back in November 2023. • Ward manager covering some clinical shifts when cover is not possible. • Other members of staff on quality roles,	People and Culture Committee Responsible Executive: Nicola Plumb BAF reference: People

Date information	Initial Risk Score at time of addition	Risk Register Reference	Risk Title	Risk Description	Primary Reporting Committee
				• also covering clinical shifts instead. • Agency still being used and very often bank and overtime hours done by permanent members of staff. *Referred back to reporter for update*	
Date risk added to register. 25/04/2024 Next review date: 15/05/2024 Overdue at time of writing report Proposed date for risk to be managed: 01/07/2024	16 (Major (4) x Likely (4))	1867	SWH Clinic Room & Clinic Template Utilisation	Low utilization poses a significant risk, potentially leading to a reduction in overall activity. This decreased activity could result in the inability to meet the anticipated benefits outlined in the business case. including vacating of medical & surgical OPD space for other trust strategic initiatives. Moreover, the facility may face resource and overhead cost pressures due to the inefficiency of operating underutilized space. MITIGATION: Original SWH schedule published Nov 23. Jan 24 scheduling meetings held with services to confirm clinic locations and timelines. review of utilisation undertaken noting average 50% room utilisation over 4/52 period. Following escalation at PPIP SG 20/03/24 of clinic utilisation AS to lead service by service review of capacity and demand. *UPDATE: 25.04.2024* *Weekly utilisation reports commenced by Outpatient management team. Div A have submitted their space request. All can be accommodated with a few swaps and the Div is now working through Bookwise to book these sessions.* *Div B, have not submitted any request for space, although 2 specialisms requiring additional identified and beginning work to identify where possible on Bookwise.*	Finance and Performance Responsible Executive: Anita Thomas BAF reference: Place
Date risk added to register. 24/04/2024 Next review date: 31/07/2024 Proposed date for risk to be	16 (Major (4) x Likely (4))	1866	Risk of regulatory non-compliance due to inadequate governance	A comprehensive action plan for implementation of the recommendations from both the maternity and governance reviews has been developed which is being overseen by senior individuals, Executives and the Quality Committee. A Quality Governance Lead has been put in place, whose role includes leading on the implementation of the required improvements. Senior advisors (authors of the two reviews) are assisting with the implementation of	Quality Committee Responsible Executive: Jo Howarth BAF reference: Place

Date information	Initial Risk Score at time of addition	Risk Register Reference	Risk Title	Risk Description	Primary Reporting Committee
managed: 30/11/2024 Baker,Abi 30/07/2024 12:31:14				the required improvements. *Update provided 10.06.2024* There continues to be consistent progress on the Joint Action Plan for delivery of the recommendations from both the Trust-wide governance review and Maternity Diagnostic Review . Approximately one third of the required actions are now complete and the remaining two thirds are all in progress. The actions have been linked to the Risk Register where relevant and all have 'owners' who are taking responsibility for delivery of the required actions. The Oversight Group continues to meet regularly and progress was reported to the Joint Executive Committee and the Quality Committee during May 2024. A Quality Surveillance Group is being set up, to commence in June. Next steps include ensuring evidence and ongoing assurance of compliance is in place Outstanding issues where least progress has been made on recommendations relating to the Trust-wide governance review relate to: • Estates and Facilities governance processes • Pathology governance • Digital systems/documentation • Implementation of the new complaints policy Outstanding issues from the Maternity Review are: • Recruitment and establishment of appropriate workforce numbers/skill mix • Leadership development • Second obstetric theatre opening • Still awaiting CQC visit to review Section 29a Warning Notice **Risk Score remains at 16**	

Date information	Initial Risk Score at time of addition	Risk Register Reference	Risk Title	Risk Description	Primary Reporting Committee
Date risk added to register. 11/04/2024 Next review date: 30/06/2024 Proposed date for risk to be managed: 31/12/2024	16 (Major (4) x Likely (4))	1857	Organisational CPD Funding	There has been no indication from NHS England regarding the Continuous Professional Development educational funding. This, in previous years has amounted to £323,667 of funding for learning opportunities. We have been made aware that the ongoing Workforce Development Funding from NHS Dorset will no longer be available, that amounted to £59,000 in the 23/24 financial year. Meaning that the organisation will be at a deficit of -£400,000 for the year. MITIGATION: We have mitigated this slightly by having a Framework Agreement with Bournemouth University of £70,000 ensuring there will be a variety of accredited and non-accredited courses available. However, this will not meet the current requirements of the organisation and will only be available to Nurses, Midwives and AHP's. We are expanding our Apprenticeship offers to explore different avenues to meet a proportion of our learning needs. There have been discussions with System Partners to explore the possibilities of joint approaches to programmes of learning. *No update as not yet due for review.*	People and Culture Committee Responsible Executive: Nicola Plumb BAF reference: People
Date risk added to register. 06/03/2024 Next review date: 04/07/2024 Proposed date for risk to be managed: 31/03/2025	16 (Major (4) x Likely (4))	1843	Capacity issues within Haematology	The booking of routine FOWL patients is becoming a real issue. Clinic slots for routine patients is now looking at September all consultants. The team have registrar support who sees 5(+) patients in clinic). The team receive around 10 4-6 week follow ups each week following new clinic appointments. Follow up clinic slots also include breaking bad news and discussions on treatments, 30-minute slots are not always long enough for these discussions. Some patients are having to be rebooked to allow for further discussions. Upcoming retirement next year for a consultant - need to succession plan for this. This also has an impact on nursing staff who support clinics as they often have to stay late and are overstretched.	Finance and Performance Responsible Executive: Anita Thomas BAF reference: Place

Date information	Initial Risk Score at time of addition	Risk Register Reference	Risk Title	Risk Description	Primary Reporting Committee
				The secretaries are having to move some patients to accommodate more urgent reviews which impacts on patients. Out of area referrals is also increasing. RCHOP Chemo - should be reviewed every 3 weeks - the team are currently unable to accommodate this. New referrals are increasing (8-12 per month). MITIGATION: • Additional clinics have been put on to try and manage the backlog, but this is putting additional strain on the consultant team. • increasing capacity - once a month clinics - Gynae pts. • Using slots on bone marrow clinics and fast track slots (overbooks) to accommodate for these patients. *No update as not yet due for review.*	
Date risk added to register. 25/04/2024 Next review date: 15/05/2024 Overdue at time of writing report. Proposed date for risk to be managed: 01/07/2024 Baker,Abi 30/07/2024 12:31:14	15 (Catastrophic (5) x Possible (3))	1868	Plenum Redesign Construction	There is a risk that the proposed works for the plenum on 25-27th, could exceed the proposed timescales or do not meet acceptable air testing results which could impact the re-opening of the treatment suite. MITIGATION: Tilbury Douglas Currently working to the proposed programme for the 25th- 27th. Proposed works to be undertaken over one weekend, air testing to be undertaken on 28/5 with 8 - 10 days for the results. Proposed opening to be the 10/6. If the dog Kennel and duct work cannot be completed over 1 weekend, the duct work will be sealed to allow the dog kennel to be completed and prevent the need for further sir testing. But would require one day down time of air flow during completion. *Referred back to reporter for update.*	Finance and Performance Responsible Executive: Anita Thomas BAF reference: Place
Date risk added to register. 04/03/2024	15 (Moderate (3) x Certain (5))	1842	Renal Outpatient Space	There is insufficient outpatient space at DCH/SWH/MOPD/OOPD to host the Low Clearance (LC) Renal clinics for Consultant, Dietician & Specialist Nurse.	Finance and Performance Responsible Executive: Anita Thomas

Date information	Initial Risk Score at time of addition	Risk Register Reference	Risk Title	Risk Description	Primary Reporting Committee
Next review date: 30/06/2024 Proposed date for risk to be managed: 31/12/2024 Baker,Abi 30/07/2024 12:31:14				Additional Consultant joined the Trust 04.03.24 and no space in the outpatient areas to set up clinics. As a consequence of the lack of space, there will be a reduction in clinic activity and the waiting list will increase further (in particular the DCH/Yeovil waiting lists. MITIGATION: • Review of Consultant job plans but due to the nature of their rota and the patients requiring dialyses on set days, we have been unable to move clinics to the PM. • Even if we were able to move to a PM, there is no permanent space available at DCH to house any clinics especially those which require 3 rooms. • Possibly able to book rooms on an adhoc basis but this will require close monitoring and at present unable to book rooms as the roll out of "bookwise" training has been cancelled (04.03.24). • There are 2 rooms in the Dialysis Unit which we could use as a temp solution to our clinics but these are not fit for purpose due to the size/infection control etc and we also would need to look at converting a Consultant Office into a clinic room which will require money and time. There is no waiting area for patients, nor receptionist and is in an area where we have high risk patients (immunosuppressed) therefore would want to reduce the footfall as much as possible. If we did use this as an option, we would be displacing the counsellor clinics with again no rooms to offer her. • Review outpatient space at Peripheral Sites (Weymouth/Blandford/Bridport) *Update: 13/03/2024 Yeovil, RBH and Poole Hospital are unable to accommodate requests for additional clinics for CKD patients. Looking at whether the Dolphin Centre may be an option. We are also exploring options at the Yeatman but*	BAF reference: Place

Date information	Initial Risk Score at time of addition	Risk Register Reference	Risk Title	Risk Description	Primary Reporting Committee
				there is a concern that the IT infrastructure is not set up correctly and therefore the clinics would not run efficiently. *Pending further discussions with the Consultants around what is required and if we can make this work.* *No further update as not yet due for review*	

1. Introduction

1.1 This report provides an update to the report presented to the March 2024 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)
- Risk Register items closed during reporting period 01.03.2024 -31.05.2024 (Appendix 3)

2. Update from previous report.

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 Due to the lack of formal policy/procedures and given the discrepancies identified during the 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.

2.1.3 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.

2.1.4 As an update to the above points:

- Policy has been drafted and will be presented to the Finance and Performance Committee (FPC) in June 2024. There is still a question, and agreement is being sought from FPC, as to whether staff are able to use supermarket loyalty cards with the Trust fuel cards, which would be classed as a monetary benefit.
- The policy has been reviewed by Risk, TIAA, Finance and Human Resources prior to the final draft being submitted to FPC.
- Policy covers all aspects of the management of a fleet of cars; however this policy will need to be supported with departmental standing operating procedures (SOP) to ensure that systems and processes are in place to make the policy effective. These are not yet in place and remain outstanding at the time of producing this report.

2.1.5 It was stated in the previous report to the Committee, that the Transport Manager and Facilities Manager responsible for the service were working to address the recommendations and actions in the Counter Fraud report and that a report would be provided to the June RAC meeting fo assurance. This piece of work is in progress but has not yet been updated or provided to the Head of Estates and Facilities for agreement and review. This will be picked up with the relevant managers as without this, we have no assurance that following the review actions have been taken.

2.1.6 The Deputy Head of Estates and Facilities, Head of Risk Management and the Head of Emergency Planning, took the decision to undertake an unannounced safety check of the pool cars and vans following a whistleblowing concern raised by a member of staff.

2.1.6.1 This random check was undertaken by the Head of Emergency Planning, who is ex-police, supported by the Deputy Head of Estates and Facilities and two members of staff from the Procurement Team responsible for managing the contract with the hire firm.

2.1.6.2 This spot check evidenced that:

- A high percentage of the vehicles checked were low on tyre tread. Clearly if the Trust employees were stopped and tyres are not legal this has the potential to be a financial and reputational damage risk to the Trust.
- All of the vehicles had some form of damage, scratches, dents, and scuffs which were not centrally recorded.
- Sack trucks were not secured in the back of the vehicles.
- Vehicle handbooks were missing from the majority of vehicles checked.
- On one vehicle the registration plate was damaged and cracked.
- Sharps containers were found in the passenger side of the vehicles unsecured.
- PPE was not available in all vehicles.
- One vehicle checked had no securing points in the rear of the vehicle to enable equipment etc to be transported or collected safely.
- One vehicle had the fuel flap missing.
- One vehicle had no secure straps to secure crates in the back of the vehicle.
- Hub caps missing on one vehicle.
- One vehicle had the fuel card and mileage book missing.
- Screen wash was empty in one vehicle.
- One vehicle smelt of alcohol.
- Vehicles internal cleanliness was variable.

2.1.7 Following the spot check, it was requested that actions be added to the overarching action plan to ensure that safety checks were undertaken by the transport team before issuing a vehicle to a driver. A SOP was requested to provide assurance that checks were being undertaken daily by

the transport team and the driver before use, which is still outstanding.

2.1.8 The random check will be used as a baseline for future random checks to establish if there has been any improvement.

2. System Wide Risks

3.1. Following the Trust Board Workshop on 31 January 2024, we 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. These system risks are shared with the ICB patient safety team monthly with a request for updates or progress.

3.2 UPDATE: **1816 Pace required for implementing National Virtual Ward requirements present clinical safety risks. (MODERATE risk score 12 (4 Major x 3 Possible) previously HIGH risk score 16)** 

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.

3.2.5 An update has been provided by DTI on 04 April 2024, advising that following further work with the D@SH Team at the ICB, DCH has contributed to the output-based specification for remote monitoring as part of the virtual ward developments in conjunction with Dorset digital colleagues. This has lowered the likelihood of this risk. Next review is due 05 July 2024.

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

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 wheelchair 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. Until guidelines change and funding for other aspects 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.

3.3.5 Update provided on 14 May 2024 advising that the Deputy Head of Paediatrics Occupational Therapy is meeting with Wheelchair Services and other stakeholders during June. It was noted that the guidelines seem outdated as they do not differentiate between the needs of adults and the developmental needs of children. Next review was due 05 June 2024, so is overdue at time of writing the report.

3.4 456 Patient Transport Provision & Urgent Patient Transfers (HIGH risk score 16 (4 Major x 4 Likely) was previously HIGH scored 20) 

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 now separated out the Renal Transport issues into a separate risk, ref: 1893. (details at the start of this report).

3.4.3 We have 457 incidents linked to this risk (365 (80%) reported between 01.04.2023 and 31.05.2024). We also have 61 incidents linked to 1893 directly related to renal transport issues.

3.4.4 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. The system risk is also provided monthly to the ICB Patient Safety Team, anonymous incident information is also provided to the ICB via the Learning from Patient Safety Events (LFPSE) upload when an incident is reported as a patient safety event.

3.4.5 The risk score has lowered as the highest risk area is in relation to Renal transport, which is now a separate risk register item.

3.4.6 Whilst delays in collection for admissions and discharges impacts on Trust flow and services, they are not as high risk as other patients. They do cause some delays in discharges where the discharge may be time critical to ensure that the patient is home in time for their package of care, which then results in patients having to stay in a hospital bed for an additional night. This remains

as HIGH risk due to the volume of incidents reported and the impact on hospital flow as well as patient experience. This was due for review 31 May 2024, so is overdue at the time of writing the report.

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. 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.

3.5.2 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 This risk was due for review February 2024, so it is overdue and has been escalated to the Divisional Managers and Head of Operations to update.

3.6 **866 External Multiagency Delays Resulting in Delayed Discharge of Complex Paediatric Patients (HIGH risk score 15 (3 Moderate x 5 Certain) previously HIGH risk score 16)** ↓

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

3.6.3 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.

3.6.4 This risk is next due for review 31 July 2024.

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 Work is continuing with the Business Information team to extract information to produce a database of young people with long term conditions that are entering transition age, this is estimated to be currently around 3000 young people across west Dorset.

3.7.5 Next review due 31.07.2024.

4 Corporate Risk Register

4.1 There are currently 88 risks on the risk register that are scored 15 or above. This is down on the last Committee report when 93 were reported. Services are continuing work through their risk registers to align with the new framework and as part of their governance review processes.

4.2 Whilst a full revision of the risk registers was completed, operational pressures can result in delays to updates of risks and mitigations.

4.3 These are broken down in the heat map in the appendices and full details provided for those scoring 20. A summary is provided for those risks scoring between 15 and 19. It should be noted that these risks are allocated to the Risk and Audit Committee as the secondary committee and the risks are reported in detail to the primary committee.

5. Risks closed within reporting period

5.1 20 risks were closed between 01.03.2024 and 31.05.2024. These are summarized in Appendix 4

6. Conclusion

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

7. Recommendation

The Board is recommended to:

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

Name and Title of Author:

Mandy Ford, Head of Risk Management and Quality Assurance
Date: data correct as at 10.06.2024
Appendices

- Heat Map (Appendix 1)
- Corporate Risk Register items (All committees) (Appendix 2)
- Risks closed between 01.03.2024 and 31.05.2024 (Appendix 3)

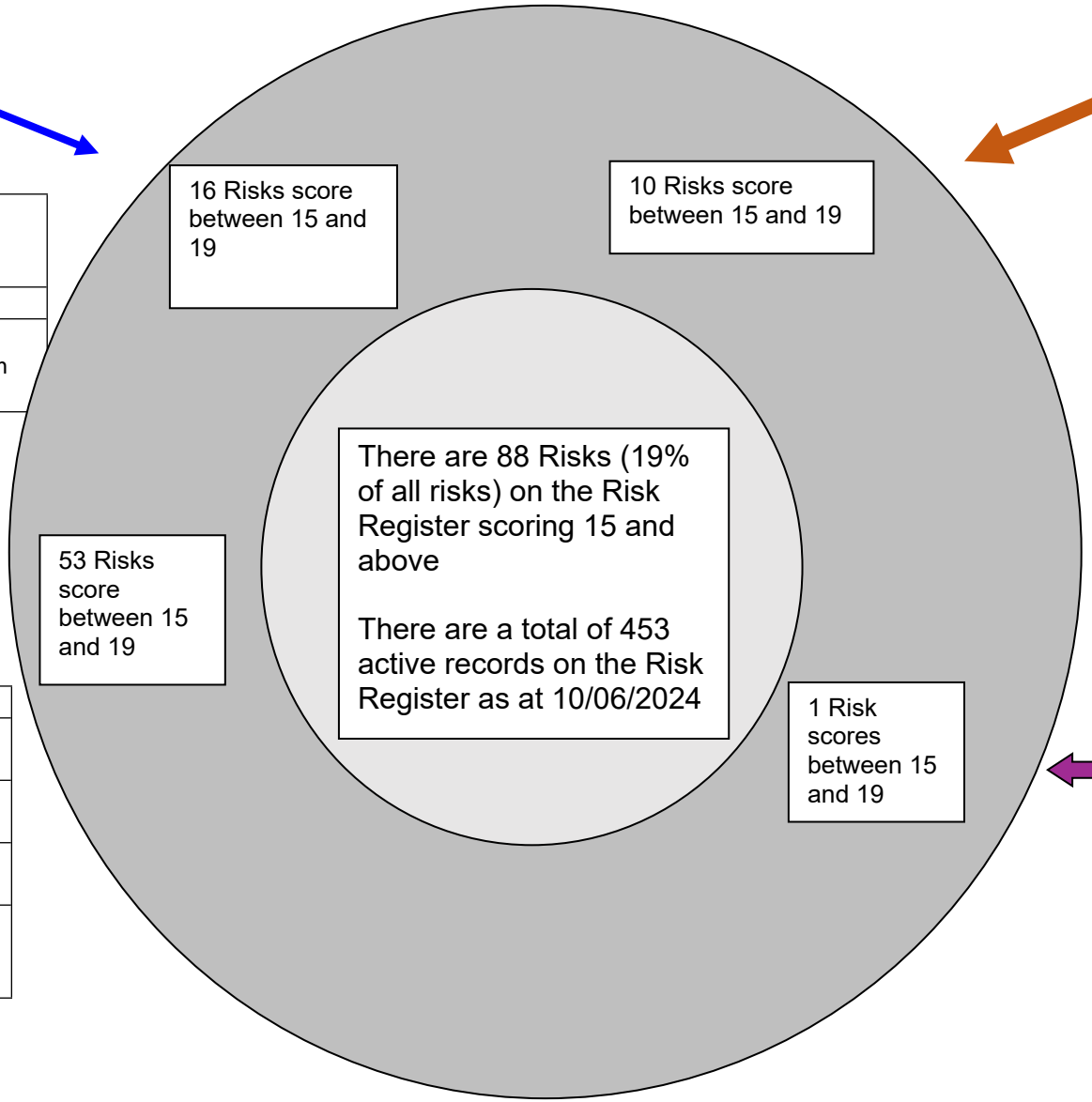
Corporate Risk Register – Risks scoring 20 or above detailed in the table

People and Culture Committee

1152	Current Digital Staffing levels present risk to both operational and strategic activities ⇧
1568	Community Dietetic Service ⇧
1833 **NEW**	Risk to Clinical Coding due to current agency staff not being on NHS Approved Framework

Finance and Performance

1886	Financial Sustainability ⇔
472	Community Paediatric Long waits for ASD patients ⇔
1221	Tackling the backlog of elective care ⇔
1749	Theatre Utilisation below 85% ⇔
1584 **NEW**	24 Beds - Overall Refurbishment Completion Delay



Quality Committee

Risk and Audit Committee

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**	⟺	16	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. Date risk added to register. 02/02/2024 Next review date: 30/06/2024 Proposed date for risk to be managed: 30/06/2024	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. Update: 10.06.2024 • Draft policy has been produced and is being presented to Finance and Performance Committee. This has had input from Risk, HR, Counter fraud and transport team. However, we have received: • **No Action plan updates** • **No SOPS drafted or in place** • **Random vehicle audit undertaken due to issues raised by whistleblower. Identified issues as detailed in the main body of the report.** **Risk to remain at 16 until we have assurance all governance measures are in place to effectively manage the vehicle fleet, booking processes, licence checks, safety checks on vehicles before allocation, robust management and allocation of fuel cards, accurate mileage recording, appropriate service scheduling etc.**
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**	⟺	16	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 of CYP to develop independence and have access to education, community facilities and play/leisure. Date risk added to register. 08//02/2024 Next review date: 05/06/2024 overdue at time of writing report. Proposed date for risk to be managed: 31/12/2024	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 Wheelchair service must prescribe within the guidelines of the NHS Wheelchair services. Update provided on 14 May 2024 advising that the Deputy Head of Paediatrics Occupational Therapy is meeting with Wheelchair Services and other stakeholders during June. It was noted that the guidelines seem outdated as they do not differentiate between the needs of adults and the developmental needs of children. Next review was due 05 June 2024, so is overdue at time of writing the report.
Reporting Committee Baker,Abi 30/07/2024 12:31:14	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	**12**	↓	16	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. Date risk added to register. 02/02/2024 Next review date: 05/07/2024 Proposed date for risk to be managed: 31/12/2024	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. **Risk scored lowered on review and will not appear in next report unless score returns to above 15.** **Update: 04.04.2024** Following further work with the D@SH Team at the ICB, DCH has contributed to the output-based specification for remote monitoring as part of the virtual ward developments in conjunction with Dorset digital colleagues. This has lowered the likelihood of this risk.
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**	↔	16	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. Date risk added to register. 29/09/2021 Next review date:	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.

				31/01/2024 overdue for review at time of writing report. This has been escalated. Proposed date for risk to be managed: 31/03/2025	
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. Date risk added to register. 24/12/2019 Next review date: 31/07/2024 Proposed date for risk to be managed: 31/03/2025	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**	⟺	16	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. Date risk added to register. 09/02/2021 Next review date: 31/07/2024 Proposed date for risk to be managed: 31/12/2024	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.	

Ref:	Current Score		Previous Score	Risk Title: **Patient Transport Provision & Urgent Patient Transfers**	**SYSTEM RISK** Responsible Executive: Anita Thomas, COO Comments/ Mitigations
456	**16**	⟺	**16**	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 Date risk added to register. 01/07/2023 Next review date: 31/05/2024 overdue for review at time of writing report Proposed date for risk to be managed: 31/03/2025	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. No update since September 2023. This has been escalated.
Primary Reporting Committee Baker Abi 30/07/2024 12:31:14	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	⟷	20	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. Date risk added to register. 10/09/2018 Next review date: 15/05/2024 overdue for review at time of writing report Proposed date for risk to be managed: 04/09/2024	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. Update: 15.04.2024 Community Consultant due to retire end of July. ASD Coordinator vacant, currently recruiting. Management team working with community clinicians to map referral process to streamline triage process to reduce unnecessary referrals being discussed at triage meetings.

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
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. Date risk added to register. 26/10/2023 Next review date: 24/06/2024 Proposed date for risk to be managed: 29/03/2025	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. Update 15/04/2024 Utilisation has improved though still not at the required levels. March capped - 71.46% & Uncapped - 75.9%. Weekly focus continues via the Theatre Productivity meeting to ensure actions are being followed. Update 21/05/2024 Utilisation is still below 85% but remains level. The team are working hard to bring this figure in line with expected targets
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 2024/25**	Responsible Executive: Chris Hearn, CFO Comments/ Mitigations
1886	20	⟺	20	The final plan for 2024/25 reflects a breakeven position for the Trust. Date risk added to register. 01/04/2024 Next review date: 30/06/2024 Proposed date for risk to be managed: 31/03/2025	Value Delivery Board has been established focussing 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.
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 - transforming the way we provide elective care - providing better information and support to patient. Date risk added to register. 09/03/2022 Next review date: 30/06/2024 Proposed date for risk to be managed: 31/03/2025	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. 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	12	↓	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	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).

				patients on the waiting list. Date risk added to register. 05/01/2024 Next review date: 03/06/2024 review overdue at time of writing report Proposed date for risk to be managed: 30/09/2025	Trainee Nurse Injector still requires final approval. Update 03/05/2024 Updated score to 12 (moderate). Nurse Injector post approved at Business Planning - to initiate recruitment process. Insourcing to commence May 2024 every other weekend until end of September providing an additional 60 patients per weekend. Nurse Injector who has been training has had to halt their training due to medical issue. A/w Medical investigations.
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.			

All Risk Register items closed between 01 March 2024 and 31 May 2024. **Appendix 3**

ID	Division of responsibility	Care Groups	Location of responsibility	Risk Statement	Supporting Information	Risk level (initial)	Risk level (at closure)	Risk level (Target)
1669	Urgent & Integrated Care Division	Integrated and Holistic Care (A2)	Blood Sciences - Haematology Laboratory	Integrated reporting is a United Kingdom Accreditation Service (UKAS) requirement for the operation of a clinical haematology service. Numerous biochemistry and histopathology test results are combined into an integrated report to give a hollistic view of the patient's status. This functionality was not available in the previous Laboratory Information Management System (LIMS) and was introduced with the implementation of the current LIMS solution WinPath. The solution is not working as intended, meaning an integrated report is not available for patients in the required form.	Work has been undertaken with University Hospitals Dorset NHS Foundation Trust (UHD) as the LIMS is a joint one. Certain results such as JAK2 results weren't being released into ICE (Pathology Requesting and Results solution). Work has been done to mitigate the risk with tests being "Uncoupled" from the integrated reports so that they are available to clinicians, reducing the risk of a missed diagnosis or communication of a clinically relevant test result.	Moderate Risk	Low Risk	Low Risk
1758	Family Services and Surgical Division	Family Services (B4)	Maternity Unit	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.	the IPC team do not have access to the maternity EPR which has proved challenging for the ward-based audit.	Moderate Risk	Low Risk	Low Risk
1766	Family Services and Surgical Division	Theatres, Anaesthetics, Critical Care & Decontamination (B3a)	Decontamination Unit	SLA between DCH & Alderney for contingency in case of EDU washer failure has expired. Meeting with Decon Lead at Alderney SSD 25/08/2023 and verbal agreement made to include SSD in renewal of SLA as this has also expired and Nuffield are not currently re-newing with us. Decon Lead for Alderney agreed to speak with legal team and have SLA reviewed and sent over.	Several attempts at making contact regarding renewal of SLA (emails sent 25/08/23, 19/09/23, 29/09/23 & 09/11/23 also phone calls and voice messages left). Escalated to DCH Decon Lead JL formally 17/11/23 as this has potential to leave DCH in a very vulnerable position is our machines broke down and if unannounced audit took place then this would lead to a Major ono-conformance. JL now in communication with Alderney to get updates on SLA.	Low Risk	Low Risk	Very low Risk

ID	Division of responsibility	Care Groups	Location of responsibility	Risk Statement	Supporting Information	Risk level (initial)	Risk level (at closure)	Risk level (Target)
1794	Family Services and Surgical Division	Trauma, Orthopaedics, Urology & Junior Doctors (B1a)	Urology Department	A stone nurse (B6) in Urology is required to cover all benign urological work. The service does not currently have the finances to support this. This places additional pressure on the consultants as they are having to pick up this work. This takes them away from the work that they should be doing which is causing a backlog of patients.	This nurse would be able to: - Lithotripsy (ESWL) - Lead a stone MDT - Book and review CT KUB prior to planned URS leading to less on the day cancellations or negative URS - Support laser cases in CEPOD theatre which would free up capacity due to bringing patients back for multiple procedures - Follow up the patient on medical expulsive therapy - Perform Urodynamics (which would support our DM-01 position) in the long term	High Risk	Low Risk	Very low Risk
1430	Chief Information Officer	Chief Information Officer	Digital Services (formerly IT)	Microsoft Extended support for SharePoint Server 2010 ends in October 2020 Increased risk of failure due to cyber security risks. Loss of the Sharepoint system would mean loss of availability to information. Of particular significance would be that doctors have no access to the clinical guidelines, patient data stored on Sharepoint, legal claims, policies, SOPs, Risk Register Lack of support for any of the third party software on this server means it may not be able to recover the server in a working form.	ISO standard reference External parties; Supporting Utilities; Implementing Information Security Continuity Control in place there is a support contract from a supplier to monitor the server. In addition there is a SharePoint supplier who responds to any reduced functionality. Future control needed An improvement would be to move to a supported environment.	High Risk	Low Risk	Low Risk
646	Urgent & Integrated Care Division	Pharmacy, Pathology and Medical Physics (A4)	Pathology Service	There is a lack of clarity around all SLAs, from commisioners to suppliers and internal providers.	ISO15189 standard 4.4.2 requires review of service agreements, these are those with our commissioners and suppliers. Current Pathology has limited knowledge of those with our commisoners, for example around sample transport provission and responsiblities around bloods transfusion. Similarly agreements with suppliers of service and goods are not transparent.	Moderate Risk	Low Risk	Very low Risk

ID	Division of responsibility	Care Groups	Location of responsibility	Risk Statement	Supporting Information	Risk level (initial)	Risk level (at closure)	Risk level (Target)
660	Urgent & Integrated Care Division	Pharmacy, Pathology and Medical Physics (A4)	Blood Sciences - Haematology Laboratory	Specimens are being received in the department labelled with addressograph labels or hand written. This does not promote positive patient identification at the time of sample collection. Patients at risk of receiving incorrect results due to incorrectly labelled samples.	Blood sciences has been collecting information regarding incorrectly labelled samples for over 6 months. This data can be found on the department quality systems (2018 CAPA 028). The majority of the samples recorded have been deemed 'non-repeatable' and have had an unrepeatable sample form completed which requires the person obtaining the sample to declare that they will take full responsibility for the correct identification of the patient. There are also events which have been recorded on the datix system where results have been issued on samples where the labelling matched the request form but subsequently it was discovered that it was the wrong blood in tube. The addressograph labels also cause issues with the processing of samples through the department as they do not 'fit' the sample tubes. The analysers struggle to mix the samples and read the laboratory ID due to the bulky nature of the labels. This causes delays to results. It is impossible to identify issues with sample quality when the samples are completely covered by the labels without having to spend time removing them.	Moderate Risk	Low Risk	Very low Risk
763	Family Services and Surgical Division	Theatres, Anaesthetics, Critical Care & Decontamination (B3a)	Theatre - North Wing	The operating lights in theatres 2, 3, 4 & 5 are obsolete. There are some spare parts available for the lights in theatre 2, 3 & 4 but the spare for theatre 5 lights are no longer available. Contingency plan for mobile lights would preclude certain operations and Theatre productivity would be compromised.	2016: With limited or no spare parts available for these operating lights maintaining them in a working order will become increasing difficult. Failure of the operating lights will lead to operations being cancelled on the day. If the lights can not be repaired the operating lists for that room would have to be cancelled or severely modified potentially for up to 12 to 16 weeks (times quoted by companies for the average time to replace an operating light from ordering to completion). Operating lights need to be custom built to the layout and ceiling height of the operating room. Due to the fact that theatre 5's light has very few spare parts it is the most urgent for replacement. Th 5 operating light was discontinued in 1998 and spare parts were stopped in 2008. Th 2,	High Risk	Moderate Risk	Very low Risk

ID	Division of responsibility	Care Groups	Location of responsibility	Risk Statement	Supporting Information	Risk level (initial)	Risk level (at closure)	Risk level (Target)
					3 & 4 lights were discontinued in 2004 and spare parts stopped in 2014. Obsolesce was raised by the maintenance company during servicing in 2015. 2018: this year's servicing of the operating lights has raised a further issue: Paint is flaking off the operating light n 2, 3 & 4 and creating a potential contamination risk for surgical wounds. Theatre 2 & 5 lights replaced in March 2020 Theatres 3 & 4 delayed due to COVID-19 Pandemic.			
858	Family Services and Surgical Division	Family Services (B4)	Special Care Baby Unit (SCBU)	Staffing on SCBU is often critical with vacant shifts unfilled with QIS nurses. recruitment remains poor and sustainability not assured	Although pregnant women (< 32 weeks gestation) with threatened premature labour are transferred to Poole, there are still regular occurrences of premature babies being born too quickly for transfer and babies born in poor condition unexpectedly who require hours of stabilisation before transfer to a tertiary unit. The failure to meet BAPM recommendations for staffing could, in theory result in the contract to provide neonatal services being withdrawn. Were that to happen, the maternity unit would be unsustainable without neonatal services and would have to close or redesignate as a midwife led unit. Jan 2022 - staffing remains very challenging, exacerbated by covid absences. The business case for increased scbu staffing is being finalised. Datix are submitted regularly for unsafe staffing - 14 last month. Twice last month, nurses stayed overnight after a long day to ensure safe staffing Feb 15th - situation remains unchanged. LTS returned but staff	High Risk	Moderate Risk	Low Risk

ID	Division of responsibility	Care Groups	Location of responsibility	Risk Statement	Supporting Information	Risk level (initial)	Risk level (at closure)	Risk level (Target)
					still affected by covid related absence. April 11th - business case agreed by SLG. However, staffing remains very challenging with covid absence notably May 2022 only one datix in April relating to poor staffing. Improvement in shift coverage because of staff returning from sickness. However, still reliance on agency and staff working extra shifts to ensure safety. funding agreed for banding for nurses and HCAs - thus making the vacancies more attractive for recruitment. Oct 2022 now fully recruited. No incidents in September			
955	Urgent & Integrated Care Division Baker, Abi 30/07/2021 12:31:14	Integrated and Holistic Care (A2)	Respiratory Medicine Department	CPAP Delays for Outpatients	Oct 16 – Concern over delays for patients diagnosed at DCH getting CPAP treatment because they have to be referred to Blandford Service. Oct 17 – There have been ongoing attempts at resolution but CCG is not looking at Respiratory at the moment. Perhaps will be incorporated in any review that might be prompted by Risk#10 Aug 18 – DOCM discussing reconfiguring the service away from Salisbury Dec 18 – Meeting on 14/1/19 May 19 – Comments sent back to CCG initial scoping document – Task & Finish Group to be set up Jul 19 – Meeting on 17th June – CCG scoping main option and intending to present to CCG Finance Group in August Oct 19 – Discussed at CCG Elective Care Board.	Moderate Risk	Moderate Risk	Low Risk

ID	Division of responsibility	Care Groups	Location of responsibility	Risk Statement	Supporting Information	Risk level (initial)	Risk level (at closure)	Risk level (Target)
					Awaiting final approval. Aim to start Spring 2020 if personnel in place Dec 19 – Still not finally approved by CCG – need to ensure SMT have authorised. Mar 20 – Poole want Service Specification – CCG redrafting and discussing with them hence CCG board approval delayed. Sep 20 - Virtual meeting was had with CCG with a view to restarting the process of reallocating the service within the CCG. Jan 21 - discussed at Dept meeting. Covid stalled the process of transferring the service in the 20-21 financial year. Due to cessation of Blandford service during Covid and already large backlog waits have increased to around 12 months. Risk rating raised to reflect possible mortality & morbidity consequences of delayed treatment. Jan 2022: New referrals may now be waiting >2 years for their 1st CPAP appointment, and ~46 months for their 1st follow-up appointment. Patients who have been advised not to drive and becoming highly frustrated and we are becoming the target of their frustration, despite not being able to influence this other service.			
1144	Family Services and Surgical Division	Theatres, Anaesthetics, Critical Care & Decontamination (B3a)	Theatre - East Wing	Serial no 101358. Due to the age, Neomed will no longer offer a comprehensive contract on this equipment, it was originally purchase March 2012. Consequence would result in cancelling procedure which could result in patient harm due to delays. This laser is used for ENT.	Additional costs will occur if call outs and repairs are required. Possible delays in arranging repairs and possibility of no spare parts due to age of equipment. Equipment on it way to being obsolete. We currently have 1 for Ophthalmology & 1 for Urology which are not interchangeable so if they break we are unable to procedure. Theatre now have a brand new Laser	Moderate Risk	Moderate Risk	Very low Risk

ID	Division of responsibility	Care Groups	Location of responsibility	Risk Statement	Supporting Information	Risk level (initial)	Risk level (at closure)	Risk level (Target)
1262	Family Services and Surgical Division	Theatres, Anaesthetics, Critical Care & Decontamination (B3a)	Day Surgery Unit (DSU)	The current Faxitron Biovision is obsolete and spare parts are no longer manufactured. The service contract finished in December 2022 and this has been extended to February 2024 but Hologic won't renew.	The Faxitron Biovision was purchased in 2013. This model is obsolete and spare parts won't be available if it breaks down. Hologic have already reduced the current service contract from fully comprehensive to preventive maintenance and will not renew the contract when it finished. The Biovision is an x-ray machine that is used in theatre to take x-rays of breast tissue samples, this reduces the amount of surgical time per procedure as the samples do not need to be taken to the x-ray department and the surgeon doesn't have to wait for the results.	Moderate Risk	Moderate Risk	Very low Risk
1401	**Chief Information Officer**	**Chief Information Officer**	**Digital Services (formerly IT)**	At end of manufacture support, no software upgrades are now available Loss of telephony system , internal and external calls not available	Control in place project for migration to SIP trunks, multi year project Future control needed Approve future funding and implement strategy	Moderate Risk	Moderate Risk	Moderate Risk
1408	Chief Information Officer	Chief Information Officer	Digital Services (formerly IT)	Hardware failure, end of life Hosts the Trust's virtual environment	Control in place backplane is the oldest part of the system, blades and network switches are currently in support	High Risk	Moderate Risk	Low Risk
1593	Chief Operating Officer	Chief Operating Officer	Transformation – All projects	If programme is unable to deliver against business case timescale national funding availability could be impacted. If Digital requirements are unable to be delivered against business case timescale the whole programme could experience delays.	Inability to deliver against business case timescale could have an impact on overall affordability and quality.	High Risk	Moderate Risk	Moderate Risk

ID	Division of responsibility	Care Groups	Location of responsibility	Risk Statement	Supporting Information	Risk level (initial)	Risk level (at closure)	Risk level (Target)
1715	Chief Information Officer Baker,Abi 30/07/2024 12:31:14	Chief Information Officer	Medical Records	An issue with down stream system not being updated when PAS is changed has been highlighted from the pathology team, this has been investigated and there isn't an issue with any messages going to the system. This means adopted and transgender patients who's details have been formally processed and changed are incorrect on PAS EH, DG and JF are aware of the issue and working on a process to notify a small member of staff of such changes detailed below, until this is resolved health records are not able to merge and have the correct details on PAS, there are currently 3 transgender patients and 9 adoptions were we are unable to current show the correct details on PAS. There is also an issue in relation to DCR, when we update PAS. EH has worked on a process to notify when any changes are going to be made, but until we have resolved the in-house concerns, we are waiting to start this process with the DCR team.	The Trust receives notification from Aspire of any they are aware of, this is passed to the Health records team to process the changes. The records are detailed on a spreadsheet and the national spine id checked to see when the NHS number has been removed and the details no longer valid, current process is to register the patient with the new details, remove the old NHS number and merge the new hospital numbers. The old record is redacted to remove any references to previous name, hospital number NHS number and family details, all clinical information is retained, this redacted record is then uploaded to DPR. All records are scanned. There are occasions where the adoption doesn't come through Aspire and these are forwarded to the Information Assurance team to check and then the process above is followed. Transgender patients records are identified by either the patient attending hospital and register under the new details or they or GP will contact the hospital to advise of a change. transgender patients don't have to have a new NHS number to change their records, they can change their name, currently the gender can only been changed by patient having surgery and given a new identity or via the formal transgender process.	Moderate Risk	Moderate Risk	Low Risk
1756	Chief Operating Officer	Chief Operating Officer	Strategic Estates-Programme Wide NHP	External resource capacity relating to specialist consultancy services and the impact of project slippage resulting in the parallel running of projects under both the PPIP Programme and other DCH	The consequence is high (4) as conflicting priorities across multiple concurrent projects means that at times appropriately resourcing projects is challenging. Due to the nature of these	High Risk	Moderate Risk	Moderate Risk

ID	Division of responsibility	Care Groups	Location of responsibility	Risk Statement	Supporting Information	Risk level (initial)	Risk level (at closure)	Risk level (Target)
				Programmes such as NHP. This relates to the appointed QS, PM and NEC Supervisor roles.	appointments, the impact of this is usually directly related to multiple other managed risks such as Time, Cost and Design Changes etc.. if this is not managed the impact can be exponential especially where there is a single point of failure. This is likely due to the SWH slippage and the fact that this is now not only running in parallel to NHP but also Ridgeway.			
1545	Family Services and Surgical Division	Radiology, Outpatients & Neurophysiology (B3b)	Radiology IT systems	Failure to Upgrade PACs Clinical Reporting System. Current version (8.2.19) installed as quick fix for Trust Windows 10 project to be functional but not fully Windows 10 supported.	PACS software out of date and suboptimal for reporting. PACS software requires upgrading from versions 8.2n>8.3n>8.4n>9.1 algorithm PACS Version 8.3n. Fully Windows 10 supported. User self resetting of passwords. Enhanced handling and display of mammography imaging (required for up to date reporting of Breast Imaging) Full support of Mammography tomosynthesis imaging (see above) PACS Version 8.4n Full support of Image Sharing functionality (required for DCH/UHD image sharing) Support of XCA (required for DCH/SWASH PACS image availability) PACS Version 9.1 (latest version) Supports AI algorithm various outputs (required for optimal use of THLC Aidence, Rapid AI, Heartflow reports)	High Risk	Very low Risk	Very low Risk

ID	Division of responsibility	Care Groups	Location of responsibility	Risk Statement	Supporting Information	Risk level (initial)	Risk level (at closure)	Risk level (Target)
1546	Medical Director Baker,Abi 30/07/2024 12:31:14	Medical Director	Pharmacy Department	Pharmacy/Research have recruited a Pharmacy Research Lead on a fixed-term basis (12 months). A review of Pharmacy governance and study specific pharmacy site files has been completed and highlighted significant quality and process concerns which will require intensive resource to remedy. A pipeline of new commercial studies which DCH is going to support on-site, and at the Weymouth Research Hub, require pharmacy specialist support to meet the essential requirements of the Trust, sponsor and the MHRA. The current fixed-term post for this role ends 6th August, 2024. Should the post not be made substantive, the risks are that there will be insufficient specialist pharmacy resource and expertise to: - ensure patient safety for all IMP studies (existing and new) - take remedial action to address the pharmacy site file and governance issues discovered in pharmacy - support the pharmacy team to ensure site file maintenance and file management issues are not repeated - provide continued support and oversight to existing IMP studies - open any further IMP studies - support safe and effective delivery of new and existing IMP studies - manage risks to patient safety associated with IMP studies - support the Research Strategy and income generation/sustainability objectives through provision of IMP studies - provide a programme of remedial action which will result in inspection readiness for the service - review and maximise pharmacy income for IMP studies, retrospectively and prospectively - continue to support existing IMP studies, and	Report on audit of pharmacy clinical trial service. Spreadsheet detailing Standard Operating Procedure status for the pharmacy clinical trial service. Spreadsheet detailing pharmacy clinical trial site file review findings.	Moderate Risk	Very low Risk	Low Risk

ID	Division of responsibility	Care Groups	Location of responsibility	Risk Statement	Supporting Information	Risk level (initial)	Risk level (at closure)	Risk level (Target)
				support the commencement of new IMP studies, to maintain and strengthen relationships with commercial pharma, and the ceasing of which would result in breach of contract and reputational damage - assist in development of the research portfolio for west Dorset to support the provision of new opportunities for the local population - provide a robust pharmacy clinical trial service to meet the requirements of the MHRA - demonstrate that the Trust meets MHRA and GCP requirements for IMP studies				
1364	Chief Information Officer	Chief Information Officer	Digital Services (formerly IT)	Telephony - Unable to communicate across the site or to external parties	ISO Standard reference - supporting utilities Control in place Mitel VoIP telephone system. UPS power supply via data centre, Mitel 3300 has dual HA functionality. Switches and router are on a UPS en route so call continuity remains. Power capacity of PoE may be a challenge. Future control needed Assess power requirement ISO standard reference Verity, review and evaluate information security continuity Control in place UPS is in place, console in standby room, maintenance contract 24/7 support in place.	Moderate Risk	Very low Risk	Very low Risk

Baker, Abi
30/07/2024 12:31:14

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NHS
Dorset County Hospital
NHS Foundation Trust

Escalation Report

Executive / Committee: Finance and Performance Committee

Date of Meeting: Monday 17th June 2024

Presented by: Stephen Tilton

Significant risks / issues for escalation to Committee / Board for action	• The Hospital Fleet Policy and Loyalty Card proposal were approved and are recommended to the Board. • The Radiology Out of Hours Reporting Contract was approved and is recommended to the Board. • Key risks remained delivery of the cost improvement programme, the 109% Elective Recovery Fund and the cash position.
Key issues / matters discussed at the Committee	**Performance Report** • Emergency Department performance better than trajectory in May. • The number of patients with No Reason to Reside remained higher than trajectory. • Demand growth continued to be much higher than planned with an increase in cancer referrals of 40%. • 52 and 65 week waiting time trajectories were behind plan. • Growth continued in the six-week diagnostic waiting time standard – particularly cardiology and endoscopy. • An exception report outlining the divergence between activity and plan would be included going forward. • The Cardiology backlog was discussed noting the impact of staff sickness absence and increases in demand. A task and finish group had been established to review impact on quality and a report would be shared with the Quality committee in July with an update on performance returning to the Finance Committee in September. **Finance Report** • DCH had a year-to-date deficit of £1.9m – slightly behind plan. The operating plan had been resubmitted and rephased. • 18 escalation beds remained in operation. • Agency expenditure had reduced to £500k in month. • The cash position continued to be closely monitored. • The Patient Pathway Improvement Programme Update noted slight delays in the completion of air quality handling works in the treatment room at South Walks House and ongoing discussions with the contractor. • The April Cyber Security Update was noted. The following subgroup Escalation Reports were received and noted: • CAPSUG • SIRO Annual Report • Digital Transformation and Assurance Group • New Hospitals Programme Board – not received. • Emergency Planning and Resilience Group • Commissioning Intentions were noted.

Decisions made by the Committee	• The Hospital Fleet Policy was approved alongside the Loyalty Card proposal. • The Radiology Out of Hours Reporting Contract was approved.

Implications for the Corporate Risk Register or the Board Assurance Framework (BAF)	• Key risks remained:
	  ○ Delivery of the 5% cost improvement programme
	  ○ Delivery of the 109% Elective recovery Fund due to flow constraints and productivity being behind plan
	  ○ and the cash position.

Items / issues for referral to other Committees	• A report following completion of the cardiology backlog review outlining the impact on quality to be taken to Quality Committee in July. • A report providing a review of Opthalmology patient harms and assurances that patients are waiting well to be taken to Quality Committee.

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NHS
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Escalation Report

Executive / Committee: Finance and Performance Committee

Date of Meeting: Monday 22nd July 2024

Presented by: Stephen Tilton

Significant risks / issues for escalation to Committee / Board for action	• The lease for an offsite warehouse was reviewed and is recommended to the Board for approval. • The Finance and Performance Committee in Common with DHC were recommended to the Board for approval, pending further discussion about the number of NED members on the committee. • Non-compliance with the Freedom of Information Act, as escalated by Information Governance Group
Key issues / matters discussed at the Committee	**Performance Report** • Demand at the front door continues to increase in comparison to last year and to the baseline year of 2019/2020 • Achievement of the national 4-hour wait standard of 78%, but not the Trust's own trajectory of 78.58%. • Off-trajectory for clearing the 65 week-wait backlog • Thorough discussion about the Elective Recovery Fund (ERF) • Patient and Cancer Access policies updated to comply with national requirements; ratified by Committee **Finance Report** • £370,000 variance to the plan at the end of month 3, with industrial action, high-cost drugs, inflationary pressures being the key drivers of this deficit. Increased operational pressures in June were also a factor. • Agency expenditure has continued to reduce, with a total spend of £0.5m in month • A great deal of work continues in relation to the Cost Improvement Plan (CIP), with a focus on turning identified savings in to deliverable savings. • Coding Plan Update • The Quarter 2 Cyber Security Update was noted. However, concerns were raised on the diversion of resources away from business as usual updates • The Premises Assurance Model submission was noted. • The ICB Finance Committee escalation report was noted. The following subgroup Escalation Reports were received and noted: • CAPSUG • EPRG • Information Governance Group, noting non-compliance with the Freedom of Information Act • DCH SubCo and Q4 Performance Report
Decisions made by the Committee	• The Strategic Risks for the committee (Board Assurance Framework) were discussed and approved.

	• The lease for an offsite warehouse was reviewed and is recommended to the Board for approval. • The Finance and Performance Committee in Common with DHC were recommended to the Board for approval, pending further discussion about the number of NED members on the committee.
Implications for the Corporate Risk Register or the Board Assurance Framework (BAF)	• The revised Strategic Risks for the committee (Board Assurance Framework) which aligned risks to the revised strategic objectives within the proposed joint strategy was reviewed by the committee, with a recognition that there would be iterative changes to the Board Assurance Framework as it started to be used by the Trust.
Items / issues for referral to other Committees	•

Report Front Sheet

1. Report Details			
Meeting Title:	Board of Directors		
Date of Meeting:	31st July 20224		
Document Title:	Balanced Scorecard- An integrated report for the reporting month of June 2024		
Responsible Director:	Anita Thomas, Chief Operating Officer	Date of Executive Approval	24/06/2024
Author:	Adam Savin, Director of Operational Planning and Performance		
Confidentiality:	Non-confidential		
Publishable under FOI?	Yes		
Predetermined Report Format?	No		

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

3. Purpose of the Paper

The Trusts Balanced Scorecard brings together key indicators under four dashboards of Quality and Safety, performance, People and finance.

All indicators are covered in detail in the respective sub-board committees and therefore, this paper does not attempt to duplicate the committees work or the deep dives, but rather provide oversight of the combined key metrics. The Board papers include the sub-board committee escalation reports, which have been written by each Chair and in conjunction with this report, provides the opportunity for triangulation.

Note (✓)	✓	*Discuss (✓)*	✓	*Recommend (✓)*		*Approve (✓)*	

4. Executive Summary

Key areas to highlight:

Quality

- Emergency readmissions within 30 days of discharge have risen to 9.9% year to date, this is an increase since last reporting.
- Electronic Discharge Summary sent within 24h of discharge remains below target at 75.51%. This is a decrease since last reporting.
- SHMI has remained within the expected range further improved

Performance

- UEC performance has remained steady, with the national planning guidance target being achieved.
- Cancer performance is being impacted by increasing demand, with 2 out of 3 targets not being met
- Patients waiting the longest for elective treatment have reduced, but the total waiting list size continues to increase
- Diagnostic performance has reduced further

	People • Appraisal rate has reduced to 73%, a reduction of 3% since last reporting • Vacancy rate decreased to 2.53%, this is better than the target. • Turnover increased to 9.38% but is still better than target. **Finance** • Adjusted financial plan showing a marginal overspend. • Agency spend reducing and with improved medical agency spend. • Capital expenditure is slightly behind plan, due to timings of spend.
5. Action recommended	The Board of Directors are asked to Note this report.

6. Governance and Compliance Obligations				
Legal / Regulatory Link		**Yes**		*Report of the NHS constitutional standards and the oversight framework*
Impact on CQC Standards		**Yes**		*Safe, effective, responsive*
Risk Link		**Yes**		*Quality, patient experience and clinical outcome risks associated with under performance. Sustainability and reputation risks.*
Impact on Social Value			**No**	*Standard reporting paper on organisational performance*
Trust Strategy Link		**How does this report link to the Trust's Strategic Objectives?** *Please summarise how your report will impact one (or multiple) of the Trust's Strategic Objectives (positive or negative impact). Please include a summary of key measurable benefits or key performance indicators (KPIs) which demonstrate the impact.*		
Strategic Objectives	People	N/A- Standard reporting paper on organisational performance		
	Place	N/A- Standard reporting paper on organisational performance		
	Partnership	N/A- Standard reporting paper on organisational performance		
Dorset Integrated Care System (ICS) Objectives		**Which Dorset ICS Objective does this report link to / support?** *Please summarise how your report contributes to the Dorset ICS key objectives.* *(Please delete as appropriate)*		
Improving population health and healthcare		**Yes**	**No**	N/A- Standard reporting paper on organisational performance
Tackling unequal outcomes and access		**Yes**	**No**	N/A- Standard reporting paper on organisational performance
Enhancing productivity and value for money		**Yes**	**No**	N/A- Standard reporting paper on organisational performance
Helping the NHS to support broader social and economic development		**Yes**	**No**	N/A- Standard reporting paper on organisational performance
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- Standard reporting paper on organisational performance
Quality Impact Assessment (QIA)		**Yes**	**No**	N/A- Standard reporting paper on organisational performance

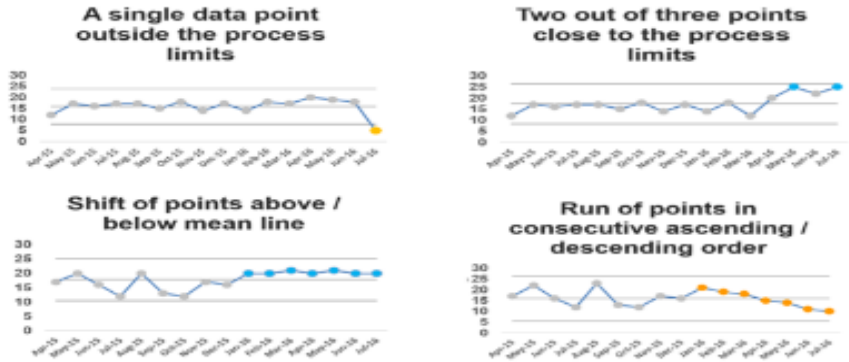
1) Understanding Statical Control Charts (SPC)

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?

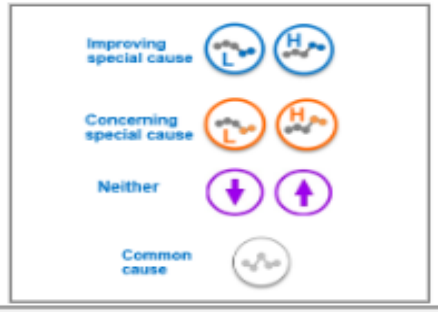
Blue icons indicate significant improvement or low pressure.

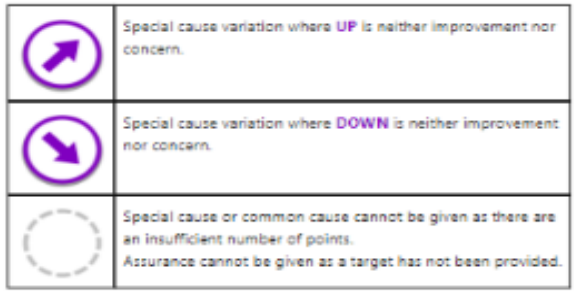
Orange icons indicate significant concern or high pressure.

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.





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.

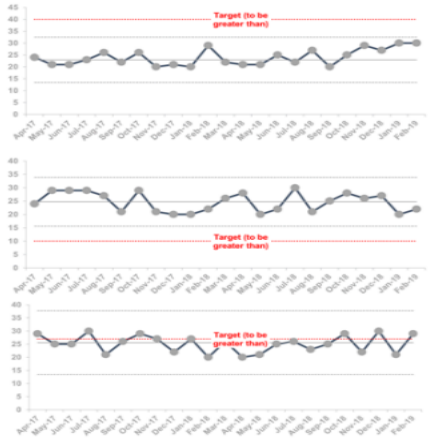
The centre line is the average value of all moving ranges.

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.

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

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

2) Executive Summary

For the reporting month of June 2024, there are 16 indicators that are failing the target or are unstable (hit or miss) and showing as special cause for concern, this compares to 15 in the reporting month of April 2024.

This may mean the process does not easily lend itself to representation as an SPC chart or that without intervention the process will not deliver the required outcome. Each is addressed below and where appropriate other measures described which give a more rounded perspective on the Trust performance within that section.

For the people dashboard, 40% of the indicators are classed as concern for variation and/ or fail for assurance, this is the same as April 24. For performance it stands at 53%, the same as April 24, finance at 28%, up from 25% and quality at 46%, up from 30%. There are 13 indicators, across all dashboards (therefore the balanced scorecard) that have not got a target, therefore assurance cannot be given either way, this is down from 14.

Work is underway to refine the Balance Scorecard further, which is now being led by the Director of Performance. This work will ensure all indicators have a target, that indicators used are appropriate for an SPC and where not, included in a different format and that the indicators are re-approved by the Executive team for the new financial year.

April 2024 data

Assurance

Variance	P	?	F		Total
H			4		4
L	1	1	2	4	8
?		10	2	4	16
H	2	2	1	2	7
L		1	1		2
				4	4
Total	3	14	10	14	41

June 2024 data

Assurance

Variance	P	?	F		Total
H			4		4
L		3	3	4	10
?	1	8	1	6	16
H	3	1		2	6
L		2	2		4
				1	1
Total	4	14	10	13	41

The matrix summarises the number of metrics (at Trust level) under each variance and assurance category. The Trust is aiming for the top left of the grid (special 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. The increase in the number of indicators without a target and therefore where assurance cannot be provided, is due to the change of target in the new financial year and it not being reflected in the current data set. This is being addressed and the BI team working on updating this.

3) Quality and Safety dashboard

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	Jun-24	75.51%	90%	-14.49%	77.55%	78.94%	75.51%		
Effectiveness	Inpatient - EDS % Available < 7 Days of Discharge	0 - Total	Jun-24	83.71%	100%	-16.29%	87.83%	88.32%	83.71%		
Effectiveness	Inpatient - Emergency Re-Admissions % (1 month in arrears)	0 - Total	May-24	9.9%	13%	-3.10%	8.23%	8.73%	9.9%		
Experience	Complaints - Formal Complaints Received	0 - Total	Jun-24	21			27	24	82		
Experience	Friends and Family - Overall % Recommendation Rate	0 - Total	Jun-24	90.8%	94%	-3.20%	91.54%	87%	90.8%		
Safety	Incidents - Confirmed Never Events	0 - Total	Jun-24	0	0.02	-0.02	0.08	0	1		
Safety	Incidents - Falls Resulting in Severe Harm or Death by Reported Date	0 - Total	Jun-24	0			0.19	0	0		
Safety	Incidents - Medication Incidents by Reported Date	0 - Total	Jun-24	97			60.87	71	263		
Safety	Incidents - Pressure Ulcers Reportable Confirmed Avoidable and Hospital A…	0 - Total	Jun-24	0			0.65	0	1		
Safety	Incidents - Serious Incidents Investigated and Confirmed Avoidable by Pan…	0 - Total	Jun-24	0	0	0.00	0.44	1	1		
Safety	Infection Control - C-Diff Hospital Onset Healthcare Associated Cases	0 - Total	Jun-24	4	3	1.00	2.59	2	6		
Safety	Infection Control - Gram Negative Blood Stream Hospital Onset Infections	0 - Total	Jun-24	2	5	-3.00	2.97	1	6		
Safety	Inpatient - SHMI Value	0 - Total	Jan-24	1.11			1.14	1.13	1.11		

In month the electronic discharge summary did not achieve target and the assurance metric shows that will this not be achieved with current processes in place. The reasons for this have been extensively reviewed by the Quality Committee and a deep dive took place in June, recognising that the long-term solution is the introduction of an Electronic Patient health record. In the interim a_Task and Finish Group has been established which is providing assurance to the committee that the EDS delays are not causing patient harm.

Emergency readmission rates continues to show special cause variation and a report and dashboard will be presented to the Quality Committee in September once all data has been reviewed.

Friends and Family recommendation rates data showed special cause variation in month. Theming of feedback included improved signage, better communication in clinic letters and emails and providing more information when there are delays in appointment times.

Renal Transport Incidents - meeting held with HTG in June, facilitated by the ICB and attended by colleagues from DCH. It was agreed that there were improvements following the ICB observational audit in May, commitment from HTG to address the remaining issues and therefore ongoing monitoring would continue with further review later in the year.

The Antimicrobial Stewardship (AMS) Group has agreed a detailed work plan for 24-25, and updates on progress will be included in the Medicines Committee Escalation Reports. AMS learning identified from the IPC PSIRF cases over the last six months has been shared with clinical teams.

The Trust continues to follow up on negative or concerning responses sent by text messages and we are currently looking to develop new processes to further interrogate FFT data against Complaint data to understand themes and reasoning around why FFT recommendations may fall at any given point. Work is ongoing to procure a replacement provider for FFT.

4) Performance dashboard

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	Jun-24	76.68%	77%	-0.32%	70.52%	61.49%	76.68%		
Cancer	Cancer - 31 Day Decision to Treatment Standard Performance	0 - Total	Jun-24	95.54%	96%	-0.46%	96.39%	96.37%	95.54%		
Cancer	Cancer - Patients Waiting 62+ Days from Referral to Treatment	0 - Total	Jun-24	77			79.78	109	225		
Elective	Theatres - Capped Utilisation	0 - Total	Jun-24	70.79%	85%	-14.21%	68.55%	68.87%	70.79%		
Elective	Theatres - Uncapped Utilisation	0 - Total	Jun-24	74.61%	85%	-10.39%	73.64%	74.09%	74.61%		
Outpatient	Diagnostic - Percentage Patients Waiting <6 Weeks Test	0 - Total	Jun-24	77.66%	95%	-17.34%	75.65%	77.06%	77.66%		
Outpatient	RTT - 65+ Week Waits	0 - Total	Jun-24	368			677.37	267	368		
Outpatient	RTT - 78+ Week Waits	0 - Total	Jun-24	2			309.61	7	2		
Outpatient	RTT - Waiting List Size	0 - Total	Jun-24	22619			19427.47	20388	22619		
UEC	ED - Ambulance Handovers Average (Minutes)	0 - Total	Jun-24	21.23	30	-8.77	13.73	12.02	21.23		
UEC	ED - DCH 4 Hour Performance %	0 - Total	Jun-24	58.65%	70%	-11.35%	69.94%	65.11%	58.65%		
UEC	ED - ED Attendances % Waiting 12+ Hours	0 - Total	Jun-24	11.5%	6.3%	5.20%	3.94%	7.3%	11.5%		
UEC	ED - Overall 4 Hour Performance %	0 - Total	Jun-24	78.19%	78%	0.19%	82.06%	80.8%	78.19%		
UEC	Inpatient - Adult General and Acute (G&A) % No Criteria to Reside Bed Occup…	0 - Total	Jun-24	19.08%			21.18%	20%	19.08%		
UEC	Inpatient - Average Number of No Criteria to Reside Patients	0 - Total	Jun-24	58	38	20.00	78	63	58		

For the reporting month of June 2024, the 28 and 31 day cancer indicators did not achieve the target, however were common cause variation, with no significant changes. The assurance is hit or miss for both metrics, which occurs when the target lies between the process limits. For 2024/25, the 62 day standard has moved away from the volume of patients in the backlog and returned to the percentage target, this has not been updated in the scorecard but will be for the next reporting period. For June, the trust achieved the 62 day target, with 75.89% of patients having started treatment within 62 days, against the target of 70%, for Q1 DCH has achieved the 62 day standard.

The two theatre utilisation indicators have improved, both capped and uncapped theatre utilisation is special cause of an improving nature, but with an assurance rating of fail, with the process not capable and will continue to fail the target without process redesign. The level of improvement has not kept pace with regional or national comparators and thus, DCH is in the lowest quartile of performance. Bi-monthly meetings have now moved to weekly with the COO, for the Theatre and Divisional Management team.

The percentage of patients waiting 6 weeks or less for a diagnostic procedure has reduced further, but due to consistent improvements prior to April, is showing as special cause of an improving nature but with assurance of fail. Cardiology continues to be the largest contributor of the underperformance, but

backlogs have grown in month in Endoscopy. Full details of this and all metrics within the performance dashboard, are covered in the Finance and Performance Committee.

In terms of the elective waiting list, the number of patients waiting over 65 and 78 weeks is special cause variation of an improving nature as the cohort of patients that have been waiting the longest, continues to reduce. The total waiting list size shows special cause of a concerning nature as it continues to grow, with demand increasing (referrals) at a faster rate than activity can keep pace with without further investment in capacity.

Average ambulance handover times have increased since the last Board reporting, the indicator is special cause of a concerning nature however, and with an assurance of pass, the process is capable of consistently passing the target. Performance of the ED 4-hour standard all (including MIUs) is common cause variation, with no significant changes and the process will continuously hit or miss the target. Performance is achieving the national planning guidance target of 78%, but is slightly off our local trajectory for the reporting month of June.

5) People dashboard

Metric Group	Metric	Group	Latest Month	Value	Target	Variance to Target	Mean	PY - Month Value	YTD Value	Variation	Assurance
Growing for our Future	Essential Skill Rate	0 - Total	Jun-24	89%	90%	-1.00%	88.92%	90%	89%		
Looking After our People	Appraisal rate	0 - Total	Jun-24	73.22%	90%	-16.78%	75.62%	75.6%	73.22%		
Looking After our People	Sickness Rate (1 month in arrears)	0 - Total	May-24	0%	3.75%	-3.75%	3.93%	3.55%	0%		
Looking After our People	Staff Turnover Rate	0 - Total	Jun-24	9.38%	12%	-2.62%	9.71%	11.52%	9.38%		
Looking After our People	Vacancy Rate	0 - Total	Jun-24	2.53%	5%	-2.47%	6.15%	8.72%	2.53%		

Essential skills remains at 89%, only 1% short of achieving the target. The indicator is special cause of an improving nature, although due to the fluctuating nature of this indicator, the assurance classification remains as fail, without process redesign.

The appraisal rate indicator had previously been special cause of an improving nature, but following four months of decline is now common cause variation with no significant change. The assurance classification is fail, the process is not capable of achieving the target without process redesign with the target not being met since before COVID. Work on the appraisal and talent management processes is being undertaken as part of the People Promise Exemplar Programme.

Staff turnover rate increased in month, but the indicator remains special cause of an improving nature, and the process is capable of consistently passing the target.

Likewise sickness absence, which increased in month but remains below target. The vacancy rate reduced to a record low for DCH, with special cause variation of an improving nature.

6) Finance dashboard

Metric Group	Metric	Group	Latest Month	Value	Target	Variance to Target	Mean	PY - Month Value	YTD Value	Variation	Assurance
Capital	Capital Expenditure	0 - Total	Jun-24	1602	1774	-172.00	1968.65	1666	4424		
Revenue	Adjusted Financial Position	0 - Total	Jun-24	-1535	-1441	-94.00	-258.51	-685	-5280		
Sustainability	Local Supplier % of Catering Spend	0 - Total	Jun-24	25.46%			24.95%	25.87%	25.46%		
Sustainability	Local Supplier % of Total Spend	0 - Total	Jun-24	6.22%			6.69%	8.12%	6.22%		
Value Board	Agency Spend	0 - Total	Jun-24	536	807	-271.00	1085	1424	1723		
Value Board	Efficiency Delivery	0 - Total	Jun-24	632	517	115.00	204.27	173	1281		
Value Board	Off Framework Agency Spend	0 - Total	Jun-24	14	83	-69.00	112.47	279	77		

Adjusted financial plan showing a £0.370m overspend linked to supporting Industrial action, heightened operational pressures and inflation above plan including patient specific drugs.

Agency spend reducing, agency as a % of pay budget is 3.3% noting NHSE target is 3.2%. Off framework spend reducing in line with NHSE target date removal 1st July 2024 - £14k spend in June.

Efficiencies have delivered £1.5m year to date of cashable savings, cost avoidance and cost reduction. Currently 16% of the total £14.3m target remains unidentified at £2.3m and must be closed to support meeting the breakeven deliver required at the end of the financial year. This is a high-risk area for the Trust overseen by the Exec SRO led Value Delivery Board.

Capital expenditure is marginally behind plan by £0.130m due to timing of expenditure. The 24/25 programme is oversubscribed being closely monitored by CPSUG with a risk-based approach adopted.

The cash position stands at £9.6m slight better than plan and is being monitored daily noting this is a high risk are for the Trust.

7) All metric glossary

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 Average (Minutes)	Average DCH ambulance handovers in Minutes against 30 Minute Average Target. Sourced from ED SWAST information.
ED - DCH 4 Hour Performance %	Percentage of patients with an unplanned DCH Emergency Department visits lasting longer than the 4 hour peformance standard. Sourced from ED Agyle/PAS.
ED - ED Attendances % Waiting 12+ Hours	Percentage of patients with an unplanned DCH Emergency Department visit lasting longer than 12 hours. Excludes patients marked as streamed. Sourced from ED Agyle/PAS information.
ED - 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 - Cost Position	Cash position of the Trust (£000) noting this is a key risk area for 2024/25. Sourced from the 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 (confirmed) 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 /
Inpatient - Average Number of No Criteria to Reside Patients	Number 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 /
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 - Emergency Re-Admissions % (1 month in arrears)	Percentage of emergency re-admissions to hospital within 30 days of previous admission. Excludes patients under the age of 16 on original admission. Sourced from Emergency Readmission
Inpatient - SHMI Value (5 months in arrears)	Ratio result of Summary Hospital-level Mortality Indicator (SHMI) which reports applicable deaths within hospital, or within 30 days post discharge against expected (does not include Covid related deaths). Results show the ratio between the actual number of patients who die following hospitalisation at the trust and the number that would be expected to die on the basis of
RTT - 65+ Week Waits	Number of referral to treatment (RTT) patients on an admitted or non-admitted pathway waiting to start treatment for 65 weeks or longer. Sourced from PAS.
RTT - 78+ Week Waits	Number of referral to treatment (RTT) patients on an admitted or non-admitted pathway waiting to start treatment for 78 weeks or longer. Sourced from PAS.
RTT - Waiting List Size	Number of referral to treatment (RTT) patients on an admitted or non-admitted pathway waiting to start treatment. Sourced from PAS.
Theatres - Capped Utilisation	Percentage of planned theatre sessions that were utilised, based on Capped methodology for theatres within a Day Surgery or Main Theatres location. Sourced from Theatre Reporting, original source PAS.
Theatres - Uncapped Utilisation	Percentage of planned theatre sessions that were utilised, based on Uncapped methodology for theatres within a Day Surgery or Main Theatres location. Sourced from Theatre Reporting, original source PAS.
Workforce - Appraisal rate	Percentage of applicable appraisals completed within time frame expected. Sourced from Workforce team.
Workforce - Essential Skill Rate	Percentage of applicable essential skills completed within time frame expected. Sourced from Workforce team.
Workforce - Sickness Rate (1 month in arrears)	Sickness Rate. Full Time Equivalent (FTE) sick / FTE Days Available. Source ESR.
Workforce - Staff Turnover Rate	Percentage showing staff turnover rate based on a 12 month rolling view. Sourced from Workforce team, original source ESR.
Workforce - Vacancy Rate	Percentage showing Trust vacancy rate (budgeted FTE minus staff in post). Excludes positions with a frozen or proposed Hiring Status, positions with Org Level 2 of Honorary, Widows & Widowers, Dump Posts, Volunteers or Nurse Bank, positions with a Cost Centre of Nursing Relief Pool RN or HCA, and positions noted as Registered Nursing Degree Apprentices. Sourced from ESR.

Report Front Sheet

1. Report Details			
Meeting Title:	Board of Directors, Part 1		
Date of Meeting:	31st July 2024		
Document Title:	Finance Report		
Responsible Director:	Chris Hearn, Chief Financial Officer	Date of Executive Approval	12th July 2024
Author:	Claire Abraham, Deputy Chief Financial Officer		
Confidentiality:	Yes		
Publishable under FOI?	No		
Predetermined Report Format?	No		

2. Prior Discussion		
Job Title or Meeting Title	**Date**	**Recommendations/Comments**
Finance and Performance Committee	22/07/2024	Noted

3. Purpose of the Paper	For Information – income & expenditure report on the finance position of the Trust for month three 2024/25 financial year.							
	Note (✓)	✓	*Discuss (✓)*		*Recommend (✓)*		*Approve (✓)*	

4. Key Issues

Dorset County Hospital NHS Foundation Trust (DCHFT) submitted a break even plan to NHS England (NHSE) on 10th June 2024 for the financial year 2024/25.

Month three delivered a deficit of £1.5 million after technical adjustments, being £0.1 million against a plan of £1.4m deficit. The year to date position is £0.3 million away from plan standing at an actual deficit of £5.2 million.

Factors driving the overspend include supporting Industrial Action, high drugs costs specifically for Gastroenterology, Dermatology and blood products which are largely patient specific. Inflationary RPI costs above planned levels are being incurred for provisions, catering, laundry and utilities.
The Trust continues to see heightened operational pressures and increased patient acuity throughout the month with escalated beds used in the region of 17, and circa 54 no criteria to reside (NCTR) patients being supported which were captured at the end of June (not average).

Agency expenditure has continued at lower levels with total month spend of £0.5 million, being the second lowest recorded for the Trust in recent years. This reflects the ongoing delivery work of the High Cost Agency Reduction Programme supported by all functions.

The Trust is actively deploying targeted recovery actions to ensure mitigations and corrective steps are in place for all overspending areas in order to support delivery of the break even position by year end.

An estimated income position for elective recovery funding (ERF) following the national baseline target revision to 109% for Dorset has been included in the position in line with NHSE methodology.

	The Trust wide efficiency target for the year stands at £14.3 million and is circa 5% of expenditure budgets in line with peers and national planning expectations. Full year efficiency identification so far stands at £6.3 million with further identified schemes equating to £5.7 million being finalised. Cost avoidance and cost reduction data capture is being included which is supporting delivery. The unidentified gap is currently £2.3 million, with regular targeted Trust wide meetings taking place, led by the Chief Financial Officer across all areas to support delivery and closing the gap. Delivery currently stands at £1.5m and includes cashable savings as well as cost reduction and cost avoidance schemes. Efficiency delivery remains a significant risk for the Trust in achieving the break even plan for the year, as such enhanced monitoring and reporting is underway, with detailed reporting currently under construction expected to be completed imminently. Capital expenditure for month three is marginally behind plan at £0.172 milliondue to timing of equipment purchases. The 2024/25 capital programme is over subscribed for 2024/25 however is being closely monitored through Capital Planning and Space Utilisation Group (CPSUG) to ensure all risks are monitored and managed appropriately. The cash position to June amounts to £9.7 million and is ahead of plan due to non-recurrent 2023/24 income from Dorset ICB received earlier than expected, in conjunction with £1.5m of national revenue support paid in April to facilitate repayment of working capital. Cash remains a high risk area for the Trust and is being closely monitored on a daily basis with key mitigating actions taking place to minimise this risk where appropriate.
5. Action recommended	The Finance & Performance Committee is recommended to: 1. **NOTE** the month three financial position for the financial year 2024/25

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 2025, of which 5% (£14.3 million) of efficiencies are required.*
Impact on Social Value			**No**	
Trust Strategy Link		**How does this report link to the Trust's Strategic Objectives?** *Please summarise how your report will impact one (or multiple) of the Trust's Strategic Objectives (positive or negative impact). Please include a summary of key measurable benefits or key performance indicators (KPIs) which demonstrate the impact.*		
Strategic Objectives	People			
	Place			
	Partnership	BAF references PA 2.1 and 2.2 references to financial sustainability and CIP delivery.		
Dorset Integrated Care System (ICS) Objectives		**Which Dorset ICS Objective does this report link to / support?** *Please summarise how your report contributes to the Dorset ICS key objectives.*		

	(Please delete as appropriate)		
Improving population health and healthcare		**No**	*If yes - please state how your report contributes to improving population health and health care*
Tackling unequal outcomes and access		**No**	*If yes - please state how your report contributes to tackling unequal outcomes and access*
Enhancing productivity and value for money	**Yes**		*Highlights current spend of the Trust.*
Helping the NHS to support broader social and economic development		**No**	*If yes - please state how your report contributes to supporting broader social and economic development*
Assessments	**Have these assessments been completed?** *If yes, please include the assessment in the appendix to the report..* *If no, please state the reason in the comment box below.* *(Please delete as appropriate)*		
Equality Impact Assessment (EIA)		**No**	
Quality Impact Assessment (QIA)		**No**	

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NHS
Dorset County Hospital
NHS Foundation Trust

Financial Position Update 2024/25

June 2024 - Month 3

Chris Hearn
Chief Financial Officer

Outstanding care for our patients in ways which matter to them

Financial Position Update - June 2024

Executive Summary

A summary of progress is presented for the period of June 2024 and is compared with the revised re-phased plan submitted on 10th June 2024 to NHSE.

In June 2024, Dorset County Hospital NHS Foundation Trust (DCHFT) has delivered a month 3 deficit of £1.5 million after technical adjustments, an adverse performance of £0.1 million against the revised plan of £1.4 million deficit.

This overspend in month has been driven by costs incurred supporting Industrial Action, inflationary RPI costs above planned levels for provisions, catering, laundry, utilities and drugs, specifically Gastroenterology, Dermatology and blood products. The Trust has also seen heightened operational pressures and increased patient acuity throughout the month. Escalated beds at the end of the month were 17 with circa 54 no criteria to reside (NCTR) patients being supported. Agency expenditure has continued to decrease due to the impact of the agency rate reduction and increase in substantive recruitment. However, 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 109% for Dorset.

The Trust wide efficiency target for the year stands at £14.3 million and is circa 5% of expenditure budgets in line with peers and national planning expectations. Full year efficiency identification so far stands at £6.3 million with a further £5.7 million of schemes linked to workforce review and productivity investment cases. Contributing cost avoidance and cost reduction is now being included which will contribute to an increase in the delivered figures.

Pay is over plan due to increase in successful registration of training nurses and the national/system agreed increase of Band 2 to Band 3 Agenda for change movement. Agency usage to cover vacancies and to support operational pressures has continued, albeit at a lower rate than previous months. 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. A further deep dive in this area will be shared with the Committee as requested.

The Trust is progressing with the capital programme for 2024/25, month 3 YTD spend totalling £4.4 million, a net £0.1 million behind rephased plan due to underspends on externally funded projects. Externally funded projects are £0.5 million behind plan due to the changes in the spend profile of the New Hospital Programme (NHP) enabling works. The internally funded projects are ahead of plan by £0.4 million relating to early spend on East Wing Theatre and 2023/24 rollover spend on Ridgeway. There is significant pressure on the internally funded programme this year due to works on the two significant Estates schemes (Chemo and East Wing Theatre) and high demand for backlog works and medical device replacement.

The cash position as at 30 June was £9.7 million (£1.0 million above revised plan) due to high levels of Low Volume Activity (LVA) income received in month. The Trust requested and was granted £1.5m of national revenue support received in April to facilitate repayment of working capital and delays in the repayment of intra NHS creditors. £1.5m of NHS creditors were repaid in June in line with planned expectations.

Financial Position Update - June 2024

Key Risks

Red Risks:

Financial Forecast Risk

There is a risk of delivering the break even position. Drivers include supporting industrial action, patient specific high drugs costs, escalated bed base and operational pressures, agency usage, efficiency under delivery and inflationary costs above planned levels. 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.

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 2024/25 national target aims to reach 109% of the activity levels seen in 2019/20 (pre-pandemic).

Dorset County Hospitals target is set at 104% of 2019/20 Elective Activity and as a Dorset system has an ambition to reach 109% of its 2019/20 activity, this will be to alleviate some of the financial pressures within the system and reducing the size of the Dorset waiting list.

National ESRF calculations will not be available until Q2 to inform actual ESRF payments. Estimated ESRF payments will be calculated using the NHSE methodology used to inform lost ESRF payments due to Industrial Action in 2023/24. This methodology applies an average tariff by point of delivery for the count of elective activity over or under the baseline.

Cash Position

While the current cash position has improved due to non-recurrent 2023/24 income received, there is a risk to cash levels throughout the year due to planned deficits in the first 5 months of the year and challenging efficiency targets. This risk has been highlighted to NHSE with a request for additional Provider Revenue Support successful for April, with £1.5 million drawn down in the form of Public Dividend Capital. Further requests will be made throughout the year if required. Ongoing mitigating solutions include review of local payment terms and driving income collection at pace will continue to be used to minimise this risk. System conversations are also still active on this subject.

Internally Funded Capital

The Trust is set a capital envelope each year which details the maximum internally funded capital spend allowed by the Trust. Due to significant demands on the capital programme this year there is a risk of exceeding this envelope. The 2024/25 Estates schemes include two large projects (Chemo and East Wing Theatre) plus roll over spend from 2023/24 on Ridgeway, with significant digital projects also ongoing in year. Consequently there is limited capital budget available for backlog and medical device replacements which are now becomming urgent and unavoidable, resulting in over subscription against the internally funded capital programme. The Capital Planning and Space Utilisation Group (CPSUG) has requested a priortised and risk scored list from each area to actively oversee and appropriately manage.

Financial Position Update - June 2024

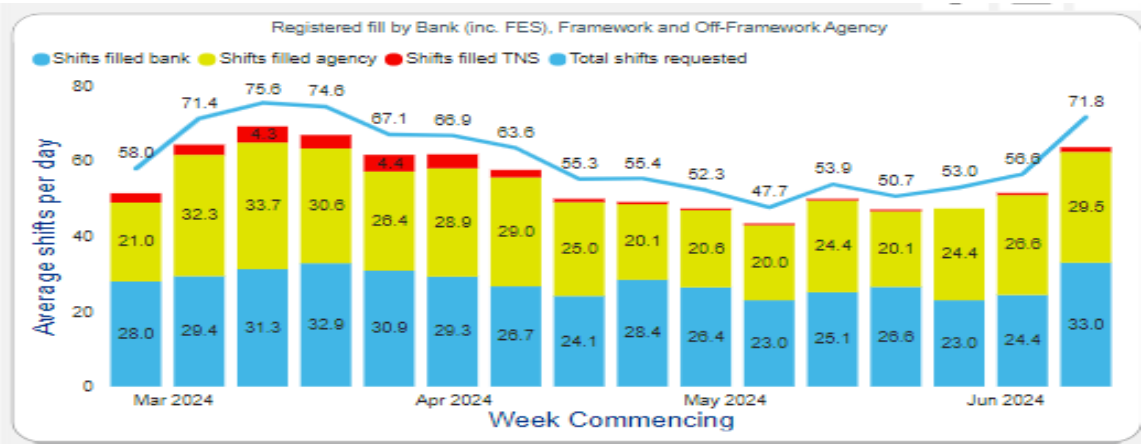
Key Risks

Red Risks:

The Trust has an efficiency delivery requirement of £14.1 million in order to reach the planned full year break even position. £6.3 million has been fully identified and detailed plans are being worked up placeholder schemes inclusing workforce review and productivity stretch totalling £5.7m leaving £2.3m as unidentified at present. Without these further developed schemes, 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 is led by the Value Delivery Board. This is designed to reinforce the accountability and deliverables of programmes across the Trust.

Agency expenditure continues to improve due to a combination of factors including system agency rate reduction and vacancy level decreases. Off Framework Agency spends is expected by NHSE to cease completely from 1st July 2024, where the Trust will aim to see a further FYE reduction of £1m on spend. 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 and begin to work further on medical agency and locum spend. The table below shows registered nursing shift fill by bank, on framework agency and highest cost off framework agency. The Trust must increase bank usage and decrease agency usage whilst maintaining patient and staff safety and quality levels.



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

Financial Position Update - June 2024

Key Risks

Amber Risk:

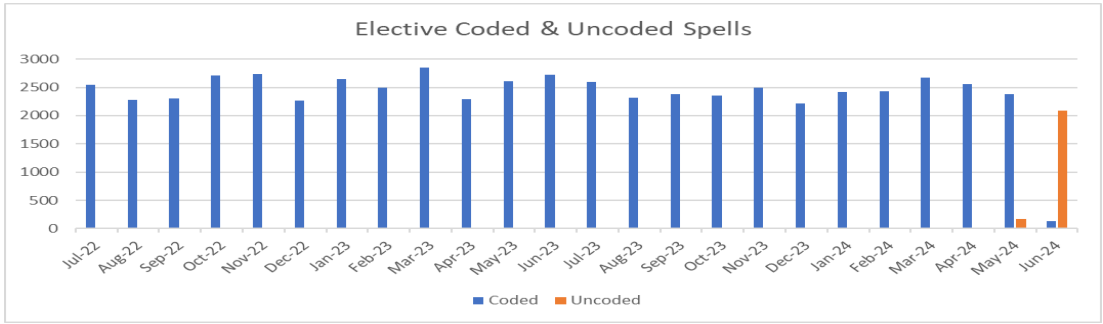
From 2023/24 NHS England introduced the Aligned Payment and Incentive (API) approach to all NHS standard contracts. This approach splits the payment mechanism for the majority of NHS contracts into two envelopes, Fixed and Variable.

The fixed element of the contract will be agreed between NHS providers and commissioners for the provision of specified services, this will be paid on a block basis across the year regardless of activity delivery. The fixed element of the contract will pay for any activity not covered under the variable element. The variable element of the contract will cover most elective activity: Elective Inpatients, Day cases, Outpatient First Attendances, Outpatient Procedures, Chemotherapy delivery and Diagnostics.

An income envelope will be agreed between NHS commissioners and providers to an agreed baseline level of activity, this will then be adjusted for actual performance using the National Tariff. Any underperformance against baseline will be repaid at 100% of the national tariff and any over performance will be received at 100% of the national tariff.

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

As at June 2024 the Trust has 4,595 uncoded spells, 2,255 are for Elective activity and 2,340 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 over a two year rolling period, no significant coding issues have been incurred.



2024/25 Flex Freeze Dates

Month	Flex	Freeze
Apr-24	20 May 24	19 Jun 24
May-24	19 Jun 24	17 Jul 24
Jun-24	17 Jul 24	19 Aug 24
Jul-24	19 Aug 24	18 Sep 24
Aug-24	18 Sep 24	17 Oct 24
Sep-24	17 Oct 24	19 Nov 24
Oct-24	19 Nov 24	17 Dec 24
Nov-24	17 Dec 24	20 Jan 25
Dec-24	20 Jan 25	19 Feb 25
Jan-25	19 Feb 25	19 Mar 25
Feb-25	19 Mar 25	17 Apr 25
Mar-25	17 Apr 25	20 May 25

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

Financial Position Update - June 2024
Income & Expenditure

Income and Expenditure

The overall revenue position is a £1.5 million in month actual deficit, £0.094m adverse to plan after technical adjustments. The YTD position is £0.372m away from plan. Costs supporting Industrial Action as well as ongoing run rates linked to inflationary pressures, in particular drugs for Gastro, Derm and bloods; utilities above plan including catering, laundry and provisions drive the year to date overspend, offset by improved agency performance.

The Operating Income from patient care activities in month variance is due to high cost drugs incomes offset with expenditure, out of contract income and estimated month 1 - 3 Elective Services Recovery Fund (ESRF) income.

Pay costs are over plan due to supporting industrial action, 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. June has again seen an improvement in agency costs incurred due to the agency rate reduction applied at the start of January and late March.

Non pay is over plan due to ongoing above plan inflationary pressures, in particular energy, catering supplies, blood products - specifically in Gastro and maintenance contracts and laundry. Drugs expenditure is also high linked to activity, as are consumables. Recovery plans are underway with all overspending areas to ensure mitigations are applied to support recovery of the adverse position.

STATEMENT OF COMPREHENSIVE INCOME	In Month (£'000)			Year to Date (£'000)		
	Budget	Actual	Variance	Budget	Actual	Variance
Operating income from patient care activities	21,222	22,595	1,373	63,649	67,451	3,802
Private Patients	87	126	39	260	282	23
Other clinical revenue	37	55	18	111	76	(35)
Other non-clinical revenue	2,019	2,146	127	5,987	6,094	107
Operating Income	**23,365**	**24,922**	**1,558**	**70,007**	**73,904**	**3,897**
Charitable income	0	0	0	0	0	0
Total Income	**23,365**	**24,922**	**1,558**	**70,007**	**73,904**	**3,897**
Raw materials and consumables used	(3,883)	(4,582)	(699)	(11,799)	(13,732)	(1,934)
Employee benefit expenses:						
Substantive	(13,907)	(14,765)	(858)	(41,451)	(44,358)	(2,894)
Bank	(889)	(977)	(88)	(2,874)	(3,194)	(320)
Agency	(804)	(536)	268	(2,613)	(1,724)	876
Other operating expenses (excl. depreciation)	(3,838)	(4,204)	(366)	(11,722)	(12,002)	(280)
Operating Expenses	**(23,321)**	**(25,064)**	**(1,743)**	**(70,459)**	**(75,010)**	**(4,551)**
Profit/(loss) from Operations (EBITDA)	**44**	**(142)**	**(186)**	**(452)**	**(1,106)**	**(655)**
Other Non-Operating income (asset disposals)	0	(1)	(1)	0	(1)	(1)
Other Non-Operating expenses (Impairments)	0	0	0	0	0	0
Total Depreciation and Amortisation	(1,035)	(1,035)	0	(3,106)	(3,105)	1
PDC Dividend expense	(408)	(408)	(0)	(1,225)	(1,225)	(0)
Total finance income	23	76	53	68	230	162
Total interest expense	(64)	(60)	4	(193)	(179)	14
Total other finance costs	(0)	(0)	(0)	(£0)	(£1)	(0)
SURPLUS/ (DEFICIT)	**(1,441)**	**(1,570)**	**(128)**	**(4,907)**	**(5,385)**	**(478)**
Technical Items Adjusted for:						
Donations Non-Cash Assets	(40)	(2)	38	(120)	(2)	118
Depreciation Donated Assets	40	37	(3)	120	108	(12)
SURPLUS/ (DEFICIT)	**(1,441)**	**(1,535)**	**(94)**	**(4,907)**	**(5,279)**	**(372)**

Financial Position Update - June 2024
Industrial Action

2024/25 Industrial Action

Costs incurred in June and the initial part of July supporting Industrial Action amount to £0.135m with a further £0.255m estimate of lost activity income. For June reporting purposes, £0.081m of net staff cost and an estimated £0.153m of lost activity income were incurred.

For DCHFT, June & July 2024 the combined net cost & lost elective recovery activity is estimated at £0.390m

This total estimated cost covering the full industrial action period during June and July has been reported to NHS England (NHSE) as part of national reporting requirements.

At this stage and in line with national advice, no income has been assumed in the position to offset these costs incurred.

2024/25 Industrial Action Staff Group	Junior Doctors	Junior Doctors	Total £'000
Strike Date	***27-30 Jun***	***1-2 July***	
Immediate backfill costs to cover services	*£106*	*£71*	**£177**
Offset by Salary Savings	*-£25*	*-£17*	**-£42**
Net Cost	***£81***	***£54***	**£135**
Number of Industrial Action Days	*3*	*2*	5
Estimate of Lost ERF Activity	*£153*	*£102*	**£255**
Net Cost & ERF Income Loss	**£234**	**£156**	**£390**
Estimated Cost Per Day £'000	£78	£78	£78

Rescheduled Elective Inpatients	6	4	**10**
Rescheduled Day Case Activity	77	51	**128**
Rescheduled Outpatient Appointments	362	241	**603**

Outstanding care for our patients in ways which matter to them

Financial Position Update - June 2024
Trust Wide Performance: Agency

Pay Analysis - Agency

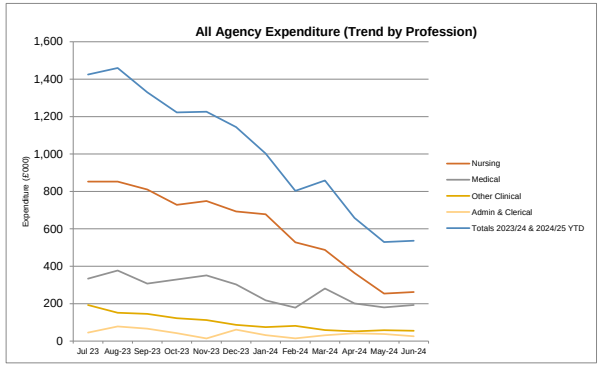
Agency costs equated to £0.5 million of actual expenditure in month against a plan of £0.8 million, again seeing improved performance month on month since Q4 of last year.

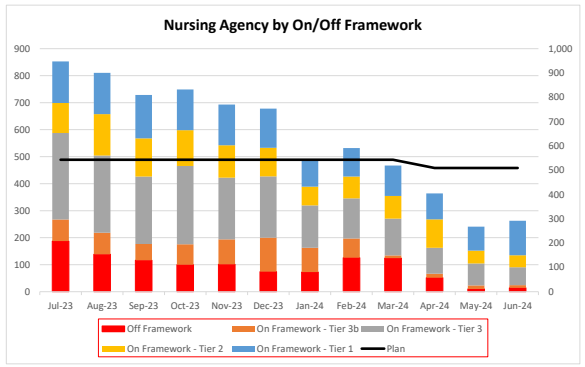
Agency expenditure is an improved 3.3% of total pay budgets, closely reaching the NHSE target set at 3.2% for 2024/25.

June continues to see significant improvement in agency expenditure, however ED remains an area of focus to reduce spend, which is supported through the safer staffing and high cost agency working groups.

Agency reduction remains a high priority for the Trust noting expected achievement of the NHSE applied System spend cap of 3.2% of pay budget for 2024/25 and the mandation of no use of Off Framework from 1st July 2024.

System collaborative workstreams including a 15% agency rate reduction being 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.
A further % rate reduction was applied as a system from the end of March 2024.





Areas Using Nursing Agency including Off Framework YTD (£'000):

Area	On Framework	Off Framework	of which: RNMH	Total Nursing Agency	%
Emergency Dept Main Dept	£201	£9		£210	24%
Moreton Ward - Respiratory	£90	£2		£92	10%
Day Surgery Unit	£66	£3	£2	£69	8%
Kingfisher Ward	£30	£29		£59	7%
CRCU	£45	£9		£54	6%
Abbotsbury Ward	£53			£53	6%
Purbeck Wd	£52	£0		£52	6%
Lulworth Ward	£46	£2		£48	5%
Fortuneswell Ward	£45	£1		£46	5%
Stroke Unit	£36	£1		£36	4%
DCH Dialysis	£33			£33	4%
Ilchester Integrated Assessmen	£23	£2	£2	£25	3%
The Mary Anning Unit	£24			£24	3%
Prince Of Wales	£18	£1		£19	2%
Theatre Suites	£16			£16	2%
Evershot Ward	£13			£13	2%
Cardiology Care Ward	£8	£1		£9	1%
SCBU	£0	£8		£8	1%
Ridgeway Wd	£7			£7	1%
Surge Area	£4			£4	0%
SDEC	£3			£3	0%
B'Mth Dialysis	£1			£1	0%
Total Nursing Agency YTD	**£813**	**£68**	**£4**	**£881**	
		Net OF excl MH:	**£64**		

Agency Spend by Profession (£'000)	Jul 23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	YTD Actual	YTD Plan	Variance
Nursing	852	853	811	728	749	693	678	528	487	364	254	263	881	1,456	575
Medical	334	377	308	329	351	303	218	179	281	201	180	193	573	733	160
Other Clinical	193	152	145	122	112	86	75	82	59	52	58	55	165	318	153
Admin & Clerical	45	78	67	42	14	62	32	15	31	42	38	26	105	106	1
Totals 2023/24 & 2024/25 YTD	**1,425**	**1,460**	**1,330**	**1,222**	**1,226**	**1,144**	**1,003**	**803**	**859**	**659**	**529**	**536**	**1,724**	**2,613**	**888**

Nursing Agency Category	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24
Off Framework	188	139	116	100	102	74	73	126	125	52	10	14
On Framework - Tier 3b	80	80	60	76	92	126	90	71	10	15	13	10
On Framework - Tier 3	320	286	250	290	229	227	157	148	136	96	81	67
On Framework - Tier 2	111	154	141	133	120	106	69	81	84	106	48	44
On Framework - Tier 1	154	153	161	150	151	145	102	105	113	96	89	128
Plan	543	543	543	543	543	543	543	543	543	509	509	509
Orders awaiting allocation	0	0	0	0	0	0	0	0	0	0	0	0
Totals 2023/24 & 2024/25 YTD	**853**	**811**	**728**	**749**	**693**	**678**	**490**	**532**	**467**	**364**	**241**	**263**

Pay Metrics	In Month Actual	YTD Actual
Agency expenditure as % of total pay	3.3%	3.5%
Off framework expenditure as % of total agency	2.7%	2.3%

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Financial Position Update - June 2024

COVID Expenditure

Covid Narrative
Covid spend increased in June to £0.2 million from £0.1 million in May. This is due to an increase in costs relating to Covid tests and spend relating to disposable ward curtains. Covid funding has reduced for 2024/25 (from £2.3 million) and all areas will be reviewed for only reasonable and expected Covid related costs - some of which have further been identified this month (i.e additional cleaning). 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, however a working group has been instructed to review this led by Facilities.

	Description	2023/24	Apr-24	May-24	Jun-24	YTD
Plan:		**£2,287**	**£211**	**£211**	**£209**	**£422**
Expenditure:						
Pay	Substantive	£282	£1	£1	£14	£16
	Bank	£108	£0	£3	£7	£10
	Agency	£1	£0	£0	£0	£0
Total Pay		**£391**	**£1**	**£4**	**£21**	**£5**
Non-pay	Clinical Supplies and Services	£223	£32	£4	£22	£58
	General Supplies and Services	£0	£0	£0	£8	£8
	Establishment Expenditure	£6	£0	£0	£0	£0
	Other Non-Pay (security)	£472	£22	£21	£21	£64
	Premises and Fixed Plant	£162	£12	£12	£12	£36
Total Non-pay		**£863**	**£65**	**£38**	**£62**	**£165**
Total Expenditure		**£1,254**	**£66**	**£41**	**£83**	**£191**
Total Surplus/(Deficit)		**£1,033**	**£145**	**£170**	**£126**	**£440**

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Financial Position Update - June 2024
Sustainability & Efficiency - REVISED REPORTING FORMAT UNDER CONSTRUCTION

Efficiency & Sustainability Programme Update

The annual efficiency target for the Trust is circa 5% which equates to £14.3 million for the financial year.

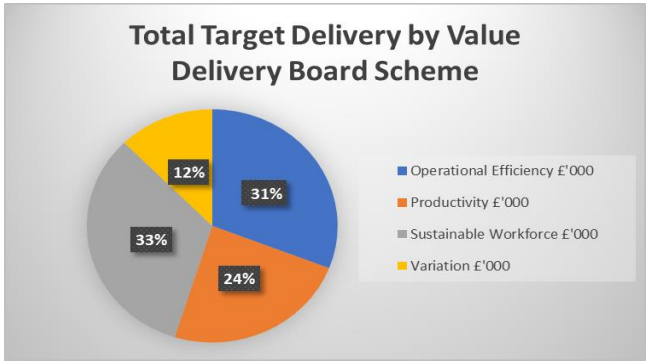
In month delivery of £0.6m has been achieved, £0.250m coming from agency cost reduction and the remainder largely from Covid lower levels than planned and pay slippage. YTD delivery stands at £1.5m (including £0.9m of agency cost reduction).

£2.8 million has been planned as fully identified schemes and in progress.
£1.1 million of schemes are identified, but not yet started.
£1.0 million of opportunities have been identified and are in the process of being developed into tangible schemes for delivery, notably further agency spend reduction.
£5.7 million of stretch schemes have been identified linked to workforce reviews and productivity stretch with detailed plans currently being assessed.
£2.3m remains unidentified with the Trust looking at all options to close this gap via transformational means, cost reduction and cost avoidance initiatives. The CFO is leading regular support meetings with all areas.

Efficiencies identified so far include further Covid reduction against plan, Procurement savings, Corporate savings generated from joint posts, Digital programme delivery, non recurrent slippage against existing planned budgets, agency spend reduction and Pharmacy review savings.
This programme of work has been shared with the Dorset System with collaborative opportunities being actively assessed and reviewed with focus on flow, bed usage noting improvements to productivity are essential, supported by System partners.

Dorset County Hospital - By Area	2024/25 Indicative Summary				YTD			
	Plan £'000	Identified £'000	Variance £'000	% Identified	Delivered £'000	Cost Reduction/ Avoidance	Total £'000	% Delivered
Division A - Urgent and Integrated Care	5,517	1,729	(3,788)	31%	175	303	478	9%
Division B - Family and Surgical Services	4,908	2,924	(1,984)	60%	163	586	749	15%
Sub-total Divisions	**10,425**	**4,653**	**(5,772)**		**338**	**889**	**1,227**	
Finance, Estates & Facilities	1,761	330	(1,431)	19%			0	0%
Digital	450	397	(53)	88%			0	0%
Nursing (adjusted for CNST)	150	31	(119)	21%			0	0%
Operations	579	94	(485)	16%			0	0%
Human Resources	387	40	(347)	10%			0	0%
Corporate	349	263	(86)	75%			0	0%
Covid related	269	508	239		240		240	89%
Sub-total Support Services	**3,945**	**1,663**	**(2,521)**		**240**	**0**	**240**	
Stretch Targets: *Workforce WTE Review*		3,922	3,922				0	0%
Productivity Stretch		1,800	1,800				0	0%
Revised Sub-Total Identified (84%)	**14,369**	**12,038**	**(2,570)**		**578**	**889**	**1,467**	
Remaining Unidentified (16%)		**2,331**	**2,331**					
Total as at June 2024	**14,369**	**12,038**	**(2,570)**		**578**	**889**	**1,467**	

Scheme Status	Sustainable Workforce £'000	Productivity £'000	Variation £'000	Operational Efficiency £'000	Total £'000
Delivered	906	0	30	531	**1,467**
Identified - in progress	525	342	387	1,538	**2,792**
Identified - not started	440	0	208	409	**1,057**
Opportunity	0	1,000	0	0	**1,000**
Identified	**1,871**	**1,342**	**625**	**2,478**	**6,316**
Total CIP 5%					**14,369**
Gap					**8,053**
Stretch Targets:					
Workforce WTE Review	3,922				**3,922**
Productivity Stretch		1,800			**1,800**
Remaining Unidentified					**2,331**



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Financial Position Update - June 2024

Cash

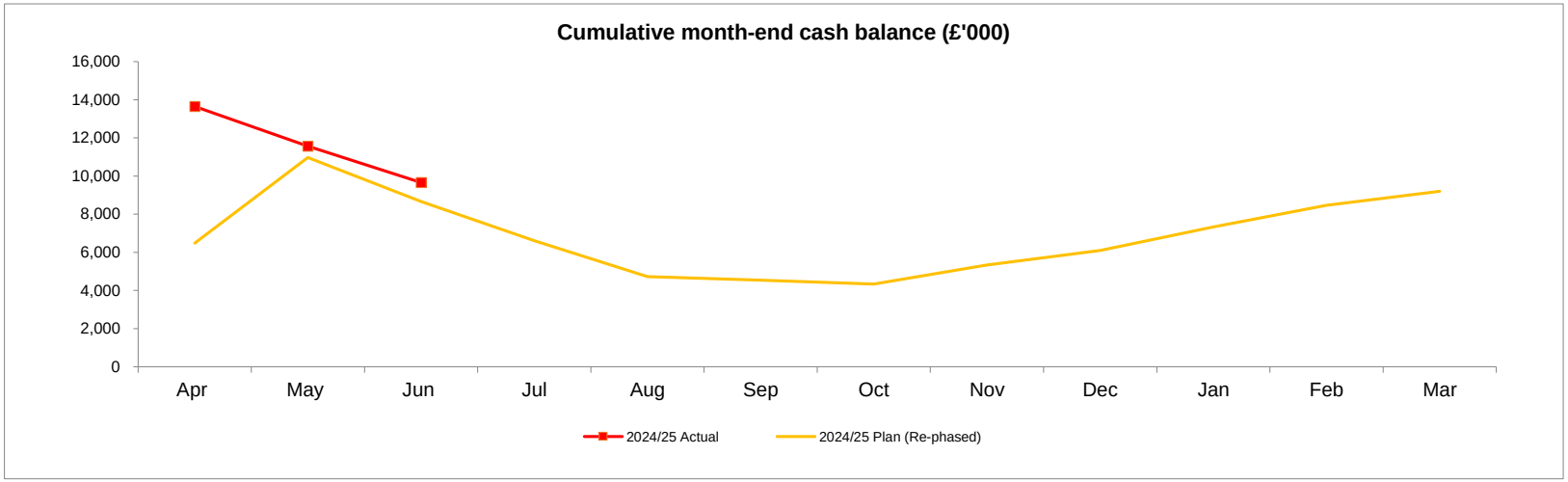
Cash Balance incl Forecast

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 £9.7 million at end of June, which is ahead of forecasted position of £8.7 million. The Trust benefitted from starting June with a higher opening cash balance £0.6 million compared to plan and it also received Low Volume Activity (LVA) income in June totalling £1.6million. This was offset by planned repayment of outstanding invoices owed to Dorset HealthCare University NHS FT.

The Trust received the first instalment of revenue support funding in April totalling £1.5m which supports the repayment of working capital, however noting revenue support funding has not been required for June.

The forecast is currently in line with the planned position and assumes full delivery of the efficiency programme. Without full delivery of these schemes, cash modelling indicates the Trust would need further draw down revenue support during 2024/25. The CFO is leading regular support meetings to develop all efficiency schemes, in conjunction with ongoing system conversations regards options for cash support.



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
2024/25 Plan (Re-phased)	6,479	10,972	8,661	6,607	4,727	4,543	4,337	5,334	6,099	7,337	8,466	9,201
2024/25 Forecast				6,607	4,727	4,543	4,337	5,334	6,099	7,337	8,466	9,201
2024/25 Actual	13,650	11,566	9,660									

Financial Position Update - June 2024

Capital

Capital Programme Narrative

Capital expenditure year to date to the end of June was £4.4 million and behind plan by £0.1 million.

Internally Funded schemes are overall ahead of plan at the end of June by £0.39 million.

Digital and Medical Equipment Schemes were ahead of plan year to date due to timing of the purchase of replacement items.

Estates schemes are ahead of plan year to date due to timings of expenditure on East Wing Theatres and Ridgeway Ward, which has carried over from 2023/24.

There is a significant requirement for internally funded capital for both backlog works and medical device replacements, which is putting pressure on the programme of works as requests become urgent and unavoidable. All areas have been asked to provide at pace an updated and prioritised list of works for review, appropriate consideration and action.

Externally Funded capital expenditure was £0.48m behind plan due to timings of expenditure on New Hospital Programme (NHP) enabling works.

Given the Trusts capital programme is over-subscribed, this is being closely monitored and overseen by Capital Planning & Space Utilisation Group (CPSUG) to ensure risks and priorities are managed appropriately throughout the year with all opportunities and slippage maximised. Due to the significant capital projects and level of high risk demands on capital there is a risk that the Trust will overspend on Internally Funded schemes in year without careful and appropriate consideration.

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CAPITAL	CURRENT MONTH			YEAR TO DATE			FULL YEAR 2024/25			
	Plan	Actual	Variance	Plan	Actual	Variance	Committed Spend	Forecast	Annual Plan	Variance
Estates	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000
Chemotherapy Unit	0	0	0	0	0	0	50	1,932	1,932	0
East Wing Theatre	150	234	(84)	450	489	(39)	1,527	1,527	0	(1,527)
Estates Schemes	**310**	370	(60)	**858**	1,069	(211)	1,953	2,112	1,650	(462)
Digital Services										
Digital Schemes	**171**	181	(10)	**547**	596	(49)	1,282	1,522	2,291	769
Equipment										
East Wing Theatre Equipping	0	0	0	0	0	0	0	295	295	0
Other Equipment	0	86	(86)	57	145	(88)	212	52	1,272	1,220
Sub-Total Internally Funded Expenditure	**631**	**871**	**(240)**	**1,912**	**2,299**	**(387)**	**5,024**	**7,440**	**7,440**	**0**
Donated										
Other Donations	0	0	0	0	0	0	14	14	0	(14)
Chemotherapy Unit Refurbishment	0	0	0	40	0	40	0	466	480	14
Sub-Total Planned Donated Expenditure	**0**	**0**	**0**	**40**	**0**	**40**	**14**	**480**	**480**	**0**
IFRS 16 Lease Additions										
Warehouse	0	0	0	0	0	0	0	480	480	0
MSCP Lease remeasurement	0	0	0	0	0	0	0	1,000	1,000	0
CEF Lease remeasurement	0	0	0	0	0	0	0	600	600	0
One Dorset Pathology	0	0	0	0	0	0	0	250	250	0
Accommodation & Vehicle Lease Additions	25	27	(2)	41	43	(2)	43	150	150	0
Sub-Total Planned IFRS 16 Expenditure	**25**	**27**	**(2)**	**41**	**43**	**(2)**	**43**	**2,480**	**2,480**	**0**
Total Internal & Leased Capital Expenditure	**656**	**898**	**(242)**	**1,993**	**2,342**	**(349)**	**5,081**	**10,400**	**10,400**	**0**
Additional funded schemes										
NHP Development	85	463	(378)	418	597	(179)	758	758	758	0
NHP Works	0	0	0	0	0	0	0	12,819	12,819	0
NHP Enabling	1,000	201	799	2,005	1,405	600	2,159	4,660	4,660	0
Digital EHR Funding	31	40	(9)	122	66	56	486	1,093	1,093	0
CDC Funding	2	0	2	16	14	2	16	16	16	0
Mental Health UEC Funding	0	0	0	0	0	0	0	257	257	0
Inventory Management System (pending)	0	0	0	0	0	0	0	0	0	0
Total Externally Funded Capital Expenditure	**1,118**	**704**	**414**	**2,561**	**2,082**	**479**	**3,419**	**19,603**	**19,603**	**0**
Total Capital Expenditure	**1,774**	**1,602**	**172**	**4,554**	**4,424**	**130**	**8,500**	**30,003**	**30,003**	**0**
Expenditure as a % of Plan			111%			103%				100%

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Escalation Report

Committee: Quality Committee

Date of Meeting: 18th June 2024

Presented by: Claire Lehman

Significant risks / issues for escalation to Board for action	• The Safeguarding Children and Adults Annual Report is recommended to the Board. • The Infection Prevention and Control Annual Report. • Good evidence of triangulation of issues across Board sub-committees.

Key issues / matters discussed at the Committee	The committee received, discussed and noted the following reports:
	• Quality Report noting:
	  ○ Prevention of Future Deaths letter
	  ○ Thematic review of complaints
	• Maternity Safety Report noting a new risk relating to the number of resuscitaires on labour ward. Charity funding had been applied for to fund this requirement.
	• The External Reviews Annual Plan was noted. Discussions reflected that this was an iterative process but was starting to provide assurance around the developing process of oversight of external reviews.
	• The Annual Clinical Audit Assurance Report was received and noted.
	• Deep Dive – Mary Anning Unit, noting the good quality improvement approach taken across the ward.
	• Deep Dive – Electronic Discharge Summaries
	• The following Escalation Reports were received and noted:
	  ○ Clinical Effectiveness Committee
	  ○ Patient Safety Committee
	  ○ Infection Prevention and Control Committee
	• The Annual Report on Organ Donation was received and noted.

Decisions made by the Committee	• The Safeguarding Children and Adults Annual Report was approved.
Implications for the Corporate Risk Register or the Board Assurance Framework (BAF)	• The Clinical Risk Register was received and the iterative review process it was undergoing was 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: 23rd July 2024

Presented by: Eiri Jones

Significant risks / issues for escalation to Board for action	• Non-quoracy due to annual leave and sickness amongst Executive team. However, the Chief Nursing Officer and Chief Medical Officer have been asked to confirm receipt and comment on the necessary reports received by the committee. • Receipt of the NHS England letter relating to patient safety and quality. Assurance report to follow. • The revised Board Assurance Framework aligned to the strategic objectives within the proposed joint strategy was recommended to the Board.

Key issues / matters discussed at the Committee	The committee received, discussed and noted the following reports:
	• Chief Nursing Officer and Chief Medical Officer Update
	• Quality Report including:
	  ○ NHSE Letter – Patient Safety and Quality
	  ○ Thematic review of Friends and Family Test Feedback
	• Maternity Reports including:
	  ○ Safety Report, noting the imminent installation of replacement call bell system.
	  ○ Reproductive Health Clinical Governance Meeting Terms of Reference
	  ○ Staffing Report
	  ○ Quarterly PMRT Report
	  ○ Saving Babies Lives Annual Report
	• National Patient Survey Results, which are embargoed until publication in August (date to be confirmed)
	• JAG Accreditation Update. The committee were informed that the service expected to meet the new requirements for the re-inspection. The committee requested an update before the re-inspection
	• Cardiology Assurance Report, noting the positive example of triangulation across committees. Whilst the Trust was not meeting the DM01 target, it was managing the backlog in cardiology based on risk, with a focus on ensuring that patients received the care they needed.
	• The following Escalation Reports were received, noting the improvement in the quality of reports, and the assurance this provided the committee:
	  ○ Medicines Committee
	  ○ Mental Health Steering Group
	  ○ Patient Safety Committee
	  ○ End of Life Committee
	• ICB Quality Committee Escalation Report

Decisions made by the Committee	• Approval of the Reproductive Health Clinical Governance Meeting Terms of Reference, pending confirmation outside the meeting from the Chief Medical Officer and Chief Nursing Officer.

Implications for the Corporate Risk Register or the Board Assurance Framework (BAF)	• The revised Board Assurance Framework aligned to the strategic objectives within the proposed joint strategy was approved as is recommended to the Board.
Items / issues for referral to other Committees	• Nil

Report Front Sheet

1. Report Details			
Meeting Title:	Board of Directors, Part 1		
Date of Meeting:	31st July 2024		
Document Title:	**Maternity and Neonatal Quality and Safety Report**		
Responsible Director:	Dawn Dawson, CNO	Date of Executive Approval	25/07/2024
Author:	Jo Hartley, Director of Midwifery & Neonatal Services		
Confidentiality:	No		
Publishable under FOI?	Yes		
Predetermined Report Format?	No		

2. Prior Discussion		
Job Title or Meeting Title	**Date**	**Recommendations/Comments**
Quality Committee	23/07/2024	

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

3. Executive Summary

This report sets out to the Trust Board the quality and safety activity covering the month of June 2024. This is to provide assurances of maternity quality and safety and effectiveness of patient care with evidence of quality improvements to Board

- SPC charts reproduced in report. CO at booking slightly above target. Smoking at time of delivery achieving compliance.
- One incident of a 3rd degree tear. Rate per thousand below target
- PPH rate over 1500mls slightly below target – normal variation
- No incidents of moderate harm
- Two RCAs remain. LIP needs to be rearranged and the action plan completed. the second case is awaiting the sign-off of the final letter
- Three babyloss incidents.
- Risk register updated.

1. The neonatal nursing staffing remains high risk due to the requirement of a supernumerary coordinator 24/7. Currently scoping how this is accommodated in other small level 1 SCBUs.
2. Good progress with triage and BSOTS in DAU (Day Assessment Unit)
3. Two models of resuscitaires identified and to be trialled prior to purchase

- Two complaints received in June. Details provided of actions identified from recent complaints
- Workforce data. Poor mental health is the primary reason for LTS. Sickness rates improving across midwives, MSWs and SCBU staff

	• NHSR announced 17/7 that there is no longer an expectation that obstetric anaesthetists who are not on the obstetric rota must attend multi-professional emergency training. • Documentation errors report for quarter 1 included detailing the themes and actions identified
4. Action recommended	The committee is recommended to: 1. **NOTE** the report 2. **DISCUSS** any performance issues 3. **APPROVE** the report

5. Governance and Compliance Obligations				
Legal / Regulatory Link		**Yes**		Integral to MIS compliance
Impact on CQC Standards		**Yes**		The contents reflect the most recent CQC recommendations
Risk Link		**Yes**		Links to Board assurance Framework
Impact on Social Value		**Yes**		
Trust Strategy Link		The quality of our services in providing safe, effective, compassionate, and responsive care links directly with strategic objectives		
Strategic Objectives	People	Credibility of Trust		
	Place	Serving the population of Dorset		
	Partnership	System working to achieve high standards of care		
Dorset Integrated Care System (ICS) Objectives		**Which Dorset ICS Objective does this report link to / support?**		
Improving population health and healthcare		**Yes**		
Tackling unequal outcomes and access		**Yes**		
Enhancing productivity and value for money			**No**	
Helping the NHS to support broader social and economic development			**No**	
Assessments		**Have these assessments been completed?** *If yes, please include the assessment in the appendix to the report..* *If no, please state the reason in the comment box below.* *(Please delete as appropriate)*		
Equality Impact Assessment (EIA)			**No**	
Quality Impact Assessment (QIA)			**No**	

Dorset County Hospital
NHS Foundation Trust

Maternity & Neonatal Quality and Safety report

July 2024

Submitted by Jo Hartley, Director of Midwifery & Neonatal Services

Executive sponsor: Dawn Dawson CNO

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Executive Summary

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- One incident of a 3rd degree tear. Rate per thousand below target
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- No incidents of moderate harm
- Two RCAs remain. One is the Maternity and Newborn Safety Investigation case – LIP needs to be rearranged and the action plan completed. the second case is awaiting the sign-off of the final letter
- Three baby loss incidents (Intrauterine)
- Risk register updated.

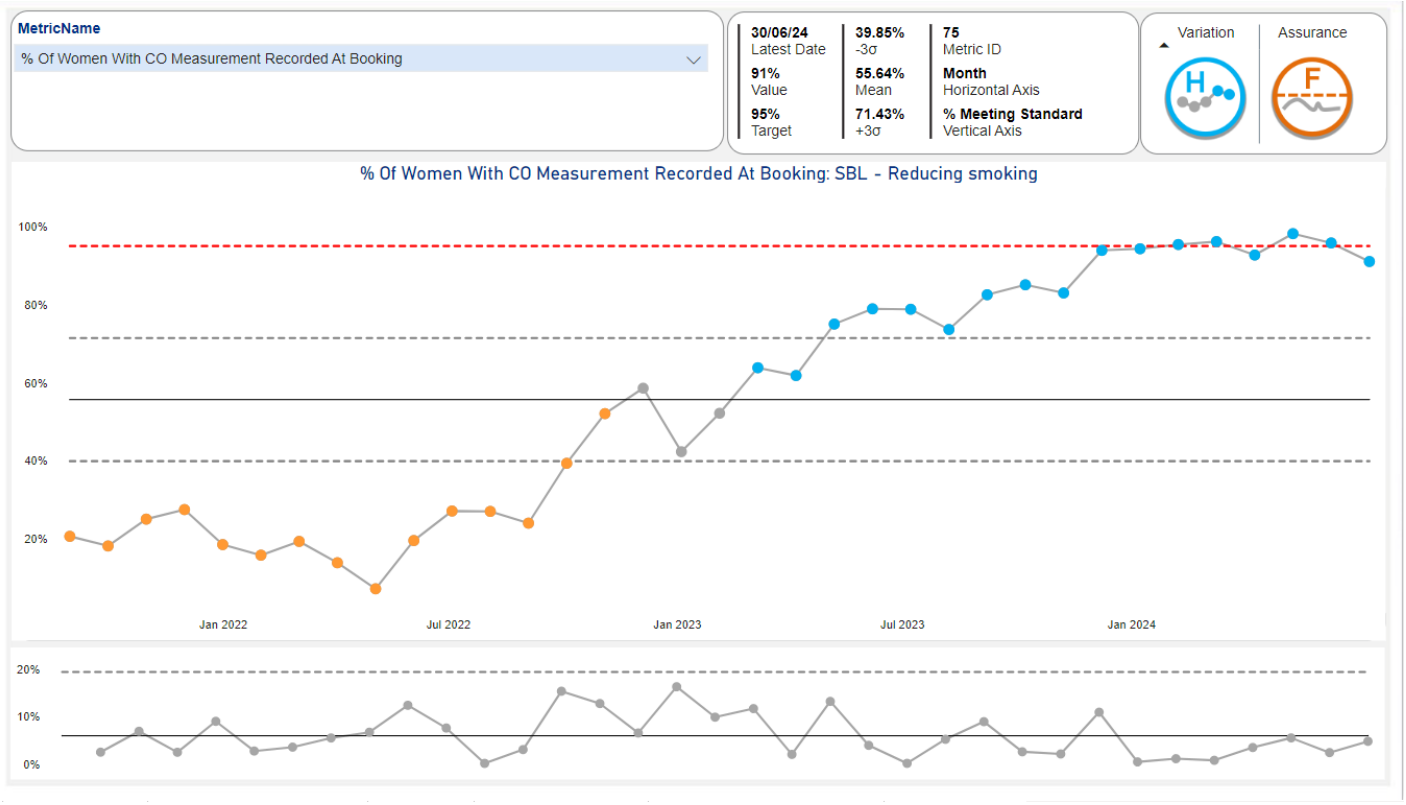
    1. The neonatal nursing staffing remains high risk due to the requirement of a supernumerary coordinator 24/7. Currently scoping how this is accommodated in other small level 1 SCBUs.
    2. Good progress with triage and Birmingham Symptom Specific Obstetric Triage System (BSOTS) in DAU (Day Assessment Unit).
    3. Two models of resuscitaires identified and to be trialled prior to purchase

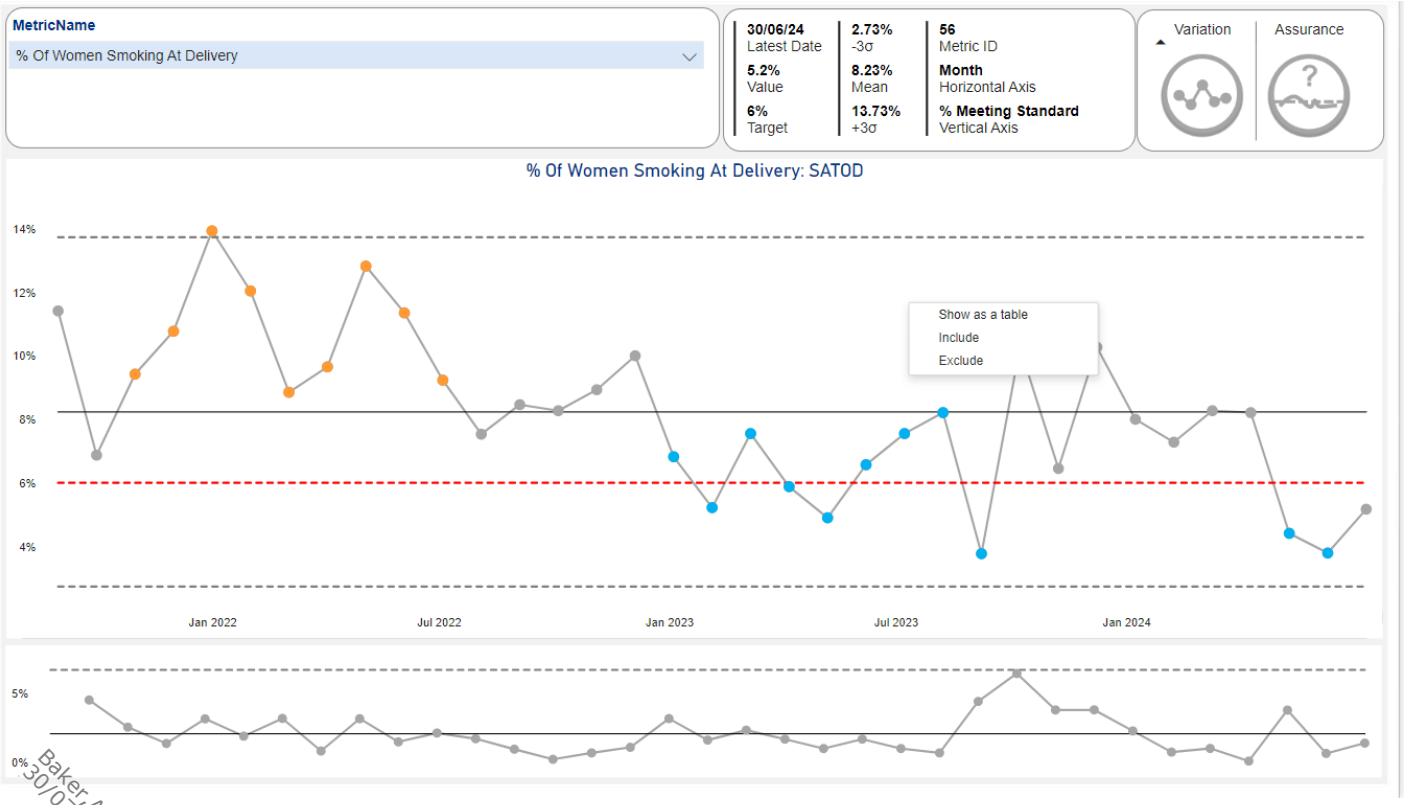
- Two complaints received in June. Details provided of actions identified from recent complaints
- Workforce data. Poor mental health is the primary reason for LTS. Sickness rates improving across midwives, MSWs and SCBU staff
- NHS Resolution announced 17/7 that there is no longer an expectation that obstetric anaesthetists who are not on the obstetric rota must attend multi-professional emergency training.
- Documentation errors report for quarter 1 included detailing the themes and actions identified

Activity

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

Metric	Target	Current position and mitigation/actions
Smoking at time of delivery	6%	5.2%
CO recorded at booking	95%	91%
Rates per 1000 of stillbirth	4	nil
Rates per 1000 of neonatal deaths	2	Nil
% babies >37 weeks admitted to SCBU	5%	7.6%
Rates per 1000 of PPH >1500mls	30	25.9
Rates per 1000 of 3rd/4th degree tears	25	20
% live births <37 weeks gestation	6%	7.6%
Babies transferred to a level 2 or 3 Neonatal unit	NTI	0
Hypoxic Ischemic Encephalopathy incidents		Nil
Percentage of babies with 1st feed maternal	NTI	80.2%



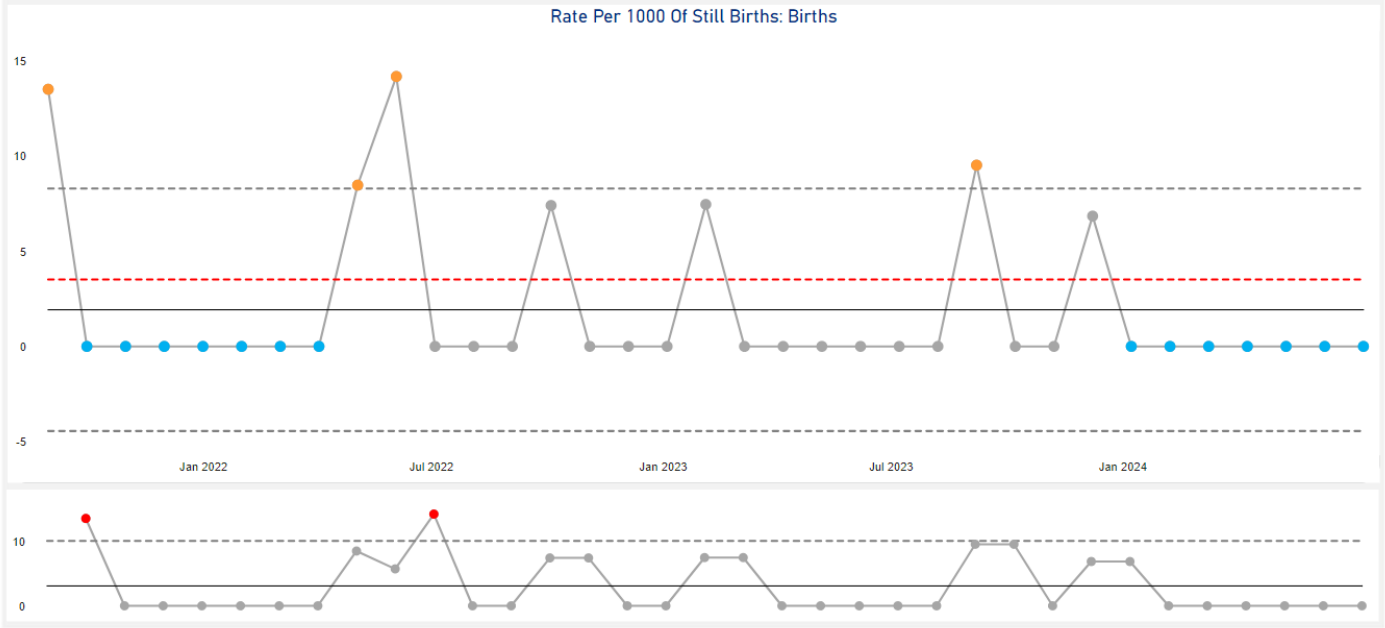


MetricName

Rate Per 1000 Of Still Births

30/06/24 Latest Date	**-4.45** -3σ	**102** Metric ID
0 Value	**1.93** Mean	**Month** Horizontal Axis
4 Target	**8.3** +3σ	**Rate Per 1000** Vertical Axis

Variation: L | Assurance: ?

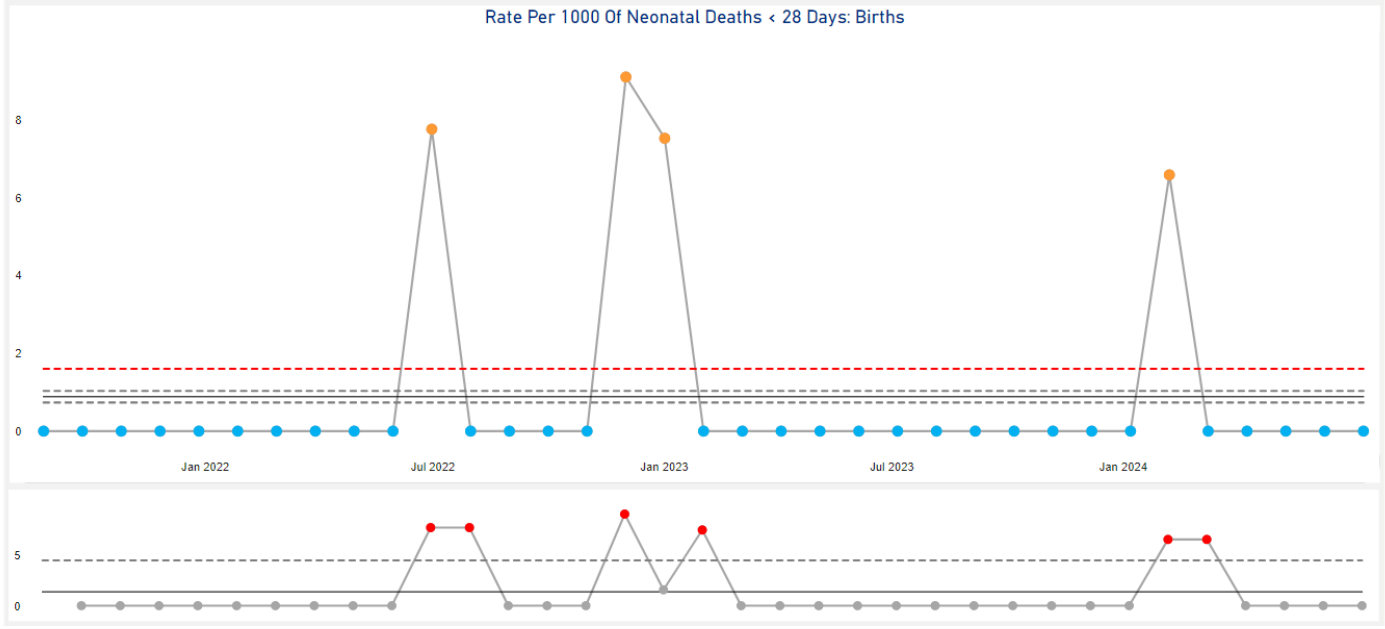


MetricName

Rate Per 1000 Of Neonatal Deaths < 28 Days

30/06/24 Latest Date	**0.73** -3σ	**103** Metric ID
0 Value	**0.88** Mean	**Month** Horizontal Axis
2 Target	**1.03** +3σ	**Rate Per 1000** Vertical Axis

Variation: L | Assurance: P

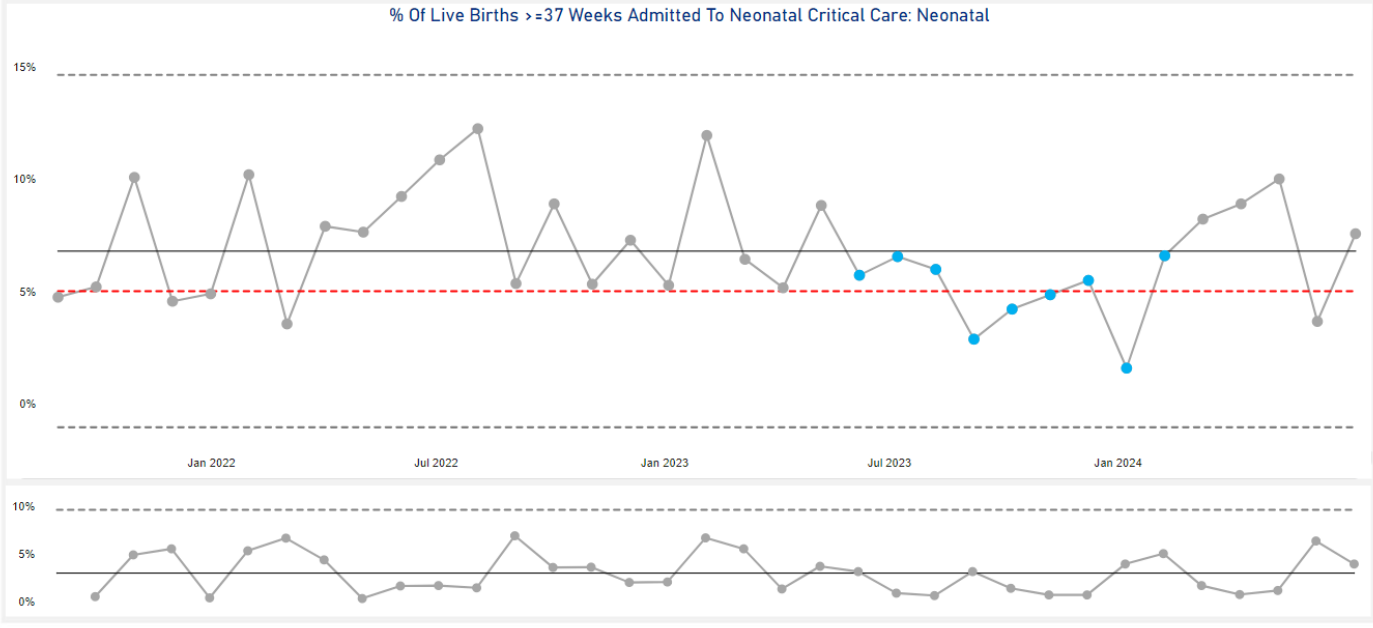


MetricName

% Of Live Births >=37 Weeks Admitted To Neonatal Critical Care

30/06/24 Latest Date	**-1.07%** -3σ	**101** Metric ID
7.6% Value	**6.78%** Mean	**Month** Horizontal Axis
5% Target	**14.63%** +3σ	**% Meeting Standard** Vertical Axis

Variation | Assurance

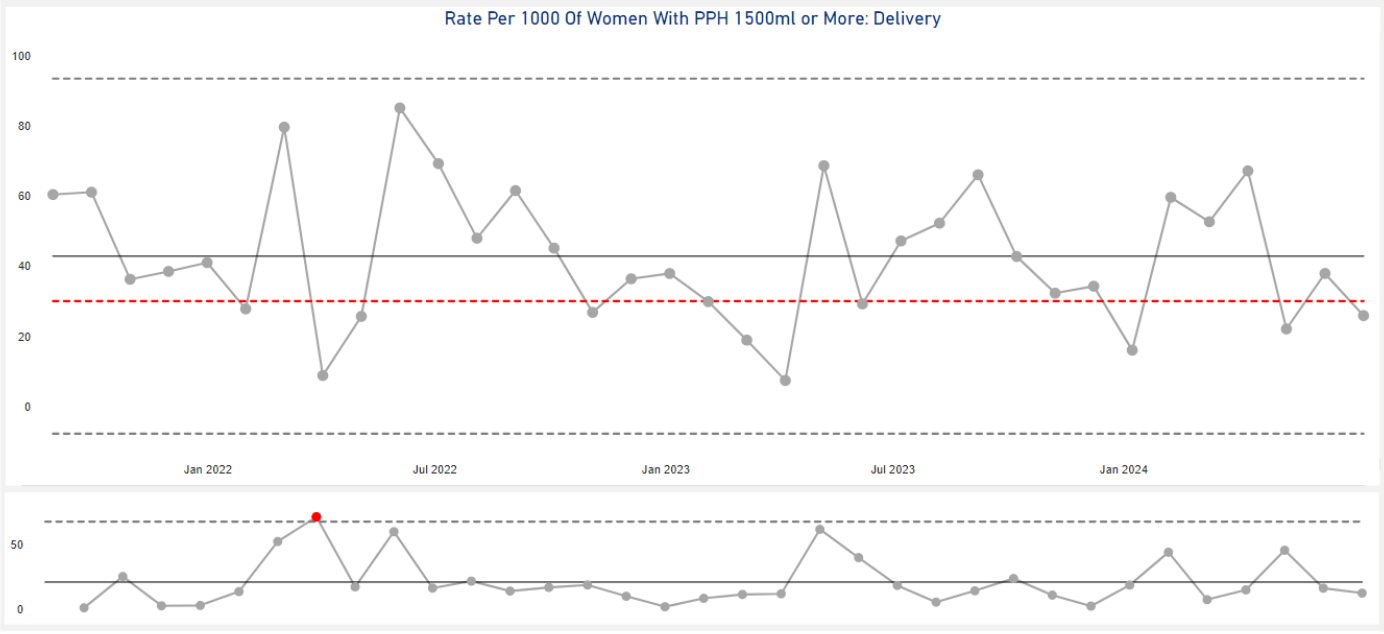


MetricName

Rate Per 1000 Of Women With PPH 1500ml or More

30/06/24 Latest Date	**-7.83** -3σ	**89** Metric ID
25.9 Value	**42.82** Mean	**Month** Horizontal Axis
30 Target	**93.47** +3σ	**Rate Per 1000** Vertical Axis

Variation | Assurance

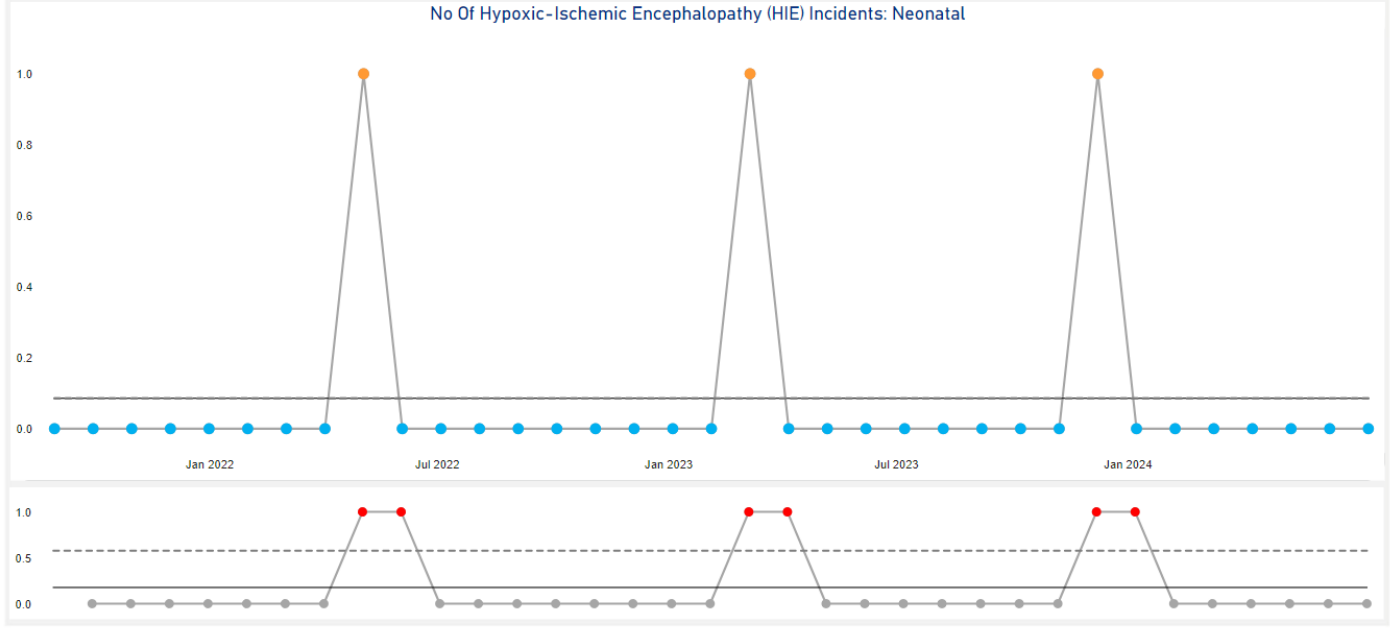


MetricName

No Of Hypoxic-Ischemic Encephalopathy (HIE) Incidents

30/06/24 Latest Date	**0.09** -3σ	**57** Metric ID
0 Value	**0.09** Mean	**Month** Horizontal Axis
Target	**0.09** +3σ	**Number Of Births** Vertical Axis

Variation | Assurance

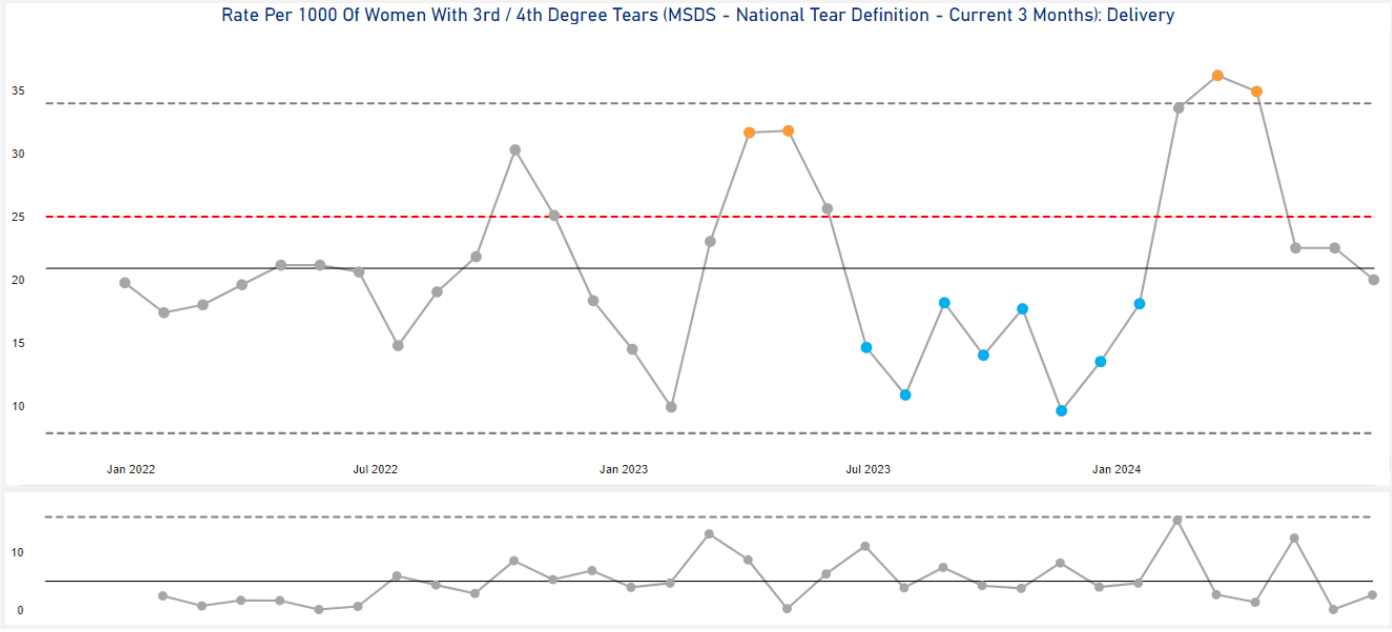


MetricName

Rate Per 1000 Of Women With 3rd / 4th Degree Tears (MSDS - National Tear Definition - Current 3 ...

30/06/24 Latest Date	**7.83** -3σ	**182** Metric ID
20 Value	**20.91** Mean	**Month** Horizontal Axis
25 Target	**33.99** +3σ	**Rate Per 1000** Vertical Axis

Variation | Assurance

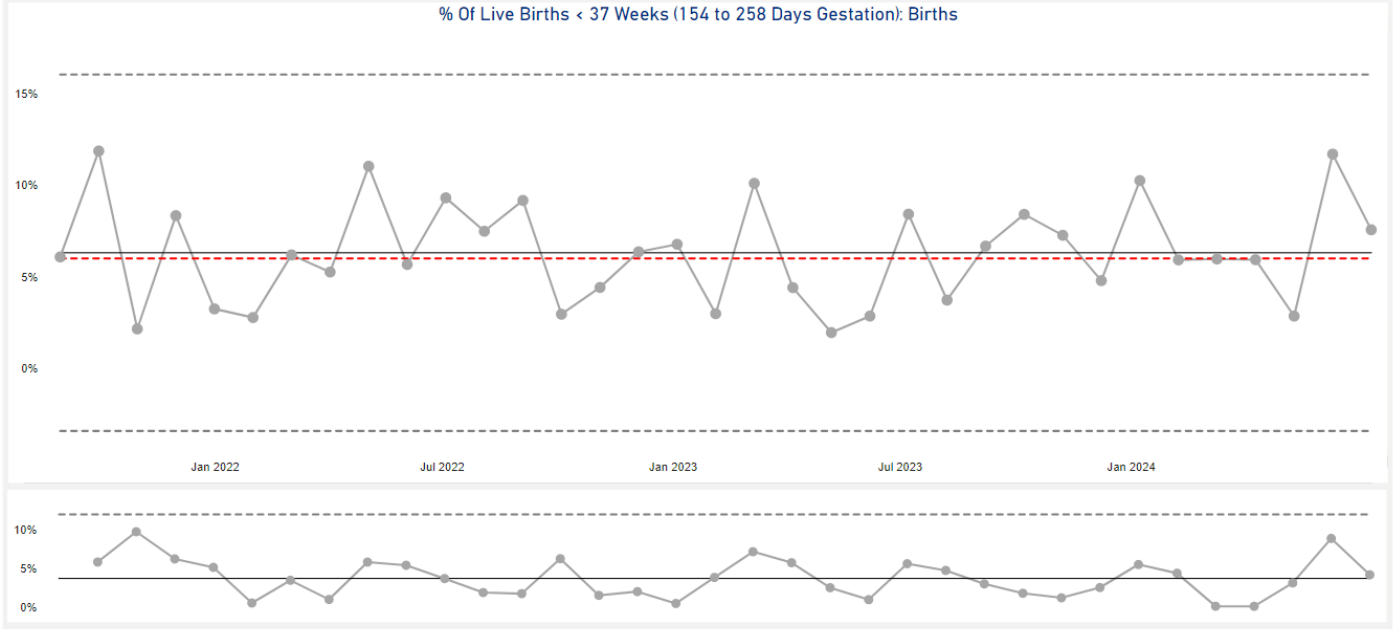


MetricName

% Of Live Births < 37 Weeks (154 to 258 Days Gestation)

30/06/24	Latest Date	**-3.4%**	-3σ	**106**	Metric ID
7.6%	Value	**6.31%**	Mean	**Month**	Horizontal Axis
6%	Target	**16.01%**	+3σ	**% Meeting Standard**	Vertical Axis

Variation Assurance

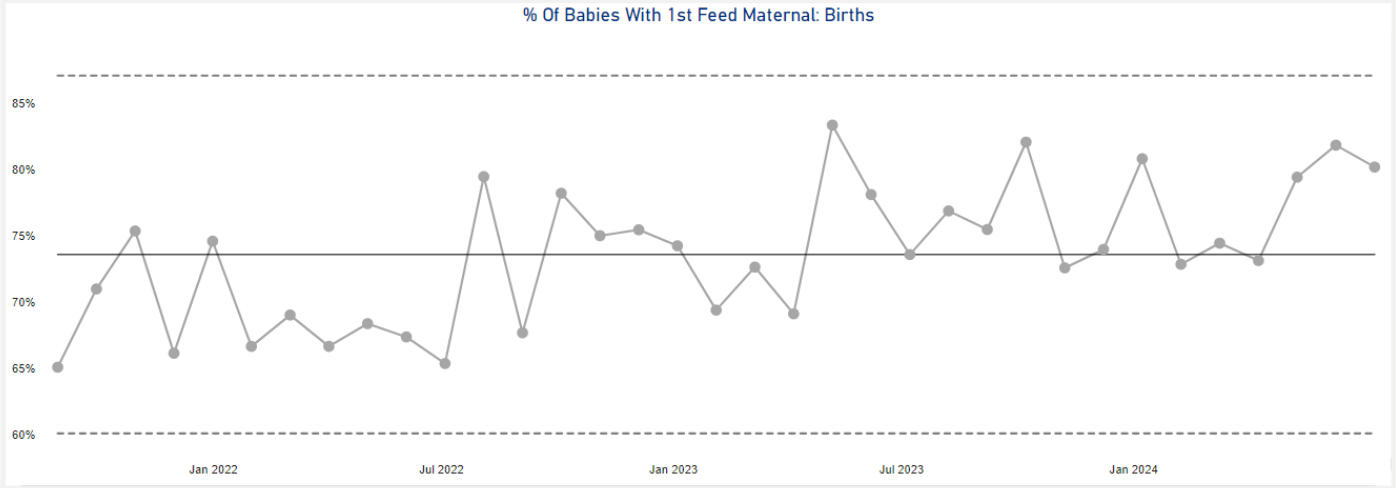


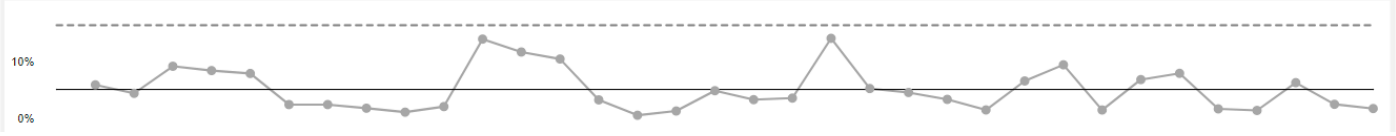
MetricName

% Of Babies With 1st Feed Maternal

30/06/24	Latest Date	**60.11%**	-3σ	**34**	Metric ID
80.2%	Value	**73.58%**	Mean	**Month**	Horizontal Axis
	Target	**87.05%**	+3σ	**% Meeting Standard**	Vertical Axis

Variation Assurance





Total Number of Incidents submitted for June 2024

Maternity & Neonatal	
Total	71
Red Flag	22

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

	Jun
Antepartum: Delay of ≥2 hours between admission for induction of labour and beginning of process	2
Escalation to divert of maternity services	1
Intrapartum: Unable to facilitate homebirth	2
Staff/work capacity: Other	3
Administration: Missed or delayed medication	3
Administration: Wrong medicine	0
Dispensing: missed/delayed medicine	0
Dispensing: Wrong medicine	1
Prescribing: Missed or Delayed	0
Prescribing: Wrong frequency	0
Antepartum:Total In-utero transfer	5
UHD in-utero transfers.	2
RUH Bath in-utero transfer.	1
Portsmouth in-utero transfer.	1
Winchester in-utero transfer	1

Incidents graded as moderate harm or above for June - nil

Baby loss statistics in June

Intrauterine death	Medical termination	Neonatal death	Late neonatal death
3	0	0	0

3rd & 4th degree tears – for June 2024

OASI Tear review June

	Parity	Ethnicity	BMI	Age	Grade of tear	Mode of birth	Length of 2nd stage	Birthweight/ centile	Hands on/off/poised	Oasi Bundle Implemented?	Position of woman	Blood loss	Referrals made?
Case 1 D809182	1 (CS)	Caucasian	26	35	3a	Vaginal	10 mins	3558 17.7 cnt	Hands on	Not documented	Not documented	801mls	Physio √ Gynae √

One case identified during June of 3a tear following spontaneous vaginal birth. Para 1 with history of caesarean birth with placenta praevia. Spontaneous onset of labour. First stage <4 hours, 2nd stage 10 minutes. Episiotomy performed to expedite birth due to CTG concerns, preparing for LSCS as woman declined instrumental birth. Tear sutured in theatre with spinal anaesthetic.
Blood loss 801mls.

Weight of baby 3.5kg which plots on the 17th centile for GROW.

Appropriate prescribing of laxatives post birth and referrals made to physiotherapy and gynaecology for follow-up.

Current SIs and MNSI cases (including cases awaiting presentation at the Perinatal Mortiality Review Committee (PMRT)

DCH88563 – 27/11/23

Update Tripartate meeting with MNSI and the family (12/06). Slides being prepared for LIP, including action plan. LIP to be rescheduled
DCH79162 - 23/12/22
Medical Device failure **Update** Presented at LIP. Meeting to be arranged with parents plus sharing the RCA. The only outstanding actions relate to those to be addressed once LIP completed. Awaiting finalised letter for parents

Risk Register

ID	Title	Risk Statement	Open	Risk	Responsibility
1881	Neonatal Nursing	Current neonatal nursing establishment not compliant with safe levels of staffing according with BAPM and Neonatal Nursing workforce Calculator. Regular bank and overtime hours required each month to cover the unit with 2 RN and 1 HCA. Often agency is used too, when no other option is available. **Update** Neonatal Nursing staff are expected to deliver care inside the different rooms in the unit, on labour ward, post-natal ward and in some emergency situations attending A&E and Main theatres. The Service specifications for Neonatal care from NHS England, details that a minimum of one nursing coordinator per shift should be available. **Update** Headroom uplift being applied. Seeking advice from other level 1 SCBUs about presence of supernumerary coordinator in small units. Formal arrangement for mutual support being explored with Kingfisher. BAPM Audits taking place quartlery.	01/05/2024 Debora Coalwood-Horta, Maternity Matron, monthly review	High risk 15	corporate

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 **Update** Planned digitalisation of SCBU delayed by digital transformation as they are reviewing all systems across the Trust. Additionally, we have been informed of a pan Dorset/Somerset EPR that is being developed that we have recently been informed we are officially stakeholders	26/02/2024 Debora Pascoal-Horta Neonatal Matron, quarterly review	Moderate 12	Care group
1825	Ventilator SLE 5000	Current ventilators available in SCBU (X3) reached end of life and the period of maintained support has now passed. The current models in the unit ceased manufacture in May 2015 and the 7 year period of maintenance support has now passed. Currently the devices only have standard level service contract. This means that a repair is not guaranteed due to non availability of spare parts. **Update** Standard contract until 28/02/2025. Risk highlighted in the 2024/25 Capital Programme for prioritisation as needing replacement as soon as possible	26/02/2024, Debora Pascoal-Horta, neonatal matron, quarterly review	Low 6	Service specific
1898	Resuscitaires for labour ward	The CQC inspection and report highlighted the need to have a resuscitaire for every labour room. This requires the purchase of two new resuscitaires. Scoping exercise underway to identify a suitable modelThere have been no incidents of a resuscitaire not being available for every labouring woman. **Update** Two models identified as possibly suitable. Arrangements underway to trial both models.	28/05/2024, managed by Jo Hartley DoM, monthly review	Moderate 9	division
1899	Provision of specialist service for women with raised BMI in pregnancy	the Maternity Public Health Team comprises one fulltime band 7 midwife lead and 0.8wte band 6 midwives funded externally. Current priorities are the provision of smoking cessation support and vaccinations. This leaves no capacity for any service development for women with a raised BMI or engagement with initiatives such as Active Hospital or This Mum Moves. Reference to a specialist clinic for women will be removed from the Raised BMI guideline.	28/05/2024 managed by Becky Fry, Public Health Lead Midwife, 6 month review	Moderate 8	Service specific

1861	Maternity and Neonatal Audit Capacity	Currently the maternity and neonatal service does not have an audit lead. The audit requirements for the service are extensive (approximately 100 a year) and fundamental to national KPIs including SBLCB and MIS. There is no capacity within the governance team to absorb this workstream **Update** Audit lead appointed. Successful candidate will be in post during August.	18/04/2024 managed by Jo Hartley, DoM monthly review	Moderate 12	Service specific
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. 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). Discussions starting about establishing a pathway for elective theatre work - planned caesareans. This would require 4 split theatre sessions a week, a theatre team including surgical first assistant, anaesthetic and obstetric consultant availability **Update** Planning continues	29/06/2023 managed by Jo Hartley DoM, quarterly review	moderate 9	division
1742 & 1759	additional obstetric consultant capacity required to meet national KPIs	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** New consultant has made a very successful start with the service. F2F handover and ward round acknowledged as a priority and job planning underway with wider team. Likely funding for tenth consultant – awaiting confirmation from ICB	013/10/2023, managed by James Male, service Manager, quarterly 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** Monthly audit completed today and positive results demonstrating good compliance around KPIs relating to triage - approaching 90%. There is evidence that reduced compliance elates directly to reduced staff in ANDAU	08/01/2023 Managed by Nichola Coliandris, Matron quarterly review	Moderate - 8	Corporate

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 update	02/09/2022 Managed by Paul Daniell, Estates. quarterly review	moderate -9	divisional
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 Nichola Coliandris, 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** Successful recruitment of NQM - not starting in post until October 2024.Interviewing soon for MSWs. BR Plus audit commenced to provide recommendations around safe maternity staffing. Only 4 datix relating to staffing submitted in June	21/09/2021 Managed by Jo Hartley, Director of Midwifery, Monthly reviews	Moderate - 12	corporate

Complaints

Total informal and formal

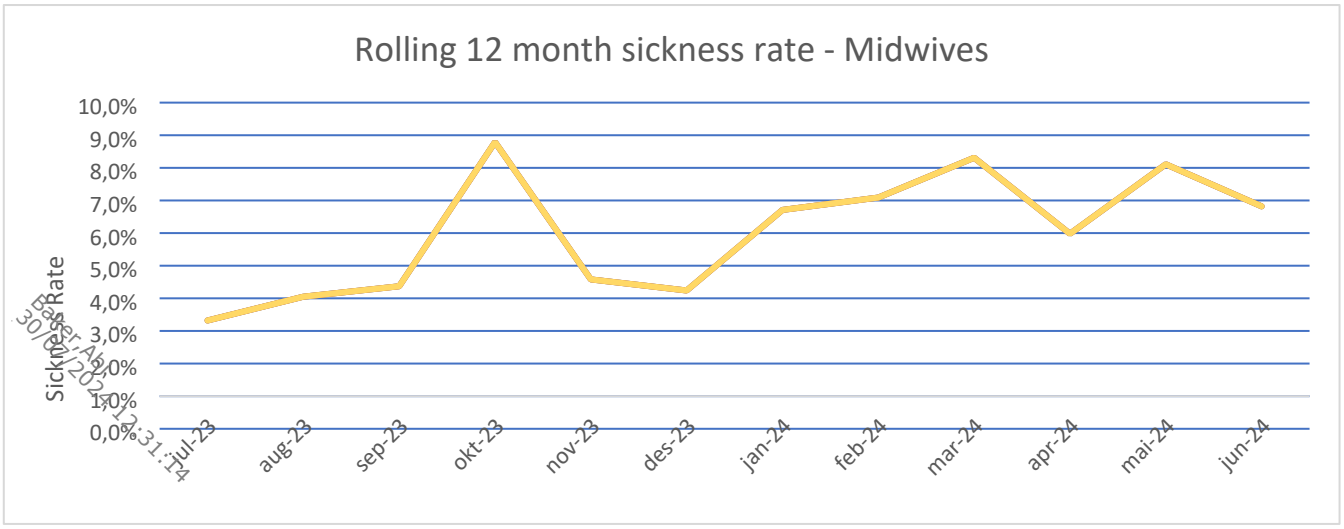
Month	July	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	April	May	June
total	0	1	2	0	3	2	1	2	2	6	3	2

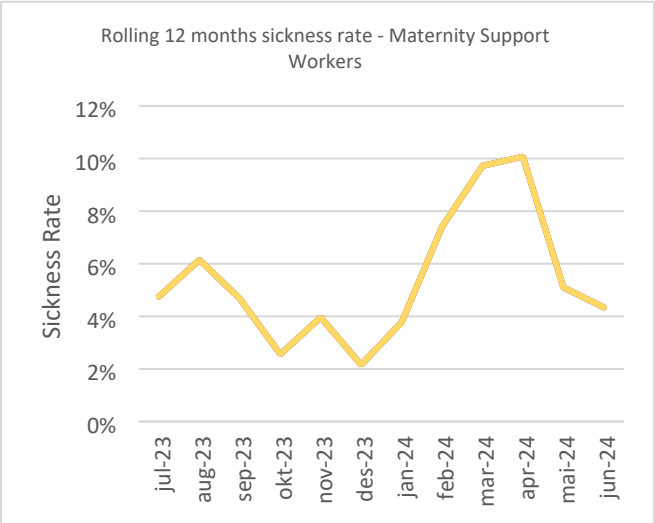
The table below triangulates complaints, for quarter four with the Trust claims scorecard, themes, learning and action plan

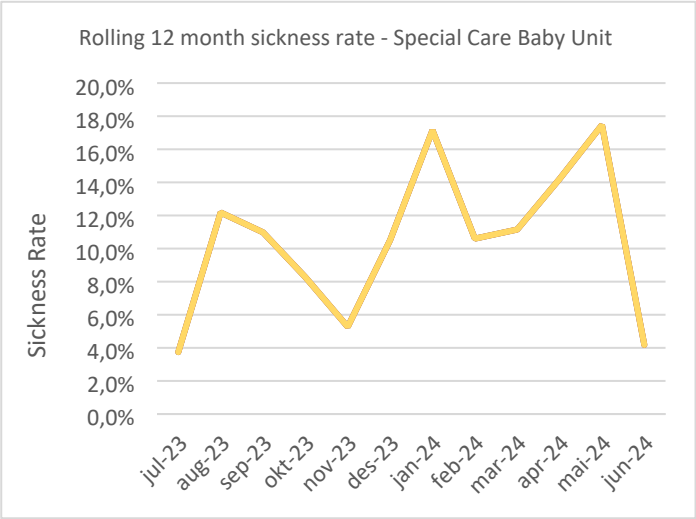
Description
To discuss with the Obstetric Anaesthetic Lead, the process for contacting another anaesthetist to attend out of hours, if required.
To reopen discussions with the wider team about partner and baby being allowed into recovery.
To continue to try and improvehow staff communicate with partners waiting for news when women have a general anaesthetic.
Experience will be used to inform teaching and discussion focusing on meaningful discussions with women about their choices and how this is communicated in stressful situations.
Patient's labour and birth recommended to be presented and discussed anonymously at the joint Anaesthetic and Obstetric meeting.
It is essential that parents with a baby in the Neonatal Unit are treated with compassion and kindness. Due attention and time must be given to understanding their experiences and responding to their concerns and questions.
To continue to improve access to pain relief postnatally, including control drugs on discharge.
Ms Hartley will remind midwives that dihydrocodeine is available to dispense to women when they leave the hospital. It has been available for a long time, so she is unable to explain why two midwives thought it was not.
For the team to discuss and assist with expressing promptly after birth.
Consideration around incorporating discussion into the infant feeding update and training sessions about talking to women about the impact of postpartum haemorrhage and traumatic birth.
Share the concerns around cleaning beds with the relevant staff.
Discuss with staff at the next staff meeting the importance of responding to concerns raised by family.
Review the referral pathway for the Frenulotomy service, including the initial review, the information given to parents and the way in which the referral is followed up.
A continued focus on improving women's access to postnatal analgesia particularly when they are resident on SCBU. Continue to focus on the importance of kindness, compassion and civility.
Staff must prioritise supporting partners who cannot be with women in theatre due to general anaesthetic being required. Midwives must take time to discuss the options available for pain relief after birth.
Ensure the postnatal lead midwife checks in the morning, which babies require a NIPE. Ensure the consultant ward round reviews postnatal women in the morning after reviewing women on the ward.
Improve the provision of pain relief for postnatal women. Remind staff to check prescription charts carefully before dispensing medication.
Ensure the homebirth team are providing clear, correct advice about managing spontaneous rupture of membranes,

Workforce data

Staffing Report – June 2024



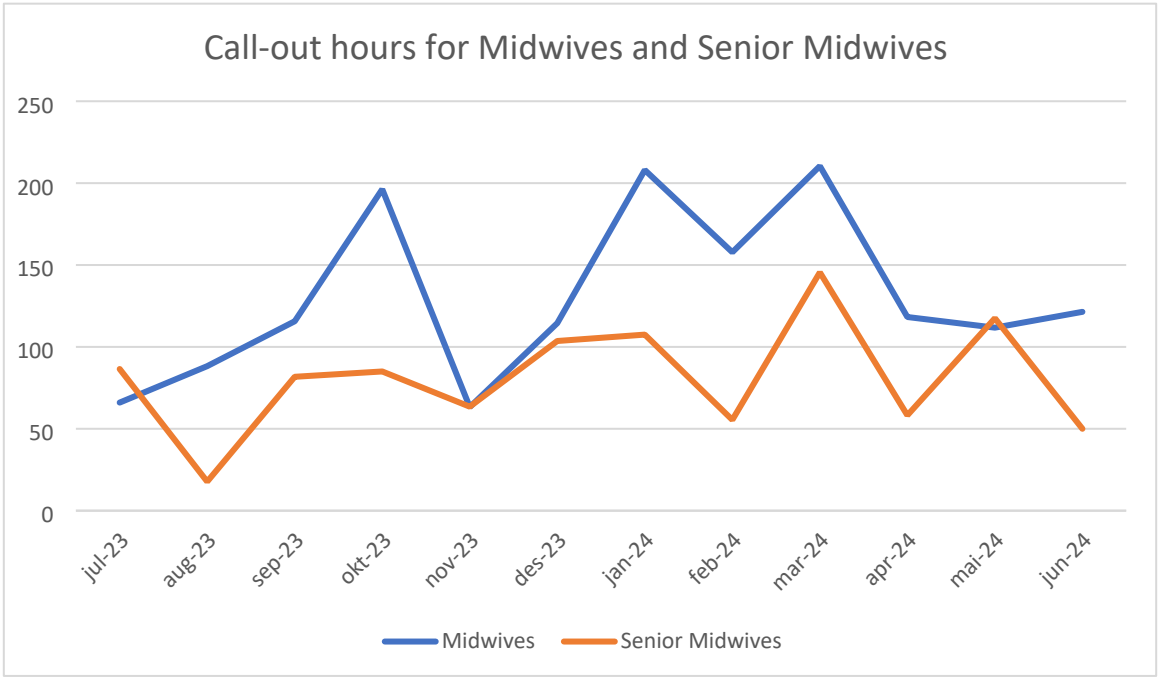




Overall sickness rates from 1st June 2023 – 31st May 2024
Midwives – 5.98%
Maternity Support Workers – 5.39%
Special Care Bay Unit – 10.41%

June Call-Out Hours

Midwife call-out for the unit – **121.41 hours.**
Senior Midwives call-out – **50 hours**



Bank and Excess hours

	Maternity Unit/ DAU	Community	MSW's / DAU	SCBU Band 5/6 & NEO	SCBU Band 3
Bank	216.75 hrs / 87.9 hrs	229.75 hrs	268.75 / 66 hrs	191 hrs / 121 hrs	0 hrs
Incentives	17		1	3	0
Excess/Overtime	509.9		112.5	59	0

Shifts not covered by substantive or bank staff

Maternity Unit – based on 6 midwives per shift		Maternity Support Workers	
Day Shift	13.6 %		23.8 %
Night Shift	20.5 %		
Total	15.9 %	**Special Care Baby Unit**	
ANDAU	12 shifts not covered	Band 5/6	1 shift not covered
		Band 2	2 shifts not covered

Neonatal transfer out data for June - nil

Training compliance

MIS Year 6 Reportable Maternity and Neonatal Mandatory Training Compliance

Rolling 12-month period ending June 2024

Training	Role	Compliance (percentage)	Non-compliance (number)	Narrative
Practical Obstetric Emergency Procedure Training (PROMPT)	Obstetric Anaesthetist *regularly covering Obs	48%	12	The Medical Director has now confirmed that for this year, there is no requirement for staff to request study leave. The training can be rostered with clinical activity cancelled . Minimum 8 need to be rostered on before November to reach 90%.
	Obstetric Anaesthetist *contributing to obstetric rota*	26%	14	Update from NHSR received 17th July confirmed this standard will be removed with immediate effect
	Consultant Obstetrician	87.5%	1	1 out of date booked to attend in July, 1 more is in date but will need to be booked on before November to achieve compliance.
	Registrars	66%	3	
	ST1/F2/GP Trainees	50%	4	All rostered to attend before November 2024.
	Midwives	95%	6	BAU
	MSW – not reportable to MIS Year 6	95%	2	BAU
Newborn life support (NLS) Yearly	Midwives	94%	7	BAU
	Neonatal nurses	100%	0	BAU
	Paediatric Consultants	75%	3	Discussion with Dr Clare Hollingsworth who has contacted the consultants regarding best option to capture everyone yearly. Current thinking is putting it in the learning zone – need to determine who can do this…
	Paediatric Registrars	80%	1	Long term plan- Dr Clare Hollingsworth is currently reviewing the registrar's induction to include NLS.
	ANNP	100%	0	BAU
NLS 4 Yearly	Senior & Cygnet Midwives	100%	0	BAU
	Neonatal nurses	100%	0	BAU

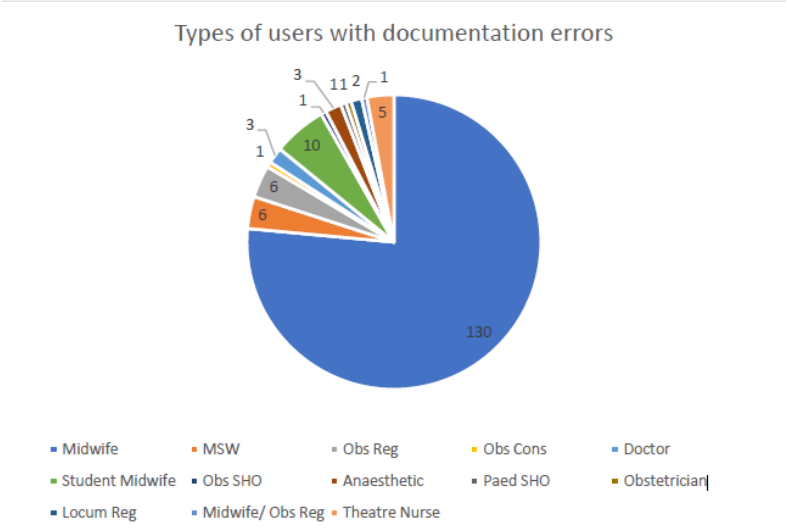
	Paediatric Consultants	100%	0	BAU
	Paediatric Registrars	100%	0	BAU
Saving Babies Lives study day	Midwives	94%	8	BAU
	Obstetricians, Registrars & SHO's	56%	11	All staff rostered to attend before November 2024. **Overall compliance for staff group as a whole is 89% for June.**
SBLv3 Element 1	Intervention 1.8 – CO monitoring Midwives and MSWs giving AN care	92%	11	BAU - MSW compliance is 79% but Midwives is 94%, MSW compliance will be improved in MSW day in September.
	Intervention 1.9 – VBA all staff – m/w's, obstetricians and MSWs	82%	35	This will be embedded within the induction programme for new doctors particularly rotating staff. Work continues to improve MSW compliance **54%**– will be captured in September MSW day**. Midwives compliance meets target 94%. Cons obs 50% and Obs Reg's and SHOs 65%.**
K2 CTG & IA	Consultants	63%	3	Managed by Fetal Monitoring Lead.
	Registrars	90%	1	Managed by Fetal Monitoring Lead.
	Midwives	89%	13	Managed by Fetal Monitoring Lead.

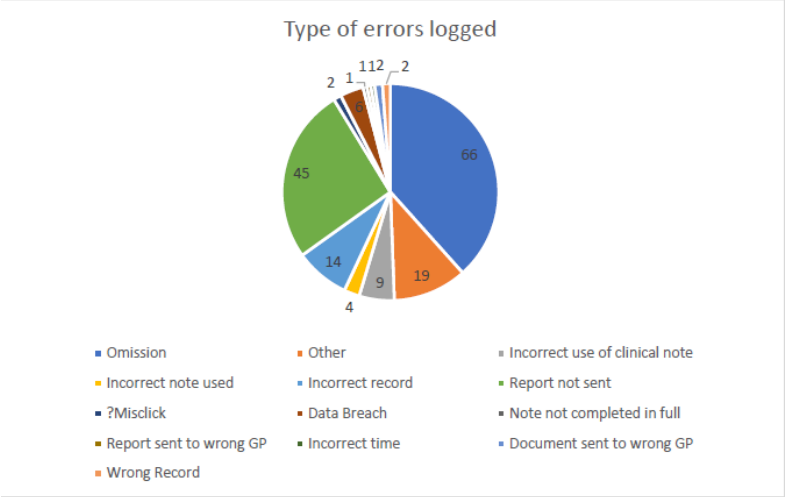
Documentation Errors report quarter 1

This report will look at documentation errors on BadgerNet Maternity System logged by the digital maternity team in the months reported. The information is captured via:

- A user emailing the team with relevant information of an error.
- A review of notes completed by the team or other members of the senior midwifery team (during a datix investigation or fetal monitoring review etc.).
- Data quality errors reported during national submissions (MSDS, smoking cessation reports etc.)
- Data completeness reports on BadgerNet Maternity system

Please note that this report will only contain on errors noticed using methods above, this may not be comprehensive of all documentation errors on the system.
173 errors have been logged in this period and the data is broken down below.





Themes	Actions/update
Birth notifications not being sent	Despite more errors on the log, the number of these has reduced. Will continue to monitor and inform staff that miss this step. Checklists are being discussed with System C so staff will be prompted from the system
Writing on the wrong record	“Leave the bedside, leave the record” is being pushed universally and in training If noticed immediately by the user, digital team correcting this with a reminder to be vigilant. If noticed later and/or by a different user, a datix is being completed for further investigation. Patient’s records should be searched for by hospital number to reduce risk.
Wrong baby gender entered at birth	To observe. System has a pop-up to ensure that this information is correct prior to saving this information.
Episiotomy, Tears and Trauma note omission	To monitor since the introduction of OASI. Occurrence has increased from 26 to 30 between quarters but digital team are more vigilant of this. Continues in mandatory training plan for 2024.
(Lower section caesarean section) LSCS documentation not being completed in full	LSCS documentation in plan for 2024 digital training for all midwives. Discussions continue for Obstetric registrars and consultants to have a mandatory digital update.

Report Front Sheet

1. Report Details			
Meeting Title:	Board of Directors, Part 1		
Date of Meeting:	31 July 2024		
Document Title:	Safeguarding Annual Report		
Responsible Director:	Jo Howarth, Director of Nursing (Acute Care)	Date of Executive Approval	07/06/2024
Author:	Sarah Cake / Jo Findlay / Katrina Cunningham		
Confidentiality:	no		
Publishable under FOI?	no		
Predetermined Report Format?	no		

2. Prior Discussion		
Job Title or Meeting Title	**Date**	**Recommendations/Comments**
Safeguarding Committee	Quarterly meeting 2023-2024	
Quality Committee	18/06/2024	Recommended to Board

3. Purpose of the Paper	Offer assurance of the process & activity for Safeguarding at Dorset County Hospital NHS Foundation Trust							
	Note (✓)		Discuss (✓)		Recommend (✓)		Approve (✓)	x
4. Key Issues	Review of activity Mandatory Training Digital Risks							
5. Action recommended	The Board is recommended to: 1. **APPROVE** the report & Quality Improvement Plan							

6. Governance and Compliance Obligations			
Legal / Regulatory Link	**Yes**		Mental Capacity Act / Care Act / Childrens Act / Equality Act / Working Together to Safeguard Children / Mental Health Act
Impact on CQC Standards	**Yes**		Regulation 13 https://www.cqc.org.uk/guidance-providers/regulations/regulation-13-safeguarding-service-users-abuse-improper
Risk Link	**Yes**		1099 Chief Information Officer Recording of carers or parental responsibility on electronic systems *Moderate* 1097 Chief Nursing Officer CPIS child protection information flagging *High Risk*

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	Recognising protective factors , people's needs , & wishes whilst using our care ,adapting our services to support them 7 helping reduce health inequalities and barriers .		
	Place	Recognise the place-based needs of our communities / population		
	Partnership	Working in conjunction with partner agencies to support those who use our service, (PDSCP / DSAB / ICS)		
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**		Safeguarding means protecting people's health and wellbeing and human rights
Tackling unequal outcomes and access		**Yes**		Highlighting protective factors and improve access to services
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		**Yes**		As above
Assessments		**Have these assessments been completed?** *If yes, please include the assessment in the appendix to the report.* *If no, please state the reason in the comment box below.* *(Please delete as appropriate)*		
Equality Impact Assessment (EIA)			**No**	
Quality Impact Assessment (QIA)			**No**	

Title of Meeting	**Board of Directors, Part 1**
Date of Meeting	**31/07/2024**
Report Title	**Annual Safeguarding Report**
Author	Sarah Cake, Head of Safeguarding Joanne Findlay, Learning Disability and Mental Capacity Act Lead Katrina Cunningham, Lead Midwife for Safeguarding
Responsible Executive	Jo Howarth, Interim Chief Nurse for the reporting period

Purpose of Report

The purpose of this annual report is to inform and assure members of the Quality Assurance Committee the Safeguarding activities within Dorset County Hospital during 1st April 2023 – 31st March 2024

Foreword

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

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

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

The annual safeguarding report aims to:

- Provide assurance of compliance with the local multi-agency guidelines for safeguarding adults (Dorset Adults Safeguarding Board / Dorset Clinical Commissioners Group, Pan Dorset Children's Safeguarding Partnership).
- Provide assurance of compliance with the Care Quality Commission Registration Standards: Regulation 13 (safeguarding service users from abuse and improper treatment), fundamental standard 5 (safeguarding from abuse) and Safe Domain (safeguarding arrangements).

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

Paper Previously Reviewed By

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

Strategic Impact

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

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

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Risk Evaluation

Key Risks for the Service

1. **Activity and Demand –** Increasing safeguarding activity Trust wide.
2. **Training –** Training compliance.
3. **Information Sharing –** To ensure information shared with community services is in a timely and robust manner following the attendance of a child at DCHFT. Patient information systems integration. Digitalised systems to improve the ability to streamline the review of records.
4. **Talent Management –** Ensuring that the DCH Safeguarding Team has the correct people with the capabilities to deliver outstanding care, now and going forward.
5. **Mental Health –** Increasing need for mental health provision in an acute physical environment, specifically for children and young people.

Impact on Care Quality Commission Registration and/or Clinical Quality

Safeguarding Children, Young People & Adults, Mental Capacity Act compliance and Deprivation of Liberty assessments are key quality indicators and are subject to external inspection. All Deprivation of Liberty outcomes are forwarded to CQC for notification.

Governance Implications (legal, clinical, equality and diversity or other)

The Trust has legal responsibilities as detailed within the strategic impact section. The reassurance of a robust service is measured through audit or assurance tools comparing practice against policy.

Electronic flagging of patients with learning disabilities and/or autism is a recognized national system, however, this does categorise individuals and, therefore, has an acknowledged implication for equality and diversity. This is in line with our equality duty and supporting published papers on Equality in Health. This ensures pathways of care are reasonably adjusted and patients with disability are not disadvantaged by the service provided. National Flagging through CPIS (Child Protection Information Sharing) for children who are subject to a Child Protection Plan; or a cared for child; or an unborn infant who will be subject to a Child Protection at birth, is maintained by Social Care partners and is shared to Health Providers.
Financial Implications Failure to adhere to the standards can result in penalties and/or legal claims.

Freedom of Information Implications – can the report be published?	No

Recommendations	The Board is asked to: a) Receive and review the report, recommending any areas for further improvement at Safeguarding Group. b) Receive assurance of Safeguarding activity. c) Support delegated responsibility to the Safeguarding Group for the development of the 2024–2025 work-plan, which the Lead for Safeguarding will focus on in conjunction with the Safeguarding Team. d) Approve the annual report.

Safeguarding Annual Report Quality Committee

2023 - 2024

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

1.0 PURPOSE OF REPORT AND INTRODUCTION

1.1 This report provides a summary of the Safeguarding activity from 1st April 2023 – 31st March 2024. The purpose of this annual report is to provide assurance and inform members of the Committee of how Dorset County Hospital meets its duties to safeguard adults by preventing and responding to concerns of abuse, harm, or neglect.

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

1.3 This year has been challenging for the Team due to depletion of the Team for a period of 10 months, thankfully as of March 2024 the Team is now fully resourced. This annual report will outline the work the Trust has undertaken to improve and strengthen its safeguarding assurance and governance.

The Safeguarding Annual Report 2023 - 2024 provides a summary of the activities of the Adult, Children and Midwifery Safeguarding Teams across the Trust to demonstrate to the Trust Board, external agencies and the wider community how the Trust discharges its statutory duties in relation to current safeguarding expected national standards and best practice guidelines challenges and future priority.

Definitions

Safeguarding:

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

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

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

- an adult who has care and support needs (whether the needs are being met or not).
- is experiencing, or at risk of, abuse or neglect.

- and because of those care and support needs, is unable to protect themselves from either the risk of, or the experience of, abuse or neglect.

Assurance to support Trust Board confidence.

All DCHFT staff have a statutory responsibility to safeguard and protect those who access our care regardless of their position in the Trust. Though, some defined named safeguarding roles do exist. Named professionals have specific roles and responsibilities for Safeguarding Children and Adults, as described in the Intercollegiate Safeguarding Competencies for Adults (2018) and Intercollegiate Safeguarding Competencies Children (2019). The Trust`s Human Resource Department governs safe recruitment practices. All staff newly employed and those in substantive posts are subject to pre-employment checks (Disclosure and Barring Service).

There is senior management commitment to the importance of safeguarding and promoting welfare	• The Interim Chief Nurse throughout 2023 - 2024 is the Trust Board Executive Director for Safeguarding. The Deputy Chief Nurse has supported the attendance at external safeguarding board meetings. • The Board received an annual report. • The Trust Safeguarding Committee meetings are held quarterly. • Trust wide training compliance is reported and reviewed by the Trust Quality Committee and Safeguarding Committee.
A clear statement of the Trust responsibilities towards safeguarding is available to staff	• Adult / Child Safeguarding Policies. • Details of the Safeguarding Team referral processes and information are available via the Intranet. • All staff receive as a minimum Level1 training as part of their induction process. • Audits are presented both internally and externally as part of the audit programme. • External website support safeguarding declaration. • Safe Procurement statement in line with Modern Slavery protocols. • Bi-monthly meetings with Freedom to Speak up Guardian.

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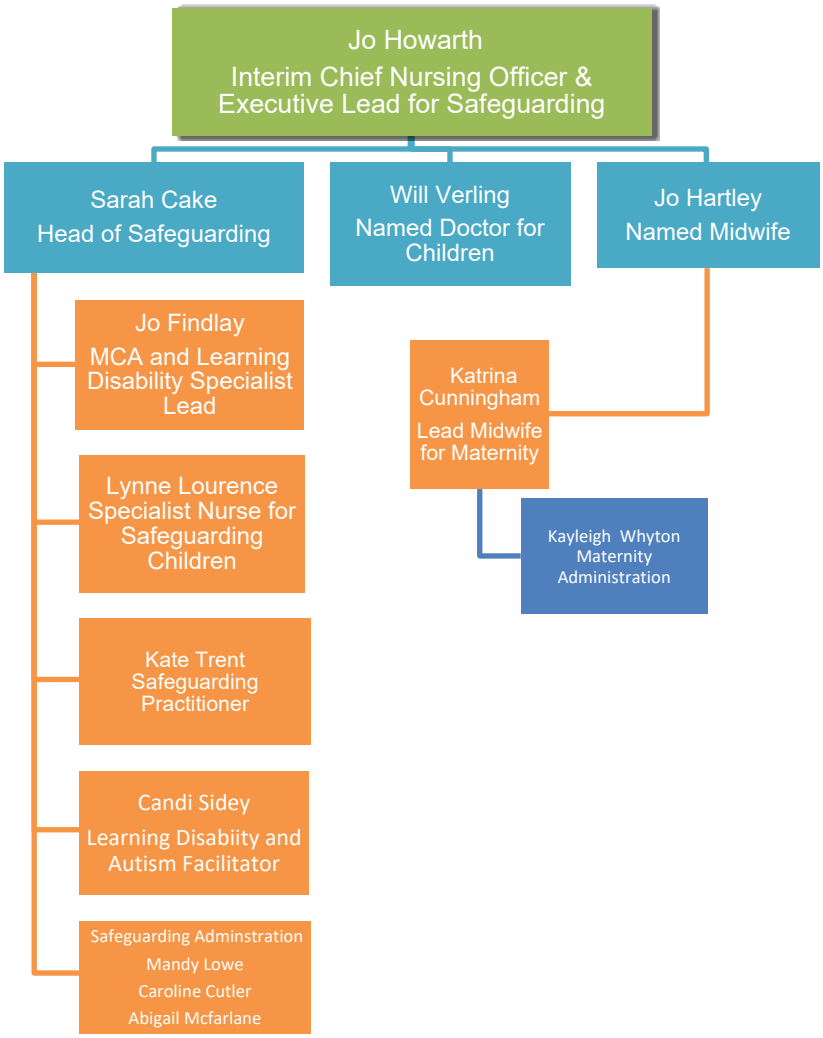
<td>There is a clear line of accountability within the organisation for the work on safeguarding</td>
<td> 
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<td>Service development consider the need to safeguard and promote welfare of all those using our services.</td>
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All service developments incorporate the appropriate risk assessment for safeguarding.
Work through collaborative flagship programmes to ensure a safeguarding lens is applied.
Developments in Midwifery has extended their perinatal mental health offer to those requiring this service.

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<td>Training on safeguarding is in place for all staff</td>
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There is a training plan in place to ensure that all staff meet the minimum standards required by the intercollegiate guidelines.
In line with the “Safeguarding Children and Young People: Roles and Competencies for Health Care Staff”, Intercollegiate Document (2019) the Team now work towards a “Think Family Approach” which covers Children at Level 3 and Adults at Level 2.
Training is integral to the induction process for all new staff, Safeguarding Annual Report: Aug 2023.

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	• All training is recorded electronically and process a robust audit trail. • Level 1 and 2 training is available via e-learning for staff, however, face to face and target training is also delivered. • Access to Level 3 Teams and e-learning for health training is available to staff and has continued to be accessed during mandatory training sessions. • In addition, the Named professionals provide bespoke Safeguarding Level 3 training face to face. • MCA bespoke sessions are delivered to a variety of professions.
Safer recruitment procedures including vetting procedures and those managing allegations are in place	• Safer recruitment is in line with statutory guidance. • Disclosure and Barring/DBS checks and references are taken up prior to job offer. • A recruitment training programme is in place for all managers. • Named professionals share responsibility for reporting staff allegations to the Local Authority Designated Officer (LADO) or Adult Local Authority.

2.0 ADULT SAFEGUARDING ACTIVITY

2.1 During the past 12 months staff have formally submitted official concerns for 134 people using our service. The majority of these were not investigated through a safeguarding investigation but were signposted to other services. The 'other' activity in relation to contact with the Safeguarding Team has also intensified, common themes have been regarding discharge planning/safety netting/advice on mental capacity. Many contacts are made for advice rather than through the formal route of referral through the cause for concern process. The highest number of referrals were made for those between the ages of 18-64, which does not align with other areas of the systems age range where predominately the highest age range is over 65. Substance addiction and self-neglect as a vulnerability factor has increased through 2023 - 2024.

In 2023 - 2024 there were 8 official concerns raised in relation to Dorset County Hospital Foundation Trust by external agencies. All of these were investigated through a nominated enquiry process and did not proceed on through to a full safeguarding investigation. The main issues related to discharge planning, communication with partner agencies at point of discharge and safe transfer into the community. The findings of the investigation are communicated to the department where the incident occurred for learning. They are informed that the issue is not being pursued through safeguarding, but any changes to practice will need to be adopted through their quality-of-care agenda.

2.2 There were **no** external investigations by Dorset County Council under Adult Safeguarding Procedures during 2023 - 2024.

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

2.4 There have been no Radicalisation referrals through the Prevent Programme in 2023 - 2024. Data has been submitted quarterly through the National NHS data collections portal.

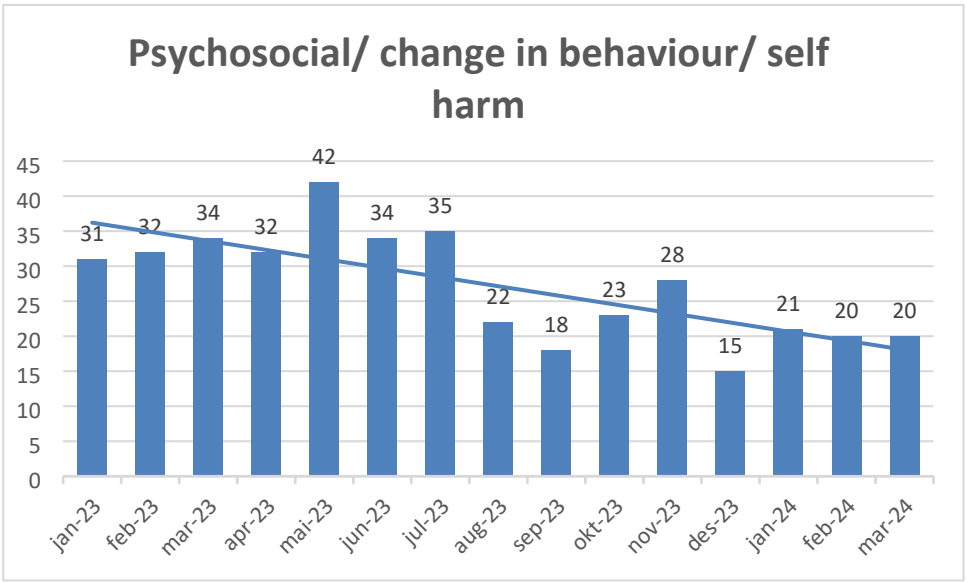
The Team attend BCPDSAB (Bournemouth, Poole, Christchurch, and Dorset Adult Safeguarding Board) quality assurance meetings and full Board meetings, where trends and themes of referrals are scrutinised. DCH are not core members of the Safeguarding Adults Review Group and will only attend by invitation.

3.0 CHILDREN'S SAFEGUARDING ACTIVITY

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

3.2 The Safeguarding Team continue to review the Emergency Department records for all 0 –17-year-olds - 8346 records were reviewed. The Team have been fully involved in the creation of the safeguarding module for the new digital system (AGYLE) in the Emergency Department. The live access has improved the documentation for the Safeguarding Team, although the Team still cannot review CPIS (National flagging information sharing service through AGYLE or DPR). This means that all CYP hospital number details are manually put in through PAS by the safeguarding practitioners reviewing the ED records.

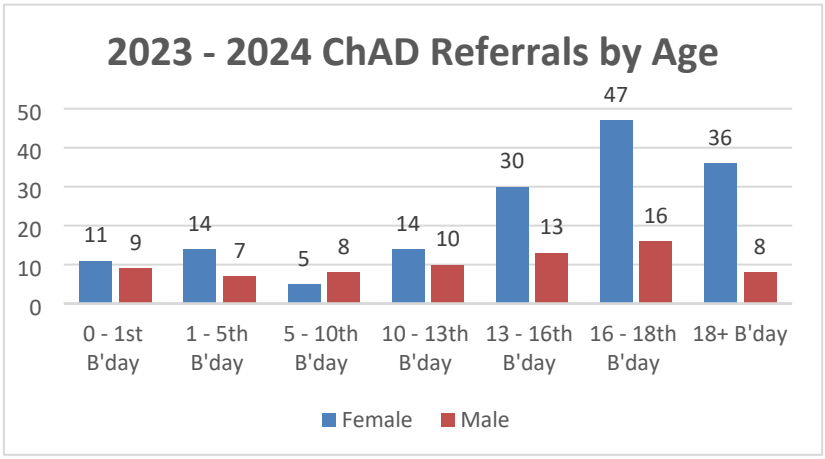
3.3 The Safeguarding Team in conjunction with Kingfisher Ward/Liaison Psychiatry/ED and Paediatricians review on a weekly basis any children that have a mental health diagnosis, presented with self-harm and/or a safeguarding concern or a frequent attender to ensure all documentation and processes have been completed. Themes are reviewed and escalated as applicable, learning shared in the departments. The below graph indicates the attendances for children with psychosocial coded reason for attendance.



3.4 The Safeguarding Team participate and attend a variety of external meetings as part of the Pan Dorset Safeguarding partnership, this includes Quality Assurance, extra-familial harm panel, extra familial harm tactical group policy and procedures and integrated front door group.

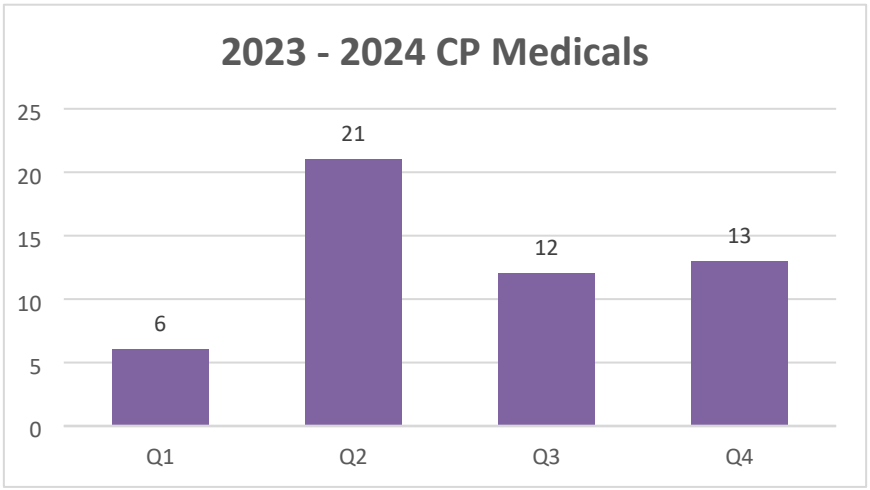
3.5 Children's and Advice Duty Service

ChAD is the Children's and Advice Duty Service Dorset Council, which is a 24-hour service/ priority line in Dorset, which offers advice to professionals requiring immediate responses for safeguarding children/young people and families.

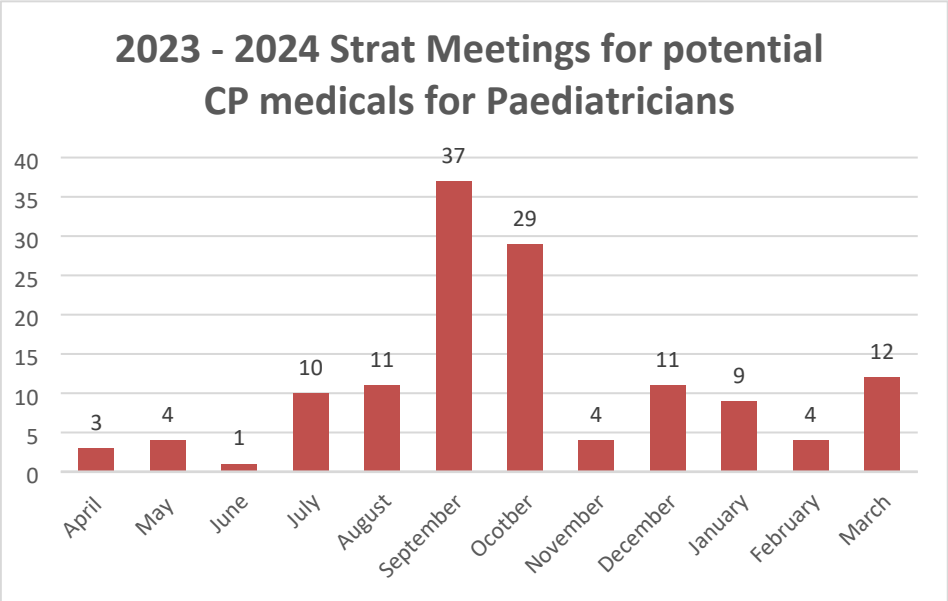


3.6 The above graph only indicates the referrals or contacts that the Safeguarding Team were aware of. There have been significant increases quarter on quarter of referrals for adults who have used our service who have children, demonstrating the effectiveness of our training around 'Think Family' approach.

Child Protection Medicals undertaken by Dorset County Hospital Paediatricians



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



4.0 MATERNITY

4.1 The Maternity Safeguarding Team have been somewhat depleted for the beginning of this year, firstly due to sickness, then to bereavement. We have managed to stay on top of essential work, but have fallen behind somewhat on completing Mum and Baby forms for Children's Social Care etc. We will be back to full capacity within the Team at the beginning of June, which should help to relieve some of the pressure.

4.2 Final tweaks are being undertaken to get the Standard Operating Procedure (SOP) completed for the Sharing Information Regarding Safeguarding (SIRS) project – it is the first SOP I have worked on and it has been a great benefit and learning opportunity to work with colleagues from different organisations in creating this piece of work. The SIRS project aims to gather safeguarding information from GPs, where partners of pregnant people are registered, to try and reduce the risk of harm from people who are not our patients.

A request was put into System C the company that designed and provide Badger Notes, to gather partners' GP addresses within Badger, June 2023. However, System C shared in April 2024, that they are not intending to implement this change, due to Maternity not gathering partners' NHS numbers. South West Safeguarding Midwives intend to challenge this.

4.3 Dorset has been chosen as one of three localities to be Wave 1 for the Government's Families First for Children (FFC) Pathfinder Programme. It has

proven somewhat challenging, trying to ensure that all relevant professionals that contribute to safeguarding children are considered within the planning. Dorset Locality is the only one of the three localities that has accepted the challenge of trying to make Child Protection Conferences more family friendly. The changes that have been implemented are difficult for Maternity to contribute to as shift workers, due to time constraints when completing the reports for Conference.

The push to reintroduce the Infant crying is normal; Comfort measures can help; Ok to leave baby safe and walk away for a bit. Never, ever shake your baby (ICON) Programme within the Trust has led Maternity to revisit the conversation within the Maternity Level 3 Safeguarding Training and posters placed in all rooms, highlighting the importance of never shaking a baby. All posters have a QR code to take families to the ICON.cope website for further information. Maternity intends to embed videos that share the ICON message onto our rolling screen once set up.

5.0 Multi Agency Working / Serious Case Review

5.1 The Trust has several legal duties and safeguards to uphold as part of its organisational governance and operational activities. The adult and children's Safeguarding Boards/Partnerships across Dorset ensure the Trust deliver their duties under Section 11 (Children's Act ,2004 and the Safeguarding Adult Assurance Frameworks (SAAF) as part of the requirements of the Care Act (2014).

5.2 The Trust is required to submit quarterly to the Children's Safeguarding Partnership and to the ICB who share adult assurance information to the Adults Safeguarding Board. Collaborative work continues with NHS Dorset and other health agencies as part of this work, bi-monthly meetings with the Heads of Safeguarding have matured to enable formulisation of joint quality improvement initiatives.

5.3 DCH have successfully delivered on their duties during 2023 - 2024 and there have not been any concerns raised regarding the overarching governance, processes, or practice at the Trust.

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

5.5 DCH have participated actively over the past 12 months, in domestic homicide reviews, Safeguarding Adults reviews, Child Safeguarding practice reviews, multi-agency /partnership audits, child death reviews and learning disability mortality reviews.
Learning actions are disseminated through the Safeguarding Committee, training programmes and formulate part of the safeguarding quality improvement programme.

5.6 During 2023-2024 the Heads of Safeguarding across the health system have met to review quality improvements collectively, areas reviewed have included

managing allegations, review of impact on drugs and alcohol referral services, planned review of all learning actions from serious case reviews that required health implementation of actions.

6.0 TRAINING

6.1 DCH services are expected to have a 90% compliance rate with most safeguarding programmes (Prevent is lower at 85%). Discussions have been had throughout the past 12 months at the Safeguarding Committee due to the drop in Level 1 compliance rates, it was agreed that mandatory training should formulate part of the annual review process. On a positive note, the Safeguarding Level 3 for children compliance is at its highest compliance rate at DCH in the past 7+ years. The training offer for MCA had to be refreshed part way through the year. There is now a very comprehensive package to aid compliance with the application of the Law.

Trust Wide Results.	**Quarter1 (average) scores includes all staff and volunteers**	**Quarter 2 (average) scores include all staff and volunteers.**	**Quarter 3 (average) scores include all staff and volunteers**	**Quarter 4 (average) scores include all staff and volunteers**
Adults				
SGA level 1 >90%	**89**	**89**	**89**	**88**
SGA level 2 >90%	**91**	**90**	**90**	**88**
MCA/ DoLS level 1 >90%	**91**	**91**	**90**	**89**
MCA/ DOLs level 2 >90%	**90**	**89**	**89**	**86**
BPAT	**92**	**90**	**91**	**90**
WRAP	**95**	**96**	**96**	**94**
Children				
Level 1 >90%	**85**	**86**	**91**	**86**
Level 2 >90%	**91**	**90**	**91**	**91**
Level 3 >90%	**81**	**80**	**79**	**84**
Level 4/5 Adults and CYP	**100**	**100**	**100**	**100**

7.0 SUPERVISION

7.1 Supervision sessions have been undertaken throughout 2023-2024. Supervision sessions are recorded/actions documented, although daily ad-hoc supervision is not, unless action is required.

Key themes noted through the past 12 months have been application of escalation processes disguised compliance, and neglect.

guidance
safeguarding supervis

8.0 MENTAL CAPACITY ACT

8.1 The LD and MCA Lead and wider Safeguarding Team have continued to provide advice and support to staff around the application of the MCA in practice. This includes ward-based coaching and support. The MCA training offer has been reviewed and updated utilising online modules from NHS England. There has been a drive to raise awareness of the MCA for 16- and 17-year-olds within Paediatric Services which includes an MCA element as part of the Level 3 safeguarding children's training.

9.0 DEPRIVATION OF LIBERTY SAFEGUARDS

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

9.2 There have been a total of 859 Deprivation of Liberty Safeguards (DoLs) applications in the reporting period; this is a significant increase from 812 in 2022-2023 and 741 in 2021- 2022.

10.0 DOMESTIC ABUSE

10.1 Domestic Abuse and Violence against Women final statutory guidance published July 2023 Domestic Abuse Bill. Throughout 2023-2024 Dorset County Hospital NHS Foundation Trust has had in post a Health Domestic Abuse Advocate, this partner agency commissioned post is due to end August 2024.

10.2 There has been a significant rise in contacts and referrals through to domestic violence pathways during 2023 - 2024. 134 enquires have been made in reference to domestic violence, 27 required escalations through as moderate or high-risk cases that required direct management through DV services or high-risk domestic abuse panel/police. Employee numbers seeking support have also increased through 2023 - 2024.

10.3 The Domestic Violence training programme has continued throughout the year, although disrupted through periods of industrial action and the DV Advocate being unable to undertake due to ill health.

11.0 LEARNING DISABILITY

11.1 DCH submitted data to the NHS I E Learning Disability Benchmarking exercise 2023 - 2024.

The report details the findings of the third NHS England NHS Improvement learning disability improvements standards collection. The standards focus on 5 areas:

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

There is a 3-pronged approach of organisational level, staff level and service user level data collection.

A benchmarking Action Plan has been developed and continues to be 'live'. This was shared within the Health Inequalities Group as well as the Mental Health and Learning Disability Steering Group.

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

11.3 The LD and MCA Lead has worked with the Business Intelligence Team to look at Primary Care Data and PAS data for those with a learning disability and autism. The Business Intelligence Team have created a learning disability and autism dashboard. The dashboard covers:

Emergency Department presentations
High Intensity Users (10 or more ED visits in last 12 months)
Admissions and emergency re-admissions (within 30 days)
Outpatient appointments
Patient deaths
No patients identified as having learning disability and / or autism

11.4 Oliver McGowan Mandatory Training for learning disabilities and autism

The Health and Care Act 2022 made it a statutory requirement from 1 July 2022 for all Health and Care staff to receive training on learning disability and autism appropriate to their role. The Oliver McGowan Mandatory Training on Learning Disability and Autism is the Government's only preferred and recommended training. It is not just a statutory requirement for staff working in learning

disability and autism services, it is for all staff working in CQC regulated services in Health and Care.

11.5 Within the Dorset system there is a Steering Group responsible for the implementation of the training. There are several elements to the training which require significant planning and resourcing. We are now pleased that the second face to face element is being rolled out across the system.

12.0 PREVENT

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

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

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

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

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

13.0 SAFEGUARDING INCIDENTS INVOLVING STAFF

13.1 Over the past 12 months the Safeguarding Team have worked in conjunction with Human Resources, LADO (Dorset Council Local Authority Designated Officer) and Adult Safeguarding Dorset Council when safeguarding concerns have been raised concerning DCH employees. Appropriate actions, escalation to police where applicable and referrals through to support services to ensure the wellbeing of the employee throughout the process have been enacted.

14.0 AUDIT

14.1 In terms of MCA audits, an audit into the completion of the restrictive interventions and deprivation of liberty care plan was completed in Q4.

14.2 PAN Dorset Safeguarding Children's Partnership (Dorset) & BCPDSAB audit programme contributions made throughout 2023 - 2024.

14.3 Consent audit for CYP, quarterly reports completion 2024.

14.4 Royal College of Paediatrics National Audit of Child Protection Medical Process.

14.5 NHS Dorset managing allegations rolling audit.

14.6 6 monthly Safeguarding assurance audit

15.0 OTHER ACTIVITIES

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

Both intranet sites for Safeguarding have been updated and refreshed.

Six monthly Safeguarding Newsletters shared with all employees at DCH.

Improvements to recording Safeguarding within the DPR system.

Review updates made to the processes within child protection medicals.

Development work with DCH Business Support Teams to support health inequalities initiatives, these have included reminder e-mails to Social Care Teams regarding outpatient appointments for CYP that we are aware are subject to Child Protection Plans.

Four virtual tour films recorded awaiting final editing for sharing at Trust Board Summer 2024.

Collaboration with Budmouth 6th form , to develop apps for CYP.

Updated child protection proforma in preparation for digitalised version .

Refreshed Integrated liaison meeting criteria and purpose.

Delivered bespoke training for internationally recruited employees .

Collaborative working with Dorset Council Safeguarding teams working on transitional safeguarding .

Submitted a learning review request to Pan Dorset Safeguarding Partnership , that has been accepted , key area of concerns , neglect , poor multi agency oversight and disguised compliance .

Supported and attended workshops for the Flagship Programme for DCH / DHC for CYP

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

References

1. Care Act 2014

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

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

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

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

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

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

NHS
Dorset County Hospital
NHS Foundation Trust

Safeguarding Quality Improvement Programme

April 2024 to March 2025

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

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

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

What is Safeguarding?

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

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

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

Core Legislation and Legal Frameworks Underpinning Safeguarding

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

Introduction

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

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

Key Objectives

Objective 1 – Safeguarding patients that we care for:

We will do this by:

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

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

We will do this by:

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

Issue	Desired Outcome	Actions	Evidence/ Assurance	Lead/ responsibility	Target Date	Update	Rag
Inadequate documentation of mental capacity, under-utilisation of care plans (RI/ DoLs care plan)	Improved patient centred care planning. Clear evidence of consideration the service user's ability to consent to their care and treatment.	For ward teams to implement Restrictive interventions care plans for those people using our service that require them as per MCA and DoLs guidance.	Audit Q4 (RI/ DoLs Care Plan)	Ward Leads/ Matrons ref: ensuring care plans in place. LD/ MCA Lead (audit)	~~Feb 2024~~ Agreed Revised Date for completion Oct 2024	**Face to face training:** Preceptorship MCA/ DoLs F1 MCA **MCA/ DoLs Mandatory training** offer reviewed and put forward to Education Team/ now in place. **Practice Educator Forum.** Linking in February to discuss MCA/ Dols **Explore digital** options- MCA/ DoLs tab on DPR. ? Digital care planning --- *Brought through with agreement to 2024-2025 plan as digital options not currently sourced/ care plan work still being completed. New training package implemented for MCA*	
Improve the recognition of potential contextual risk for CYP	All CYP that attend with criteria for CE risk review have completed a CERAT, exploration of how life looks for them, their worries and	CE risk assessment checked through ED records, through Integrated Liaison Meeting. Risks identified by partners	Integrated Liaison Meeting Dip check of Emergency Department and Paediatric notes for HEADSS assessment/ Child exploitation	ED/Paeds Matron Safeguarding Team	Sept 2024	PDSCP extra familial harm strategy (Dorset) still not published, DCH policy will need to be re-written to mirror the change from exploitation risk. --- CARRY FORWARD TO	

	concerns documented and escalated as required. Actions Links to CSPR `EDIE` May 2024  FINAL-LCSPR-Edie-v2-23.04.2024.pdf	shared with departments. Serious Violence Duty work to be progressed with digital process for capturing this metric.	risk assessment. Evidence of professional curiosity. Clear documentation within clinical notes/digital records of the voice of the child, their worries and concerns. .			2024-2025 / Links to CSPR `EDIE`	
Improve the IT systems to ensure they accurately record family/ carers details. Alerts for CPIS.	That all CPIS alerts can be viewed through DPR That staff can add key contacts to individual's digital care records to reduce non-attendance/ was not brought	Nil progress for CPIS PAS system waiting to be switched to allow more than one contact, however, this is still not viewable		IT SYSTEMS Digital Transformation Team	No dates offered .	Nil updates on progression of PAS system No updates received, escalation through Quality Committee and remains on the risk register	
Improve the recognition of hidden vulnerabilities. Protected characteristics (Childhood trauma, acquired brain injuries, limited mobility, addiction & deprivation) that may increase	Review needs-based assessments with a whole person approach – links to 2nd National Review of Safeguarding Adult reviews due publication June 24.	Understand barriers to effective multi-agency practice to prevent harm or respond effectively where there are safeguarding risks;		Discharge teams. Ward discharge coordinator Addiction services IT systems to aid recording of protected characteristics .	Jan 2025		

needs for adult safeguarding response.	https://www.local.gov.uk/our-support/partners-care-and-health/safeguarding-resources/analysis-safeguarding-adult-reviews-0						
Improve on quality markers for child protection medicals as per RCPCH guidance	Improve experience and outcomes for children attending DCH for child protection medicals. CP Medicals, Dorset County Hospital - Auc Feedback%20from%20RCPCH.docx	Audit results collated. Review guidance on chaperones / training for nursing team. Review of way information is shared with family (language leaflets / QR etc	Re -audit Oct 2024	Dr Will Verling Paedatrics Matron for Paedatrics Safeguarding team	Oct 2024		
Improvements to digital recording of safeguarding advice	Alignment of levels of harm from health perspective	Exploration of potential to undertake collaboration with DHC to review advice recordings templates		Safeguarding teams DHC/ DCH	Jan 2025		

Report Front Sheet

1. Report Details			
Meeting Title:	Board of Directors, Part 1		
Date of Meeting:	31 July 2024		
Document Title:	**Infection Prevention & Control Annual Report 2023-2024**		
Responsible Director:	Jo Howarth, Director of Nursing (Acute Care), Director Infection Prevention & Control	Date of Executive Approval	07/06/2024
Author:	Emma Karamadoukis, Infection Prevention & Control Lead Specialist nurse.		
Confidentiality:	No		
Publishable under FOI?	Yes		
Predetermined Report Format?	No		

2. Prior Discussion		
Job Title or Meeting Title	**Date**	**Recommendations/Comments**
Quality Committee	18/06/2024	Noted

3. Purpose of the Paper	**Infection Prevention & Control Annual Report 2023-2024**							
	Note (✓)	✓	*Discuss (✓)*	✓	*Recommend (✓)*		*Approve (✓)*	
4. Key Issues	As part of the assurance required for Trust Board an annual Infection Prevention and Control report is required. This meets the national requirements set via NICE, NHSE. The Board of Directors is asked to accept the report from Quality Committee (18 June 2024). For noting: • The Trust met the trajectories set for MRSA bacteraemia, and following Root Cause Analysis or the new IPC Patient Safety Incident Response Framework process for *Clostridium difficile* infections and was below Gram-negative Pseudomonas blood stream infection (BSI) trajectories, for 2023-2024. Noting a reduction in cases from last year of Clostridiodes Difficile infection. • We have implemented the IPC Patient safety Incident Response Framework (PSIRF). • The Trust continued to develop and adjust our response to the local and national requirements for COVID-19, as we continued to move away from pandemic to endemic guidance 'living with COVID-19' plan set out by the government. • The trust was over the recommend trajectory for total gram –ve BSI but much improved numbers compared to the 2021-2022 figures.							

	• No covid outbreaks for 2023-2024. • All the IPC audit results have shown an improved yearly audit compliance percentage. • Hand hygiene compliance has remained high and sustained at 97.8%. • The trust continued to meet mandatory requirements for Surgical site surveillance for Fractured hip, small and large bowel elective surgery and elective knee replacement. • The Sterile Services department continues to maintain a full Quality Management System and maintain certification to BS EN ISO 13485:2016. The department is also registered with the Medicines and Healthcare products Regulatory Agency (MHRA). • Face to face IPC education and training has continued, combined with an updated IPC e-learning programme. We have regularly increased our face-to-face training within specific departments, especially when a requirement has been deemed necessary. We have maintained very good compliance with IPC mandatory training. • Enhanced water monitoring continued to mitigate risk of pseudomonas and legionella in tap water in high-risk areas.
5. Action recommended	The Board of Directors is recommended to: 1. **NOTE** the report. 2. **RECEIVE** assurance on actions to address any performance issues.

6. Governance and Compliance Obligations				
Legal / Regulatory Link		**Yes**		Inability to achieve progress or sustain set standards could lead to a negative reputational impact and inability to improve patient safety, effectiveness, and experience.
Impact on CQC Standards		**Yes**		As this report incorporates standards outlined by the CQC it is important to note progress or exceptions to these standards.
Risk Link		**Yes**		Links to IPC Board Assurance Framework
Impact on Social Value			**No**	
Trust Strategy Link		**How does this report link to the Trust's Strategic Objectives?** *Please summarise how your report will impact one (or multiple) of the Trust's Strategic Objectives (positive or negative impact). Please include a summary of key measurable benefits or key performance indicators (KPIs) which demonstrate the impact.*		
Strategic Objectives	People	Credibility of the trust and linked to IPC Board Assurance Framework.		
	Place	Serving the population of Dorset.		
	Partnership	Collaborative system working to achieve high standards of care.		
Dorset Integrated Care System (ICS) goals		**Which Dorset ICS goals does this report link to / support?** *Please summarise how your report contributes to the Dorset ICS key goals.* *(Please delete as appropriate)*		
Improving population health and healthcare		**Yes**		Collaborative working with the Integrated Care System IPC team and post infection monthly review process to identify learning.

Tackling unequal outcomes and access		**No**	
Enhancing productivity and value for money		**No**	
Helping the NHS to support broader social and economic development		**No**	
Assessments	**Have these assessments been completed?** *If yes, please include the assessment in the appendix to the report.* *If no, please state the reason in the comment box below.* *(Please delete as appropriate)*		
Equality Impact Assessment (EIA)		**No**	
Quality Impact Assessment (QIA)		**No**	

2023/2024 Infection Prevention & Control Annual Report

Contents

Abbreviations

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

EXECTIVE SUMMARY

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

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

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

The yearly IPC Optimisation plan, led and supported by the Infection Prevention and Control lead specialist nurse and Infection Prevention and Control Team (IPCT), sets clear IPC objectives for the organisation to achieve with strategies in place to meet the overall Trust strategic mission: “Outstanding care for people in ways which matter to them”. The IPC optimisation plan is developed closely with the completion of the new National Infection Prevention and Control Board Assurance Framework, which was launched in March 2023.

Overall, 2023- 2024 was another successful year, meeting key standards and regulatory requirements for infection prevention and control. Below documents a highlight for the IPC year: -

- The Trust met the trajectories set for MRSA bacteraemia, and following Root Cause Analysis reviews or the new IPC Patient Safety Incident Response Framework process for *Clostridium difficile* infections and Gram-Negative Pseudomonas blood stream infections Organisms, for 2023-2024.
- We have implemented the IPC Patient safety Incident Response Framework (PSIRF).
- The Trust continued to develop and adjust our response to the local and national requirements for COVID-19, as we continued to move away from pandemic to endemic guidance ‘living with COVID-19’ plan set out by the government.
- Trust Hand hygiene compliance has remained high and sustained at 97.8%.
- The trust continued to meet mandatory requirements for Surgical Site Surveillance (SSI) for Fractured hip, small and large bowel elective surgery and elective knee replacement.
- The Sterile Services department continues to maintain a full Quality Management System and maintain certification to BS EN ISO 13485:2016.

The department is also registered with the Medicines and Healthcare products Regulatory Agency (MHRA).

- Face to face IPC education and training has continued, combined with an updated IPC e-learning programme. We have regularly increased our face-to-face training within specific departments, especially when a requirement has been deemed necessary. We have maintained very good compliance with IPC mandatory training.
- Enhanced water monitoring continued to mitigate risk of pseudomonas and legionella in tap water in high-risk areas.

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

INTRODUCTION

The Director for Infection Prevention and Control (DIPC) annual report summarises the work undertaken in the Trust for the period 1st April 2023– 31st March 2024. The Annual Report provides information on the Trust's progress on the strategic arrangements in place to reduce the incidence of Healthcare Associated Infections (HCAI's). The purpose of the report is to provide assurance that the trust remains compliant with the Health and Social Care Act (2008) – Code of Practice on the Prevention and Control of infections and related guidance Department of Health, 2015). The code sets out 10 criterion which are listed in the contents and the report uses these criterions as a guide to provide evidence and assurance.

The Trust met the target for zero cases of preventable MRSA bacteraemia. The Trust identified 12 trajectory cases of *Clostridium difficile* against a target of 45 cases (53 total cases), a reduction from last year and was slightly over trajectory for the total gram-negative organisms. The Infection Prevention and Control Team have seen system and partnership working key to supporting the health and safety of the population. We have ensured continued collaborative working, sharing good practice, offering support where able and championing the benefits of digital support in the management of infection prevention and control.

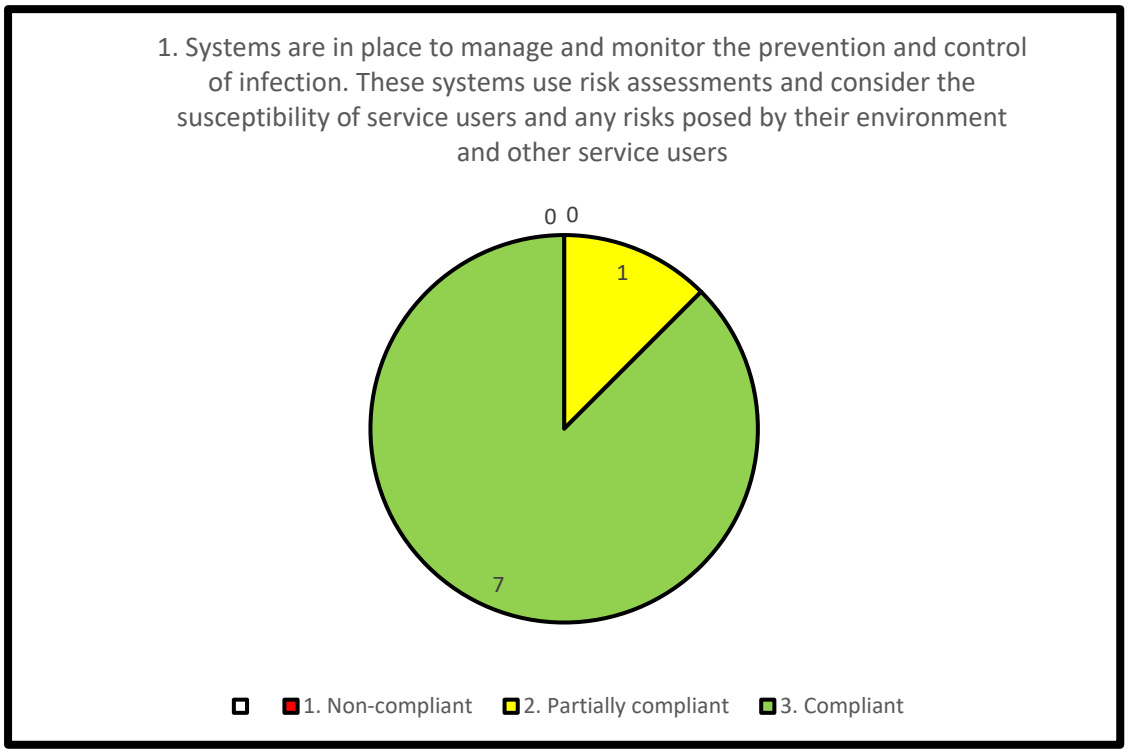
These lower rates of infection have been achieved by the continuous engagement of the Trust Board and most importantly the efforts of all levels of staff. The commitment to deliver safe, quality care for patients remains pivotal in the goal to reduce HCAI's to an absolute minimum of non-preventable cases.

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

The Health and Social Care Act 2008: code of practice on the practice on the prevention and control of infections and related guidance sets out ten compliance criteria. This IPC Annual Report is divided into these ten-compliance criterion which follow below individually, demonstrating the trust compliance and evidenced assurance in meeting the ten criterions. The IPC lead has completed the new IPC Board Assurance Framework, which was issued in March 2023 by NHS England, which enables organisations to respond an evidenced-based approach to maintain the safety of patients, service users, staff, and others. It enables, supports, and provides an assurance structure for boards against which the system can effectively self-assess compliance with the measures set out in the National IPC Manual and the Health and Social Care act 2008. The IPC yearly IPC optimisation plan within Appendix A, links closely with the IPC Board Assurance Framework setting out a clear IPC workplan.

The framework enables clear compliance rating pie charts which are evident within this report below each criterion, reduced compliance links with the IPC Optimisation Plan – APPENDIX ONE.

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



Partially compliant 1.7: All staff receive the required training commensurate with their duties to minimise the risks of infection transmission. Tier three of the IPC education framework not rolled out following national guidance but mitigated by all staff receiving yearly IPC mandatory training. The IPC team plan to implement separate face to face training to cover this tier.

INFECTION PREVENTION & CONTROL GROUP (IPCG)

The IPCG met 6 times during 2023- 2024. It is a requirement of *The Health and Social Care Act 2008 Code of Practice on the prevention and control of infections,* that all registered providers: "*have in place an agreement within the organisation that outlines its collective responsibility for keeping to a minimum the risks of infection and the general means by which it will prevent and control such risks".*

The IPC Committee (IPCC) meeting was chaired by the Interim Chief Nursing Officer, Jo Howarth, who is also the Director of Infection Prevention and Control (DIPC), with the responsibility for reporting to the sub-board Quality Committee for assurance.

DIPC REPORTS TO QUALITY COMMITTEE

The DIPC has presented the following items during 2023-2024:

- Monthly Gram-negative Bacteraemia surveillance.
- Monthly *Clostridium difficile* surveillance.
- Monthly hand hygiene rates.
- Monthly IPC audit results
- Outbreak and incident reports.
- IPC Escalation reports following bi-monthly IPC committee meetings.

INFECTION PREVENTION & CONTROL TEAM

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

- Jo Howarth, Chief Nursing Officer / Director of Infection Prevention and Control
- Emma Hoyle, Associate Director Infection Prevention and Control/Deputy Chief Nursing Officer
- Dr Amy Bond, Infection Control Doctor Consultant Microbiologist
- Dr Cathy Jeppesen, Antimicrobial Stewardship (AMS) Doctor and Consultant Microbiologist
- Dr Lucy Cottle, Consultant Microbiologists lead
- Dr Mary Varghese, Consultant Microbiologist
- Emma Karamadoukis, IPC Lead Specialist Nurse
- Christopher Gover, IPC Specialist Nurse
- Abigail Warne, IPC Specialist Nurse
- Julie Park, IPC Specialist Nurse
- Helen Hindley, IPC Nurse
- Sophie Lloyd, IPC Nurse
- Cheryl Heard, Senior Administrator & Fit Mask Co-ordinator
- Rhian Pearce, Antimicrobial Pharmacist (left the trust January 2024)

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

IPC Implementation of Patient Safety Incident Response Framework (PSIRF)

We have changed the way we are reviewing our infections, in line with Patient Safety Incident Response Framework (PSIRF). The PSIRF sets out the NHS approach to developing and maintaining effective systems and processes for responding to patient safety incidents for the purpose of learning and improving patient safety.

Patient safety incidents are unintended or unexpected events (including omissions) in healthcare that could have or did harm one or more patients. PSIRF promotes a proportionate approach to responding to patient safety incidents by ensuring resources allocated to learning are balanced with those needed to deliver improvement.

PSRIF

• Advocates a co-ordinated and data-driven approach to patient safety incident response that prioritises compassionate engagement with those affected by patient safety incidents

• Embeds patient safety incident response within a wider system of improvement and prompts a significant cultural shift towards systematic patient safety management.

The Infection Prevention and Control team launched the implementation of PSIRF on the 1st of January 2024, and we commenced reviewing our Healthcare Associated Infections (HCAI) differently, working within the framework to identify learning, recurrent themes and improve patient safety. The Root Cause Analysis (RCA) process ceased, and the below organisms are included in our internal PSIRF Programme; Clostridiodes Difficile - (HOHA Hospital Onset Healthcare Associated, COHA Community Onset Healthcare Associated), Gram-negative bloodstream infection – (klebsiella spp., pseudomonas aeruginosa, E. coli – HOHA cases), MSSA and MRSA

bloodstream infections (HOHA cases). We now hold monthly 'learning together' MDT (Multi-Disciplinary Team) meetings to discuss each case that has identified learning following the IPCT/Consultant microbiology after action review. As an IPC ICS (integrated Care system), we also commenced reviewing cases using the PSRIF ideology during our system wide post infection review meetings and cases that trigger an in-depth system wide case review, having triggered a PSII (Patient Safety Incident Investigation) will have an in-depth case review by all healthcare services involved. Quality Improvement projects are then driven following the identified learning and thematic reviews. Escalating concerns via IPCC, PLACE based partnership meetings and South West regional meetings.

HEALTHCARE ASSOCIATED INFECTIONS

This year NHS England updated the trajectories figures for C*lostridium Difficile* and Gram-negative blood stream infections. The Gram-negative organisms are *Escherichia coli (E. coli), Pseudomonas aeruginosa (P. aeruginosa)* and *Klebsiella* species (*Klebsiella spp.).* The definition of a case are agreed as follows:

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

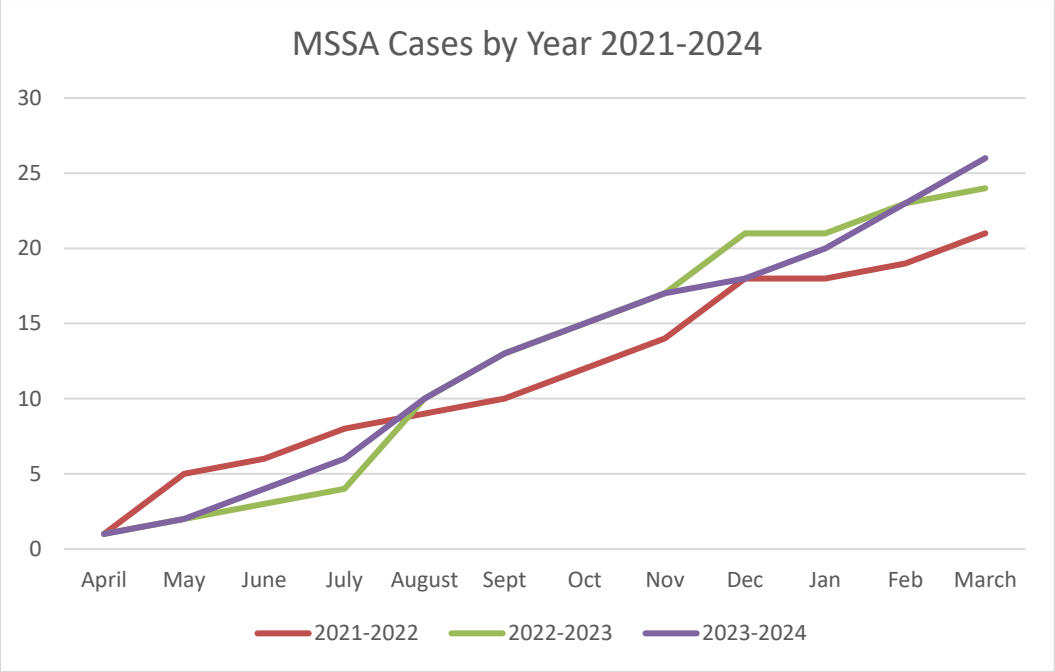
For the purposes of agreed trajectories HOHA and COHA are now combined in reporting.

METICILLIN RESISTANT *STAPHYLOCOCCUS AUREUS* (MRSA)BACTERAEMIA

There were no preventable cases of MRSA bacteraemia in 2023-2024 assigned to the Trust. The last case of preventable MRSA bacteraemia assigned to the Trust was July 2013. This provides confidence that the IPC practices in place have been sustained. In 2023-2024 the trust had 3 MRSA Bacteraemia cases in total.

STAPHYLOCOCCUS AUREUS BACTERAEMIA (MSSA)

In 2023-2024 there were a total of 26 cases of MSSA bacteraemia (HOHA and COHA), 19 HOHA cases, a reduction from the previous year of 21 HOHA cases, identified >48 hours after admission. No national trajectories have been set for these organisms. At DCHFT this demonstrates stability in cases over the last three year and a reduction in HOHA cases.



To manage MSSA blood stream infections we have implemented control measures that include, screening for certain high-risk patient groups, decolonisation of high-risk patients prior to procedures and close monitoring of indwelling devices via audit. All Hospital Onset Healthcare Associated MSSA infections have had a full Root Cause analysis review or the new PSIRF review, with the results and learning feedback to IPCC and senior leaders within the trust, quality improvement projects are then driven following these conclusions.
The IPCT have led on a deep dive review within the renal service of MSSA bacteraemia's with the aim to align policy with practices and ensure high standards of evidenced based practice. We have also reviewed and improved our elective orthopaedic screening and decolonisation treatment.

GRAM NEGATIVE BLOOD STREAM INFECTIONS

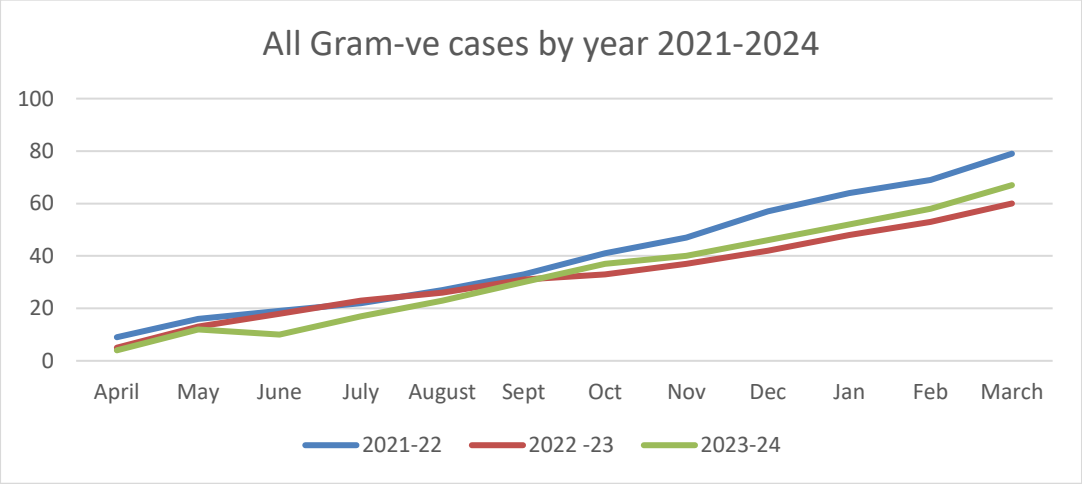
Gram-negative blood stream infections (BSIs) are a healthcare safety issue. From April 2017 there has been NHS ambition to halve the numbers of healthcare associated Gram–negative BSIs by 25% March 2021 (PHE 2017) and 50% March 2024 (PHE 2019). In February 2019 it was announced that the date for achieving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

Mandatory data collection has been in place for many years for E. coli. In addition, from April 2017 additional mandatory data collection and surveillance has been in place for Klebsiella app. and Pseudomonas aeruginosa. 2023-2024 formal trajectories for gram-negative blood stream infections were set by NHSE/I at 62 cases (39 Escherichia coli 9 Pseudomonas aeruginosa and 14 Klebsiella sps). Noting this trajectory is for HOHA and COHA combined. All cases of Gram-negative BSI HOHA cases are reviewed by the Infection Prevention & Control Team using the PSIRF process.

In 2023-2024 there were a total of 46 positive BSI samples for E. coli which were attributed to the Trust – HOHA & COHA. Noting a slight increase from 2022-2023 data but improvement from 2021-2022 data. A full data collection process is carried out in accordance with UKHSA guidance; this includes all mandatory and optional data.

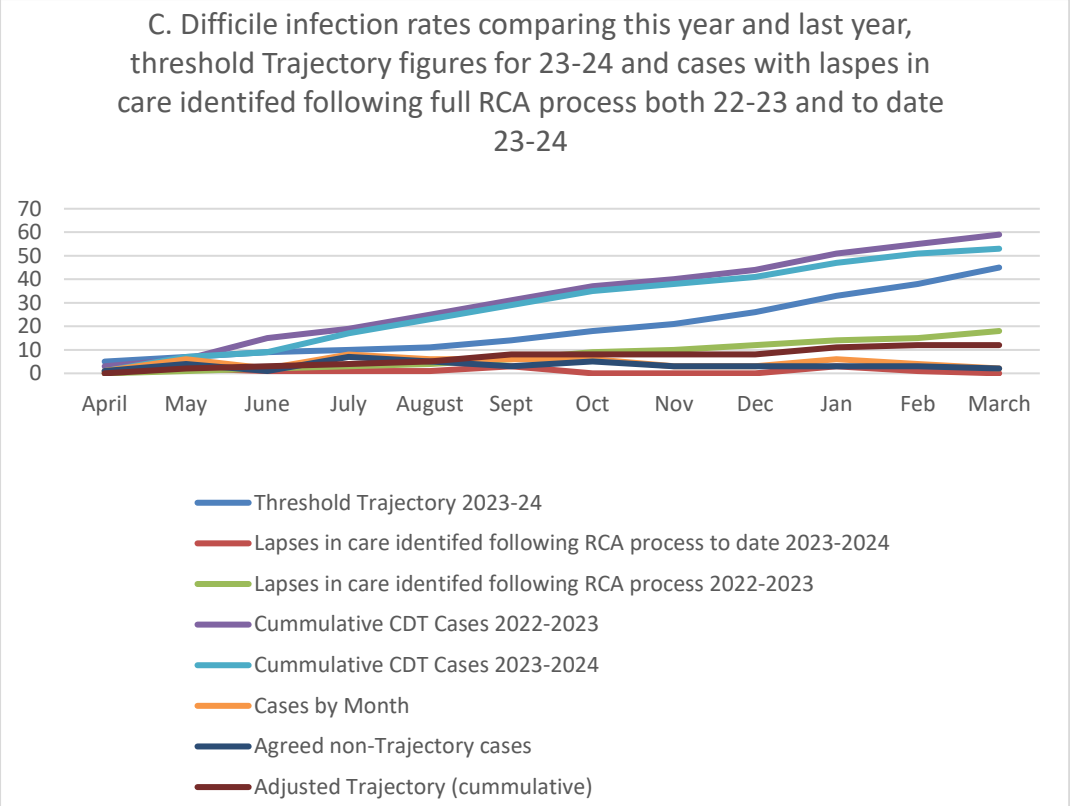
In 2023-2024 there were a total of 16 positive BSI samples for Klebsiella, which were attributed to the Trust – HOHA & COHA. Noting a slight increase from 2022-2023 data but improvement from 2021-2022 data. A full data collection process is carried out in accordance with UKHSA guidance; this includes all mandatory and optional data.

In 2022-2023 there were a total of 5 positive BSI samples for Pseudomonas aeruginosa, which were attributed to the Trust – HOHA & COHA. Noting an improved reduction in cases over the last three years. A full data collection process is carried out in accordance with UKHSA guidance; this includes all mandatory and optional data.



CLOSTRIDIOIDES DIFFICILE INFECTION (CDI)

In 2023-2024 Clostridioides Difficile infection formal trajectories for were set by NHSE/I at 45. In total the Trust reported 53 cases detected HOHA/COHA; of these cases 12 were identified as preventable with lapses in care; and learning implemented trust wide. This data represents a reduction in cases from last year, with regards to both the number of cases and the cases which identified learning.



All cases CDI HOHA and COHA cases have a PSIRF investigation, pre-January 2024 a Root Cause Analysis investigation. The results following these investigations are escalated to IPCC and are presented Jo Howarth (Interim Chief Nursing Officer/Director of Infection Prevention and Control) and Emma Hoyle (Deputy Chief Nursing Officer/Associate Director of Infection Prevention and control) and any relevant learning from the cases is escalated via the correct governance processes and will also help trigger wider quality improvement projects. The learning actions when completed are then presented and signed off by the Divisional Matrons at the IPCC. The IPCT and consultant microbiologists have continued a CDI Deep dive review of all the CDI cases, looking for trends, areas of improvement and emerging themes. The IPCT have also completed an extensive collaborative data collection on all Potential CDI and CDI cases. NHS England are continuing to review this data, which also includes all Dorset anonymised case information. The IPCT have rolled out the use of Peracetic Wipes across the trust, which are to be only used for commode and equipment cleaning within side rooms for patients with known CDI, with the aim to support environmental cleaning for CDI.

OUTBREAKS OF INFECTION

NOROVIRUS

There have been four outbreaks of Norovirus in the reporting year 2023-2024. This is against the backdrop of a large incidence of norovirus within the community across the country. All declared outbreaks follow our trust procedural policy and the IPC lead always carries out a de-brief meeting afterwards, with the senior ward leadership team and escalates learning via IPCC.

INFLUENZA/RESPIRATORY SYNCYTIAL VIRUS (RSV)

During winter of 2023-2024 winter cases of Influenza A, B & RSV remained steady in comparison to the previous year. The identification of these cases at point of admission into DCHFT has been greatly assisted by point of care testing available in our emergency department and paediatric unit, which has enabled prompt isolation of patients attending for emergency care and subsequent admission and therefore reducing transmission in hospital and the occurrence of outbreaks.
In preparation for 'seasonal flu' all Trust staff were offered the annual flu vaccine.

CLINICAL AUDIT

SURGICAL SITE SURVEILLANCE

Surgical site infections (SSIs) are defined to a standard set of clinical criteria for infections that affect the superficial tissues (skin and subcutaneous layer) of the incision and those that affected the deeper tissues (deep incisional or organ space).

Preventing surgical site infections is an important component of Infection Prevention and Control programmes. There is a Mandatory requirement by the Department of Health for all Trusts' undertaking orthopaedic surgical procedures to undertake a minimum of three months' surveillance in each financial year.

SSI for all surgery involves 3 stages of surveillance:
Stage 1- collection of data relating to the surgical procedure and inpatient stay.
Stage 2 (not mandatory) collection of post discharge surveillance at 30 days post procedure.
Stage 3- review of patients readmitted within 365 with SSI.

During 2023-2024 the IPC team have supported 3 modules for surveillance. The IPCT can facilitate a less time-consuming model of data collection utilising the IPC data tool ICNet. The system facilitates readmission alerts, and data upload from PAS, theatre and microbiology systems and the ability to directly upload the data to PHE SSI site.

The audits completed for 2023/2024; October 2022 - June 2023 Elective small and large bowel surgery, this was carried out pre implementation of a consultant surgeon Quality Improvement project for evidenced baseline data. Jan 2024 – March 2024 Fractured neck of femur and January 2024 – March 2024 Elective Orthopaedic Knee Surgery. All showing a low incidence of surgical site infection rates.

PERIPHERAL VENOUS CANNULA (PVC) AUDIT

PVCs are devices commonly used in acute hospitals, for the administration of intravenous fluids and medication. Failure to monitor these devices correctly can result in early signs of infection being missed with the potential for serious infections to develop. The evidence presented in the national guidance suggests a move away from routine PVC replacement to regular review and early removal if signs of infection are evident or when the PVC is no longer required. Regular monthly auditing to check that all PVC's are having visual infusion phlebitis (VIP) score checks completed, has continued this year and remains ongoing. The annual average compliance for this year's audit was 92% up from the last two years, 91% for 2023 and 79% for 2022 last year. The IPCT has also introduced monthly Central Venous Catheter audits showing 88.5% compliance for 2023-2024.

COMPLIANCE WITH URINARY CATHETER POLICY

Over the past year the following audit has been carried out monthly in relation to Urinary Catheter Care - Indwelling Urinary Catheter Recording on Vital Pac. Insertion of a urinary catheter is known to be a significant risk factor in the development of urinary tract infections and the risk increases with the duration of catheter insertion. It is therefore important to ensure there is a comprehensive process in place to ensure that the risk of urinary tract infection is considered prior to insertion of the urinary catheter and there is a continuous process for review.

Compliance was measured against the requirement to accurately document indwelling urinary catheter insertion on Vital Pac, the audit results are excellent with an overall trust compliance of 94% of all catheters being recorded. When split between the Divisions, Family and Surgery returned 94% compliance and Urgent and Integrated Care 93% compliance. Noting a slight improvement from the data of 2022-2023. These percentages are an average.

CARBAPENEMASE PRODUCING ENTEROBACTERIACEAE AUDIT (CPE)

Carbapenem antibiotics are a powerful group of β-lactam (penicillin-like) antibiotics used in hospitals. Until now, they have been the antibiotics that doctors could always rely upon (when other antibiotics failed) to treat infections caused by Gram-negative bacteria.

In the UK we have seen a rapid increase in the incidence of infection and colonisation by multi-drug resistant Carbapenemase-producing organisms. A number of clusters and outbreaks have been reported in England during 2023 - 2024, some of which have been contained, providing evidence that, when the appropriate control measures are implemented, these clusters and outbreaks can be managed effectively.

UK Health Security Agency (UKHSA) recommends that as part of the routine admission procedure, all patients should be assessed on admission for Carbapenemase-producing Enterobacteriaceae status. UKHSA advice was updated in December 2019, and we have a dedicated policy for CPE, and it remains that all patients admitted to the Trust must have a screening risk assessment carried out on admission.

DCHFT carried out a CPE quarterly audit, between April 2023 and March 2024, which aims to determine the level of compliance across the trust with the screening assessment being conducted on admission and the correct actions taken if screening is required.

Results show that the overall compliance with undertaking the admission screening risk assessment was 89%. This has increased by 8% on the previous year's 81% result and also demonstrates a year-on-year improvement. To demonstrate continued adherence to CPE guidance and Trust policy this audit will be repeated quarterly for 2024-2025.

CANDIDA AURIS SCREENING

Following an outbreak of candida Auris within the region, and new guidance published from the UK Health Security Agency (currently remaining in draft form) the IPCT reviewed our own internal screening and policy guidance against national

recommendations mid-2023, and we have updated the local trust policy. To support the updated guidance, we have improved our own testing availability via our microbiology laboratory and developed a robust screening risk assessment, which now sits alongside our CPE screening triggers. Therefore, the CPE audit noted above also demonstrates our compliance with the trust Candida Auris screening policy for the last two quarters.

COVID-19

NHS England and UKHSA guidance has continued to be reviewed and updated over 2023-2024. Ensuring patient and staff safety remains at the forefront of providing healthcare services. The trust response continues to be led by the IPC lead and IPCT, and the trust follows the recommended national guidance.

Over the past 4 years the IPCT have continued to support the trust throughout the pandemic with updates to guidance in line with Public Health England/UKHSA. The IPCT have also continued to work closely with the Dorset wide ICS to share best practice and learn from other trusts in the Southwest region and beyond.

We have declared no Covid-19 outbreaks between April 2023 and March 2024. This is excellent comparing outbreak figures for other inpatient setting in the Southwest region, especially considering the extremely transmissible nature of Covid-19 and increased prevalence in the community. The identification of the symptomatic cases at point of admission into DCHFT has been greatly assisted by point of care testing available in our emergency department and paediatric unit, which has enabled prompt isolation of patients attending for emergency care and subsequent admission and therefore reducing transmission in hospital and the occurrence of outbreaks.

Covid-19 testing and monitoring and reporting continues to be carried out daily by the IPCT and prompt de-escalation of cases with support from the medical teams, supports our trust isolation capacity.

INFECTION PREVENTION & CONTROL WEEK - OCTOBER 2023

To celebrate 'International Infection Prevention and Control week' on the 16th – 20th October 2023. The IPCT requested wards to produce a poster presentation with an IPC theme **'What are the 'little' things you do that make a 'big' difference'.**

The overall aim is to improve staff knowledge and increase awareness on any IPC practice, we also provided a busy week's agenda, which included daily IPC clinics, rep visits, staff training, IPC quiz and general fun IPC activities. Many wards within the trust produced beautiful poster displays encompassing many different topic areas and the judging was carried out by the IPCT and A Hutchison (Chief Medical Director). Prizes were awarded to the top three wards that entered.

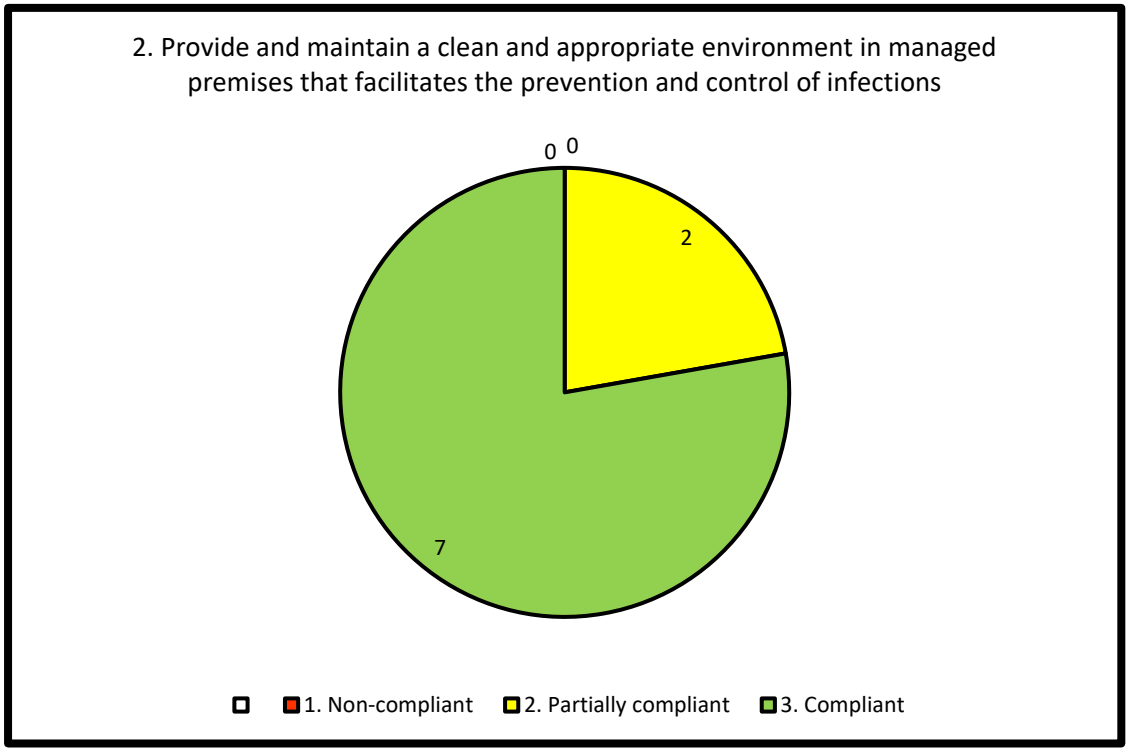
WORLD HAND HYGIENE DAY - May 2023

To celebrate world hand hygiene day the IPCT visited all the clinical areas, supporting best hand hygiene practice, including reducing the use of gloves, bear below elbow and the use of the correct hand washing technique. The IPCT carry out daily ward rounds during the week and hand hygiene audits form part of this ongoing review process and continued staff engagement with regards to supporting IPC best practice.

DCHFT RECYCLE, RESET AND REFRESH WEEK – JULY 2023

The trust organised a Recycle, Reset, and Refresh week with the aim to rest practice in many areas of the trust post Covid-19 pandemic. The IPCT played a big role during this week, aiming to reset IPC compliance following the Covid-19 pandemic, supporting leaders to find innovative ways to improve staff compliance with the National IPC Manual for England. The week also coincided with the 75th NHS Anniversary. This was part of a quality improvement plan for the IPCT and formed part of our IPC optimisation plan for 2023-2024. Appendix One. The week was very successful, especially in clearing away and recycling junk, review and resting the of the uniform policy and uniform standards, which included an IPC poster campaign, IPC education supported by reps and many more IPC activities across the whole week.

CRITERION TWO:
Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections.



Partially compliant: 2.4 There is monitoring and reporting of water and ventilation safety, this must include a water and ventilation safety group and plan. 2.4.2 Water safety plans are in place for addressing all actions highlighted from water safety risk assessments in compliance with the regulations set out in HTM:04-01. New appointments required by the Water Safety Policy have been made following changes in key personnel. Estates on behalf of the Trust has undertaken via a specialised consultant, Water Safety Risk Assessments (RA's) of the Hospitals water systems. The recommendations are not as favourable as we would have liked, however, this informs us of important actions we need to take to ensure we are managing Water Safety effectively and efficiently within the Trust. Update winter 2023 - ongoing progress now supported by DHC Trusts estates lead. Mitigations noted below in the water quality report. 2.9 Food hygiene training is commensurate with the duties of staff as per food hygiene regulations. If food is brought into the care setting by a patient/service user, family/carer, or staff this must be stored in line with food hygiene regulations. Mitigation: This is policy and checked with auditing, although more robust procedures could be in place.

ESTATES REPORT

WATER QUALITY- T Markin – Mechanical Estates Officer

The Estates Team are responsible for maintaining the Trust's water systems, across the main hospital site and satellite properties, and reporting status to the Water Quality Management Group (WQMG) and Infection Prevention and Control Committee. Provisions for water safety are independently audited by experts from the Water Hygiene Centre, who provide the Trusts third party Authorised Expert for water safety. Toby Markin is now water RP; David Oman will be undertaking the AP role once training has been completed.

Policy & Governance

New appointments required by the Water Safety Policy have been made following changes in key personnel.
Estates on behalf of the Trust has undertaken via a specialised consultant, Water Safety Risk Assessments (RA's) of the Hospitals water systems. We have received ALL FOUR (North wing, South Wing, East Wing & South Walks House) The recommendations are as we expected and not as favourable as we would have liked. However, this informs us of important actions we need to take to ensure we are managing Water Safety effectively and efficiently within the Trust.
Those most of concern are noted below: -
We are aware that there is not an all-encompassing logbook for Water Safety within Estates, rather a collection of Excel Spreadsheets, which is not ideal and was meant to be an interim measure whilst MiCad was further developed, this is now being moved forward with improvements to MiCad being made, there is no scheduled date to move this information from spread sheet to MiCad but every effort is being made to keep the momentum of recent progress.

1. It was always the intention to develop a full 'Written Scheme' being a revised and updated Water Safety Plan, following the adoption of the Water Safety Policy and the results of the Water Safety RA's, which also provide updated schematic drawings of the water systems. Staffing with Estates has been stretched and, in some areas, covered by agency staff, however, at the start of this year we recruited an Estates Mechanical Officer, who will be leading the Operational Water Group in developing the Water Plan, we are making very good progress showing a reduction in water borne infections.
2. CWS tank cleaning is now due again, Estates are liaising with specialist contractors to complete these works.

Regular sample testing has been maintained in high-risk areas as well as an expanded portfolio of general outlets throughout the Trust by Estates dedicated Operatives delivering an improved scope of sampling.

Risks

HCWS (Hot and Cold-Water Systems) are managed within capability and availability and, in general, the main site systems need investment to mitigate age related and maintenance issues.
There have been 800 reactive calls to leaks in the period 01/04/23 – 31/03/2024 of various descriptions, with (approx.) (1% or 5 Emergencies): (27% being Urgent with the potential to cause significant damage), (45: were out of hours), a further (66% or 528) were of various descriptions with a lesser significance.

New Properties

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

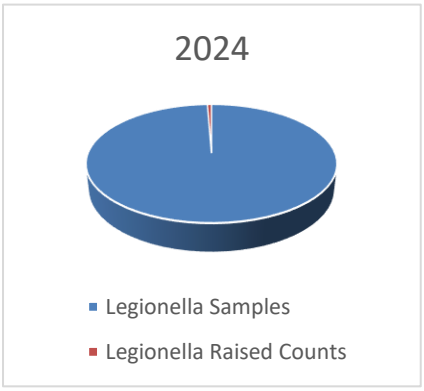
Sampling

The table below shows number of samples taken in the year; Pseudomonas (approx. 18% increase on the previous year) together with a raised count reduction & Legionella (approx. 33% increase on the previous year) together with a significant reduction on raised counts.

Legionella Samples	**2024**	538
Legionella Raised Counts	13	2.40%

Legionella Samples	**2023**	405
Legionella Raised Counts	69	17.00%

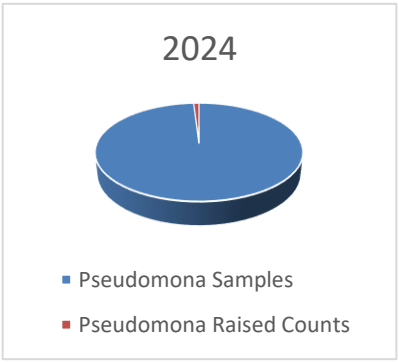
The source of these raised counts was hidden flexi tap connectors in diagnostic imaging these have since been removed. There was also a single count of 1 which would appear to be a dirty bottle.



Pseudomonas Samples	**2024**	511
Pseudomonas Raised Counts	20	3.91%

Pseudomonas Samples	**2023**	433
Pseudomonas Raised Counts	23	5.31%

9 x raised counts I SCCBU water cooler (now Removed).
5 x POW shower (now Isolated until temperatures can be raised to carry out thermal flush.
4 x POW Shower unit that has now been replaced.
2 x Maud Alex not repeated.



VENTILATION – C Carver – Senior Estates Officer

The Estates team continue to carry out routine inspections and maintenance on all ventilation systems and formal validations on all Theatre and Critical Areas in compliance with HTM 03-01 Part B and carrying out remedial work where required. In the past 12 months we have installed 2 of AHUs in South Walks House, and new AHUs in delivery rooms 27 and 25 in Maternity.

Estates are currently approving ventilation drawings for AHUs in Ridgeway Ward, Fortuneswell Ward, The New Hospital Build, The new Theatre in East Wing, and some additional ventilation in Mary Anning.

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

REPLACEMENT FLOOR COVERINGS (Floor Works) DECORATION AND ENVIRONMENT (painting) – A Kersley - compliance and Assets Officer.

Estates Completed 247 calls to flooring works, 51 jobs were completed by contractors. This included full laying of South Wing Stairs, New flooring to all cubicles on Abbotsbury. Complete new flooring to Redwood House at Charlton Down.

We have worked closely with two local contractors, Future Flooring & Carpets 2000. Both contractors liaise with clients well & always give a very high standard of work.

We seem now to have eliminated most of the carpeted areas in & around the wards & are implementing cap & cove where required to clinical areas, this allows for much better cleaning & less areas to repair moving forward.

Estates have completed 168 painting jobs, the focus this year was on wards, however we have a long way to go & only one painter makes this very difficult.

Endoscopy: had a full redecoration with colour changes to aid the patient experience.

Abbotsbury: was fully completed as well.

Maternity: had a full redecoration, once again adding various colours to aid the patient experience.

Ilchester: had re-dec of corridors.

CAPITAL WORKS – R Swatton - Estates Capital projects Manager.

Projects 2023/24	Description of works
Fire Alarm Replacement	Replace fire alarm system site-wide to address corporate risk due to age of current system and non-compliance.
Access Control	Replace existing 20-year-old cotag system with new due to current system going in to obsolescence and reliability becoming an increasing issue.
Chemo Unit Decant Arrangement	Multi-phased works in preparation for Chemotherapy decant (Chemo refurb to start 2024/25)
Respiratory Medicine Labs	Full refurbishment of department
Radiology - Angiography Suite	Full refurbishment and equipment replacement.
Kingfisher De-escalation	Mental Health Welfare room. Creating Anti-ligature light suite and bathroom
Roof Works - Priority Areas	Roofing replacement works being undertaken across priority areas of the Trust. Highlighted as main risks to the areas of Clinical departments underneath.
Offsite Therapies Centre - Roof Replacement	Lifecycle replacement of Off-site therapies centre roof and guttering.
Aseptic Works	Remove sink, extend benching, and add IPS outside of suite.

Modular Discharge Lounge	New modular building funding from NHS England to be used for Discharge Lounge combined with Discharge Lounge +. Works completed but still in the defect period until July 2024.
Modular Discharge Lounge	Further carpentry works not included in scope of scheme
Fire Compartmentation	Survey of fire compartmentation; review of existing, changing if required and including if not existing already
Mortuary	Install new body store, replace all existing rollers and making good of area
Nurse Call Replacement	Stroke - full replacement completed 2023/24 POW - install 2024/25 Maternity (Including SCBU) - install 2024/25 Moreton - install 2024/25 Radiology - install 2024/25
Ridgeway Orthopaedic 24 ring fenced beds	Alteration to ward layout to support ringfencing if bed spaces for Orthopaedic recovery. Works on-going and will finish August 2024.
Asbestos Management Policy	In progress with Ion.
Kingfisher Balcony	Replacement floor, new storage areas and column padding - to become a usable patient area
PoW Side room Alterations	Further alterations to PoW Side rooms
Paediatric DSU bathtub	Removal of bathtub in E2-1035 to increase available space
Maternity Ventilation upgrade to 2x delivery Suites	Works to two delivery rooms to ensure Nitrous Oxide exposure is maintained at below 100 ppm and ensure compliance
Old Discharge Lounge	Enabling it to become a temporary Surgical Admissions Lounge.
Women's Health Recovery Room	Take down wall between existing recovery room and kitchenette and refurb. Displace kitchenette.
Damers Restaurant	Non-clinical but remained open to staff and patients throughout refurb
Abbotsbury Sister's Office Refurb	Redecoration and new flooring
Kingfisher Accessible Bathroom	Full refurb including layout change and removal of bath to allow for wet room area with adjustable shower table
MH Funding for improvements to Mary Anning	Installation of handrails and "stopping" point and wrapping of the doors

DECONTAMINATION SERVICES REPORT - **Joe Lythe – Service Manager: Theatres, Anaesthetics, CRCU and Decontamination, Fiona Sallows – Assistant Service Manager.**

STERILE SERVICES DEPARTMENT

Quality Management System - Accreditation

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

As a result of Brexit there are some ongoing changes in regulatory requirements. The Medical Device Directive has transferred to the Medical Device Regulation UK MDR 2002 (as amended) our Notified Body that was based in Sweden as an EU Representative has been transferred successfully after a transitional audit to a UK based competent The Accreditation held by the service continues to give quality assurance on the products produced and allows the department to provide services for external customers.

External Customers

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

Environmental Monitoring

authority.

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

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

The laboratory also tests:

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

Latest testing of all areas occurred in November 2023 and the pack room was given a Class 8 clean room status, which is appropriate for the service.

All results are trended, and corrective actions are undertaken for any areas or items found to be outside of acceptable limits. There are no areas of particular concern currently.

For compliance with HTM 01-01 ProReveal testing is undertaken on a quarterly basis; this involves 50 instruments per washer (200 in total) being tested to detect any residual protein on the instrument surface, after being released from the washer-disinfector but prior to sterilisation. Results have been in excess of 99% for each test;

this gives assurance that the detergent used in each validated washer-disinfector is effective.

Tracking and Traceability
Patient registration by clinical users against sterile items at the point of operation is undertaken in one Theatre and two Outpatient Department at the moment due to South Walks House treatment suite coming online in May 2024.
Best practice would see this system being used in all patient treatment areas and this has been recommended through the Decontamination Group Meeting; currently there is insufficient funding for the purchase of the necessary scanners and software licences. Patient tracking at the time of use significantly reduces the risk of expired items or used instruments being inadvertently used on a patient.

Shelf-Life Testing

Products that had been packed and sterilised for greater than 365 days (our maximum shelf life) are sent for sterility testing on an annual basis or when a new wrap is introduced. Previous testing still showed 100% sterility which gives assurance that the decontamination process is effective.
A new double-bonded wrap was introduced in 2020 and sets wrapped in this will be sent for testing once they have expired their 365-day shelf life.
Staff Training
All Managers and Supervisors have achieved qualifications relevant to their role. This gives assurance that they have a full understanding of the Decontamination process and can effectively manage SSD on a day-to-day basis.
All members of staff receive training appropriate to the area of production they are working in and are observation assessed following initial training. Refresher training is repeated for all staff after 3 years of service followed by further observation assessment by a supervisor. No member of staff will work independently without having been assessed as being competent to undertake the role.

Joe Lythe Service Manager is the Trust's Decontamination Lead.

ENDOSCOPY DECONTAMINATION UNIT

Quality Management System - Accreditation
The department continues to maintain a full Quality Management System and maintain certification to BS EN 13485:2016 as an extension to scope of the existing certification in the Sterile Services Department.
This service is not registered with the MHRA, as the unit does not have a controlled environment product release area, therefore full registration cannot be achieved; this means that an endoscope reprocessing service cannot be offered to external customers.

Environmental Monitoring
Validation is completed by an accredited external laboratory on a quarterly basis. This consists of:

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

- • Detergent testing

The laboratory also tests:

- • Product bio burden on cleaned endoscopes at point of release from the washer and at 3 hours following release which is the maximum usage period following release – Yearly.
- • Product bio burden on surrogate scopes stored in a drying cabinet for 7 days and at 3 hours following release - Annually.

Latest testing of all areas occurred in November 2023

Tracking and Traceability

Patient registration by clinical users at point of use is undertaken in all 3 treatment rooms in Endoscopy and the outpatient Urology Suite. This provides accurate traceability of all endoscopes used and significantly reduces the risk of endoscopes that have expired the 3-hour window being used on a patient.

HOTEL SERVICES REPORT- CLEANING SERVICES - Sarah Jenkins - Hotel services manager.

Throughout the past year the Housekeeping Team have continued to work hard to maintain the cleanliness of the hospital, coping, as all services, with continued exceptional pressures we have experienced through the past months with the number of patients we have had within the hospital. There have also been new areas to clean, most particularly the opening and continuing expansion of the services at the Outpatient's Assessment Centre at South Walks House.

This work has not been done in isolation, but with the support of our colleagues across many disciplines. The importance of a clean environment, which remains the responsibility of, and has been supported by, all teams help to ensure our continued focus on providing and maintaining a hygienically clean and appropriate environment for our patients, visitors, and colleagues.

Cleanliness

Cleaning services throughout the buildings occupied by the Trust, both on and off the main hospital site, in both clinical and non-clinical areas, are provided by an in-house team of staff supervised through a 24/7 rota by a team of supervisors. This team is augmented by external contractors, managed by the Hotel management team, who undertake the window cleaning and pest control aspects of cleanliness.

As far as is practicable staff are allocated to a particular area, giving them a sense of ownership, and belonging to the area as well as continuity in the cleaning regime. The amount of time allocated daily is determined by the frequency of cleans as outlined in the Standards of Healthcare Cleanliness and by input from the clinical and housekeeping teams. We continue to review these considering changes to IPC guidance, presence of infection outbreaks and the differing pressures caused by reduced numbers of staff at times of increased sickness. The housekeeping schedules have been subject to extensive review in the last months and further changes to the service are being considered alongside the extension of the Ward Housekeeper pilot, to further enhance cleanliness and the patient experience.

Standards of cleaning are monitored through the audit process, the frequency of which is determined through the functional risk category assigned in accordance with the national standards, in consultation with our IPC colleagues. The frequency can be changed, for example in a period of increased incidence of infection or when there are other concerns as to the standard in any area. These standards also set a timetable for the rectification of failures based on the risk category. Standards are further monitored through reports received from PALS, the environmental audit process and through PLACE and PLACE lite. Feedback is given to staff on the areas from these audits.

Despite the difficulties of the past 12 months, cleaning standards have been maintained with highlighted issues being remedied in acceptable timescales.

Deep Cleaning

The continued pressures on the hospital have meant that the annual deep clean programme has once again been delayed. Whilst we would like to be able to carry out a full deep clean programme, the pressures on the hospital and the lack of space in which to decant patients from wards/ bays means that this is challenging. Along with our IPC colleagues we have identified a priority list which will indicate to us both when a deep clean of a ward / department may be needed and then a plan will be enacted with collaboration with the area concerned and other interested parties. The triggers are:

1. Concerns highlighted at an efficacy audit conducted by a team consisting of a minimum of a representative from estates, one from housekeeping and one from the IPC team.
2. Repeat low environmental audit scores.
3. Post infection outbreak.
4. Post Period of increase incidence.
5. Following refurbishment or extensive estates works, for example when the call bells are being replaced.
6. Concerns escalated by matron.

The deep clean process is supported by fogging with a hydrogen peroxide vapour. As our three machines can be vital in maintaining flow on site, two machines were hired to carry out the necessary deep cleans to ensure the safety of patients in the opening of the Outpatients Assessment Centre, particularly important to ensure the cleanliness of the new procedure suite. Training has been rolled out to several staff across all shifts so that we are able to carry out deep cleans at all times, and further training is planned so there should always be someone on site to carry out these cleans. The new machines provide far greater assurance in terms of reporting of itself and in ease of checking that an area has been cleaned and are safer for the operatives, in that the machines are turned on remotely once the operator has sealed the room, the vents and fire alarm sensors are covered without the operator having to use a ladder and reports are generated to confirm successful operation.

Internal Monitoring

The housekeeping team monitor the cleaning standards through audits. The frequency of these audits is dependent on the new functional risk categories to which the area is assigned, and these vary between weekly and annually. The timescale for rectification, by the cleaning, estates, and nursing teams, of failures is also dictated by this categorisation and by the potential IPC risk.

Star ratings are being assigned for display instead of the percentage of cleanliness achieved, rated from 5 to 1 star. The percentage needed to achieve the five-star status is also linked to the functional risk category. Should an area receive 3 stars or less than a list of remedial actions is followed to ensure that the area is brought back up to and remains at standard. It is hoped that in the coming weeks the audit software can be used to document action plans and so we will be able to report on the improvement plans as well as the progress of special projects such as the descaling of the toilets.

The housekeeping supervisors have, been using the new auditing software with increasing confidence. On the completion of the audit, the results are emailed to the department leads, the estates team and the Hotel Services management team, leading to greater awareness and more transparency than previously. Soon it is hoped that the rectifications needed by the cleaning team will be immediately sent to either the member of the cleaning team working on the ward or a rapid response team who will help remedy the failings in the department.

Efficacy Audits

At the end of 2023, the Infection Prevention and Control team have refreshed the process for trust wide efficacy audits to be in line with the National Standards for Healthcare Cleanliness. The efficacy audit is a management tool to provide assurance that the correct cleaning procedures are consistently delivered to satisfy IPC and safety standards. These audits inform the healthcare organisation that correct training, IPC, health and safety, and safe systems of work are being used. We also identify any estates jobs that are required during the audit and monitor standards such as the general appearance of staff and hand hygiene. These audits also focus on the process of cleaning rather than its outcome to ensure that standards are maintained in the process and not just the outcome.

Once a week the IPCT, plus a representative from housekeeping and estates, undertake the efficacy audit of all wards and departments across the Trust. All clinical areas have been risk stratified to provide assurance of our process for the schedule of our efficacy audits, but each clinical area is reviewed at least yearly or more frequently if concerns are raised through the processes mentioned within the deep clean plan above.

The results are fed back to the ward lead and matron to acknowledge good practice and address poor service and actions required to drive continuous improvement.

PLACE

We once again carried out a Patient Led Assessment of the Care Environment, (PLACE) in the autumn of 2023.

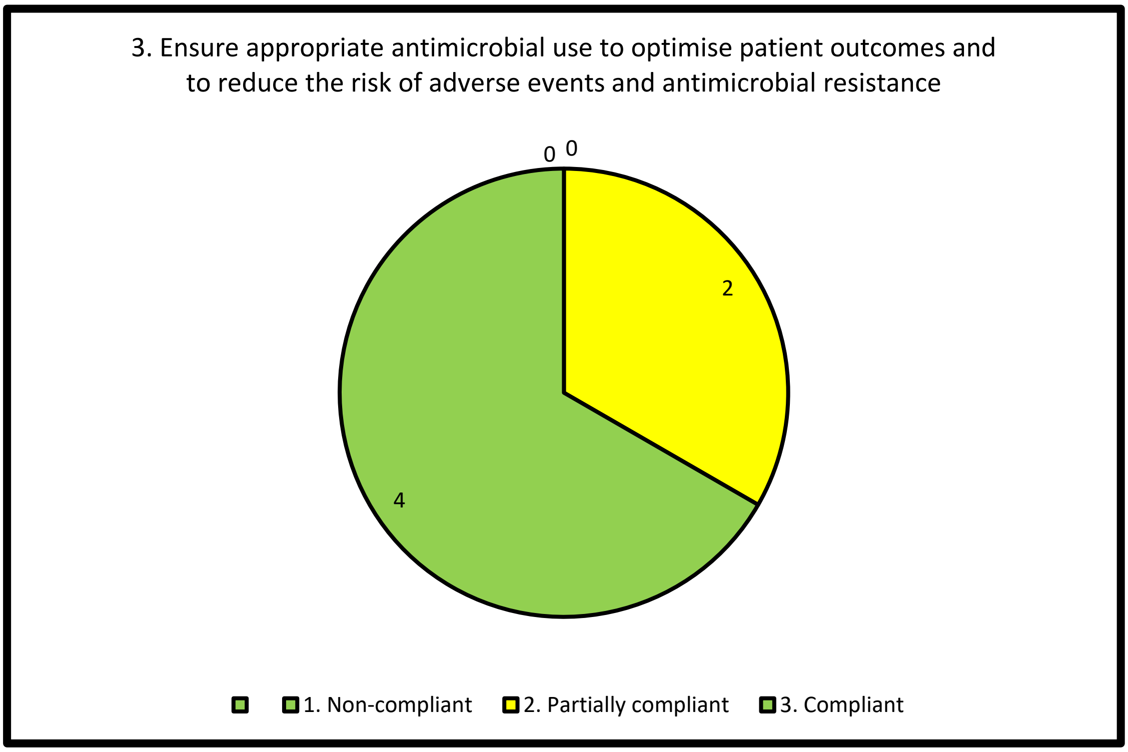
PLACE assessments are an annual appraisal of the non-clinical aspects of NHS and independent/private healthcare settings, undertaken by teams made up of staff and

members of the public (known as patient assessors). The questions are focussed around 6 domains, the relevant ones for this report being the cleanliness and condition of the buildings.

It should be noted that the PLACE findings represent a snapshot of the areas as they were found on the day, and the good scores in these domain areas are a testament to the hard work of the housekeeping and wider estates teams as they strive to maintain the environment with stretched resources. Both in the areas of condition and cleanliness we saw an improvement on already pleasing scores from the previous year.

We have also introduced PLACE lite audits at other times during the year. These act as a mini-PLACE audit and allow us to see areas in which we have improved and those areas where there is still room for action. We are joined on these by our patient assessors, to give the patient's perspective on the environment, and whilst we do not report on these nationally, they give us an indication of how we are doing.

<u>**CRITERION THREE**: Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance.</u>



Partially compliant: 3.5 Contractual reporting requirements are adhered to, progress with incentive and performance improvement schemes relating to AMR are reported to the board where relevant, and boards continue to maintain oversight of key performance indicators for prescribing, including: total antimicrobial prescribing. broad-spectrum prescribing. intravenous route prescribing. treatment course length. Mitigation: IV route prescribing monitoring is part of the AMS work plan for FY 2023/24. •QI work relating to early IVOS is part of the AMS work plan for FY23/24. 3.6 Resources are in place to support and measure adherence to good practice and quality improvement in AMS. This must include all care areas and staff (permanent, flexible, agency, and external contractors) Mitigation: Funding secured for a 0.5 WTE AMS technician role to support the AMS pharmacist, focusing on developing a digital work plan to bolster AMS efforts locally.

<u>**Antimicrobials: Summary report for financial year 2023/24.**</u>

Rhian Pearce (Antimicrobial pharmacist) – left the trust January 2024, Cathy Jeppesen (Consultant microbiologist) and Ben Squibb (Pharmacy Technician Higher Level).

Overview

Antimicrobial resistance (AMR) is an emergent crisis threatening health outcomes across all healthcare settings.
The hospital's Antimicrobial Stewardship (AMS) Programme aims to optimise the use of antimicrobial agents to improve clinical outcomes whilst limiting the emergence of AMR and *C. difficile (C-diff)*. It is our primary defence against the threat of AMR. The UK has recently published the latest five-year AMR National Action plan (NAP) 2024 – 2029 "Confronting Antimicrobial Resistance", which aims to take the UK closer to reaching its vision of containing and controlling AMR by 2040. This plan, like the previous plan, will focus on three key ways of tackling AMR: reducing the need for and

unintentional exposure to antimicrobials, optimising the use of antimicrobials, and investing in innovation, supply, and access.

This has been a challenging year for antimicrobial stewardship in DCH as our Antimicrobial Pharmacist Rhian Pearce left the trust in January 2024. Pharmacy has yet to recruit a replacement and is exploring a shared post with UHD. In the meantime, a 0.5 WTE pharmacy technician BS has been seconded to AMS since September 2023 and has been extremely valuable in maintaining many aspects of AMS work, including data collection and analysis, while microbiology consultant CJ has taken over the role of lead microbiologist for AMS and is also trying to mitigate the loss of AMS pharmacist. Lack of an AMS pharmacist has been placed on the trust risk register.

Nonetheless, there have been notable achievements by the AMS team in the year 2023/24:

- **Establishment of a new AMS Group to direct, support and re-invigorate local AMS activity.** This replaces the AMS committee, which was becoming difficult to convene, and is being chaired by Dr Cecilia Priestly. The first meeting took place in December 2023 and the group is meeting monthly to begin with, in order to maximise progress.

- **Participation in the National point Prevalence Survey of Antimicrobial Use and Healthcare associated infection.** This significant piece of work took place in October 2023 and involved surveying all patients on all wards during the data collection period and submitting the results on the UKHSA web portal. The full report and benchmarking data are due to be published in May. Overall, 31% of inpatients were on antimicrobials at the time of the survey and 88% of prescriptions were judged optimal or adequate.

- **Achievement of the IV to oral switch national CQUIN (see below)**

- **Migration of DCH antibiotic guidelines onto the Microguide app and review of guidelines – in progress.** The Microguide app is used by the majority of NHS trusts to host antibiotic guidelines. It enables ready access on laptops and mobile devices for clinicians and is easy to update with a full audit trail. It has been an aim of the DCH AMS team for a number of years to migrate our antibiotic guidelines from SharePoint onto the App, and we are eventually making good progress in this task. We are taking the opportunity to review existing guidelines, and address gaps for infections where we have no trust guidelines. Where possible we are adopting or adapting UHD guidelines to fill these gaps, with the UHD AMS team's agreement. In time we hope to harmonise guidelines across UHD and DCH, but this aim is limited by shortage of AMS pharmacists and microbiology resource on both sites at the present time.

- **Quinolone prescribing**. In response to the strengthened MHRA safety warning about the possibility of rare but disabling side effects from quinolones, we have updated the DCH patient information leaflet, produced a quinolone prescribing guideline, and reviewed current prescribing with a snapshot audit (trust audit 6064). This was relatively reassuring in that 88% of prescriptions were deemed appropriate, but did identify areas where prescribing could be improved, including accuracy of penicillin allergy status.

- **Staff Education.** The microbiology consultants have delivered AMS teaching sessions to new starting F1s in September 2023, and to junior doctors (medical directorate teaching) in March 2024. A further session for all F1s will happen in May 2024, and AMS will be included in the new TEIR 3 IPC/ AMS training for band 6 nurses, to commence in late 2024.

- **Ward audits.** Proactive ward audits have been paused since the departure of the AMS pharmacist, but the microbiologists continue to review prescribing for all HOHA and COHA cases of C difficile and perform individual ward audits during C difficile PIIs (periods of increased incidence). There have been no alarming themes about antibiotic prescribing from these audits.

- **Co-amoxiclav prescribing in ED**. Before her departure, RP was working with ED clinicians to look at apparent significant increases in co-amoxiclav consumption in the ED department. This work resulted in good engagement but has unfortunately not progressed since January.

DCH Performance against national AMS targets

1. **<u>AMS CQUIN schemes 2023/24</u>**

There are significant benefits to IVOS interventions demonstrated in research literature including: increasing hospital bed capacity; reducing exposure to broad spectrum antibiotics; increasing nursing workforce capacity; reducing drug expenditure; reducing carbon footprint of medicines; and reducing healthcare-associated bloodstream infections.

This CQUIN aligns with a commitment in NHS England's 2022-23 Priorities and Operational Planning Guidance to support reduced lengths of hospital stays by ensuring that intravenous antibiotics are only used for as long as clinically necessary.

Locally agreed performance metrics and data submission:
DCH adopted the IVOS CQUIN scheme for 2023/24, which mandated a data collection requirement of 100 cases per quarter, regardless of trust size. Given the AMS team's resource constraints, we were unable to collect data for Q1 and Q2. Data was collected and submitted for Q3 and Q4.

100 non-ICU adult patients who had been on IV antibiotics for >48h were reviewed by the AMS team to determine whether they were already eligible for oral switch, based on an IV to oral switch tool. If there was an active need for ongoing IV administration, they were defined as compliant.

Performance against the CQUIN target and QI interventions

We achieved 80.39% compliance (19.61% non-compliance) in Q3, well below the non-compliance threshold of 40%. This was maintained in Q4, achieving 80.2% compliance overall (19.2% non-compliance), which meant we met the full payment for our combined performance for the year. A breakdown of compliance against CQUIN indicators is provided below (Fig. 1)

Fig 1. DCH data vs national target

Quarter (23/24)	Percentage	Target
Q1	No Data	<40%
Q2	No Data	
Q3	19.61%	
Q4	19.8%	

During Q3 a poster campaign was started where two posters designed by the AMS Pharmacist and reviewed by the medicines committee titled “The oral solution” and “IV league” were provided to all wards in the trust. These posters aimed to provide the nurses with the information and confidence to highlight to prescribers when they felt the patient would be clinically appropriate to switch from IV to oral and to provide prescribers with some understanding of the burden of IV preparation and administration, how a switch even for the last dose would make things significantly easier, provide more time for the nurses and help prepare a patient to be discharged (as patients are rarely discharged whilst having IV medications).

We are awaiting the end-of-year report to benchmark our performance to the national mean, but benchmarking data produced by UKHSA (Fingertips website) indicates that for non-teaching hospitals, the average non-compliance rate is 21.1%, so we performed slightly better than average in this audit. However, the proportion of DCH total antibiotic consumption which is IV was 31% (in September 2023) compared to a national figure of 25% for all non-acute trusts in England, which suggests there are improvements to be made.

This CQUIN will not be mandatory in 2024/25.

2. **<u>NHS standard contract for the financial year 2022/23: Reduction in WARE antibiotic consumption</u>**

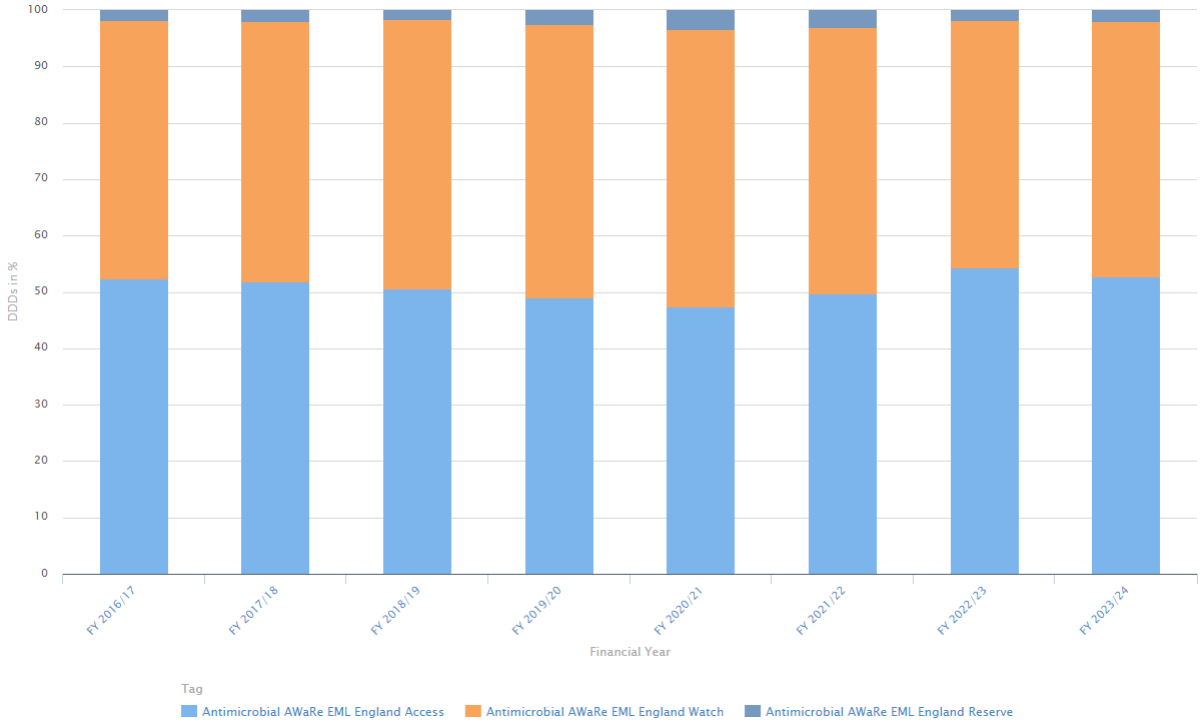
Since 2019, the NHS Standard Contract has required acute providers to make year on year reductions in their per-patient usage of antibiotics from the “Watch and Reserve” categories, in line with the ambition of the UK 5yr AMS action plan for 2019 – 2024. In the contract for the financial year (2023/24), NHS trusts were required to reduce 'watch-reserve* (WARE)' antibiotics by a cumulative 10% compared to their 2017 calendar year baseline.

(Based on the AWARE antibiotic classification system, antibiotics are classified into three groups; Access, Watch and Reserve. Access antibiotics tend to be narrower spectrum and should be used first line, whereas watch and reserve antibiotics are generally broader spectrum with activity against more resistant organisms, and their use should be limited.*)*

DCH has not achieved this target, as our use of WARE antibiotics has grown during this period by 18.7%. As a proportion of our total antibiotic consumption (fig 2), use of WARE antibiotics has remained stable, suggesting that it is our overall antibiotic consumption that has increased. The proportion of our total antibiotic prescribing that

is from the ‘Access’ group is 52%, according to UKHSA Fingertips data, similar to the national average of 51% for non-teaching acute trusts.

Fig 2. Watch (orange), reserve (dark blue) and access (pale blue) antibiotics as a proportion of total antibiotics at DCH. Trend from 2016/17 to 23/24



Reassuringly, the graph in Fig 3 shows that the jump in WARE prescribing at DCH, has stabilised since 2021. Figure 4, taken from a National Analysis of Standard Contract performance data, provided by the SW regional lead for AMS, shows that many trusts in Southwest did not meet the contract target (red lines) and shows that our total antibiotic prescribing is relatively low for our area. Of note, SW is one of the areas with the lowest WARE prescribing in England.

This data offers some reassurance about antibiotic use at DCH, but there is certainly a suggestion that there is scope to reduce use of WARE antibiotics as some of our peers have done. Whether this is best achieved through amending our empiric policies, encouraging earlier switch to ‘Access’ category antibiotics, or encouraging use of shorter durations of antibiotic overall, is something for the AMS group to work on. Our approach will also depend on what resources we have available, and whether an awaited electronic prescribing (JAC) update - which includes tools to better support antimicrobial stewardship - is introduced. Of note, there are no corresponding outcome data comparisons - it would be reassuring to know that trusts with highest use of access antibiotics saw no detrimental effects on clinical outcomes.

A new National 5-year plan has just been published in May 2024 and the contents may affect which, if any, targets are chosen for the coming year.

Fig 3. DCH trend in watch and reserve antibiotic consumption by FY (2016/17 – 2023/24). Locally produced data.

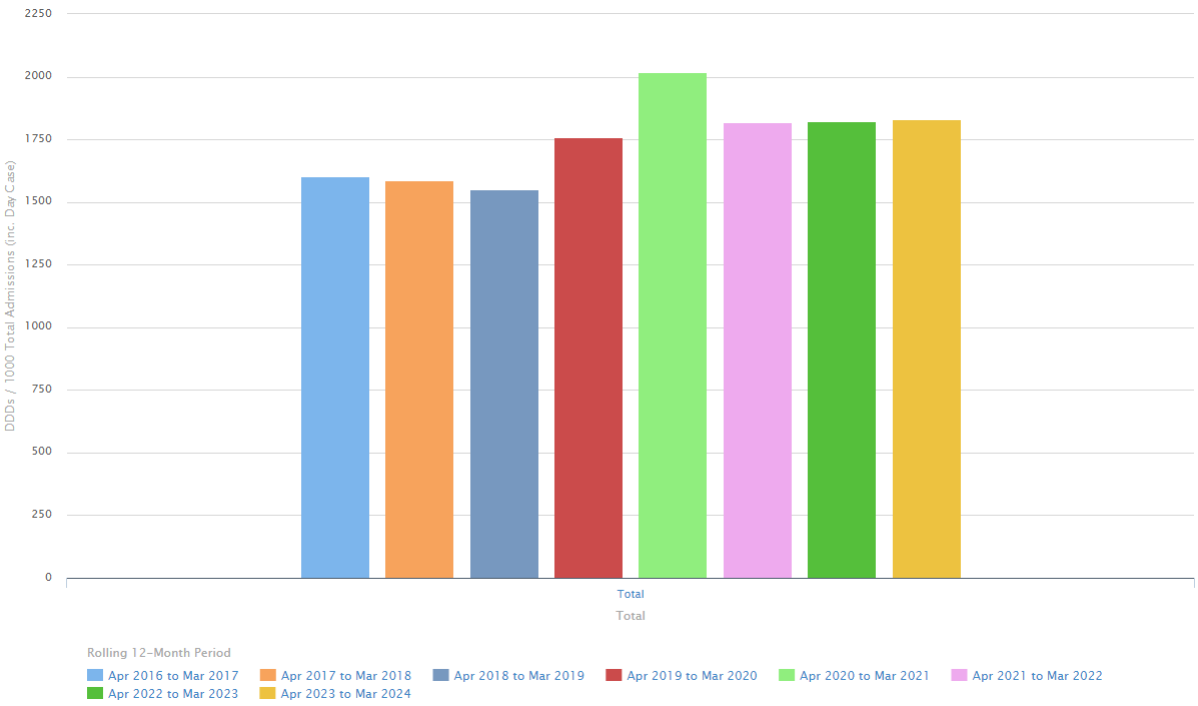
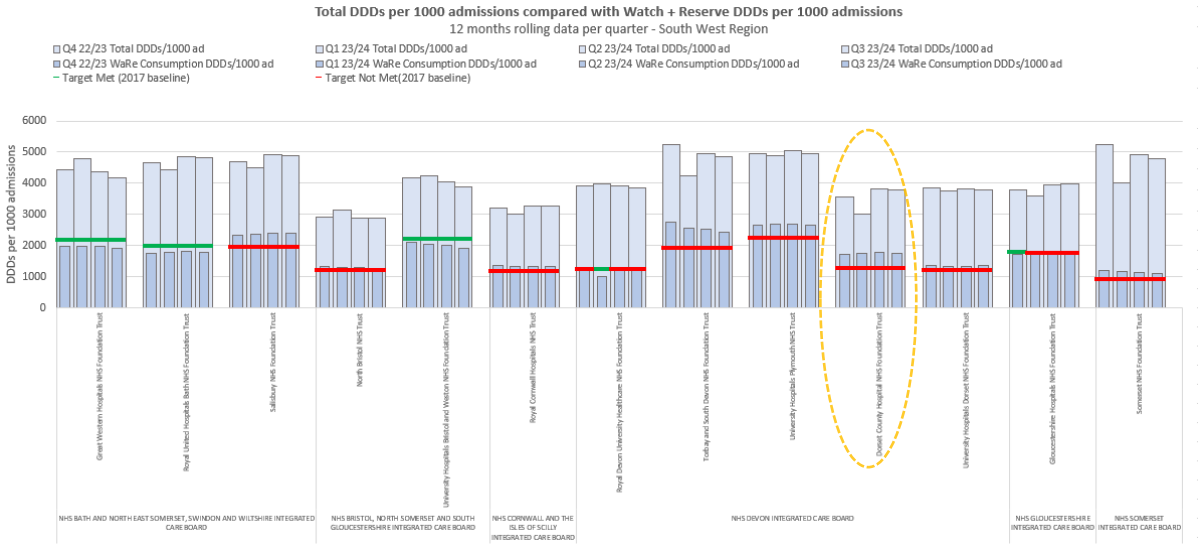


Fig 4. Total DDDs per 1000 admissions (pale blue) compared with watch + reserve DDDs (darker blue) per 1000 admissions. Bars show data from Q1-4 23/24. Lines show the 10% reduction target, if met it is in green. DCH data is circled.



Antimicrobial resistance surveillance and benchmarking

1. Resistant rates for Enterobacteriaceae in blood cultures

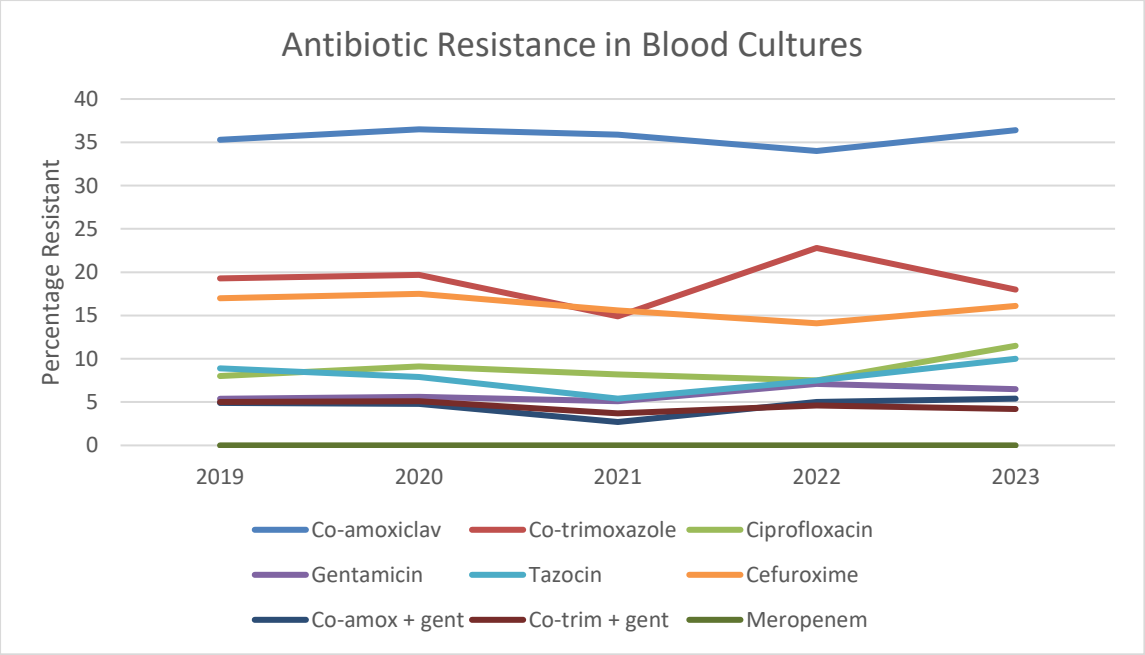
Source: local laboratory antimicrobial susceptibility results.

Table 1 shows percentage antimicrobial resistance rates and trend over time for all Enterobacteriaceae in blood cultures; Figure 1 is a graphical representation of the same data. This is annual data from 1 January to 31 December. There are no definite trends observed in resistance to our workhorse antibiotics.

Table 1

	2019	2020	2021	2022	2023
Co-amoxiclav	35.3	36.5	35.9	34	36.4
Co-trimoxazole	19.3	19.7	14.9	22.8	18
Ciprofloxacin	8	9.1	8.2	7.5	11.5
Gentamicin	5.4	5.6	5.1	7.1	6.5
Tazocin	8.9	7.9	5.4	7.5	10
Cefuroxime	17	17.5	15.6	14.1	16.1
Co-amox + gent	4.9	4.8	2.7	5	5.4
Co-trim + gent	5	5.1	3.7	4.6	4.2
Meropenem	0	0	0	0	0

Figure 1



2. Benchmarking for antimicrobial resistance in E coli isolated from Blood Cultures

Source: UKHSA Fingertips.

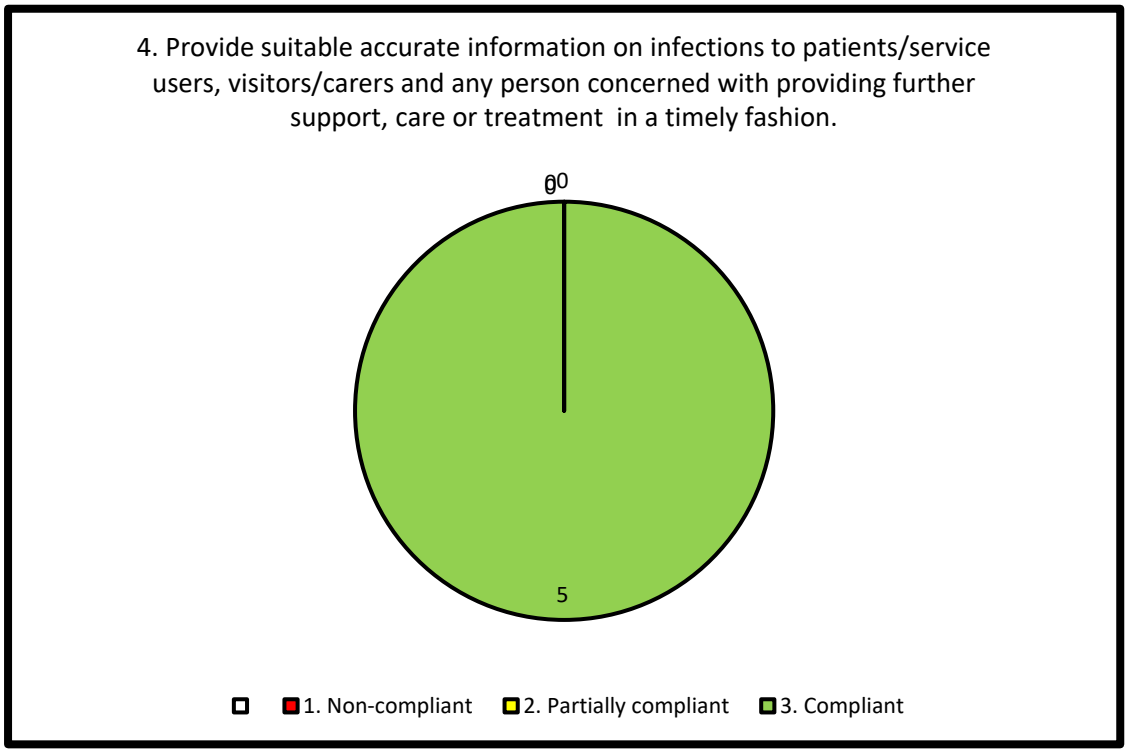
Table 3 shows quarterly average percentage of antibiotic-resistant E coli in Blood Cultures, for DCH compared with other local hospitals and England. This is data for 2023 Quarter 3.

Table 3

	England	DCH	UHD	UHS	Salisbury	RD&E
Tazocin	11.7	7.0	7.0	No data	16.0	6.0
Gentamicin	11.7	7.0	12.0	19.0	5.0	11.0
Ciprofloxacin	20.5	14.0	16.0	21.0	18.0	9.0
3rd-gen cephalosporins	16.6	13.0	13.0	21.0	11.0	7.0

Yeovil was included in this table last year but has not submitted data to Fingertips during 2023.

CRITERION FOUR: Provide suitable accurate information to patients/service users, visitors/carers and any person concerned with providing further support or nursing/medical care in a timely fashion.



The IPC Team works closely with the clinical site managers, ward leads, ward staff and facilities services and attends all bed meetings throughout the day to support patient placement and cleaning requirements. Infection control Patient Activity summary (PAS) flags are added as applicable to all newly identified infections.

The IPC team visit in person all newly diagnosed patients with MRSA and CDI infections, providing the patient with an information leaflet, discuss the diagnosis and answer any questions.

The IPC Team work closely with the communications team and together we update staff via email and staff bulletins all when new guidance that is implemented. We also have a dedicated IPC section on the trust intranet site, which is updated regularly, especially when any guidance changes are implemented. We also review the IPC information leaflets regularly and update and update the hospital IPC internet pages.

The IPC team monitor all CDI and Potential CDI infections daily and include an in-depth weekly review of patients. Escalating concerns to medical teams, wards, and consultant microbiologists. Our consultant microbiologists contact GP's directly when patients are diagnosed with CDI. We also send out GP letters, in a timely manner alerting them of any new CDI, Potential CDI, MSSA, MRSA and Gram-negative Blood stream infections. This year we have also developed new trust isolation poster for placement outside cubicles containing updated clear information. We audit the correct

use of the posters across the trust and our audit results for 2023-2024 demonstrated 83% compliance with the use of correct cubicle signage.

The IPCT work closely with the IPC ICS to identify the needs of the local population and develop strategies, collaboratively to ensure joined up working. We also have monthly post infection review meeting to share learning, raise concerns and discuss our systemwide priorities.

INFECTION PREVENTION AND CONTROL SURVEILLANCE SYSTEM (ICNET)

Over the last few years, we have worked jointly as an ICS IPC team on the procurement and implementation of a county wide utilisation of ICNet, an infection prevention and control surveillance system supplied by Baxter Healthcare Ltd.

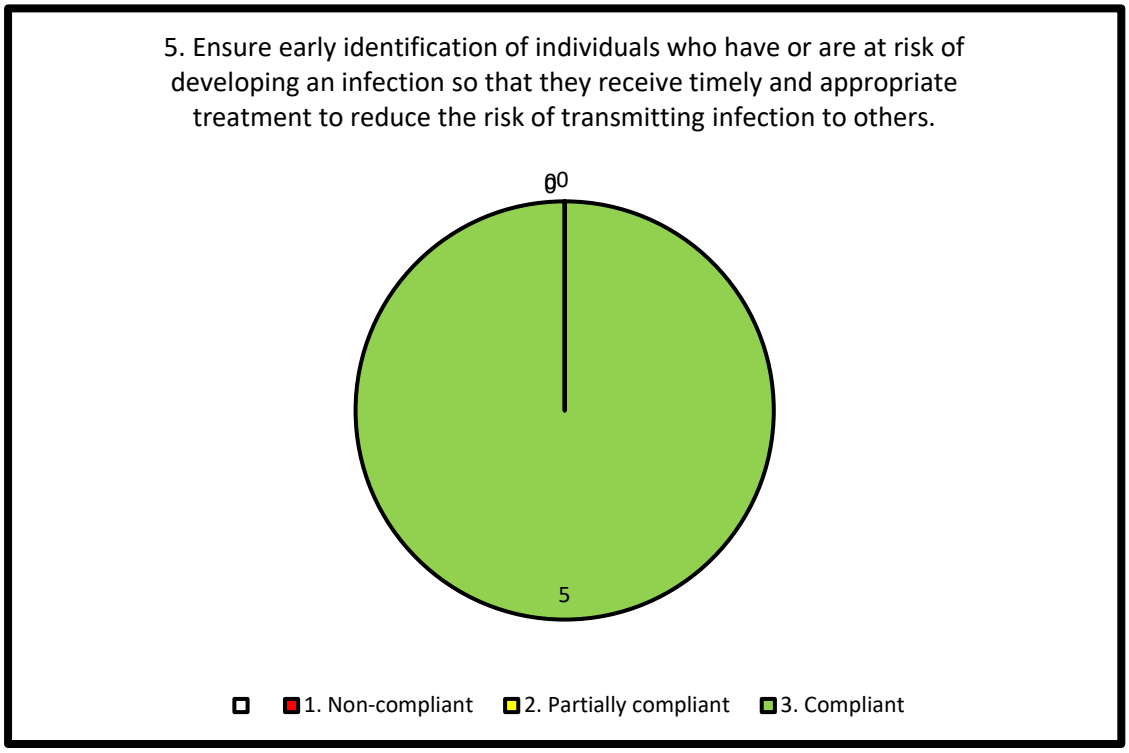
The IPC implementation Programme is divided into three phases:

- Phase 1 – DCHFT migration to hosting by DHC – completed July 2020.
- Phase 2 – UHD (both sites) implementation – completed 2021.
- Phase 3 – DHC implementation – Completed September 2022.

During 2023-2024 the system has been running smoothly across all the Dorset system trusts, and we continue to work collaboratively together to ensure as a Dorset system we are using the ICNET effectively and advantageously.

Within Dorset County hospital the Clinical Site Managers and the housekeeping team have access to ICNET, and they use it to support isolation of patients promptly and effectively and also ensure the correct cleaning is achieved. The IPCT continuously update the isolation list within the system to support prompt isolation and continuously risk assess as necessary, ensuring patient safety is paramount and effectively achieved with regards to cleaning and isolation.

CRITERION FIVE: Ensure early identification of individuals who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infections to others.



The use of ICNET allows the IPC team and clinical site managers out of hours to be alerted to any new alert organisms or existing alert organisms. The IPC team are constantly reviewing these patients. The microbiology consultants also use the ICNET system for note documentation to enable seamless sharing of information between teams. This information is also shared across NHS Dorset following the rollout of ICNET across Dorset Trusts.

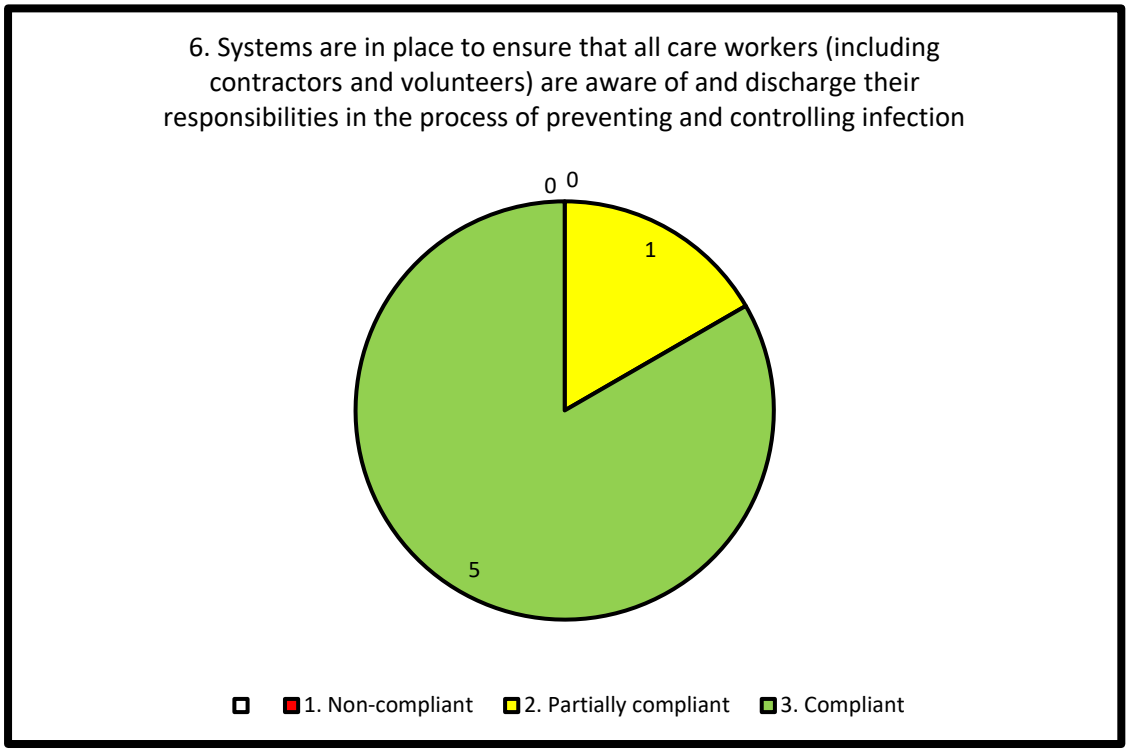
As a team we link closely with GP's, ensuring they are promptly informed via letter or verbal contact via the consultant microbiologists of any new organisms, such as C Diff, Potential C Diff infection, MSSA and MRSA BSI's and Gram-Negative organisms.

The Trust is able to demonstrate that responsibility for infection prevention and control is effectively devolved to all professional groups by means of inclusion in all job descriptions and mandatory inclusion in appraisal documentation including for medical staff.

The IPC Team are involved in the management of outbreaks and periods of increased incidence. The IPC team monitors all alert organisms to identify trends and potential links between cases based on their location. If links are identified, a Period of Increased Incidence (PII) investigation is commenced and a weekly meeting to discuss potential cases is held as soon as possible. This task is greatly aided using ICNET.

In 2023/2024 3 Periods of increase incidents of C Diff, 4 Norovirus outbreaks and 0 COVID-19 outbreaks were declared during this time frame. All outbreaks are discussed for the purpose of shared learning and service development through divisional governance meetings. The IPC team always produce a report, which is noted and discussed at IPCC and the IPC lead specialist nurse always conducts a de-brief following a PII or outbreak. Recurring themes from these investigations are disseminated through the IPC Committee meetings. Action plans that are put in place by the ward manager and/or matron are supported and monitored by the IPC team for compliance.

CRITERION SIX: Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection.



Partially compliant: 6.2 The workforce is competent in IPC commensurate with roles and responsibilities. Mitigation: Tier three of the IPC education framework, covered by mandatory training. The IPC team plan to implement separate face to face training to cover this tier.

EDUCATION

The Infection Prevention & Control Team continued to provide formal and informal face to face education training sessions for both clinical and non-clinical staff. IPCT have also been incorporated into the following teaching programmes and all the nursing team were involved in delivering the sessions:

- Care Certificate for Health Care Support Workers
- Preceptorship Training
- Medical Tutorial Teaching programme
- Overseas Recruitment Training
- Clinical Practice Educators

Mandatory IPC Training for clinical and non-clinical staff has been also offered via an online e-learning workbook. Overall compliance with mandatory IPC training over the year has remained very high for clinical staff. Compliance is part of the yearly appraisal review process for all members of staff. The Divisions are responsible to release staff to access their training. The E-learning IPC Mandatory training programme was updated last year and includes all the relevant IPC Core Skills Training Framework.

The IPCT continue to provide extra training to specific groups of staff as and when necessary, this has included Allied Health Professionals, Porters, housekeeping staff etc. The team have also supported yearly training in areas that maybe required to

care for patients with a suspected or confirmed High Consequence Infectious Disease (HCID). Including the correct PPE donning and doffing procedures to further protect themselves in their working environment. This year the trust has rolled out employing Clinical Practice Educators in most clinical areas, this group of staff support and provide education within the ward area and have a close link with IPC and support ongoing IPC best practice.

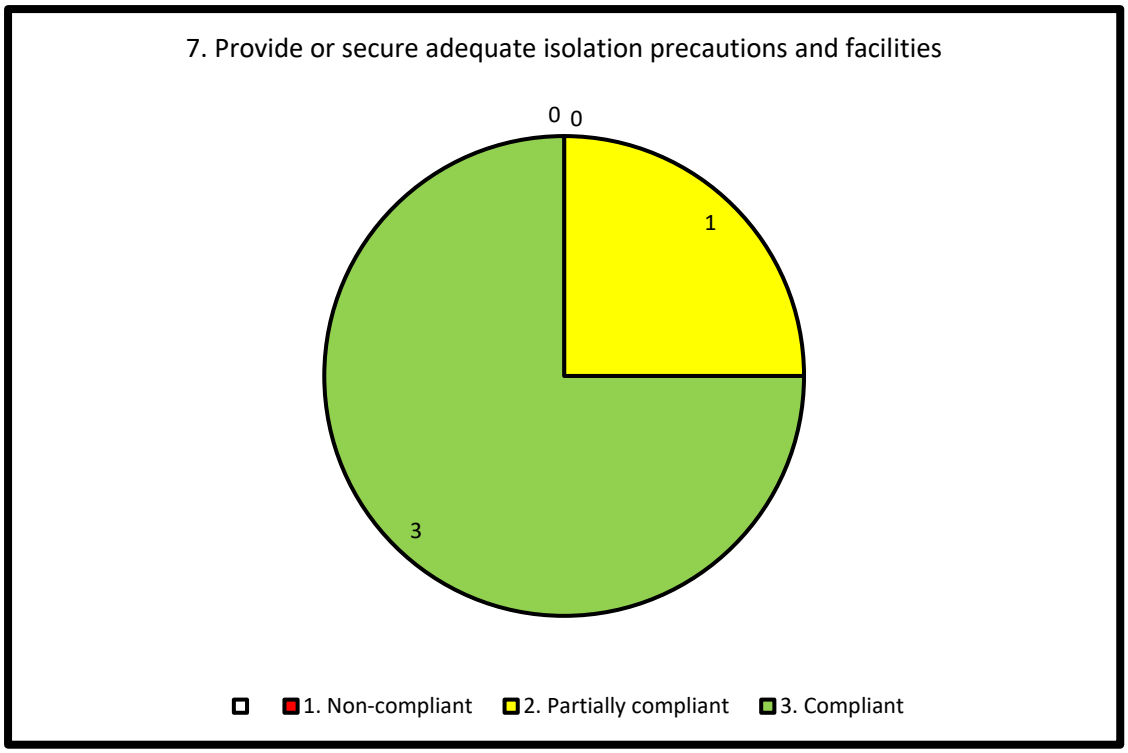
The IPCT are currently working towards ensuring we are achieving the educational recommendations within the National IPC Educational Framework. Which sets out a vision for the design and delivery of IPC education for staff that will support effective and safe care. The framework will support and enhance the skills and expertise in our existing workforce and deliver a positive impact for all learners, our people, educators, patients in our care and our populations. The learning outcomes are a minimum expectation and do not preclude additional outcomes being developed. There are three tiers, which are incremental, building from tier 1 to tier 3. We are currently fully achieving mandatory training for tier 1 and tier 2, and we are working on a new educational programme to achieve tier 3 suitable for staff who are responsible for an area of care. We plan this tier will involve yearly face to face training and include a large (Antimicrobial stewardship) AMS element.

The IPC team continue to carryout daily ward rounds, during these ward rounds we support staff, monitor practice, provide advice, and provide continued IPC education.

FACE MASK FIT TESTING

Fit testing has declined in numbers over the past two years. After many clinics being added and offered to staff, the uptake has been minimal. It is a growing concern now that the pandemic has eased that staff are not making the effort to be fit tested even though it is a legal requirement. The fit mask testing co-ordinator has escalated this via the IPC committee meeting and has been supported by divisional leads. A new agreed plan with the trust fit mask testing co-ordinator has been agreed, an action card developed, with the plan that each area has fit mask testers to cascade training within departments. These fit mask testers are provided with face-to-face half day training sessions and can either use the porta count machine or manual assessment method. The fit mask testing co-ordinator continues to improve fit mask testing compliance across the trust, particularly focusing in areas with higher risk as we move into 2023-2024.

CRITERION SEVEN: Provide or secure isolation facilities.



Partially compliant: 7.2 Isolation facilities are prioritised, depending on the known or suspected infectious agent and all decisions made are clearly documented in the patient's notes. Patients can be cohorted together if: single rooms are in short supply and if there are two or more patients with the same confirmed infection, there are situations of service pressure, for example, winter, and patients may have different or multiple infections. In these situations, a preparedness plan must be in place ensuring that organisation/board level assurance on IPC systems and processes are in place to mitigate risk. The IPCT carry out daily risk assessment for all the trust's isolation cubicles. Comments and mitigation for a request to increase the cubicle numbers on the renal ward, in May 2023 IPC lead has escalated the lack of cubicles on the renal unit, added to the trust risk register. Plan to link with estates to improve the cubicle use of the renal ward. Capital planning and space utilization meeting 30/06/2023 have a plan to improve cubicle use on the renal ward - Actions and works to be completed by January 2024.

ISOLATION

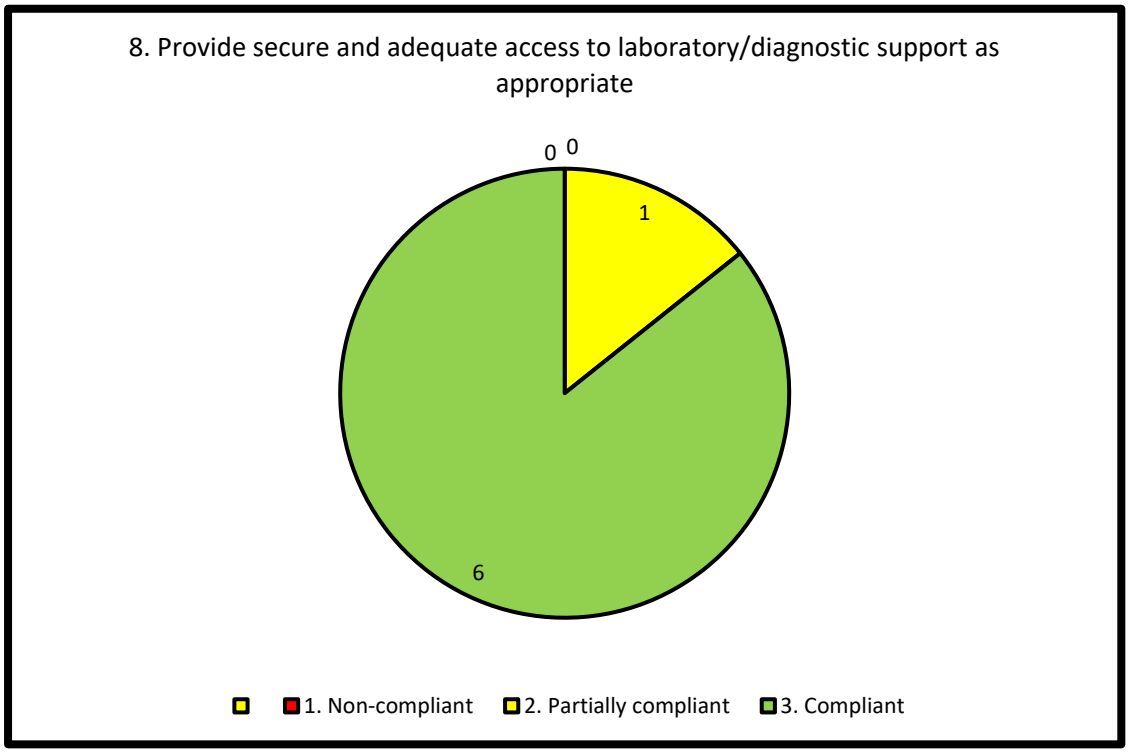
DCHFT has 18% (54) isolation cubicles against the standard bed base. There is no recent statistics to compare this figure to the national average within acute trusts. This percentage can impact the ability to isolate patients according to the national guidance, the National Infection Prevention and Control Manual for England 2024. Using the concept of cohort nursing patients during high prevalence of certain infections such as Flu A, Covid-19, or RSV, which the IPCT continue to suggest, support, and provide guidance on, when necessary. Isolation capacity is consistently well-managed and the requirement to isolate patients as required is largely achieved and if not, in-depth risk assessments are carried out to support best practice depending on the organism.

The IPCT carryout daily ward rounds to review the use of side rooms, providing an ongoing updated isolation list on ICNET, which housekeeping and clinical site managers can access. The IPC Team risk assesses as necessary, supporting ward staff and clinical site managers to ensure the most effective use of side rooms according to risk, throughout the day.

ISOLATION AUDIT

This year's side room isolation audit took place in January 2024 and looked at all inpatient areas (excluding Kingfisher Ward and ITU) with results as follows; Out of 39 rooms in use for infection control purposes 83% had correct signage, 17% incorrect signage and a total of 100% overall side rooms where in use across the trust. This data demonstrates a much-improved percentage compared to last year's audit. At the time of the audit being carried out, staff were educated on the importance of using correct signage to protect not only the patients but also themselves, visitors and thus reducing the transmission of infection. This year we have developed and implemented new trust isolation posters. The trust has been working on a strategic plan to improve our isolation capacity within the Renal unit, which is a Renal tertiary centre for renal services, with a plan to open two more cubicles in the near future.

CRITERION EIGHT: Secure adequate access to laboratory support as appropriate.



Partially compliant: 8.1 Patient/service user testing for infectious agents is undertaken by competent and trained individuals and meet the standards required within a nationally recognised accreditation system. Mitigation: The microbiology lab is currently suspended by UKAS from accreditation to the ISO15189:2012 standard, UKAS inspectors have cleared the Quality Management System findings and are looking to reinspect. An effective QMS is the key to drive the Quality mechanisms and will also be audited against by the DCH pathology quality team as part of their remit.

MICROBIOLOGY LABORATORY UPDATE – G Rees – Head BMS Microbiology

The laboratory services are located on site, there is a provision of seven-day laboratory working and 24 hour access to microbiology and virology advice, including a 24 hour Point-Of-Care Testing in ED and the Paediatric ward for PCR testing when required (e.g. COVID-19, Influenza, RSV) The IPC team are based within the Laboratory department and have a close working relationship with the Microbiology Consultants, we also have a weekly meeting between the IPCT, microbiology consultants and lead biomedical scientist.

This year DCHFT have employed another 0.85 WTE consultant microbiologist. The microbiology consultants are extremely busy but still find to assist the IPC team and we link closely together.

This year has seen the rise of two vaccine preventable diseases (Measles and Whooping Cough) and the first isolation of Candida auris in DCH.

A significant amount of additional work has been seen in the lab through the public health testing aspects of Measles and Whooping Cough from within the hospital and across the areas of Dorset we serve.

The laboratory was preparing to introduce Candida auris screening by setting up ICE test request codes, evaluating culture media and implementing the testing process when the first isolation occurred. A full screening and monitoring programme was rolled out supporting IPC two weeks sooner than had been originally anticipated. The Candida auris screen is complementary to the CPE screen patients and enhances our ability to detect infections.

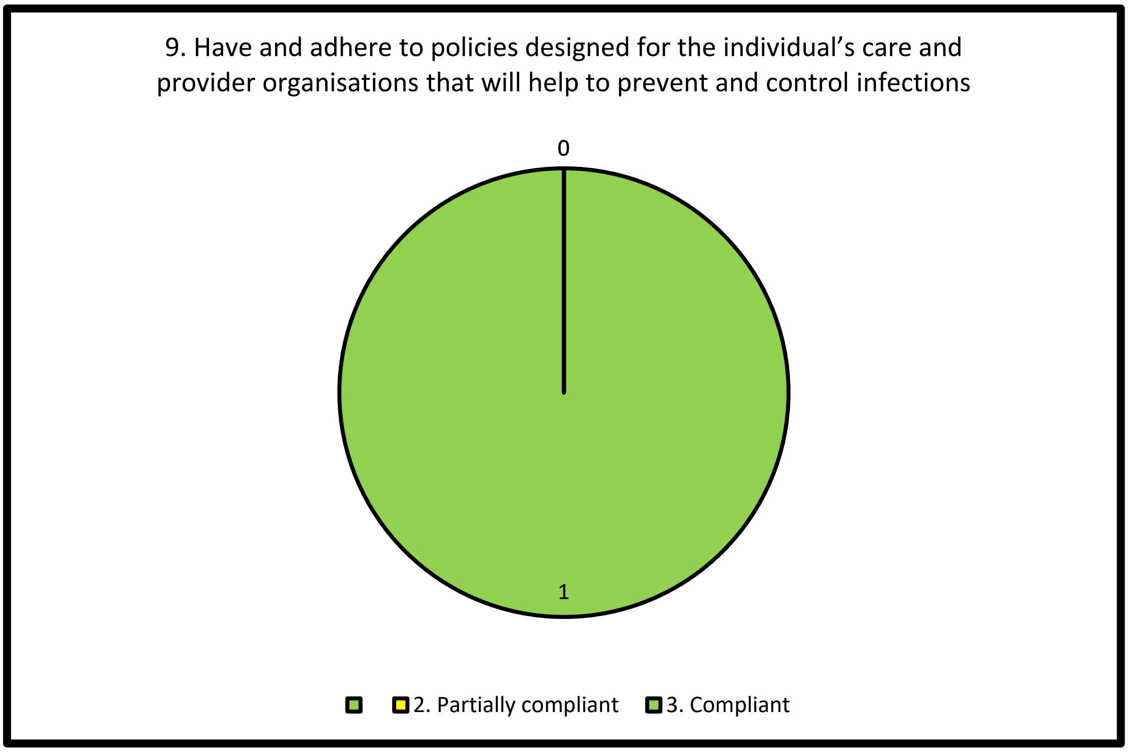
Laboratory Team members have been working for some time with our Blood Culture System vendors and Pathology IT to be able to generate blood bottle volume data to drive optimal bottle fill volumes through feedback and education. The first data set in which we can identify the originating wards against average fill volumes has been encouraging and the picture across the Trust will become clearer as more culture bottle sets are received.

Winter preparation for respiratory virus (COVID/Flu A/Flu B/RSV) testing was successful with GeneXpert PCR platforms available 24/7 in Emergency Department and Kingfisher Childrens Ward, a larger machine operated in the Microbiology Department for surge capacity and greater throughput. Testing peaked at over 500 samples per month aiding patient flow. Guidance on discharge to care homes changed earlier this year requiring fewer tests.

One Dorset Pathology Tier 1 for senior management combining both DCH and RBH Pathology was enacted in early 2024. Tiers 2 and 3 for the remaining laboratory team are anticipated in 2024. Laboratory staffing establishment vs. workload continues to be challenging with the potential to affect patient flow and IPC response at DCH if not addressed.

Following considerable reflection, DCHFT took the difficult decision to voluntarily withdraw the Microbiology Department from UKAS accreditation. We plan to become externally accredited to the latest 2022 standard once sufficient resources are available.

CRITERION NINE: Have and adhere to policies designed for the individuals care and provider organisations that will help prevent and control infections.



POLICY DEVELOPMENT/REVIEW

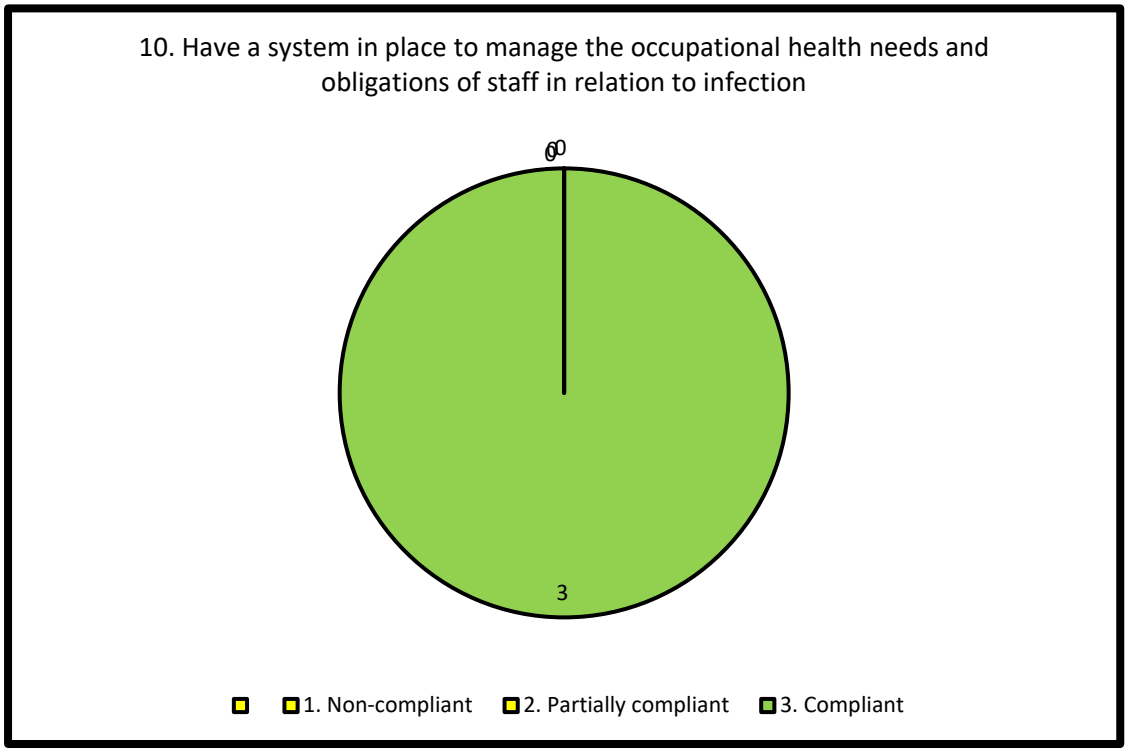
There is a comprehensive list of Infection Prevention and Control policies, procedures, and guidance on the trust intranet. These polices are reviewed by the IPCT and relevant specialities on a three or five yearly review date or when guidance changes, these documents are evidenced based and reflect national guidance. Compliance is audited with key polices as detailed in Criterion one.

The following policies have been developed / reviewed / removed during the year 2023-2024:

Ice Machines in the Trust - Guidance for the Use and Maintenance of
Transmissible Spongiform Encephalopathies (CJD/vCJD) - Infection Control of
Outbreak of COVID-19 - Policy for the Management of
Urinary Catheter Care Policy
Ebola Operational Guidance for Staff
Candida Auris - Screening Protocol for
Blood Cultures (Adults) - Policy for Taking
Infection Prevention & Control Policy
Avian Influenza - Infection Prevention and Control Advice for Management of Patients with Suspected
Multi-drug resistant gram-negative bacteria including extended spectrum beta-lactamases (ESBLs) - policy for the management of patients with
Clostridioides difficile Diarrhoea Policy
Carbapenemase Producing Enterobacteriaceae (CPE) - Policy for the Assessment and Management of Patients with
Isolation Policy
Norovirus and Infectious Diarrhoea Policy - Management of

Surveillance Guidelines
MRSA Policy
Viral Haemorrhagic Fever - Patients with Suspected - Policy for the Management of
Standard Precautions - Infection Control
Measles
Norovirus Ward Outbreak Pack
Admission for Patients Requiring a Planned/ Elective Procedure Accessing Ridgeway Ward – Low Risk Pathway - Standard Operating Procedure
Suspected Avian Influenza - Infection Prevention and Control Advice for Management of Patients with

CRITERION TEN: Have a system in place to manage the Occupational health needs and obligations of staff in relation to infection.



OCCUPATIONAL HEALTH REPORT – H Hunt Head of Occupational health.

DCHFT Occupational health service was provided by Optima health, but since January 2024 Dorset Healthcare now provide DCHFT with an Occupational health provision.

General Summary of Work relevant to the Infection Prevention and Control during this Quarter:

Dorset HealthCare Occupational Health Services (DHC OHS) commenced providing OHS to Dorset County Hospital (DCH) on the 2nd of January 2024, this report reflects the work carried in the Q4.

Vaccination data

Dorset County Hospital	Jan-24	Feb-24	Mar-24	TOTAL Q4
	No	No	No	No
Hepatitis B Vaccination	8	26	28	62
MMR Vaccination	5	16	16	37
Pertussis Vaccination	2	2	5	9
Varicella Vaccination	0	2	7	9
BCG Vaccination	0	0	1	1

Mantoux Test	0	0	1	1
Hepatitis B Blood Test	50	67	36	153
Hepatitis C Blood Test	19	25	16	60
HIV Blood Test	20	25	14	59
IGRA Test	37	42	16	95
Measles Blood Test	37	44	24	105
Rubella Blood Test	37	44	23	104
Varicella Blood Test	37	43	19	99
DNA / Canx 24 hours: Immunisation Appts	8	27	33	68

Following the Measles outbreak in areas of England, 454 questionnaires were sent to high-risk staff in this quarter 97 have been returned, 1 declined, 25 provided evidence, 61 booked in for blood test and 10 booked for MMR vaccine.

Sharps Data

28 Blood Borne Virus (BBV) incidents were reported to DHC OHS, 14 x Needlestick injuries, 5 contact with sharps, 3 x splash, 1 x bite & 5 x other.

Highest departments
5 – Operating theatres
5 - ED

Monthly BBV figures and details are sent to H&S Manager to review compliance with Datix reporting.

Other

No Occupational Dermatitis to report.

CONCLUSION

Last year has continued to be a challenging year for IPCT, as we continually strive to reduce healthcare associated infections, which has remained a priority for the trust, ensuring our patients, staff and the public are kept safe. The work of the IPC team remains unpredictable and, I would like to thank all the team for their hard work, dedication, and positive attitude throughout the year.

2023-2024 has been a successful year. The total CDI cases have reduced notably this year, trajectories for Gram negative blood stream infections have remained stable and Pseudomonas aeruginosa BSI rates well under the trajectory figure and we have continued to see a very low incidence of MRSA blood stream infections. We have successfully implemented the IPC Patient Safety Incident Response framework, completed the IPC Board Assurance Framework, and linked our compliance with the

yearly IPC optimisation plan. We have reviewed and developed many IPC related polices and improved our Candida Auris screening processes. All our ongoing IPC audits have showed an improve percentage this year.

This report demonstrates the continued commitment of the trust and demonstrates the success and service improvement through the leadership of a dedicated and committed IPC team. Infection Prevention and Control is the responsibility of all the Trust employees and the IPC team do not work in isolation. The successes over the last year have also only been possible due to the commitment for infection prevention and control of all DCHFT staff ensuring IPC is high on everyone's agenda.

The annual IPC optimisation plan for 2023-2024 reflects a continuation of support and promotion of IPC. Looking forward to 2024-2025 we will strive to maintain high standards within IPC and continue to develop strong Antimicrobial Stewardship, ensuring our staff maintain a high level of compliance with IPC. A robust governance structured approach across the whole organisation will remain crucial in the prevention of all healthcare associated infections.

Throughout 2024-2025 the IPC team will continue to strengthen and support close working relationships with the IPC Integrated Care System. Dorset-wide use of ICNET will continue support this work.

The trust remains committed to preventing and reducing the incidence and risks associated with HCAI's and recognises that we can do even more by continually working collaboratively together with colleagues, patients, service users and careers to develops and implement a wide range of IPC strategies, quality improvement projects and initiatives to deliver clean, safe care in our ambition to have no avoidable infections.

Emma Karamadoukis
IPC lead Specialist Nurse

REFERENCE

Department of Health (2015) Health and Social care Act 2008, Code of practice on the prevention and control of infections and related guidance, Available at: Health and Social Care Act 2008: code of practice on the prevention and control of infections , Accessed 15.04.2023

National Infection Prevention and Control manual for England (2022), NHS England » National infection prevention and control

APPENDIX ONE

Dorset County Hospital
NHS Foundation Trust

Infection prevention and Control Optimisation Programme

April 2023 to March 2024

Emma Karamadoukis, IPC Lead Specialist Nurse

Written: May 2023, updated September 202

Introduction

The programme will be monitored through the Infection Prevention and Control Committee with an annual progress report presented to the Quality Committee and be incorporated within the annual report. Each work stream / action is RAG rated as follows:

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

The Key Objectives have been identified from the completion of the IPC Board assurance framework, which aims to demonstrate compliance with the Health and Social Act 2008 and the Ten Criteria outlined in the Act. The objectives have been identified as partially complaint and therefore an area for development or improvement.

Key Objectives

Objective 1: Education - This objective links to the new IPC education framework and compliance with Tier three of the IPC education framework, Tier 1 & 2 are to be reviewed but expected to be already covered by the IPC mandatory training. The IPC team plan to implement separate face to face training to cover tier three.

Linked to Criterion 1 IPC BAF – 1 Systems to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks their environment and other users may pose to them, specifically - 1.7 All staff receive the required training commensurate with their duties to minimise the risks of infection transmission and Criterion 6 IPC BAF Appendix 1- Systems are in place to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection, Specifically , - 6.2 The workforce is competent in IPC commensurate with roles and responsibilities.

We will do this by:

- By the IPCT reviewing the recommended learning outcomes for Tier 1 & 2

- The IPCT to review the recommendations of Tier 3 and plan an implementation training programme to encompass all the learning outcomes. This will be largely but not inclusively, be relevant for all staff who are responsible for an area of care.

- The IPCT will liaise with all ward leads and Matrons to ensure compliance with the IPC education framework.

Objective 2: **Patient Safety - This objective links to the reset of IPC compliance following the Covid-19 pandemic, supporting leaders to find innovative ways to improve staff compliance with the National IPC Manual for England.**

Linked to Criterion 1 IPC BAF – 1 Systems to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks their environment and other users may pose to them, specifically – 1.4 - They implement, monitor, and report adherence to the NIPCM.

We will do this by:

- By developing a driver diagram QI project to reset IPC practice and compliance in four key areas: Improve hand hygiene, all staff to have the confidence and ability to challenge poor practice, improve peripheral Venous catheter. Appendix 3.

Objective 3: **Compliance - The IPCT will liaise with specific departments to ensure robust governance structures are in place to ensure close links, demonstrating IPC assurance and departmental collaboration. Which will feed into IPC Committee meetings, highlighting areas of concern and demonstrate clear escalation processes.**

Linked to Criterion 2 IPC BAF - Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections, specifically IPC BAF sections 2.3 - There are clear guidelines to identify roles and responsibilities for maintaining a clean environment (including patient care equipment) in line with the national cleanliness standards, 2.7 - The classification, segregation, storage etc of healthcare waste is consistent with HTM:07:01 which contains the regulatory waste management guidance for all health and care settings (NHS and non-NHS) in England and Wales including waste classification, segregation, storage, packaging, transport, treatment, and disposal., and 2.9 - Food hygiene training is commensurate with the duties of staff as per food hygiene regulations. If food is brought into the care setting by a patient/service user, family/carer or staff this must be stored in line with food hygiene regulations., and Criterion 3 IPC BAF Appendix 1- Ensure appropriate antimicrobial stewardship to optimise service user outcomes and to reduce the risk of adverse events and antimicrobial resistance, specifically IPC BAF sections 3.5 - Contractual reporting requirements are adhered to, progress with

incentive and performance improvement schemes relating to AMR are reported to the board where relevant, and boards continue to maintain oversight of key performance indicators for prescribing, including:

- **total antimicrobial prescribing.**
- **broad-spectrum prescribing.**
- **intravenous route prescribing.**
- **treatment course length, 3.6 - Resources are in place to support and measure adherence to good practice and quality improvement in AMS. This must include all care areas and staff (permanent, flexible, agency, and external contractors).**

We will do this by:

- By the IPCT attending all relevant committee meetings and provide IPC support and guidance when relevant.
- The IPCT will request and remind departments for their reports for discussion and review, with recommendations and presentation at the bi-monthly IPC committee meetings.
- The IPCT will liaise with AMS trust lead and AMS microbiologist to support the role and support the planned QI improvement programme within this speciality.

Objective 4 – Patient Safety - The Implementation of PSRIF (Patient safety Incident Response Framework) within IPC and within the wider Integrated Care system (ICS) for Dorset. Using this framework to review reportable infections whether they be COCA (Community Onset Community Associated), COIA (Community Onset Indeterminate Associated), COHA (Community Onset Healthcare Associated) or HOHA (Hospital Onset Healthcare Associated) cases.

Linked to Criterion 1 IPC BAF - 1 Systems to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks their environment and other users may pose to them, specifically IPC BAF sections 1.3 - That there is a culture that promotes incident reporting, including near misses, while focusing on improving systemic failures and encouraging safe working practices, that is, that any workplace risk(s) are mitigated maximally for everyone.

We will do this by:

- The IPC lead attending the trust PSIRF workshops to identify the best way to implement the framework within IPC.

- The IPC ICS team to work closely together with the aim of moving away from Post Infection reviews of all COHA & HOHA CDI, MSSA and MRSA cases but to explore ways to provide an end-to-end review of the patients journey that led to an infection. The new process will involve each trust organisation bringing to the monthly meetings cases for discussion and identifying any lesson learnt. Each trust will carry out a comprehensive review of the patient experience to include all healthcare interventions. With this process in place, we will be inviting our colleagues from primary care, community care local authority to attend these meetings and review the patient's journey. The three trusts within Dorset will continue to carry out their own internal infection review processes.

Objective 1 – Education							
Issue	**Desired Outcome**	**Action(s)**	**Evidence/Assurance**	**Lead(s)**	**Target Date**	**Update**	**RAG**
1.1 Ensure DCH achieves Tier 1 & 2 of the IPC education framework.	All Staff complaint with their IPC education framework	• IPCT to check IPC framework against trust IPC e- learning module.	• Monitor trust compliance with IPC mandatory training.	Emma Karamadoukis/Chris Gover/Julie Park	November 2023	Julie/Emma have obtained the E learning modules, now need to compare against framework.	G
		• IPCT to check IPC framework against trust IPC face to face training.	• Gain feedback for staff following completion. • Re start face to face training for medical staff • IPCT to get link persons for all allied healthcare professional specialities and department and gain better engagement.	Emma Karamadoukis/Chris Gover/Julie Park	July 2023 November 2023 November 2023	Chris is linking with medical education teams to develop medical IPC training. Update IPC now carry out IPC training as required and deemed necessary. Housekeeping staff, Preceptees, junior doctors and ward staff training completed 2023.	G

Objective 1 – Education							
Issue	**Desired Outcome**	**Action(s)**	**Evidence/Assurance**	**Lead(s)**	**Target Date**	**Update**	**RAG**
1.2 Ensure DCH achieves Tier 3 of the IPC education framework	All Staff responsible for an area of care are complaint with their IPC education framework Tier 3	• IPCT to review the learning outcomes and devise a training plan appropriately.	• System in place.	Emma Karamadoukis/Chris Gover/Julie Park	January 2024	Programme to be in place by Summer 2024, carried into next optimisation plan.	**A**
		• IPCT to review a behaviour change approach, as suggested the COM-B model, and identify was to implement.	• Understand the model and implement with the training programme	Emma Karamadoukis	January 2024	Programme to be in place by Summer 2024, carried into next optimisation plan.	**A**
		• IPCT to link with other specialist teams to support the training programme.	• System in place and all leaders attend the training yearly.	Emma Karamadoukis/Chris Gover/Julie Park	January 20204	Programme to be in place by Summer 2024, carried into next optimisation plan.	**A**

Objective 2 – Patient Safety							
Issue	**Desired Outcome**	**Action(s)**	**Evidence/Assurance**	**Lead(s)**	**Target Date**	**Update**	**RAG**
2.1 Reset of IPC compliance following the Covid-19 pandemic, supporting leaders to find innovative ways to improve staff compliance with the National	IPC compliance improves across the trust.	• IPCT to develop ways to improve IPC compliance across the trust.	• IPCT to develop a driver diagram to demonstrate IPC quality improvement plans. Appendix 3. Action tracker to be developed alongside the Driver diagram. Appendix 3.	Emma Karamadoukis	April 2023	Completed and shared at IPCC May 2023.	**G**

Objective 2 – Patient Safety							
Issue	**Desired Outcome**	**Action(s)**	**Evidence/Assurance**	**Lead(s)**	**Target Date**	**Update**	**RAG**
Manual for England.							

Objective 3 - Compliance							
Issue	**Desired Outcome**	**Action(s)**	**Evidence/Assurance**	**Lead(s)**	**Target Date**	**Update**	**RAG**
3.1 The IPCT will liaise with specific departments to ensure robust governance structures are in place to ensure close links with other key departments related to IPC, supporting IPC assurance and agreement.	IPCT support housekeeping with their compliance, with regards to national cleaning standards.	• IPCT to liaise closely with Sarah Jenkins and support Audits and overall hospital presentation.	• Efficacy audits • PLACE and PLACE LIGHT reviews	Emma Karamadoukis/Chris Gover/Julie Park/Sarah Jenkins/Helen Hindley/Sophie Lloyd	Ongoing May 2023	PLACE and PLACE LIGHT dates set for the year. Ongoing and carried forward for 24-25 optimisation plan.	**G**
	IPCT support the water safety Group with IPC compliance.	• IPCT to liaise closely with Toby Markin the Trusts Authorising Officer and Terry May. • Emma Karamadoukis to arrange meeting with Microbiology Cathy Jeppesen and Toby Markin to discuss expectations between the two departments. • IPCT to attend the Water Safety Group meetings and link closely when concerns are raised.	• Clear escalation plans • Close monitoring of water safety reports and these should feed into the Water Safety Group and IPCC	Emma Karamadoukis/Chris Gover/Julie Park/Toby Markin/Terry May	June 2023	Emma Karamadoukis has arranged a meeting with Toby Markin and Microbiology for June 2023. Meeting completed Toby is working through water safety assurance and will link closely with all relevance teams and provide an update during IPC committee meetings.	**G**

Objective 3 - Compliance							
Issue	**Desired Outcome**	**Action(s)**	**Evidence/Assurance**	**Lead(s)**	**Target Date**	**Update**	**RAG**
						Ongoing and carried forward for 24-25 optimisation plan.	
	IPCT support the Ventilation safety Group with IPC compliance.	• IPCT to liaise closely with Colin Carver, the Trusts Ventilation Authorising Officer. • Emma Karamadoukis to request a ventilation update for all IPCC meetings. • IPCT to attend the Ventilation Safety Group meetings and link closely when concerns are raised.	• Clear escalation plans • Close monitoring of Ventilation reports and these should feed into the water safety groups and IPCC	Emma Karamadoukis/Chris Gover/Julie Park/Colin Carver/Terry May	Ongoing May 2023	Emma Karamadoukis has requested a Ventilation update for IPCC, using a suggested chart to provide cleaning assurance. Ongoing and carried forward for 24-25 optimisation plan.	G
	IPCT support an effective antimicrobial stewardship in accordance with local and national guidelines	• Antimicrobial Stewardship action plan to be written. • IPCT to support the National point Prevalence Survey of HCAI and Antimicrobial use in England. • If IPC funding/staff budget allows, to recruit into a newly developed AMS nurse specialist post.	• Action plan submitted to Antimicrobial Stewardship Committee (ASC) and reviewed at Medicines Committee and Infection Prevention and Control Committee. • National PPS to be completed with the support from the trust. • AMS nurse in post.	Rhian Pearce/Emma Karamadoukis/Cathy Jeppesen	July 2023 – still ongoing	Antimicrobial stewardship Plan being created – to be reviewed at Medicines Committee and Infection Prevention and Control Committee. Emma has discussed with UHD AMS nurse specialist, Emma to develop job	G

Objective 3 - Compliance							
Issue	**Desired Outcome**	**Action(s)**	**Evidence/Assurance**	**Lead(s)**	**Target Date**	**Update**	**RAG**
						description and advertise job ASAP. AMS working group started 11/12/2023, Cecilia Priestley leading the group. UKHSA national point prevalence survey of healthcare-associated infections and antimicrobial completed November 2023, AMS nurse post paused due to funding hold. CNO to liaise with UHS and head of pharmacy re AMS support. Ongoing and carried forward for 24-25 optimisation plan.	
	IPCT support the Decontamination Group with IPC compliance.	• IPCT to liaise closely with Joe Lythe, the Trusts Decontamination Lead. • Emma Karamadoukis to request a	• Chris Gover to become the Deputy Decontamination lead, attend relevant course and support	Chris Gover/Joe Lythe	September 2023	Chris Gover is booked on the relevant course for September 2023.	G

Objective 3 - Compliance							
Issue	**Desired Outcome**	**Action(s)**	**Evidence/Assurance**	**Lead(s)**	**Target Date**	**Update**	**RAG**
		decontamination update for all IPCC meetings. • IPCT to support the decontamination lead in his role.	Joe Lythe with his role as lead.				

Objective 4 – Patient Safety							
Issue	Desired Outcome	Action(s)	Evidence/Assurance	Lead(s)	Target Date	Update	**RAG**
4.1 The Implementation of PSIRF (Patient safety Incident Response Framework) within IPC and the wider Integrated Care system (ICS) for Dorset	• DCH IPCT to review and develop a new process for the implementation of PSIRF for Gram negative/MRSA/MSSA and CDI organisms.	• Emma Karamadoukis to attend all trust PSRIF workshops and devise a plan for PSIRF to be implemented within IPC.	• Attend workshops or send a representative for IPC.	Emma Karamadoukis	September 2023	Emma Karamadoukis has attended the first two workshops.	**G**
		• Develop a process for IPC to collaborate with the microbiology team and leads for the reviews of all HOHA and COHA using the PSRIF framework for Gram negative/MRSA/MSSA and CDI organisms.	• Emma Karamadoukis to collaborate with the microbiology team and present a plan for the implementation of PSRIF.	Emma Karamadoukis	September 2023	Emma Karamadoukis has developed an IPC PSIRF plan and shared across team, awaiting feedback July 2023.	**G**
		• Once PSIRF plan agreed – implement process and review progress.	• Emma Karamadoukis to collaborate with the microbiology team and present a plan for the	Emma Karamadoukis	September 2023	Once process agreed Emma Karamadoukis will implement, awaiting new	**G**

			implementation of PSRIF.			consultant microbiologist to start to free up time for consultants to support new process. Date for meeting planned October 2023 with microbiology team. IPC PSIRF plan to start 01/01/2024, communications sent.	
	System wide process for the implementation of PSIRF and develop a new Post Infection review Process.	• PSIRF to be implemented systemwide during all PIR meetings.	• Close working with the wider Dorset system and develop an implementation programme.	IPC ICS Dorset system	April 2023	New process in place and under review for improvement. Including the use of ICNET results page to enable better initial reviews.	**G**

Appendix 3 – Driver Diagram and Action tracker for QI plan for IPCT

IPC Action Tracker

Staff involved
Emma Karamadoukis (EK)
Chris Gover (CG)
Jules Park (JP)
Helen Hindley (HH)
Sophie Lloyd (SL)
Cheryl Heard (CH)

Action status key:	Status
Open	Open and needs action
In progress	In progress or completed but needs checking
Closed	Completed and signed off
No action	Not actioned (reason for no action to be added in Progress/outcome column)

Date Action Logged	Detail/ Action	Name/Org of person responsible for	Progress/outcome	Action status	Deadline
01/05/2023	Ad hoc ward visits and education on hand hygiene, continued hand hygiene audits.	IPC team	IPC Teams carry out more ward rounds, ad hoc teaching and close engagement with wards.	Closed	
01/05/2023	Re education on the correct way to complete ward hand hygiene audits	IPC team	Chris Gover has engaged with wards and emailed the correct processes to carry out Hand hygiene audits.	Closed	
01/05/2023	DCH IPC promotion week 'Brush up on your IPC week'	IPC team	Date set for 1st week in July. Trust has completed Recycle, refresh and reset week, IPC team ensured good IPC focus particularly on PPE, hand hygiene and uniform policy adherence.	Closed	
01/05/2023	Standing item on weekly comms on relevant IPC information	IPC team	IPC team has commenced weekly IPC comms.	Closed	
01/05/2023	Staff placement for learning with IPC	IPC team	IPC team encourage all interested staff to attend IPC ward rounds to improve knowledge, Student placements within IPC continue. We have had Clinical site managers and students and the wider ICS IPC visit IPC team for training	Closed	
01/05/2023	IPC champion on celebrating success	IPC team	IPC team have started championing good IPC practice within the celebrating success bulletin	Closed	
01/05/2023	Use Shock tactics of poor compliance with PVC compliance i.e. Cannula catastrophe	IPC team		Closed	
01/05/2023	Engage volunteers in IPC Knowledge	IPC team		Closed	
01/05/2023	Quarterly IPC Newsletter	IPC team	May 2023 newsletter launched. Next one due out August 2023.	Closed	
01/05/2023	Re-Enforce uniform policy through training Particularly HCA care certificate, IPC ward rounds and modelling by senior leaders. IPC to use new ideas to get the message across.	IPC team	New uniform policy produced and was a large focus during recycle, refresh and reset week 1st July 2023. Poor compliance is an ongoing issue and the IPC team will continue it challenge daily.	Closed	
01/05/2023	Production of communications led media to demonstrate acceptable standards	IPC team	New IPC twitter account set up and CNO and Deputy CNO has assisted with social media.	In progress	

Report Front Sheet

1. Report Details			
Meeting Title:	Board of Directors, Part 1		
Date of Meeting:	31 July 2024		
Document Title:	**Clinical Audit Annual Assurance Report**		
Responsible Director:	Alastair Hutchison, Chief Medical Officer	Date of Executive Approval	
Author:	Liz Bradbury, Strategic Clinical Audit Lead/ Clinical Effectiveness Manager		
Confidentiality:	No		
Publishable under FOI?	Yes		
Predetermined Report Format?			

2. Prior Discussion		
Job Title or Meeting Title	**Date**	**Recommendations/Comments**
Clinical Effectiveness Committee		
Quality Committee	18/06/2024	Received and noted
Risk and Audit Committee	18/06/2024	Noted and forwarded to Board

3. Purpose of the Paper							
	Note (✓)	✓	*Discuss (✓)*		*Recommend (✓)*		*Approve (✓)*
4. Key Issues	A summary of our performance in the National Clinical Audit Programme is outlined in the appendix to this report: 'What this Trust knows about National Clinical Audits 2023/24. During 2023-24, 59 National clinical audits covered relevant health services that the Trust provides. During that period the Trust participated in (53/59) 89.8% National Clinical Audits and 100% National Confidential Enquiries which it was eligible to participate in This Trust Registered 189 Local Clinical Audits and 28 Non-Quality Account National Audits in 2023/24. The reports of 89 Local Clinical Audits were reviewed by the provider in 2023/24. A selection of these is catalogued in summary of our learning from these audits is attached as an appendix to this report – 'Learning from Local Clinical Audits at Dorset County Hospital 2023/24. In addition, the Trust participated in all NCEPOD studies relevant to this Trust. - The reports of National Clinical Audits were reviewed by the provider in 2023-24.						
5. Action recommended	The Board is recommended to: 1. **NOTE** the 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 goals does this report link to / support?** *Please summarise how your report contributes to the Dorset ICS key goals.* *(Please delete as appropriate)*		
Improving population health and healthcare		**Yes**	**No**	*If yes - please state how your report contributes to improving population health and health care*
Tackling unequal outcomes and access		**Yes**	**No**	*If yes - please state how your report contributes to tackling unequal outcomes and access*
Enhancing productivity and value for money		**Yes**	**No**	*If yes - please state how your report contributes to enhancing productivity and value for money*
Helping the NHS to support broader social and economic development		**Yes**	**No**	*If yes - please state how your report contributes to supporting broader social and economic development*
Assessments		**Have these assessments been completed?** *If yes, please include the assessment in the appendix to the report.* *If no, please state the reason in the comment box below.* *(Please delete as appropriate)*		
Equality Impact Assessment (EIA)		**Yes**	**No**	
Quality Impact Assessment (QIA)		**Yes**	**No**	

Dorset County Hospital NHS
NHS Foundation Trust

Annual Clinical Audit Report 2023/24

Dorset County Hospital NHS Foundation Trust

Report completed by:

Liz Bradbury
Strategic Clinical Audit Lead/ Clinical Effectiveness Manager

Alastair Hutchison
SRO Clinical Audit

Submitted to the Clinical Effectiveness Committee and Risk and Audit Committee

Date: June 2024

Contents Section

1. Overview/summary of audit activity

Clinical audit activity for 2023/24

A summary of our performance in the National Clinical Audit Programme is outlined in the appendix to this report: 'What this Trust knows about National Clinical Audits 2023/24. During 2023-24, 59 National clinical audits covered relevant health services that the Trust provides.

During that period the Trust participated in (53/59) 89.8% National Clinical Audits and 100% National Confidential Enquiries which it was eligible to participate in

This Trust Registered 189 Local Clinical Audits and 28 Non-Quality Account National Audits in 2023/24. The reports of 89 Local Clinical Audits were reviewed by the provider in 2023/24. A selection of these is catalogued in summary of our learning from these audits is attached as an appendix to this report – 'Learning from Local Clinical Audits at Dorset County Hospital 2023/24.

In addition, the Trust participated in all NCEPOD studies relevant to this Trust.
The reports of National Clinical Audits were reviewed by the provider in 2023-24.

2. Organisation of Clinical Audit at Dorset County Hospital

2.1 Clinical Effectiveness Committee (CEC)

Clinical Audit issues are discussed at the CEC.
CEC meeting initially quarterly and From January 2024 will meet every two months.

At this meeting Liz Bradbury (Clinical Effectiveness Manager) reports on how Clinical Audit is managed within the Trust, including any changes we need to make in response to HQIP guidance or changes in requirements from our regulators.

Issues arising from national or local audits are discussed; in addition good practice identified through clinical audit is also highlighted.

Concerns arising from poor clinical audit results are placed on the risk register by the clinical teams but are also escalated through CEC to the Quality Committee.

CEC receives the Trust's Clinical Audit Plan; this is then submitted annually to the Quality Committee and Risk & Audit Committee. The Trust's Risk & Audit Committee also has oversight of the Trust's Clinical Audit Plan.

The Terms of Reference for CEC and the Strategy for the group were updated in 2023/24 and can be found on the Trust's intranet pages.

The Trustwide Clinical Audit Policy was last updated on August 17th, 2022.

We have an Organisational Structure for each Division: -

Division A; Urgent and Integrated Care Division.
Division B; Family Services and Surgical Division.

There is a named Governance Lead for each of the Care Groups within the two Divisions, ensuring representation in each clinical area.

2.2 Clinical Audit and Quality Department

The Clinical Audit and Quality team comprises:

- O.6 wte Clinical Effectiveness Manager (R/N), Liz Bradbury (retired May2024)
- 1 wte (RN), Claire Jackson Clinical Quality Facilitator.
- 0.8 wte Compliance Facilitator, Christine Curran
- 3.2 wte Clinical Audit Facilitators Helen Aves 0.6 wte, Heather Sellers 1 wte, Kate Drew 0.6 wte. (Petra Johnson currently 1wte seconded as Digital Change Support Officer until 1/9/24)

The clinical audit facilitators support all areas of the Trust to ensure that clinical audit is completed in a consistent manner with robust monitoring and reporting through all divisions and up to Trust Board.

The Clinical Quality Facilitator provides support across the Trust in specifically targeted projects which support the Director and Deputy Director of Nursing and Quality in the Patient Safety Agenda across the Trust.

The Clinical Effectiveness Manager and Clinical Quality Facilitator provides line management across the audit facilitators. She oversees the recording, review and monitoring of external and internal guidance as well as undertaking specific project work to support the Director and Deputy Director of Nursing and Quality.

The Compliance Facilitator maintains the Clinical Guidelines and NICE databases ensuring that all work is monitored and recorded.

2.3 Clinical Audit Operational Group

The Clinical Audit Operational Group comprises:

- Liz Bradbury — Clinical Effectiveness Manager - retires May 2024
- Claire Jackson — Clinical Quality Facilitator
- Alastair Hutchison — Medical Director
- Emma Hoyle — Deputy Chief Nursing Officer

2.4 Clinical Audit Screening Group

The Clinical Audit Screening Group comprises:

- Clinical Effectiveness Manager
- Clinical Quality Facilitator
- Clinical audit facilitators
- Care Group Governance Leads are expected to submit their annual Clinical Audit Plans through the Divisional Governance meetings for approval. Members of the team are expected to have approval from the Governance lead before Registering their audit.

This group meets once every two weeks to review all clinical audit proposals and patient surveys. The main aim of this group is to improve the quality of clinical audits carried out at the Trust. By screening audit proposals we offer help and advice to clinicians at a planning stage and review the value of the audit against the Trust's priorities.

This screening stage also allows us to ensure that there is no duplication of audit work in different areas of the Trust. It also ensures that all stakeholders are aware of proposed audits before they are started and ensures that there are no ethical issues which need to be addressed. More Integration of the Governance groups to share information where projects overlap is expected - previously addressed through A.R.T.I.S.T. that became P.A.R.T.I in 2022 then abandoned in 2022, to be reformed as Quality Intelligence.

2.5 Clinical Audit Team Meetings

These meetings have not been established on a regular basis and process (below) has been informal but the plan from May 2024 onward is for monthly meetings attended by: Clinical Effectiveness Manager
Clinical Quality Facilitator
Clinical audit facilitators.

This team meets before CEC meetings to review progress with the Clinical Audit Plan, to chase up outstanding clinical audit reports or action plans, review progress with NCEPOD studies, discuss audits of interest or concern for escalation to CEC, review any new HQIP guidance that has been published, review any issues raised at regional networking meetings.

3. Assessment of Performance

3.1 National Clinical Audit Patients Outcome Programme (NCAPOP) audits

The terms of the NHS standard contract for acute hospitals require Trusts to participate and implement all relevant recommendations for the NCAPOP audits which are relevant to the services we provide.

In 2023/24 we were unable to participate in 5 NCAPOP audits:

- Adult Respiratory Audit - The Trust does not have a Higher Respiratory Care Ward, so could not participate.
- British Hernia Registry - lack of resource to enable participation, decision at Care Group Governance meeting by General Surgeons.
- Emergency Medicine QIPs: *a. Care of Older People, b. Mental Health Self Harm.*
- UK Renal Registry *Acute Kidney Injury programme* - Clinician Governance Lead reason was a preference that Local Audit 5866 be completed.
- National Vascular Registry
- Perioperative Quality Improvement Programme: Research project in this Trust, Governance with Research dept - not registered as an Audit.

Our learning from national clinical audits is summarised in the appendix to this report – 'What this Trust knows about National Clinical Audits 2023/24

3.2 National Confidential Enquiry into Patient Outcomes and Death (NCEPOD)

In 2023/24 we entered data into all NCEPOD studies that we were eligible to participate in.

Mark Pulletz is the DCH NCEPOD Ambassador. Mark ensures that NCEPOD reports are reviewed and that the relevant teams have action plans in place to address any shortfalls. A summary of our learning from NCEPOD reports is included in the appendix to this report – 'What this Trust Knows about National Clinical Audits 2023/24

3.3 HQIP National Clinical Audit Benchmarking (NCAB)

Updated in 2023 and presenting data from 2022; therefore 18+ months in arrears

National Ophthalmology Database Audit- National Ophthalmology Database Audit benchmarks for Dorset County Hospital NHS Foundation Trust - ncab (hqip.org.uk)

National Prostate Cancer Audit -National Prostate Cancer Audit benchmarks for Dorset County Hospital NHS Foundation Trust - ncab (hqip.org.uk)

National Bowel Cancer Audit – National Bowel Cancer Audit benchmarks for Dorset County Hospital NHS Foundation Trust - ncab (hqip.org.uk)

National Audit of Breast Cancer in Older Patients- National Audit of Breast Cancer in Older Patients benchmarks for Dorset County Hospital NHS Foundation Trust - ncab (hqip.org.uk)

Oesopho-gastric cancer audit – National Oesophago-Gastric Cancer Audit benchmarks for Dorset County Hospital NHS Foundation Trust - ncab (hqip.org.uk)

Maternal, Newborn and Infant Clinical Outcome Review Programme- Maternal, Newborn and Infant Clinical Outcome Review Programme benchmarks for Dorset County Hospital NHS Foundation Trust - ncab (hqip.org.uk)

National Neonatal Audit Programme - National Neonatal Audit Programme benchmarks for Dorset County Hospital - ncab (hqip.org.uk)

National Audit of Inpatient Falls- National Audit of Inpatient Falls benchmarks for Dorset County Hospital NHS Foundation Trust - ncab (hqip.org.uk)

National Joint Registry- National Joint Registry benchmarks for Dorset County Hospital - ncab (hqip.org.uk)

Fracture Liaison Service Database - Fracture Liaison Service Database benchmarks for Dorset County Hospital - ncab (hqip.org.uk)

4. Clinical Audit Progress and Development

4.1 Monitoring progress of the clinical audit annual plan

Annually a Trust Clinical Audit Plan (TCAP) is Produced by the Clinical Audit Team. Reviewed by Risk Manager and Corporate Risk References noted also reviewed by Head of Strategy and corporate planning and BAF References added. Progress is reviewed regularly by the Clinical Audit Team and through the Clinical Effectiveness Committee.

4.2 Reporting to divisions

The divisions are provided with monthly summaries of clinical audit activity. These summaries are reviewed at Care Group and Divisional Clinical Governance meetings and any concerns about the frequency and depth of review are addressed by the (Triumvirate (Lead Nurse, Divisional Director and Divisional Manager) assisted by the Quality Manager.

4.3 Follow up of action plans

The audit team provides the divisions with reports of outstanding actions from clinical audit reports. The responsibility for follow up of completion of these actions remains with the divisional Triumvirates.

4.4 Education and training

Our key tool for clinical audit training is the 'Online Clinical Audit Training Package'. The online training appears to be underutilised although it is actively promoted to staff new to clinical audit. Monitoring utilisation will be easier in 2024 now that all staff have migrated to Office 365.

The Clinical Audit Team can provide support to teams within the Trust who have requested training, or where we perceive a training need. The Quality Manager,

Clinical Effectiveness Manager, Patient Safety Coordinator/Clinical Quality nurse and one Clinical Audit Facilitator in the Family Services & Surgery Division received bespoke training from an external provider to update their knowledge and skills in 2022/23.

4.5 Patient and public involvement
Currently there is not a patient and public representative on the Clinical Effectiveness Committee, but the expectation is that at least one will be recruited in 2024/25.

4.6 Junior Doctors and Clinical Audit
Alison Cooper joined the Trust in May 2024 as Deputy Medical Director and in her role is working closely with the medical teams to develop improved Clinical Governance around the Trust's Clinical Audit Plan.

4.7 Sharing of good clinical audit practice
Good audit practice is shared through distribution of the following monthly reports provided by the Clinical Audit Facilitators:

- National Audit Activity for Urgent & Integrated Care Division (A)
- National Audit Activity for Family Services & Surgical Division (B)
- Divisional Clinical Audit Report for Urgent & Integrated Care Division (A)
- Divisional Clinical Audit Report for Family Services & Surgical Division (B)
- Bimonthly Clinical Effectiveness Meetings (CEC) (Chaired by Medical Director / Deputy Director of Nursing, and an escalation report is sent to Quality Committee.

The Annual Clinical Audit Competition hasn't taken place since 2019.

4.8 Networking
We continue to support clinical audit networking as we find it valuable to benchmark our audit performance against neighbouring Trusts, explore how neighbouring Trusts have tackled similar issues and share good practice and ideas.

5. Strategic Aims for 2023/24

1. **National Clinical Audit Patients Outcome Programme (NCAPOP) audits –** ensure participation in all eligible NCAPOP programme audits

2. **Quality Account audits –** ensure participation in all eligible Quality Account audits. To escalate nonparticipation of any audits through CEC to the Trust's Quality and Audit Committees

3. **Documentation and Consent –** to review how we audit the quality of our medical records and consent processes as we migrate to a full digital patient record.

4. **Action planning -** To work with the divisions to improve appropriateness of clinical audit action planning and follow up of action plans

Appendices

Appendix 1 – Quality Account 2023/24 - Overview of what this Trust learnt from Clinical Audit in 2023/24.

Respect Integrity Teamwork Excellence

NHS Dorset County Hospital NHS Foundation Trust

Quality Account 2023/24

Part 2

Clinical Audit

During 2023-24, 59 National clinical audits covered relevant health services that the Trust provides.

During that period the Trust participated in (53/59) 89.8% National Clinical Audits and 100% National Confidential Enquiries which it was eligible to participate in.

The National Clinical Audits and National Confidential Enquiries that the Trust was eligible to participate in during 2023-24 are as follows within the table.

The National Clinical Audits and National Confidential Enquiries that the Trust participated in during 2023-24 are as follows within the table:

The National Clinical Audits and National Confidential Enquiries that the Trust participated in, and for which data collection was completed during 2023-24, are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry.

National Clinical Audits

The NHS England-funded National Clinical Audit and Patient Outcomes Programme (NCAPOP) are a mandatory part of NHS contracts, and as such we are required to participate in those that relate to services provided by this Trust. The following table describes the audits we have participated in, and the relevant compliance.

* Please note that in some cases the % of Registered Cases is above 100%; this is because the trust was able to identify additional cases than those identified by the HES (Hospital Episode Statistics) data

Name of Audit	Notes	Trust Eligible	Trust Participation	Cases Submitted	Percentage cases registered
Adult Respiratory Audit	Trust does not have a Higher Respiratory Care Ward	Y	N		
BAUS Nephrostomy Audit	Audit Data submitted on BAUS jotform 13/2/24.	Y	Y	2	100%
Breast and Cosmetic Implant Registry		Y	Y	no data available	
British Hernia Registry	Lack of resource to enable participation. Decided at Care Group Governance meeting	Y	N	no data available	

Case Mix Programme	Critical Care	Y	Y	679	100%
Child Health Clinical Outcome Review Programme		Y	Y	no data available	
Elective Surgery: National PROMs Programme		Y	Y	no data available	
Emergency Medicine QIPs:					
a. Care of Older People		Y	N	no data available	
b. Mental Health Self Harm		Y	N	no data available	
Epilepsy 12 - National Clinical Audit of Seizures and Epilepsies for Children and Young People		Y	Y	no data available	
Falls and Fragility Fracture Audit Programme 1:					
a. Fracture Liaison Service Database		Y	Y	no data available	
b. National Audit of Inpatient Falls		Y	Y	6	
c. National Hip Fracture Database		Y	Y	#NOF – 333 Peri-prosthetic # - 22 Femoral # - 12	
Improving Quality in Crohn's and Colitis (IQICC)		Y	Y	no data available	
LeDeR - learning from lives and deaths of people with a learning disability and autistic people		Y	Y	7	100%
Maternal and Newborn Infant Clinical Outcome Review Programme 1		Y	Y	no data available	
Medical and Surgical Clinical Outcome Review Programme 1		Y	Y	no data available	

National Confidential Enquiry into Patient Outcome and Death					
National Adult Diabetes Audit					
a. National Diabetes Core Audit		Y	Y	1044	100%
b. National Diabetes Foot care Audit		Y	Y	no data available	
c. National Diabetes Inpatient Safety Audit		Y	Y	20	100%
d. National Pregnancy in Diabetes Audit		Y	Y	10	100%
National Respiratory Audit Plan (NRAP)	(Previously NACAP)				
a. Adult Asthma Secondary Care		Y	Y	48 (3 opted out	100%
b. Chronic Obstructive Pulmonary Disease Secondary Care		Y	Y	159 (5 opted out)	100%
c. Paediatric Asthma Secondary Care		Y	Y	17 (1 opted out)	100%
d. Pulmonary Rehabilitation- Organisational and Clinical Audit		Y	Y	no data available	
National Audit of Cardiac Rehabilitation		Y	Y	no data available	
National Audit of Care at the End of Life	During pause in 23/24 a Local Audit #5843 was undertaken based on NACEL round 3, 2021/22 benchmarks and NG31.	Y	Y	14 Staff Surveys 0 Quality Surveys 31 Case note Audits. To date 23/4/24	NACEL Audit Resumed Data collection from 1/1/24.
National Cancer Audit Collaborating Centre- National Audit of Metastatic Breast Cancer		Y	Y	no data available	
National Cancer Audit Collaborating Centre- National Audit of Primary Breast Cancer		Y	Y	no data available	

National Cardiac Arrest Audit		Y	Y	no data available	
National Cardiac Audit Programme					
c. National Heart Failure Audit		Y	Y	302 (15 opt outs)	
d. National Audit of Cardiac Rhythm Management		Y	Y	no data available	
e. Myocardial Ischaemia National Audit Project		Y	Y	no data available	
f. National Audit of Percutaneous Coronary Interventions		Y	Y	no data available	
National Child Mortality Database 1		Y	Y	no data available	
National Comparative Audit of Blood Transfusion:				no data available	
a.2023 Audit of Blood Transfusion against NICE Quality Standard 138		Y	Y	138	100%
b. 2023 Bedside Transfusion Audit		Y	Y	10	100%
National Early Inflammatory Arthritis Audit (NEIAA)		Y	Y	data being collected	
National Emergency Laparotomy Audit		Y	Y	80/92	87%
National Gastro-Intestinal Cancer Audit Programme (GICAP)					
a. National Bowel Cancer Audit (NBOCA)		Y	Y	no data available	
b. National Oesophageal-Gastric Cancer Audit (NOGCA)		Y	Y	no data available	
National Joint Registry Knees primary/Revision		Y	Y	TKR 295	

Hips primary +revisions		Y	Y	THR 349	
Shoulder primary revisions		Y	Y	Shoulder 34	
National Lung Cancer Audit (NLCA)		Y	Y	no data available	
National Maternity and Perinatal Audit (NMPA)		Y	Y	no data available	
National Neonatal Audit Programme (NNAP)		Y	Y	no data available	
National Ophthalmology Database Audit	Medisight software installed 9/10/23 & Data uploaded since then.	Y	Y	no data available	
National Paediatric Diabetes Audit 1		Y	Y	no data available	
National Prostate Cancer Audit (NPCA)		Y	Y	no data available	
National Perinatal Mortality Review Tool 1		Y	Y	no data available	
National Vascular Registry		N	N	no data available	
Perinatal Mortality Review Tool (PMRT)		Y	Y	no data available	
Perioperative Quality Improvement Programme	PQIP: DCH Research project	Y	N	No data available	Governance with Research dept-not registered as an Audit.
Sentinel Stroke National Audit Programme 1		Y	Y	no data available	
Serious Hazards of Transfusion UK National Haemovigilance Scheme		Y	Y	15	100%
Society for Acute Medicine Benchmarking Audit		Y	Y	42	100%
Trauma Audit and Research Network (TARN)	TARN shut down in June 2023 due to cyber-attack. TARN taken over by NHS	Y	Y	1/4/23-1/6/23 30 submissions.	

	England, new National Major Trauma Registry. DCH data submissions will recommence in May 2024.				
UK Renal Registry					
a. *Acute Kidney Injury programme*	Local Audit 5866	Y	N	no data available	
b. UK Renal Registry Chronic Kidney Disease Audit		Y	Y	Quarter 110 - Renal status 24/05/2023 - 840 patients Quarter 111 - Renal status 31/08/2023 - 829 patients Quarter 112 - Renal status 12/01/2024 - 844 patients Quarter 113 - Renal status 23/02/2024 - 844 patients	

National Confidential Enquiries into Patient Outcome and Death (NCEPOD)

NCEPOD's purpose is to assist in maintaining and improving standards of care for adults and children for the benefit of the public by reviewing the management of patients, by undertaking confidential surveys and research. The following shows the National NCEPOD reports published and a precis of their findings:

Report Title	Report Precis
#5277 The Inbetweeners: A review of the barriers and facilitators in the process of the transition of children and young people with complex chronic health conditions into adult health services. June 2023	**Areas of good performance:** DCH 'Flag'' Young people going through transition on electronic records. Many young people are given the opportunity to be seen alone in clinics. DCH has established a multi-agency stakeholder group meeting monthly, Agreed a 3-year project plan for Transition Service, Agreed Trust Quality Statements aligning to NICE Guidance and Raised the profile of Transition across the Trust – now presented at Care group and Divisional meetings. **Areas of concern:** Unable to provide keyworkers. Unable to provide equitable youth work service. No separate commissioning for transition care. Lack of (joint) transition clinics across services. Lack of unity with Primary care. DCH Electronic systems are a barrier to working across organisations and for empowering young people to manage their own healthcare. Lack of available/accessible information about adult services within DCH for young people and their parents/carers. No annual transition reviews. No transition page on website. Lack of holistic care documented. **What does this mean for DCH?** DCH is not compliant with National Guidance. DCH has employed a Transition Nurse Specialist who is leading on the development of a Transition and Young People's Service with a Consultant who is Clinical Lead for Transition with x1 PA, an Assistant Project Manager and a Youth Worker funded in the Diabetes Service.
#5419 NCEPOD Crohn's Disease Study: Making the Cut? A review of the care received by patients undergoing surgery for Crohn's Disease. 13/7/23	Key Audit Results: **1.Provision of Holistic Support:** Basic psychoeducation provided on the effects of mental health on IBD provided by staff and signposting/referrals made to Steps to Wellbeing or private fully accredited counselling services. Support services: The Community Front Rooms & The Retreat promoted. Good peer support- all our patients are signposted to Crohn's and Colitis UK for additional resources and support. We have also set up a Facebook DCH IBD Community Group with 60 patients where we share useful resources and are planning to set up a patient panel. Recent increase in Dietetic support including a 1x monthly clinic to accommodate referrals for newly diagnosed patients and pre-operative patients for nutritional optimisation, patients at high risk of malnutrition, IBS overlap and requiring low-residue diets. Limited time and resource to support mental wellbeing for our IBD patients given the increasing prevalence of mental health conditions such as anxiety, depression, trauma, and OCD that have a direct impact on chronic health conditions. IBD UK recommend access to a Health Psychologist which we currently do not have as part of our service. 150 referrals were received by Steps to Wellbeing for clients with IBD in 2022 in Dorset. More Dietetic support required given our increasing patient cohort. **2.Medications for Crohn's should be managed effectively at all stages of the pathway**. We have a high standard of pharmaceutical, medical, and nursing oversight- regular medication reviews at scheduled appointments and Biologics and IBD MDT. Plans are made pre and post operatively in liaison with surgical team. **3.Consider surgery as a potential treatment option for patients with Crohn's Disease. Surgery should not be perceived as a failure of medical management and could be undertaken sooner.** Most patients considered as potentially suitable for resection are discussed at IBD MDT in close liaison with the IBD Colorectal surgeons and Consultant Radiologist present. It is evident in the audit and historically that surgery is

	often perceived as a final option if medical therapy has failed and from reviewing case notes it has highlighted the need to address surgery as a viable option with patients early in their pathway alongside medical therapies. This is often not considered until patients have failed multiple medical therapies. This will help the patient to adjust their mindset to surgery earlier rather than later and feel more in control of the choices available to them. 4.**Perform surgery promptly once a decision to operate is made. Recommendation from the audit is that patients should be operated on within 1 month of entry onto the waiting list to avoid patient deterioration and emergency surgery.** We have a robust system in place for identifying and discussing Crohn's patients potentially suitable for surgery at IBD MDT. From review of 8 Crohn's resections performed between November 2021-September 2023 the time from referral to the Colorectal Surgeons to their initial outpatient review varied from 2-6 months. Time from waiting list entry to date of operation varied from 2-8 months. **5. Make sure that handover of care from the Surgical Team to Medical Team is robust to promote joined up care post operatively including patient medication reviews.** All post operative Crohn's resections are now reviewed at IBD MDT to plan future management including review of medical therapy and need for surveillance. We have set up an inpatient alert report with Business Intelligence which is emailed to the IBD Nurses inbox daily. This alerts us of elective admissions for surgery to prompt follow up. Nil concerns identified. **What does this mean for DCH?** Better Psychological support and Dietetic resource required. Crohn's patients identified as suitable for resection to be referred to the Colorectal Surgeons earlier in their patient pathway to discuss surgical verses medical treatment options. Crohn's patients referred to the Colorectal Surgeons should be seen urgently in clinic and discussed at the surgical planning meeting with an aim to be scheduled for surgery as soon as practically possible and should not be downscaled in favour of colorectal cancer patients. Report presented at Gastroenterology Business Meeting 6/12/23 & IBD MDT on 14/12/23**.** **Actions** 1.Employment of a Health Psychologist to cover Colorectal & Gastroenterology- Business Case to be completed. Data gathered to support the need from Steps to Wellbeing. Need to secure funding. 2. Increase in Dietician resource- Increase in Dietetic clinics for IBD required to accommodate increasing patient cohort - Pending replacement of new Lead Dietician. Once established to review benefits of IBD Dietetic involvement and source additional funding. 3.Crohn's patients suitable for surgical resection to be referred to the Colorectal Surgeons earlier in their patient pathway when treatment is required- Referrals completed by Gastroenterology Consultants and IBD Nurses in a timely matter on agreement with the patient when considering all treatment options. 4.For Crohn's patients to be seen by a Colorectal surgeon in clinic to discuss surgical options within 1 month. Plan made to email the Colorectal Secretaries when a referral is made to prioritise the appointment as urgent (to be seen within 4 weeks). 5.To reduce the waiting time to surgery for patients listed for surgical resection- New Crohn's referrals to be discussed at Surgical Planning Meetings 29/12/23 (Not always routinely discussed at Surgical Planning Meetings due to Cancer patients being prioritised). To aim to schedule in where possible in a timely manner to avoid patient deterioration
#5585 NCEPOD Community Acquired Pneumonia	**Key Audit Results:** This was a national audit of community acquired pneumonia care in English hospitals. Of 767 cases included, 6 were from DCH. During 2022-23, we undertook ongoing audit of all CAP admissions at DCH, performance was good in terms of getting a CXR done within 4 hours of

	admission and in terms of administering appropriate antibiotics within 4 hours. Reporting of inpatient CXRs generally takes longer than 24 hours at DCH – often up to 1 week. Whilst this is not optimal, it is good that CXR reporting is now happening, and the impact of this delay is likely to be minimal. At DCH, we have a robust system for following up repeat CXRs for people with CAP at 6 weeks. We were less good at assessing the CURB65 severity score, but this audit recommends NEWS2 scores as an alternative to CURB65 scores since they are also closely linked to mortality rates. At DCH, we routinely assess NEWS2 scores on all admissions. We do not have a named lead with specific time in their job plan for CAP and we do not employ a specialist pneumonia nurse (the recommendation is for 1 WTE per 400 admissions per annum) and we do not have any written patient information about pneumonia on discharge. **What does this mean for DCH?** Overall, not much in the way of action is required: Whilst it may be desirable to develop the use of Agyle in ED to prompt the use of CURB65 scoring in patients with CAP, this is not essential since NEWS2 scoring will probably suffice. These severity scores are used to guide the location of care (home, ICU etc), the use of antibiotics and subsequent investigations. Microbiological tests are indicated in our local CAP guideline in patients with more severe pneumonia, as recommended by this report. We are prompt in getting CXRs done and administering antibiotics. Our CXR reporting could be quicker but is adequate. Use of escalation plans is generally appropriate at DCH, in patients with CAP and in other patients. We have a smoke stop team who review any patients (CAP or otherwise) who smoke and offer nicotine replacement treatment. Our follow up of patients with 6-week CXRs is robust and more complex patients will receive face to face outpatient consultant review, based on individual clinical judgment. Whilst we have 6 specialist non-cancer respiratory nurses (only 2 of them spending significant amounts of time on inpatient care), we do not have a specialist pneumonia nurse. One study in 2020 (comparing clinical practice prior to and after 2013) demonstrated a significant reduction in overall CAP mortality in one NHS hospital associated with the introduction of a Specialist Pneumonia nurse who supported adherence to national guidance for CAP management. 6-month survival improved from 64% to 70%, with those seen by the pneumonia nurse having a survival of around 77%. Length of Stay was no different. However, whether a nurse at DCH would have such an impact in 2024 is debateable, given that our guideline adherence is good and now with the widespread use of NEWS2 scoring. There are nationwide plans to introduce ongoing CAP audit as part of the National respiratory audit programme which we will participate in and gain greater insight. 1.Discuss outcome at the respiratory clinical governance meeting- 29/2/24 2.Develop a CAP patient information leaflet (Draft done)- to discuss at governance meeting 29/2/24
#5652 NCEPOD Testicular Torsion Study; Twist and Shout 8/2/24	**Key Audit Results:** Acute scrotum is always seen as a priority; In a case of suspected torsion, the consultant speaks to the anaesthetist and CEPOD team directly to avoid any delay, this at times may mean opening another theatre given the time critical nature of the procedure. At DCH the decision of exploration is always consultant led. We have a torsion pathway which is explained to the juniors at induction. The Junior Doctor contacts the surgical registrar on call and the urology consultant get notified immediately. Torsion may still be present despite reassuring doppler Ultra-sound scan (US); therefore, we do not ask for an US and offer urgent exploration when there is any doubt. What does this mean for DCH? The audit and its recommendations were discussed in urology departmental meeting. Our practices are in line with most of the recommendations, but we can certainly improve in providing public awareness.

	Adult urology service at DCH does not provide any paediatric urology work apart from acute scrotum as an emergency. Public awareness, however, is vital and we can involve the visiting paediatric urologist in public awareness programs and training at primary health care level.

The reports of National Clinical Audits were reviewed by the provider in 2023-24. The Trust intends to take the following actions to improve the quality of healthcare provided – summarised below.

Audit / Clinical Outcome Review Programme	What this Trust learnt
#5051 National Lung Cancer Audit: State of the Nation Report 2023 Data period: 2021	**DCH Results**: Data completeness: Performance status (PS) = 97%: Met standard. Ethnicity = 96%: Met standard. Disease stage = 95.5%: Met standard. Route to diagnosis = 99.4%: Met standard. Lung Cancer Nurse Specialist (LCNS) = 71%: Did not meet standard. Smoking status = 94.2%: Met standard. 85.2% (adjusted) of patients with stage I/II PS 0–2 NSCLC undergo curative-intent treatment in line with NICE guidance: Met standard. 58.9% (adjusted) of patients with NSCLC stage IIIB-IV and PS 0-1 receive systemic anti-cancer therapy in line with NICE guidance. This is only 34 patients: (65%) Did not meet standard. 92.9% of lung cancer patients are seen by a lung cancer clinical nurse specialist at diagnosis: Met standard.
#4829 Getting It Right First Time - GIRFT Surgical Site Surveillance Audit 2019 01/05/2019 – 31/03/2021	An observational audit to measure Surgical Site Infections (SSIs). During the audit period, 241 index procedures were undertaken at DCH (appendicectomies, emergency laparotomies and elective colorectal resections). 4 SSIs were identified (2 each after emergency laparotomy and elective colorectal resection). **Areas of Good Performance**: At 1.7%, DCH's SSI rate is better than the national average (4%) and places the trust in the top quartile of Trusts participating nationally (14th out of 57). Scrutiny of care of each patient who developed an SSI confirmed that perioperative antibiotic prophylaxis had been administered. **Areas of Concern**: No specific concerns were highlighted using the nationally agreed GIRFT methodology. **Learning Points**: This audit confirms local compliance with a nationally agreed standard of perioperative care. This audit also demonstrates a rate of SSIs is below the national average. Good record keeping facilitates subsequent audit of practice. Electronic prescribing facilitates validation of retrospective datasets.
#5042 National Bowel Cancer Audit Annual Report 2022 2020/21	**Good performance-** 0% risk-adjusted 90-day mortality. Data completeness for pre-treatment TNM status (99%) and performance status (87%). 100% seen by CNS (85% national). Laparoscopic attempted in 90% (67% national). 12 or more lymph nodes excised 91% (86% national). Length of stay >5days 38% (56% national). Urgent or emergency surgery 5% (20% national) **Within expected range-** 2-year post-operative mortality rate 13.5% (national average 17.7%). Risk-adjusted unplanned 30-day readmission rate 11.6% (national average 10.7%). Adjusted 18-month unclosed ileostomy rate 22.4% (national average 28%). **Areas for improvement-** Case ascertainment "fair" (national aggregate N/A) Data completeness "fair" 74.1% (national average 89.4%). **Benchmarking-** 90-day mortality rate, 2-year post-operative mortality rate, 30-day unplanned readmission rate trending downwards. No trend data for other variables **What does this mean for DCH? -** this audit demonstrates good practice, especially considering a 0% 90-day post-operative mortality. Improvement can be made in case ascertainment (target >80%) and data completeness (>70%, [age, sex, ASA grade, pathological T-stage, pathological N-stage, distant metastases, and site of cancer.]) improvement work to improve this commenced.

#5044 PROMS Elective Surgery 2020/21: Finalised PROMs in England, for Hip and Knee Replacement 01 Apr 2020 to 31 Mar 2021	**Key Audit Results:** Nationally 97% and 94% of respondents reported an improvement in Oxford score for Hip and Knee replacements respectively. In previous years DCH has reported similar or better outcomes compared to national outcomes. **Benchmarking:** For the year 2020-21, DCH reported insufficient records to assess status. This is secondary to reallocation of duties to ensure we met urgent clinical priorities during the COVID pandemic. **What does this mean for DCH:** Overall, little elective activity occurred during this period, so few conclusions can be drawn. Presented at Ortho Meeting 12/5/23 – Service Manager will investigate the current process for obtaining patient PROMs data within the Trust. It appears an external company is paid to do this on the Trust's behalf.
#5308 National Joint Registry 2021: 19th Annual Report 2022 Data period: 2021	**Key Audit Results:** DCH recorded 311 procedures with a 99% link ability during this period. We were not an outlier for 90-day mortality or revision rate for any type of joint implanted. **Benchmarking:** Over the last 5 years, 9 Total Hip Replacements (THRs) were revised for infection (against an expected 4). This has been investigated in a separate Consultant led process. Our unit has a significantly lower (better) periprosthetic fracture revision rate (4 vs 10.6 expected) than the National expectation. 92.8% of hip implants were ODEP rated A*. 100% of knee implants were ODEP rated A or A*. **What does this mean for DCH:** Continue to use well-established implants. Adopt robust procedures to prevent infection (specifically true ringfencing of elective orthopaedic beds is planned imminently). Ortho Dept meeting 12/05/2023.
#5306 NACAP Audit Programme Children and Young People Asthma 2021-2022	**Good:** All patients had clinical observations in a timely manner. Majority of patients received steroids with the date and time recorded for these. Inhaler technique checked and documented for high percentage of these patients. High proportion of patients received PAAP's. Respiratory Nurse in post **Concerns:** FeNO for diagnostic purposes unavailable in hospital setting Reviews post discharge could be improved. Hospital setting unable to provide all physiological tests at the hospital. Not always had a specialist review within 24 hours. Limited number of staff competent in performing spirometry testing **What does this mean for DCH:** Further work detailed below is required to meet national audit standards. Large gaps were found across the UK, and this is part of a national issue around diagnosis, access to expert advice, in patient management and follow up. **Recommendation 1:** For every person to receive an early and accurate diagnosis based on a guideline-defined approach and a plan for their care. Aiming to source and train in FeNO. We currently offer spirometry. Need to obtain funding and training. **Recommendation 2:** For care to be provided to people with asthma and COPD within the recommended timeframe after hospital admission, to support optimal outcomes; Liaising with ED to ensure early (<1hr administration of oral steroids) **Recommendation 3:** For people with asthma and COPD to receive care by appropriately trained healthcare professionals, at each stage of their care pathway; DCH now meet this standard fully. **Recommendation 4:** Primary, secondary and community services to implement ways to work together, offering people with asthma and COPD a seamless pathway of care. This is mostly met. (ePAAP's, smoking status). We started a transition clinic, but this needs formalising; Dorset wide work on how to implement an asthma discharge bundle. Work with transition team to establish transition clinic. Dorset wide plan to improve discharge bundle.
#5022 'Epilepsy 12' Round 3 Cohort 3 2022 Combined organisational and clinical audits: Report for England and	**Recommendation 1;** Epilepsy clinical teams should review the Epilepsy 12 data, and the criteria and implementation of, prescription of rescue medications for prolonged convulsive seizures in children and young people. All children at DCH with epilepsy have an individual seizure plan whether they have rescue medication or not. **Recommendation 2;** All females of child-bearing potential prescribed Sodium Valproate should have ongoing documentation regarding their status within the valproate Prevent Programme. DCH are 100% complaint with this and provide annual NH|S benchmarking data.

Wales; Round 3, Cohort 3: (2019-December 2019 to 30 November 2020 (and subsequent year's care) 21).	**Recommendation 3;** Ensure there is a process in place to ensure discussion of Sudden Unexpected Death in Epilepsy (SUDEP), and care planning for risks and participation, is achieved for children and young people with epilepsy. This is discussed and documented by epilepsy nurses at first home visit. **Recommendation 4;** Review the waiting times for standard EEG in their services; ensuring sufficient capacity and pathways in place to achieve EEG within four weeks of referral. DCH waiting times are now back within the 4-week target**.** **Benchmarking:** This national audit does not have bench-marking standards available **Areas of concern for DCH:** Mental health support and screening: Nationally, very few children and young people with an identified mental health condition in cohort 2. (2%). Without widespread use of screening, opportunities for referral into the appropriate pathway for assessment could be missed. DCH does not use a specific screening tool and relies on the expertise of Clinicians and Epilepsy nurses to identify ASD, ADHD and mental health problems during clinic appointments, referrals are made, or patients signposted to support services. DCH now have an emotional and wellbeing psychologist. **Transition:** **DCH** does not have a separate Epilepsy clinic to support transition to adult services. The ready /steady /go model is started around age 13 years old. Formal referrals are made to adult clinic age 17, adult service will not see patients until 18 years old. Currently the adult service has no capacity to support a face-to-face transition clinic. We continue to work with transformation team in Dorset and the regional network on Epilepsy transition pathway.
#5293 National Audit of Cardiac Rehabilitation (NACR) Quality and Outcomes Report 2021	**Areas of good performance:** Cardiac rehabilitation groups (CRG) restarted, tight infection control protocols in place, no transmission of infection occurred, giving confidence that the CRG could re-start in Spring 2022. The Project Lead presented the quarterly data for 2021 at the NACPR national conference with a poster display, also was involved in a national presentation with Mymhealth in October 2021 and Spring 2022.The Cardiac rehabilitation team (CRT) at Dorset County Hospital is already achieving the national uptake targets. The CRT, been a part of the team building the Myheart Cardiac Rehabilitation app and the Public Health England produced Active at Home exercise booklets. The variety of resources we have from The British Heart Foundation, Heart UK, Livewell Dorset and Steps2wellbeing, meant they were able to continue to offer a viable range of options which were able to accommodate patient's needs, post MI, PCI and or Heart Surgery, during a period of severe turmoil in the Covid19 Pandemic. **Areas of concern:** The team have **not achieved certification** due to financial and staffing limitations. **Benchmarking** National target of 85% uptake by 2027. 88.6% uptake of cardiac rehabilitation offered by the cardiac rehab team at Dorset County Hospital in 2021. **What does this mean for DCH?** **The impact of Venue location, budget restrictions and staffing:** 1.Restrict the patients to one 1 session of CRG exercise session per week per group-this should occur twice per week. 2.The team is unable to provide functional testing for patients following their clinic and completion of their 7-week cardiac rehabilitation programs to assess improvement. 3.The team hasn't been unable, for the past 12 years, to post the 10-page NACR 2 questionnaires to patients at the end of their treatment to patients, with reply paid envelopes (only patients who attend a CRG, are offered the NACR 2 questionnaire,50% of patients who use home-based cardiac rehabilitation with telephone consultations do not receive these questionnaires).

	4. At the end of the patients' CRG programs, they should have a holistic review and plan written for their next 12 months for secondary care-this has been impossible to establish. **These issues mean that not all NACR patient outcomes, have been able to be recorded within the NACR dataset meaning that the team are unable to meet all 6 of the requirements for Cardiac Rehabilitation Certification.** This is something the team would like to achieve. Although significant non-recurring funds have been offered to Dorset County Hospital by NHS England in March 2022 and March 2023, which could allow the service to develop and achieve certification, the management team have not felt able to take up this offer of ring-fenced funds. The team and service manager are planning to develop their service to meet these service deficits utilising funds from the speciality budget. A meeting regarding these developments is due to be scheduled for August 2023. **Actions** 1.Work towards certification. 2.Investigate and possibly establish cardiac rehab exercise sessions twice per week 3.Functional Testing to be investigated and established if beneficial to patients 4.Establish a system for NACR 2 Audit forms to be given to all patients at their end of program. 5.Investigate methods of providing end of cardiac rehab holistic review.
#5519 National Audit of Care at the End of Life (NACEL); Fourth round of the audit (2022/23) report	**Areas of good performance.** We performed as well as or better than the national average in 6 of 11 key performance indicators, including 3 new indicators based on the staff survey. **Where we performed less well** (in 5 indicators) we were not significantly below. Our performance trend over the last 4 audit cycles has been one of improvement in all indicators apart from "families' and others' experience of care". This reflects similar improvement nationally, but we have improved to a greater extent. Nationally performance in "assessing the needs of families and others" has reduced, but in our case it has increased. Areas of concern: Areas where it was identified that we could improve were: Communication with the dying person; Discussing possibility of drowsiness with medication; Discussing hydration and nutrition. Communication with families and others; Discussing possibility of drowsiness with medication, Discussing risks and benefits of nutrition. Involvement in decision making Discussing extent to which patient wishes to be involved in decision making. Discussing CPR with patient and family by senior clinician. Individualised plan of care; Nutrition status reviewed regularly, Benefit of starting/ stopping/ continuing blood sugar monitoring; Discussing anticipatory medications with patient and family. Needs of families and others Asking about their needs, Giving enough *emotional* support From the staff survey areas of improvement were identified as: Staff confidence All areas other than recognising dying and accessing the hospital palliative care team. Staff support Accessing specific training in EOL care and Managerial support to deliver EOLC. Care and culture Able to raise a concern about end-of-life care, providing a peaceful and private environment, Deaths reviewed with action plan to improve end of life care. **Benchmarking;** Recognising the possibility of imminent death. National 87%, DCH 84.6%. **What does this mean for DCH?** Areas to focus on might include Communication; Discussions with family about DNACPR decisions; Discussions around hydration and nutrition; Discussions around risks of drowsiness with EOL medications; Education; Asking about and supporting needs of families. These results will inform our EOL strategy for EOL care and the actions and from this. **Actions.** Reported at End-of-Life Care Committee June 2023

	Hospital Mortality Group June 2023 Improve communication and documentation around DNACPR and TEP decisions-1st meeting held and action plan developed. Education to ward staff- Additional nurse recruited to allow for increased EOLC facilitator role time.
#5514 National Audit of Dementia- Care in General Hospitals 2022-2023 Round 5 Audit Report	**Areas of good practice:** Increase in delirium screening. Teir 2 Dementia training (90%). Increase in initial assessment of pain. **Areas of concern:** Decrease in the use of a structed pain assessment tool. Decrease in positive feedback from carers. **Benchmarking** Contained within the national report. **What does this mean for DCH?** Increase use of structured pain assessment tool to be evidenced in case notes (Abbey pain scale). Try to increase and capture the positive feedback from carers. **Recommendations/actions:** Increase use of the Abbey pain scale for patients living with dementia- Discussed in the Dementia Action group 25/7/23 & discussed with the pain team to raise awareness. To Increase and capture the positive feedback from carers- Discussed in the Dementia Action group 25/7/23.
#5488 UK Parkinson's Disease Audit	**Areas of good practice**: 1. Access to therapists with experience in Parkinson's: Meetings are organising weekly with neurology and elderly care to look at the individual patients as well as monthly meetings with HUB (PT, OT, SALT). 2.Standardised Practices; & 3. Communication and information sharing; - Brochures with Information, appropriate to patients with PD, about Parkinson's are given out. 4.Medication management; Aim to ensure PD patients get medication on time whilst in hospital. 5.Educating the workforce; Workforce currently 50% down on Parkinson's nurses. Impact of COVID on teaching student nurses, junior doctors. **Benchmarking**- From the UK full audit, compared with Parkinson's UK Recommendations for people with Parkinson's. **Areas of concern**: -1. Specialised multidisciplinary workings; There is a need for specialised physiotherapy (PT) and occupational therapy (OT). Training is available from Parkinson's UK web page for PT but not for OT. We want early referrals to therapy services so will be introducing newly diagnosed workshops to introduce people with Parkinson's to the therapists. Working with speech and language to know the best time for voice and swallow. Out of 265 patients, 136 Elderly Care and 129 Neurology, it was found: 34.7% patients were referred to therapists by Parkinson's nurses, 23.7% patients were referred to therapists by neurology consultants, 10.3% patients were referred to therapists by Elderly Care consultants. **What does this mean for DCH**- To meet national standards. **Recommendation's & Actions** Specialised multidisciplinary workings: By December 2023: 1. Monthly meeting with the local HUB to discuss what is on offer to people with Parkinson's as this is an ever-changing picture. 2.Weekly meetings with the neurologists to discuss individual patients are now being held and access to elderly care is consistent as in the same hospital 3. Newly diagnosed workshops to introduce the person with Parkinson's to therapy teams face to face. 4.Secure funding for newly diagnosed workshops for the future. Standardised Practices & Communication and information sharing: Give out information packs for newly diagnosed people with Parkinson's at nurse led clinic or sent by post once confirmation by consultant has been received. Use appropriate patient centred brochures. Telephone consultations to take place on receipt of confirmation so the patient is fully informed of their condition and correct information is sent (Information pack supplies regularly checked) Medication management: Monitor daily on JAC system by both pharmacy and Parkinson's team and check information is up to date. Get it on time campaign still being adopted to educate ever changing ward staff Daily once PD nurse in post. Educating the workforce; Hold training sessions for new staff, awaiting a time when the hospital or local church will allow a group of people in for educational needs. Funding found for room in church
#5302	Benchmarking- we demonstrate much better rates of early contact with pregnant women compared to nationally (Eng &W).

National Pregnancy in Diabetes Audit 01 January 2021 to 31 December 2022	Local Actions: 1.Continue to provide access to diabetes technologies (continuous glucose monitoring (CGM) and hybrid closed-loop systems (HCL) to all women with Type 1 diabetes of reproductive age – currently all women with Type 1 diabetes have access to CGM and eligible ones to HCL. 2.Continue and ensure women with Type 2 diabetes have access to appropriate dietary support, glucose monitoring and intensive insulin therapy. 3.Ensure there remains capacity for women to have regular clinic reviews (including monthly A1c checks, access to weight management programmes) for preconception care. 4.Outreach into community to improve preconception care, particularly in young onset type 2 diabetes but noting that this is currently outside of job plans and commissioning. Report presented 15 Nov 2023.
#5300 National Diabetes Audit: Care Processes and Treatment Targets 2021-22	We continue to work with our partners in DHUFT and primary care to support improvements in achieving treatment targets and provision of technology via the specialist DCH diabetes service. The DCH diabetes team is represented at the ICB Dorset Diabetes Programme Board and are involved in the treatment targets workstream. There are ongoing discussions across the ICS system regarding provision of diabetes technologies including CGM and insulin pumps which will be further developed following the anticipated NICE guidance for HCL technology. This is likely to require investment in additional DSN and specialist diabetes dietician staffing within the DCH specialist diabetes team to support improved access to these technologies and tackle inequalities. All the actions from the NDA report are for Commissioners of Care. There is no one person responsible for the work and the targets are very broad and vague so not easy to identify timescales.
#5060 Child Mortality Database; Deaths of children and young people due to traumatic incidents	Robust child death review processes leading to detailed evaluation of contributory factors and identification of key learning to underpin recommendations. 63% of deaths that have been reviewed at a Child Death Overview Panel (CDOP) had modifiable factors identified (much higher than all deaths where modifiable factors are found in approx. 1/3). This suggests that many of these deaths are preventable. Overall risk to children in the southwest of England is relatively high at 18.84 / 1 000 000 children per year (national range 13.49). Children with neurodiversity are disproportionately at risk. 11% of completed reviews for children aged 5-17yrs noted neurodiversity in the history while the population rates are reported as ASD 1.3% and ADHD 1.9%. The Report has 18 recommendations; Those of relevance to DCH and the local child death review team are – Recommendations; 3,4,5,6,12,13,14,15, 17 &18. The actions below relate to these. 1.Staff to know how to manage penetrating wounds; DCH to engage with work being led by the major trauma ODN 2.Bleed control and resuscitation training for young people; DCH to consider how we may support 3.Ensure safe bathing techniques are being promoted; Maternity services to work with public health and primary care to update parenting programmes for antenatal and postnatal delivery 4.SUDI/C protocol to be updated; Local policy to be presented to the paediatric governance meeting, January 2024, Draft policy needs final revisions and will then be submitted 5.MOU with police and coroner to be developed to support multiagency working following an unexpected death; Draft to be circulated by the end of December 2023 Aim is for completion by February 2024.
#5309 NACAP Audit Programme COPD/Adult Asthma 2021 - 22	A report of an ongoing continuous national audit into Asthma and COPD care. The data refers to January 2023, but we now have more up to date data (which show similar patterns). We are in the process of trying to improve our practice and monitoring that improvement. 1.Improve use and capture of asthma and COPD discharge Moreton Specialist nurses to liaise with Audit dept over capturing bundle data bundles- 2.Improve recording of spirometry results in record for COPD- Moreton Specialist nurses to review patients early and capture DCR info

	3.Improve access to and use of PEF meters in asthma on admission- Discuss with ED about access and educate ED teams 4.Improve use of asthma and COPD admission bundles in ED and acute medicine- Discuss bundle use with ED and acute med teams Monitor admission bundle use when patients reviewed for discharge. 5.Improve smoke stop use in asthma and COPD Review improvements with smoke stop team now in place - 6.Discuss asthma and COPD discharges with community teams and monthly MDTs- Explore access to inpatient asthma and COPD DiiS for community nurses 7.Improve oxygen prescriptions through use of medical admissions bundle- Continue to feedback to juniors more regularly about medical admissions bundle use. Report presented at Respiratory dept meeting7/11/23
#5358 Outpatient Management of Pulmonary Embolism Audit 2021	**Key Audit Results:** This audit compares the management of acute PE by DCH (11 patients) compared to national records (1509 patients) in September 2021. With such small numbers, comparisons are unreliable. Our patients were all managed by ED or Acute medicine 45% were not admitted (48% nationally). 1.Improve PESI recording-Discuss with SDEC team to implement change in practice 2.Ensure ST3+ senior review for all patients- Discuss with SDEC team to implement change in practice 3.Devise and provide written information about PE- Discuss with SDEC team to implement change in practice 4.Discuss a plan for 7-day review 5.Ensure administration of anticoagulation within 1 hour of clinical suspicion ((e.g., +ve d-dimer result)- Discuss with SDEC team to implement change in practice 6.Ensure CT reports contain evidence for RV dysfunction, and this is recorded in the clinical record- Discuss with SDEC team to implement change in practice
#5388 National Asthma & Chronic Obstructive Pulmonary Rehabilitation Programme (NACAP); Drawing Breath 2021/22	**Key Audit Results.** ***Primary care teams offering referral to pulmonary rehabilitation for all people with COPD and an MRC breathlessness grade of 3–5*** – Included on the template used for primary care during annual reviews for COPD patients. Recent update evenings have been held across the primary care networks highlighting the importance of pulmonary rehab and the patient pathway. ***Ensuring that pulmonary rehabilitation commences within 90 days of receipt of referral for people with stable COPD and within 30 days of leaving hospital for those admitted with COPD exacerbation*** – waiting times increased after covid lockdowns, now improving. The service is working towards achieving the national targets. ***Protecting time for pulmonary rehabilitation clinical leads to provide leadership to the team*** – since December 2022, we now have a clinical service manager in post who has designated leadership time. quality assuring pulmonary rehabilitation programmes for people with COPD, including the provision of discharge assessments and exercise plans – this is recorded on the separate NRAP data collection for pulmonary rehab. All DCH patients who complete the course and invited to a discharge assessment and ongoing exercise is discussed during this and written information given to the patients along with signposting to local community groups, LiveWell Dorset etc. **Benchmarking.** National Targets 90 days from receipt of referral for routine referrals – quarter 1 2023 - 24 weeks average, quarter 2 2023 - 15 weeks. **What does this mean for DCH:** We are meeting the recommendations in this report from a pulmonary rehab perspective and referral times are pointing to improvements.
#5500 National Audit of Inpatient Falls: Falls & Fragility Fractures Programme: The 2023 National	**Good performance.** Cases where patients were checked for injury before being moved. DCH 83% (improvement from 75% last year). NAIF Overall 77%. Cases that received a medical assessment within 30 minutes of a fall. DCH 83%. NAIF 67%. **Area of Concern.** MFRA quality score. DCH 33% (improvement from 25% last year). NAIF 34%. This will be addressed by changes that DCH implemented this year in July 2023 where we have changed our current PACT score to a Multi

Audit of Inpatient Falls (NAIF) report on 2022 clinical data	Factorial Risk Assessment called Fall Safe. Cases where a safe manual handling method was used to move a patient from floor. DCH 17%. NAIF 32%. **What does this mean for DCH.** In July 2023 DCH changed the falls risk assessment PACT score to a Multi Factorial Risk Assessment called Fall Safe. As a result of this, it is expected that the DCH audit data will be improved during the next audit. The slips, trips and falls policy was also reviewed in July 2023 and a new post fall assessment proforma was introduced as a guide to best practice for those undertaking checks for injury. This will be adapted to include the recommendation / prompt for analgesia. The procedure for a safe manual handling manoeuvre from the floor will need to be addressed by the trust. The Falls Action Group is held bi-monthly, and the risk department provide a risk management data report which is discussed and analysed by the group. The trust has advertised for a Falls Lead for the trust to lead on improvement projects. The trust currently has good audit data for dementia and delirium screening and a team specifically focussed on this.
#0000 Epilepsy 12 National Clinical Audit of Seizures and Epilepsies for Children and Young People 2023 combined organisational and clinical audits: Report for England and Wales Round 4, Cohort 4 (2020-22	**Key Audit Results:** Overall, there has been improvement in care in 8/12 performance indicators within the Epilepsy 12 audit including timely access to key professionals, Investigations, treatment, and agreement of care plans. The main challenges remain access to mental health services and appropriate screening for learning disabilities and other neurobehavioral diagnosis. The purpose of the Epilepsy 12 audit is to demonstrate our compliance with the best practice tariff for our epilepsy clinic however we do not currently meet that (see page 76 and 78. 23-25NPS Annex DpC Guidance on best practice tariffs (england.nhs.uk) g – no agreed pathway for mental health concerns (we have a 'pathway' for those Dr PM refers into the ASD pathway but have basically done the screening and a significant chunk of the work before referral there is not recognised time with the medical clinic to do this) h-no agreed action plan describing steps towards integrating mental health provision in epilepsy clinics. **What does this mean for DCH.** DCH needs to be working with the ICB's within the 4 recommendations: Epilepsy12: Percentage of children with epilepsy and a mental health problem who have evidence of mental health support. Epilepsy12: Percentage of Trusts with agreed referral pathways for children with mental health concerns. Local Audit: evidence of the availability of specialist psychological advice and local pathways.
National Child Mortality Database: Infection related deaths of children and young people in England. National Child Mortality Database Programme Thematic Report. Data period: April 19 – March 22	In a 3-year study period there were 1507 infection related deaths in England, 4.2/100 000 / year. In 37% of these deaths; infection was a complete and sufficient explanation (accounts for 6% of all child deaths). **Benchmarking: NCMD child death data: year ending 31/3/2023.** Child death rates in the southwest of England are relatively low compared to other areas. This may reflect the demographics of the southwest and known relative risk factors for child deaths. **What does this mean for DCH?** **Ensure coherent and aligned guidelines on infections and treatments are developed and followed across service. This includes the use and development of tools to support the recognition of the sick child:** National PEWS tool not yet rolled out; a scoring system is included in the AGYLE ED system for neonates the NEWT2 screening tool is embedded in BadgerNet. Senior paediatric staff are trained in APLS which includes the deteriorating child. This topic is covered at induction for paediatric trainees. Tools to support decision making re antibiotic treatment are used for children and neonates. **Ensure that recognition of infants and children who are at higher risk of death form infection is included within guidance and training:** High risk cohorts are identified by clinicians e.g. neonates and children with cardiac

	problems at increased risk from RSV infection. Children on immunosuppressive treatments have emergency treatment protocols. The sepsis screening tool used includes a question about whether the child is immunocompromised and this impacts on the scoring and recommendations. These are issues that are addressed on an individual patient level and in teaching about topics e.g. oncology. **Commission research to develop, evaluate and trial risk assessment tools:** staff should continue to participate in appropriate research studies. **Investigate further and gain better understanding of the barriers to accessing services by parents when their child may be presenting symptoms and signs of infection: C**onsidered at paediatric and neonatal mortality and morbidity meetings and child death reviews. Where learning is identified, actions are developed to address the issues. **Listen to and act on parental concerns about their baby's or child's health as per NICE Guideline194 and ensure timely escalation for senior review:** Martha's law has been discussed at M&M meetings; clinicians are sensitive to the need to respond to parental concerns. The national PEWS chart includes a question about parental concerns which impacts on the score and the recommended action. There is an escalation pathway in place. When the national PEWS is in use in paediatrics it may be appropriate to audit compliance with this aspect. A Kingfisher app will be available from the end of January 2024 with information in many different languages. Development of this app will be ongoing, and it is anticipated that there will be a function linked to Martha's law in the 2nd version. Any child representing to the emergency department within 7 days for the same condition is seen for review by a SpR or consultant in accordance with guidance from the Royal College of Emergency medicine. **Increased public awareness of potentially significant symptoms and signs of infection particularly in infants e.g. by promoting the use of appropriate apps and websites for information:** Wessex healthier together is widely used by clinicians. It is accessible in many languages and includes the option to speak the text in each language. **Ensure that all children and families are offered all vaccinations their child is eligible for and are supported appropriately to consider and take up the offer. Increase awareness of the national children's vaccination schedule and green book guidance amongst child health services:** The pan Dorset and Somerset CDOP suggest all hospitals should consider the immunisation needs of patients with complex health needs at the point of discharge. For some people it may be appropriate to administer the vaccinations before they go home. This may help reduce the problem of missed vaccinations due to frequent admissions which has been seen to be a significant contributory factor to the death of a Somerset child. While there is no formal protocol in place about this it has been highlighted to all paediatric units across the CDOP area and has been discussed with the paediatric team at this hospital. **Ensure that any additional needs are identified prior to a child attending for vaccination so that person-centred reasonable adjustments can be accommodated where needed:** Action for primary care and immunisation services. **Ensure that any written and oral information and advice on immunisations is accessible to all groups and local communities and made available widely, and in multiple languages, to all parents, carers, and young people, in order that an informed decision can be made. Support from local immunisation services, children's health services, local community leaders and community outreach partners can be helpful in disseminating information and providing reassurance to parents who may be hesitant in accepting any vaccination offer:** This is a national recommendation. **Support and develop initiatives to improve health and reduce disparities and mitigate the social determinants such as housing, as well as risk factors such as smoking and obesity, all being associated with increased mortality risk from infection in children: S**taff should promote a healthy lifestyle. **Commission future research focusing on improvements in diagnosing specific causes and on the mechanisms underlying the much higher infection mortality rates in infancy. Further research should study**

	the complex interaction of deprivation, ethnic disparities, and underlying health conditions, and inform maternal vaccine implementation work and future perinatal vaccine research: Staff should contribute to appropriate research projects where possible. **Continue to develop data linkages between NCMD and other national datasets, including lab-confirmed infections within the Second-Generation Surveillance System (SGSS) dataset at the UK Health Security Agency:** This is a national recommendation. **Actions to be implemented.** 1.Listen to and act on parental concerns about their baby's or child's health- National PEWS to be adopted by DCH when the national roll out programme occurs. 2. Listen to and act on parental concerns about their baby's or child's health- When the national PEWS has been implemented consider auditing compliance with this aspect of the tool. This could include linking with ED for joint audit.
#5499 Fracture Liaison Service Database February 2024	**Key Audit Results:** DCH – Patient capture rate achieved 92.2% which is 16% increase, with a 14% (65.9% against 51.8%) increase in spinal fracture capture. This represents a strong uptake for the service. Our time to DXA scanning has improved from 44.6% to 61.1%. This is well above the National Average of 29.2%. Patient Follow Up (F/U) rate at 16wks – 37.7% against 39.7%, is above the national average. All the F/U calls were made, although didn't meet the 16wk time reframe. **Benchmarking** Poole patient capture – 18.2% - Spinal 5.4% - DXA 27.4% - F/U 14.7% Yeovil patient capture – 97.6 % -Spinal 62.4% - DXA 47.8% - F/U 89.8% **National Averages** Patient Capture 40.6%, Spinal 22.5%, DXA 29.2%, F/U 27.1%. What does this mean for DCH? DCH have outperformed Poole and the Yeovil figures except Yeovil patient capture and F/U. All the DCHFT areas, are above the National Averages. Our DXA team have switched to the Radiology Department and has been allocated a well measured space with more resilience available for the service. Actions To identify the fracture risk as close to 100% as possible, follow up, scan dates and treatments in a timely manner. To ensure a smooth progression for FLS practitioners to maintain continuity and consistency. To modify follow-up structure to include returnable questionnaires for patients not wishing to attend appointments to receive their feedback for auditing.

Local Clinical Audits

Local audits are carried out by specialties in relation to areas of their work where they are wishing to explore quality improvement or risks in services. These may be re-audits of past work, new services, audits relating to risk or service evaluations. 189 local audits and 28 National Audits were registered during 2023-24 and work will continue to see these through to completion. The reports of 89 local clinical audits were reviewed by the provider in 2023-24. A selection of these is catalogued below, and the Trust intends to take the following actions to improve the quality of healthcare provided:

Audit Reference number: 5901.
Title: Compliance to Venous Thromboembolism (VTE) Risk Reassessment
Data Collection Period: 11/06/2023-20/08/2023
Intention of the audit
To comprehensively evaluate the current VTE prophylaxis practices for medical patients. To identify areas where improvements can be made in practice which can potentially lead to positive patient outcome and reduction in mortality rates.

Standards Source:
1. NG 89 1.1.2
2. Section 11 of Clinical Guideline 0984 – prevention of venous thromboembolism-VTE for adults:

How it was undertaken:
Random sampling of 30 Inpatients in acute and General medicine and Gastroenterology wards.
VTE risk assessments on admission and 24 hours post admission for all these 30 patients reviewed and analysed using documentation on JAC, Vital Pac and Digital patient record. Analyse quality of VTE risk assessments on admission and the appropriateness of VTE prophylaxis prescription as per standards.

Findings.
Areas of good practice: Remarkable Initial VTE assessment completion ratio.
Areas of poor practice: Delayed completion of initial VTE risk assessment. Poor quality of VTE assessment. Complete Lack of VTE Re-assessment at 24 post-admissions. Insufficient recognition of the significance of VTE assessment. Lack of awareness of need for re- assessments.

Actions
1.To Understand Junior doctors' perspective regarding importance of VTE risk assessment, re-assessments, and impact of VTE on patient safety a questionnaire survey on VTE risk assessment-completed 30/09/2023.
2.Educating Junior doctors on significance of VTE assessment and prophylaxis by 'Grand Round' Teaching on VTE risk assessment, reassessment, and prophylaxis. - Completed 30/09/2023.
3.Simplifying VTE risk assessment and prophylaxis. - Flow chart and VTE bulletin in Junior doctor's mess and offices.

Audit Reference number: 5984**.**
Title: Dorset County Hospital (DCH) Quick fire A-E prompt cards for Foundation Year 1 Doctors Quality Service Improvement (2nd Cycle)
dates: August to November 2023

Intention of the audit
The aim of this initial retrospective Quality Improvement Project (QIP) was to improve the confidence of dealing with deteriorating patients at the bedside, whilst under pressure, by having an easily accessible prompt.

Standards Source:
LeBlanc VR, McConnell MM, Monteiro SD. Predictable chaos: a review of the effects of emotions on attention, memory and decision making. Adv Heal Sci Educ [Internet]. 2015 Mar 6 [cited 2023 Mar 22];20(1):265–82. Kensinger EA. Remembering the details: Effects of emotion. Emot Rev [Internet]. 2009 [cited 2023 Mar 22];1(2):99–113. Available from: /pmc/articles/PMC2676782/
Leblanc VR. The effects of acute stress on performance: Implications for health professions education. Acad Med [Internet]. 2009 [cited 2023 Mar 22];84(SUPPL. 10). Keinan G. Decision Making Under Stress: Scanning of Alternatives Under Controllable and Uncontrollable Threats. J Pers Soc Psychol. 1987;52(3):639–44. Baradell JG, Klein K. Relationship of Life Stress and Body Consciousness to Hypervigilant Decision Making. J Pers Soc Psychol. 1993;64(2):267–73.
Sharkey SW, Berger CR, Brunette DD, Henry TD. Impact of the electrocardiogram on the delivery of thrombolytic therapy for acute myocardial infarction. Am J Cardiol. 1994 Mar 15;73(8):550–3. Weigl M. Physician burnout undermines safe healthcare [Internet]. Vol. 378, The BMJ. BMJ Publishing Group; 2022 [cited 2023 Mar 24]. Av DCH Management of the Deteriorating Patient Policy 1570:

How it was undertaken:
A questionnaire was developed and disseminated to the foundation year 1 Doctors, via presentation and QR code, during an early F1 teaching session. The A-E cards were distributed during this teaching period. Initial questionnaire responses were provided in August. F1s used the A-E cards. Second questionnaire was disseminated at an F1 teaching session and the responses were provided in November.

Findings: The findings show; like the 1st cycle, overall, there appears to be a positive outcome from implementing the card. Proportionally people were more confident, less anxious and stated the card helped perform more thorough A-E assessments. The overwhelming majority of respondents think they would benefit from more simulation training. There were no issues with the robustness of the card which was a major drawback during the 1st cycle.
In conclusion, the second cycle of the QIP, suggests that implantation of a A-E card as a prompt may benefit incoming F1's when dealing with deteriorating patients as the results indicate proportional improvement in most domains. A major problem with the first cycle was the robustness of the card.

Action:
Prompt cards to be given to foundation doctors during induction.
More simulation training opportunities should be made available to doctors during foundation training specifically on deteriorating patients.

Audit Reference number: 5866.
Title: Dorset County Hospital (DCH) Acute Kidney Injury (AKI) Co-Morbidities & Patient Recovery Audit
Dates: 04/05/2023 – 15/05/2023
Intention of the audit
The aim is to assess, retrospectively a range of parameters relating to AKI in patients admitted to the renal ward with AKI at DCH. The sample included all patients admitted to the renal ward between 01/05/21 - 30/04/22 who had AKI. Management, mortality, and renal outcomes of these patients were tracked until 12 months post admission.
Standards Source:
How it was undertaken:
Findings.
The audit showed that patients with Type 2 Diabetes Mellitus (T2DM) or chronic kidney disease (CKD) have poorer outcomes (death or renal replacement therapy) following AKI than those without, suggesting these co-morbidities are significant risk factors for poor renal outcomes after AKI. It also showed that not all patients are receiving urine dip investigations or timely renal tract USS in the context of AKI investigation and management.
Action
Recommended the use of sick day rule cards for patients with co-morbidities at risk of poor outcomes following AKI.
Further analysis of why renal USS and urine dip investigations were not always performed as per guidelines and further in-depth analysis of patient outcomes following AKI in those with other co-morbidities.

Audit Reference number: #5992
Title: Pre-operative Tranexamic acid (TXA) administration to eligible patients with a hip fracture treated surgically.
Intention of the audit
The aim of this retrospective audit is to identify if 27 patients (over age 65; between September and October 2023) with hip fracture who are eligible are receiving TXA prior to hip fracture surgery following the original audit no. 5553. To help us identify if there has been any improvement in practice.
Standards Source:
How it was undertaken:
Findings.
The audit shows that at DCHFT a greater number of eligible patients receive pre-operative TXA than Nationally (as shown in the PATHS study). Following the initial audit and poster displayed post audit there was an improvement in compliance to 85.2%, meeting the gold standard of eligible patients having TXA pre-operatively.
Actions
To discuss the results in January 2024 and for a formal multidisciplinary guideline use of TXA pre-operatively in eligible patients; and document when TXA in, In-patients is inappropriate in the operative notes/anaesthetic charts.

Audit Reference number; #5835
Title: Audit on Caesarean Sections at full Cervical dilatation and impacted fetal head (IFH)
Intention of the audit
Aim: To audit caesarean sections performed at full cervical dilatation and impacted fetal head (IFH).
And evaluate:
(i)The incidence of caesarean deliveries in the second stage of labour.
(ii)Risk factors of impacted fetal head (IFH) at caesarean section (CS).
(iii)The indication for delivery.
(iv)Associated fetal and maternal morbidity.
with a view to suggesting strategies for improvement in the future.
Standards Source:
How it was undertaken:
Findings.
This audit identified that IFH is a serious complication that can occur at c-section. There is a need for additional training and a local guideline to help identify women at risk of IFH and to manage IFH.
Use of the fetal pillow helped reduced haemorrhage, surgical complications, and improved neonatal outcomes. The audit highlighted the need to improve documentation during labour and c-sections and to document the debriefing patients are given following delivery.

Learning points
There is an increasing incidence of IFH at CS and this will continue as CS rates increase.
Management of IFH is extremely important, it has serious and significant neonatal and maternal outcomes. Currently there are no clear guidelines on the best way to manage IFH.
Our audit identified that use of the fetal pillow was associated with easier delivery of the IFH, reduced blood loss and better neonatal outcomes.
While the fetal pillow is helpful with second stage CS, it is not clear what is the best method for IFH for a first stage CS or management of an unexpected IFH at CS.
Actions
1.Creating local guidelines in the management of IFH.
2.More training in the management of IFH e.g., incorporating an IFH station at PROMPT training.
3.Better documentation.
4.Improving debriefing patients following CS
5.Re-audit.

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NHS
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Escalation Report

Executive / Committee: People and Culture Committee

Date of Meeting: Monday 17th June 2024

Presented by: Eiri Jones (Chair)

Significant risks / issues for escalation to Board for action	• Positive People dashboards. • Leavers and Retention Report. • Medical Revalidation Report. • Workforce Health and Well Being Report. • Risks as below.

Key issues / other matters discussed by the Committee	The committee considered the following items:
	• People and Performance Report and Dashboard noting:
	  ○ Positive moves in several performance indicators including, vacancy rate, sickness absence rate and agency expenditure reductions.
	  ○ Appraisal compliance had further reduced, and the matter had been escalated to the senior management team.
	  ○ The need to further promote mandatory training compliance.
	  ○ The aging workforce demographic.
	• Estates and Facilities Divisional Report noting:
	  ○ Reduced vacancy rates and improved sickness absence overall.
	  ○ Reduced agency expenditure
	• Medical Revalidation Report noting 98% compliance overall
	• Workforce Health and Wellbeing Report noting an increase in work related sickness absence due to anxiety, stress and depression.
	• There were no subgroup escalation reports.

Decisions made by the Committee	• The Leavers and Retention Report was approved.
Implications for the Corporate Risk Register or the Board Assurance Framework (BAF)	• The committee was concerned about maintaining safe service provision given a 40% increase in cancer referrals and the requirement to deliver workforce reductions.
Items / issues for referral to other Committees	• None

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NHS
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NHS Foundation Trust

Escalation Report

Executive / Committee: People and Culture Committee

Date of Meeting: Monday 22nd July 2024

Presented by: Margaret Blankson (Chair)

Significant risks / issues for escalation to Board for action	• The revised Joint Strategic Risks aligned to the strategic objectives within the proposed joint strategy with DHC were approved. • The People and Culture Committee in Common Terms of Reference are recommended to the Board for approval, subject to a further discussion regarding the number of NEDs in the membership. • The Joint Inclusion and Belonging Strategy was recommended to the Board for approval.

Key issues / other matters discussed by the Committee	The committee considered the following items:
	• People and Performance Report and Dashboard noting:
	  ○ Increase in number of issues raised to FTSU Guardian
	• Family and Surgical Services Divisional Report noting:
	  ○ Volume of communication methods contributing to staff stress
	• Informatics and Business Intelligence Report noting:
	  ○ Improvements within Health Records team
	  ○ Clinical Coding Workforce Strategy
	• The People Plan Annual Progress report was noted.
	• The Education, Training and Development Report was noted.
	• The ICB People Committee Minutes were noted.
	• There were no subgroup escalation reports.

Decisions made by the Committee	• The People and Culture Committee in Common Terms of Reference are recommended to the Board for approval, subject to a further discussion regarding the number of NEDs in the membership. • The Joint Inclusion and Belonging Strategy was recommended to the Board for approval.
Implications for the Corporate Risk Register or the Board Assurance Framework (BAF)	• The revised Joint Strategic Risks aligned to the strategic objectives within the proposed joint strategy with DCH was approved.
Items / issues for referral to other Committees	• None

Report Front Sheet

1. Report Details			
Meeting Title:	Board of Directors, Part 1		
Date of Meeting:	31 July 2024		
Document Title:	Joint Workforce Inclusion and Belonging Strategy 2023-25		
Responsible Director:	Nicola Plumb Chief People Officer	Date of Executive Approval	12th July 2024 (EH)
Author:	*Manpreet Aujla-Gudgeon and Jan Wagner – EDIB Leads*		
Confidentiality:	No		
Publishable under FOI?	Yes		
Predetermined Report Format?	No		

2. Prior Discussion		
Job Title or Meeting Title	**Date**	**Recommendations/Comments**
People and Culture Committee	22 July 2024	Recommended to Board for Approval

3. Purpose of the Paper	To note and approve the Dorset County Hospital (DCH) & Dorset HealthCare (DHC Joint Workforce Inclusion and Belonging two-year Strategy (2023-25). The report summarises the reasoning and main body of the strategy.							
	Note (✓)	✓	*Discuss (✓)*		*Recommend (✓)*		*Approve (✓)*	✓

4. Key Issues

The development of the Joint Workforce Inclusion and Belonging 2023-25 reflects Dorset County Hospital (DCH) and Dorset HealthCare (DHC)'s commitment to fostering a supportive and inclusive environment. This strategy addresses the challenges faced by diverse communities and staff, ensuring equity in access, opportunity, and experience.

Key highlights of the strategy include:

Creating an Inclusive Culture: The strategy emphasizes the importance of developing an inclusive culture for all staff. This includes implementing initiatives for inclusive recruitment, promoting a culture of dignity and respect, and increasing opportunities for cultural awareness among staff groups.

Demonstrating Inclusive Leadership: Leadership at all levels within the Trust will showcase and promote inclusive practices. The Senior Leadership Group will lead bespoke activities and work plans to spearhead necessary changes and improvements.

Commitment to Equity by Design: The strategy outlines the Trust's approach to ensuring equity in opportunity, access, and experience by respecting and valuing diversity. Policies, processes, and practices will be reviewed and designed to remove systemic biases and barriers.

	Strategic Commitments: **Cultural Development:** Embedding inclusive recruitment initiatives, fostering respect and dignity, and enhancing cultural awareness among staff. **Leadership Practices:** Ensuring inclusive practices are evident at all leadership levels, with leadership actively championing EDI principles. **Systemic Equity:** Reviewing and revising policies and practices to ensure equity and remove systemic biases. **Governance and Compliance:** **Legal Obligations:** Compliance with the Equality Act 2010, specifically the Public Sector Equality Duty (PSED), is central to the strategy, focusing on eliminating discrimination, advancing equality of opportunity, and fostering good relations. **CQC Standards:** The strategy aligns with the 'Well Led' domain of the CQC standards, linking inclusive leadership and staff wellbeing to higher patient satisfaction and better outcomes. **Social Value:** Championing EDI is integral to the Trust's Social Value pledge, ensuring resources are equitably allocated to support diverse populations. **Strategic Alignment:** The EDI strategy supports the Trust's strategic objectives by enhancing staff satisfaction and patient experience, promoting inclusive leadership, and ensuring a supportive environment for all. The People and Culture Committee is asked to note and approve the Strategy and pass to Board for ratification, to enable formal publication and implementation, reinforcing our commitment to an inclusive and equitable environment for all staff, patients, and visitors.
5. Action recommended	The Board is recommended to: 1. **NOTE** the Joint Workforce Inclusion and Belonging 2023-2025 2. **APPROVE** the Joint Workforce Inclusion and Belonging 2023-2025

6. Governance and Compliance Obligations			
Legal / Regulatory Link	**Yes**		The general equality duty is set out in section 149 of the Equality Act 2010. Public organisations including NHS Trusts are subject to the general duty and must have due regard to the need to: eliminate unlawful: discrimination, harassment and victimisation. The Public Sector Equality Duty (PSED) requires public bodies to have due regard to the need to eliminate discrimination, advance equality of opportunity and foster

			good relations between different people when carrying out their activities.
Impact on CQC Standards	**Yes**		Development of fair and inclusive leadership, practice and culture contributes to the 'Well Led' CQC Domain. Inclusive workplaces report better staff health and wellbeing, which is linked to markedly higher patient satisfaction and better patient outcomes, meaning that there is potential for progress in EDI work to positively contribute to all CQC Domains
Risk Link	**Yes**		Non-compliance with the PSED would create risks for the organisation in terms of reputation and potential fines.
Impact on Social Value	**Yes**		Championing Equality, Diversity and Inclusion is a key ambition of the Trust's Social Value pledge.
Trust Strategy Link	**How does this report link to the Trust's Strategic Objectives?** *Please summarise how your report will impact one (or multiple) of the Trust's Strategic Objectives (positive or negative impact). Please include a summary of key measurable benefits or key performance indicators (KPIs) which demonstrate the impact.*		
Strategic Objectives People Place Partnership	People, Place, Partnership – The Trust strategy signals our intention to truly value our staff. Our people are our most important asset, and we want them to feel valued, welcomed, respected, they belong and matter. We recognise the link between high levels of staff satisfaction and improving patient experience and outcomes.		
Dorset Integrated Care System (ICS) goals	**Which Dorset ICS goals does this report link to / support?** *Please summarise how your report contributes to the Dorset ICS key goals.* *(Please delete as appropriate)*		
Improving population health and healthcare	**Yes**		*Target the focus on segmenting our population and providing bespoke outcomes for our patients*
Tackling unequal outcomes and access	**Yes**		deliver equitable services that are informed by engagement and involvement
Enhancing productivity and value for money	**Yes**		*Avoids waste and enhance productivity through a better understanding of staff and patients diverse needs*
Helping the NHS to support broader social and economic development	**Yes**		*Ensures equity in the allocation of resources towards our diverse population whether it is staff or patients*
Assessments	**Have these assessments been completed?** *If yes, please include the assessment in the appendix to the report.* *If no, please state the reason in the comment box below.* *(Please delete as appropriate)*		
Equality Impact Assessment (EIA)		**No**	
Quality Impact Assessment (QIA)		**No**	

Dorset County Hospital and Dorset HealthCare

Workforce Inclusion and Belonging Strategy

2023-2025

Author: Manpreet Aujla-Gudgeon (she/her) equality, diversity and inclusion lead
Co-Author: Jan Wagner (he/him) equity, diversity, inclusion and belonging lead (DCH)

1.0 Introduction

Foreword by Matthew Bryant, Joint Chief Executive

At Dorset HealthCare and Dorset County Hospital, we believe in the power of diversity. We recognise that our collective strength is drawn from our diverse perspectives. We aim to create a compassionate and inclusive culture, where we are united by our sense of belonging and purpose and where our people have equitable opportunities to flourish.

Our Inclusion and Belonging Strategy is more than a document, it is a call to action and represents our commitment to ensure everyone who works here feels valued, heard and empowered. We firmly believe that discrimination has no place at Dorset HealthCare and Dorset County Hospital, and we will actively work towards achieving a zero-tolerance approach to discrimination and developing a consciously inclusive culture.

We all have a collective responsibility to achieve the actions outlined in this strategy and hold ourselves and each other accountable. We acknowledge that this will be an ongoing process but, by fostering inclusion and belonging, we not only enrich our lives at work, but also bring about a positive change to ensure we continue to provide the highest quality of care to our patients and communities.

Our vision for Inclusion and Belonging

"We work together as one community to provide outstanding quality of care, in an environment where diverse voices are not only heard but valued, where differences are celebrated as sources of strength, and where discrimination has no place."

Dorset HealthCare and Dorset County Hospital value diversity and actively encourages inclusion so we can better understand the differing backgrounds and perspectives of the communities we care for. We are committed to:

- Attracting, retaining and developing people from a wide variety of backgrounds to reflect the diversity of the patients we care for.
- Ensuring our policies, practices and processes support our people's needs throughout different times in their lives and during their career with us.
- Our people understanding their role in creating an inclusive culture and demonstrate compassion and conscious inclusion towards one and other.
- Creating an environment where our leaders role-model inclusion and are committed to ensuring the decisions they make are equitable.
- Reporting on our progress through statutory frameworks (e.g., Workforce Race and Disability Equality Standards, Gender Pay Gap and the Equality Delivery System).

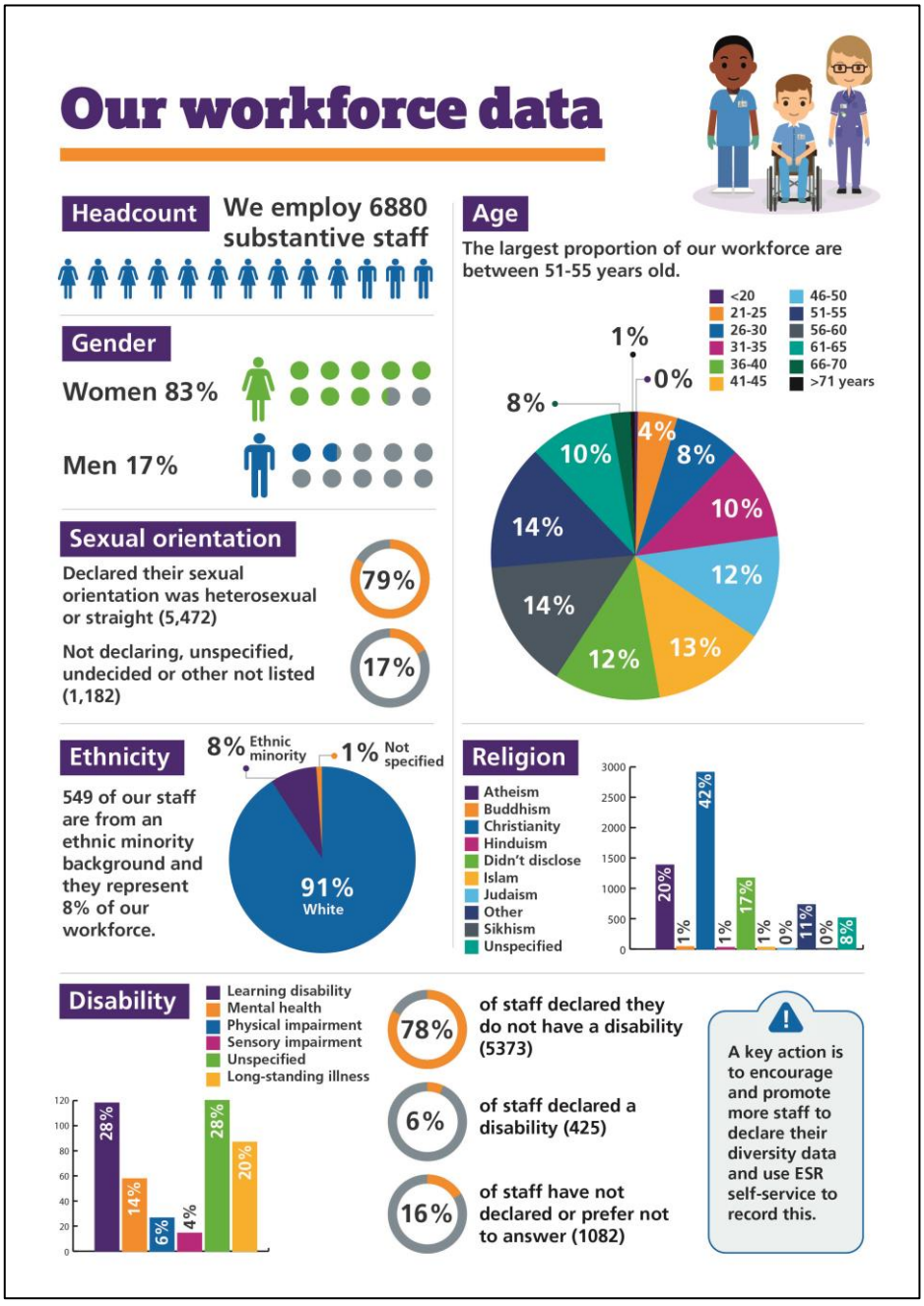
Our Inclusion and Belonging Strategy will take us from 2023-2025 and is based on four key pillars to firmly embed equality, diversity and inclusion in the way that we work. It will enable us to provide a baseline so we can measure the progress we make. To truly be an inclusive organisation, we need to focus on all elements of inclusion to ensure all our people feel supported and valued for their diverse perspectives. Every protected characteristic under the Equality Act 2010 is of equal importance, as well as the variety of different backgrounds of our people. For the purposes of this strategy, we have highlighted the characteristics that we report on as part of our contractual obligations.

2.0 Context – Where we are now at Dorset Healthcare

Our people

The importance of our staff at Dorset HealthCare cannot be overstated. We value the diverse perspectives they bring to provide an outstanding quality of care to our patients. Dorset HealthCare is the biggest provider of healthcare in Dorset, and we serve a population of nearly 800,000 and currently employ around 6800 substantive staff over 300 sites. The following infographic provides an overview of our workforce profile at a snapshot date of 1 June 2023:

"To address inequalities, we must consider **intersectionality** – we all have overlapping social identities that impact on our experiences and some of our people may face multiple forms of discrimination"



Ethnicity Representation

Our diversity data shows that people from an ethnic minority background represent **7.8%** of our workforce at Dorset HealthCare. In the Southwest region, ethnic minority representation is **15.0%** and nationally it is **26.4%**.

Non-Clinical staff on AfC paybands

Ethnic minority staff are represented in **4.9%** in all non-clinical AfC roles. There is proportionate representation at Band 4 and under, with ethnic minority staff representing **4.9%** of staff overall. At Band 5 and over, ethnic minority representation is also **4.9%** and there is proportionate representation by pay band.

Clinical staff on AfC paybands

Ethnic minority staff are represented in **8.5%** in all clinical AfC roles. At Band 4 and under, ethnic minority representation is **11.9%** overall and there is underrepresentation at Band 4 (**8.6%**). At Band 5 and over, ethnic minority representation is **6.8%** overall and there is underrepresentation at Band 6 and above (**5.0%**).

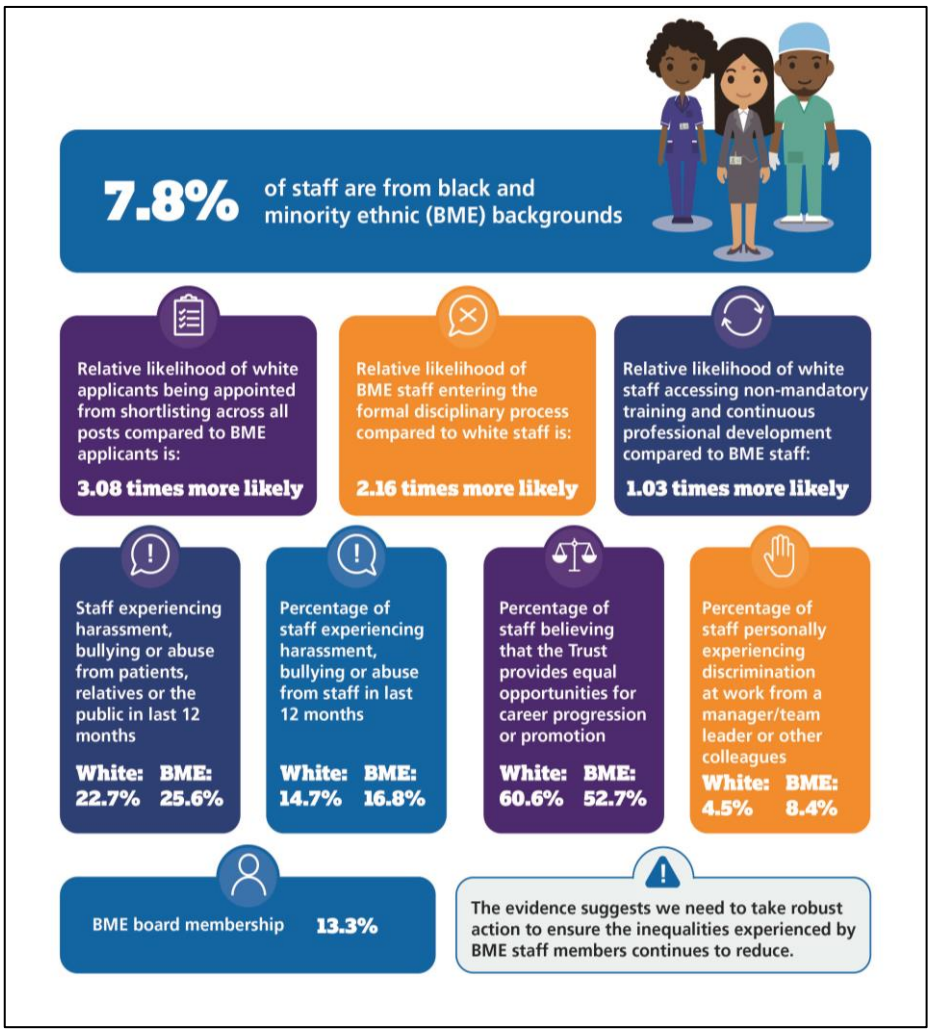
Medical staff

Ethnic minority representation is **27.4%** in all medical roles. There is underrepresentation at Non-consultant specialist level and above (**24.8%**).

Our **Workforce Race Equality Standard (WRES)** has shown that there is still a disparity in the experiences of staff from an ethnic minority background compared with those from white backgrounds. We have made some progress but know we need to take action to work towards reducing this disparity. Our WRES 2022-23 report outlines our key priorities that will enable to drive cultural change (Inclusion and Belonging Action Plan, Appendix 1).

"We are committed to being an **anti-racist** organisation – we will actively challenge and remove systemic barriers that enable racism"

Baker,Abi 30/07/2024 12:31:14



Disability Representation

Our diversity data shows that Disabled staff represent **6.1%** of our workforce at Dorset HealthCare. The national average for disability declaration in the workforce is **4.9%**.

Non-Clinical staff on AfC paybands

Disabled staff represent **6.2%** in all non-clinical AfC roles. At Band 4 and under, Disabled representation is **6.3%** overall and they are proportionately represented by band. At Band 5 and over, Disabled staff representation is **6.0%** overall and again they are proportionately represented by band.

Clinical staff on AfC paybands

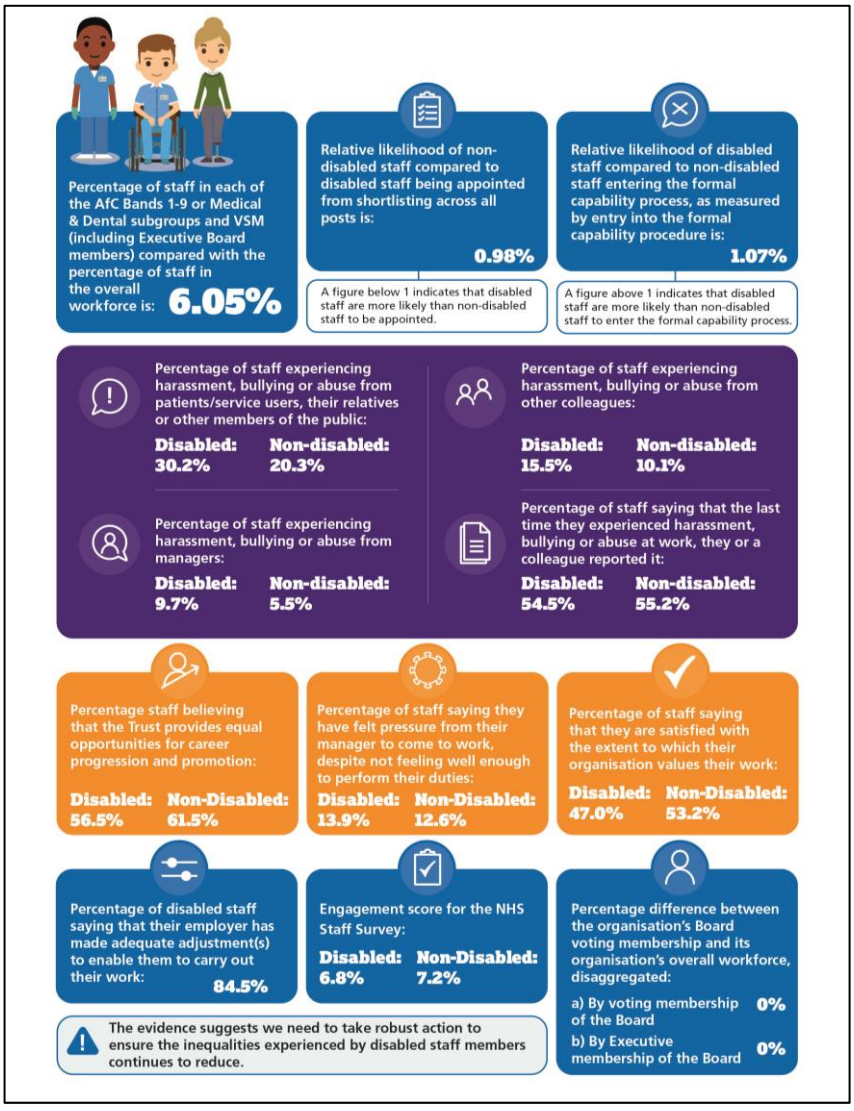
Disabled staff represent **6.1%** in all clinical AfC roles. At Band 4 and under, Disabled staff representation is **4.1%** overall and they are proportionately represented by band. At Band 5 and above, Disabled staff representation is **7.1%** overall, however, Disabled staff are underrepresented at Band 7 and above (**5.3%**).

Medical staff

Disabled staff represent **2.5%** in all medical roles, and they are proportionately represented by pay band.

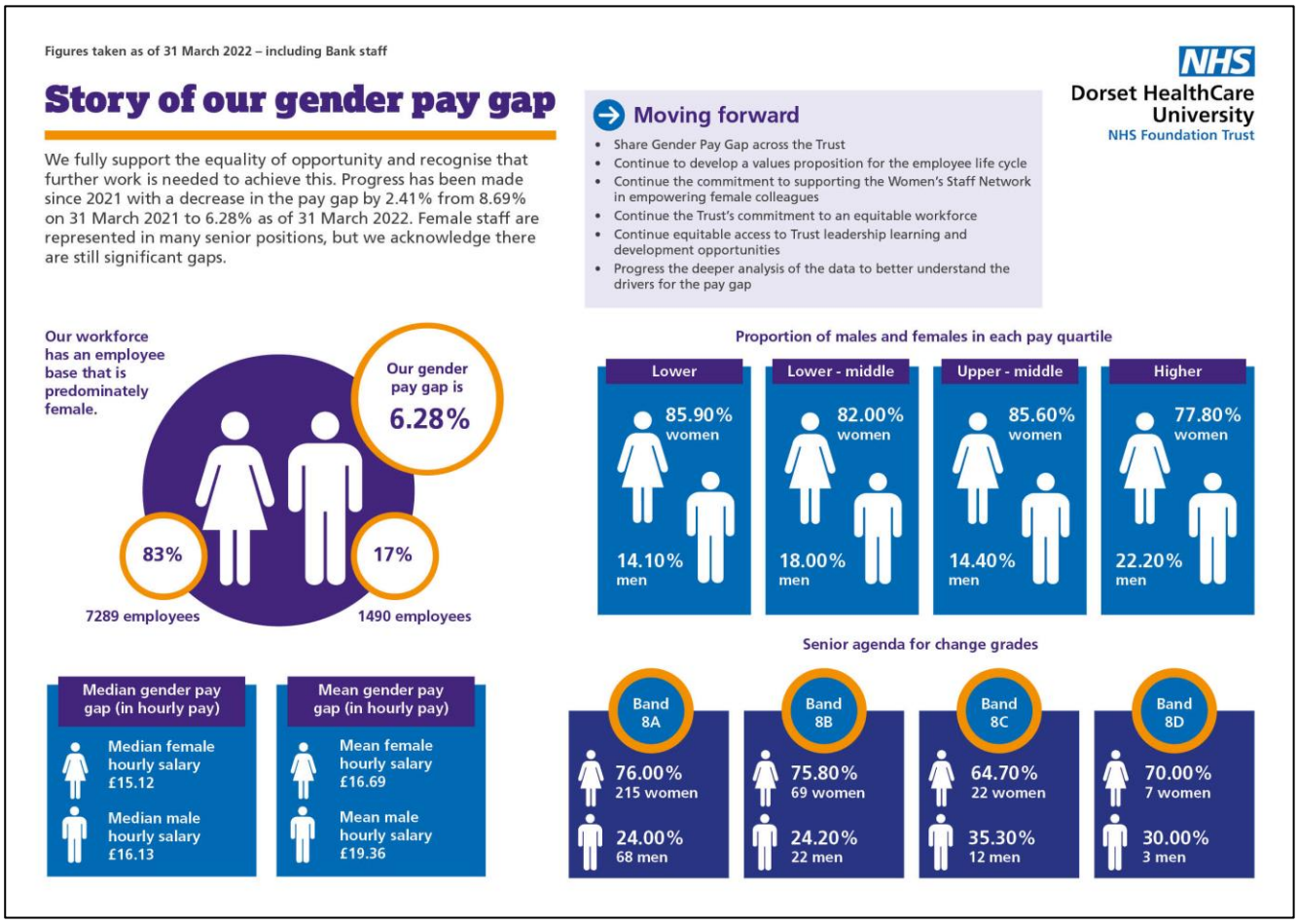
Our **Workforce Disability Equality Standard (WDES)** submissions have shown steady progress in Disability inclusion over the last few years. We are committed to making continual progress to ensure parity between our Disabled and non-disabled staff through the actions we have committed to in our WDES report for 2022-23 (Inclusion and Belonging Action Plan, Appendix 1).

"The evidence suggests we need to take **robust action** to ensure that the inequalities experienced by Disabled staff continues to reduce"



Gender Representation

Our workforce data shows we have an employee base that is predominantly female, with **83% female staff** and **17% male staff**. According to our **Gender Pay Gap (GPG)** data, we have progressively reduced our pay gap from **8.69%** on 31 March 2021 to **6.28%** on 31 March 2022. Female staff are represented in many senior positions, but we acknowledge that there are still significant gaps. An analysis of our pay gap has shown that the disparity mainly sits within unbanded roles within our GP and Consultant population. There is less variance between male and female counterparts across the AfC workforce. By carrying out this analysis, we can focus our efforts on reducing our Gender Pay Gap further – our overarching Inclusion and Belonging Action Plan outlines the steps we will take to achieve this (Appendix 1).

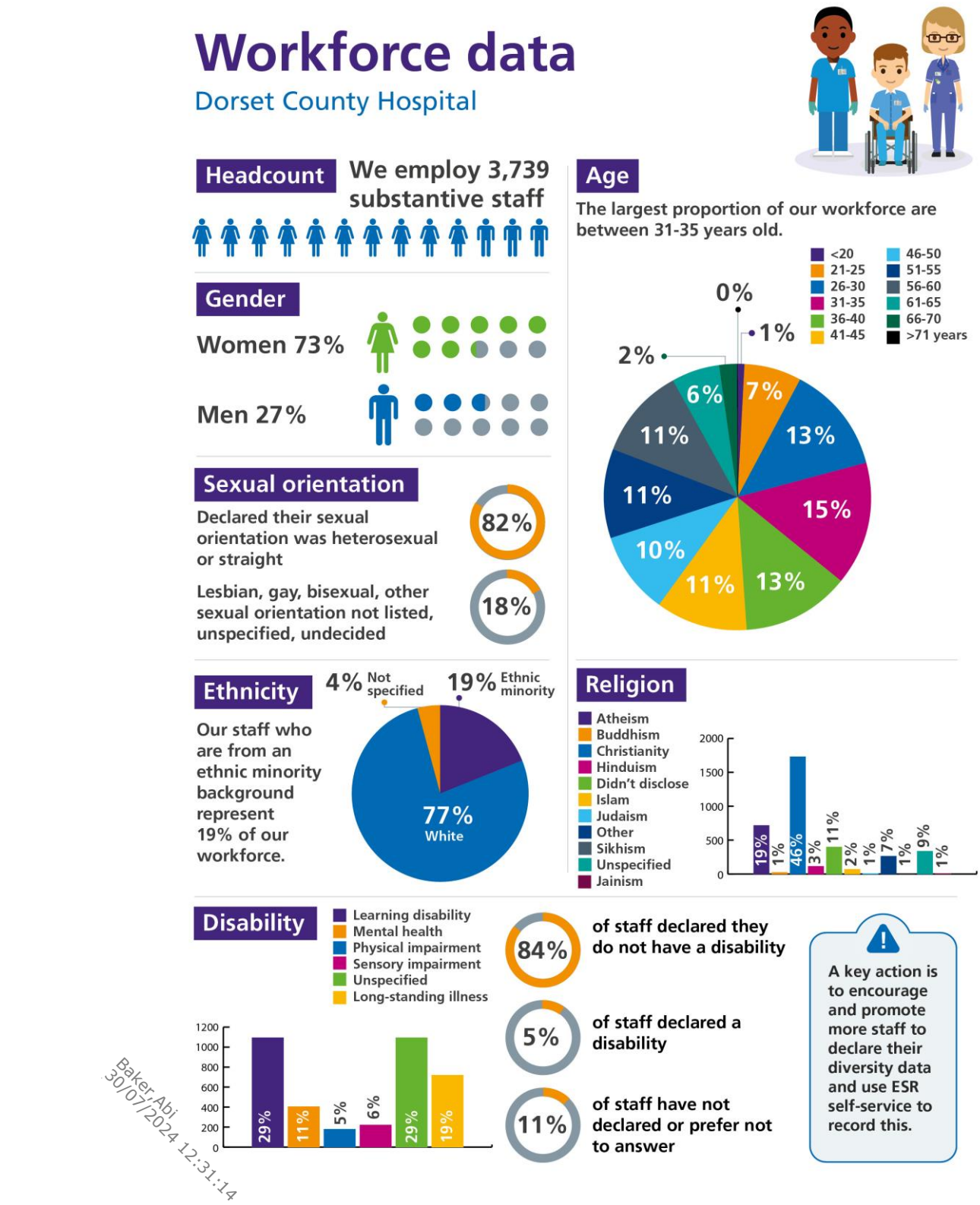


At both Trusts, we want to go further when it comes to gender inclusion by obtaining a clearer insight into our people who are transgender and or whose gender is not binary. Currently, the NHS Electronic Staff Record (ESR) does not provide categories that are fully representative. Research conducted in 2023 by the LGBTQ+ Leaders Network, NHS Confederation "Leading for all: supporting trans and non-binary healthcare staff" suggests that trans and non-binary staff are being excluded from providing their demographic information via ESR. To ensure that every voice counts, we will consider what adaptions we can make until the outcome of the Unified Information Standard for Protected Characteristics (UISPC) review being conducted nationally is complete.

"if we're not **counted**, we don't count"
~ LGBTQ+ Leaders Network, NHS Confederation

2.1 Context – Where we are now at Dorset County Hospital

Our people



Ethnicity Representation

Our diversity data shows that people from an ethnic minority background represent **15.2%** of our workforce at Dorset County Hospital. In the Southwest region, ethnic minority representation is **15.0%** and nationally it is **26.4%**.

Non-Clinical staff on AfC paybands

Ethnic minority staff are represented in **6.2%** in all non-clinical AfC roles. At Band 4 and under ethnic minority representation is **6.6%** overall. However, ethnic minority staff are underrepresented at Band 3 and above (**4.5%**).

Clinical staff on AfC paybands

Ethnic minority staff are represented in **14.4%** in all clinical AfC roles. At Band 4 and under, ethnic minority representation is **10.6%** overall and there is proportionate representation by pay band. At Band 5 and over, ethnic minority representation is **17.2%** overall and there is underrepresentation at Band 6 and above (**7.8%**).

Medical staff

Ethnic minority representation is **33.5%** in all medical roles. There is underrepresentation at Consultant level and above (**24.1%**).

Our **Workforce Equality Standard (WRES)** has shown positive trajectories when assessing the percentage of staff who experienced discrimination at work from a manager or colleague, but there is still a disparity in the experiences of staff from an ethnic minority background compared with those from white backgrounds. We have made some progress but know we need to take action to work towards reducing this disparity. Our WRES 2022-23 report outlines our key priorities that will enable to drive cultural change (Inclusion and Belonging Action Plan, Appendix 2).

Disability Representation

Our diversity data shows that Disabled staff represent **4.3%** of our workforce at Dorset County Hospital. The national average for disability declaration in the workforce is **4.9%**.

Non-Clinical staff on AfC paybands

Disabled staff represent **5.1%** in all non-clinical AfC roles. At Band 4 and under, Disabled representation is **5.5%** overall and they are proportionately represented by band. At Band 5 and over, Disabled staff representation is **4.0%** overall and again they are proportionately represented by band.

Clinical staff on AfC paybands

Disabled staff represent **4.3%** in all clinical AfC roles. At Band 4 and under, Disabled staff representation is **4.8%** overall and they are proportionately represented by band. At Band 5 and above, Disabled staff representation is **3.9%** overall and again they are proportionately represented by band.

Medical staff

Disabled staff represent **2.9%** in all medical roles, and they are proportionately represented by pay band.

Our **Workforce Disability Equality Standard (WDES)** submissions have shown steady progress in Disability inclusion over the last few years. To improve the experience of people with disabilities, we need to encourage more disabled staff to share that they have a long-term condition or disability so that we can appreciate the numbers and track our progress via a number of parameters. We are committed to making continual progress to ensure parity between our Disabled and non-disabled staff through the actions we have committed to in our WDES report for 2022-23 (Inclusion and Belonging Action Plan, Appendix 2).

Gender Representation

Our workforce data shows we have an employee base that is predominantly female, with **76% female staff** and **24% male staff**. According to our **Gender Pay Gap (GPG)** data, we have progressively reduced our pay gap from **9%** on 31 March 2021 to **8%** on 31 March 2022.

Our overarching Inclusion and Belonging Action Plan outlines the steps we will take to achieve this (Appendix 2).

3.0 Strategic Alignment

3.1 Workforce Strategy

The Inclusion and Belonging Strategy has been developed in line with Dorset HealthCare's corporate Workforce Strategy and Dorset County Hospital's Trust Strategy, with improved equality, diversity, inclusion and wellbeing being central to both. Inclusion is a golden thread throughout the objectives set by both Trusts, and it considers wider Trust programmes linked to our transformation and Best Quality, Best Value programme as well as our collaboration together and system working with Dorset ICS.

Dorset HealthCares' Workforce Strategy:

Understanding and action on equality, diversity and inclusion is everyone's business at Dorset HealthCare. For our workforce, this means maintaining a diverse workforce that represents the communities we serve; and it means ensuring every member of our team experiences equality of experience, opportunity and satisfaction.

- Continue to promote and embed equality and diversity in all that we do
- Ensure we make progress against the requirements of the Workforce Race Equality Standard and Disability Equality Standard
- Redouble our efforts to reduce discrimination, violence, bullying and harassment

Dorset County Hospitals' People Plan

Putting our people first to make DCH a great place to work and receive care.

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

Our Dorset (Dorset ICS People Plan):

• Our people feel valued, included and psychologically safe to bring their whole self to work.• There is a culture of pro equity and inclusion across the system that is the foundation for a great staff experience and delivering on health inequalities.• Talent Management and leadership development approaches are inclusive and values based to increase diversity in senior positions.

- Align the ways we collect and interpret workforce data by protected characteristic across workforce health and wellbeing services to address workforce health inequalities.
- Design system wide inclusive talent management offer that focuses on increasing diversity of senior leadership
- EDI programme group to support other programme groups in relevant objectives where inclusion and diversity are a focus of improvement.
- Adopt and roll out consistent middle management leading and managing for inclusion offer.
- Ensure transparency of workforce inclusion reporting, actions and lessons learnt as integral to our governance and performance reporting.
- Bring our staff networks across the system together and develop a plan for them to constructively challenge us in various programmes of work.

3.2 Workforce Data

To develop this strategy, we have analysed our workforce data at both Trusts, identified areas where we can reduce disparities of experiences to create a culture of inclusion and belonging, and reflected upon the type of support or interventions that will make a sustained and measurable difference.

3.3 Our Values

Our values are at the centre of what we do, guiding our actions and behaviours on both an organisational and individual level. It is vital that these values are reflected and embedded when designing interventions that encourage a culture of inclusion and belonging at both Dorset Healthcare and Dorset County Hospital.

3.4 National Guidance

Our Inclusion and Belonging Strategy is aligned with the NHS National Guidance from NHS England's NHS Equality, Diversity and Inclusion (EDI) Improvement Plan. The NHS EDI Improvement Plan builds upon the People Promise and NHS People Plan by using the latest data and evidence to identify six high impact actions Trusts can take. This strategy has focused on the high impact actions that are a priority for Dorset HealthCare first, with the intention of achieving any outstanding high impact actions in due course.

High impact action 1: Chief executives, chairs and board members must have specific and measurable EDI objectives to which they will be individually and collectively accountable

- Every board and executive team member must have EDI objectives that are specific, measurable, achievable, relevant, and timebound (SMART) and be assessed against these as part of their annual appraisal process (by March 2024).
- Board members should demonstrate how organisational data and lived experience have been used to improve culture (by March 2025).
- NHS boards must review relevant data to establish EDI areas of concern and prioritise actions. Progress will be tracked and monitored via the Board Assurance Framework (by March 2024).

High impact action 2: Embed fair and inclusive recruitment processes and talent management strategies that target under-representation and lack of diversity

- Create and implement a talent management plan to improve the diversity of executive and senior leadership teams (by June 2024) and evidence progress of implementation (by June 2025)
- Implement a plan to widen recruitment opportunities within local communities, aligned to the NHS Long Term Workforce Plan. This should include the creation of career pathways into the NHS such as apprenticeship programmes and graduate management training schemes (by October 2024). Impact should be measured in terms of social mobility across the integrated care system (ICS) footprint

High impact action 3: Develop and implement an improvement plan to eliminate pay gaps

- Implement the Mend the Gap review recommendations for medical staff and develop a plan to apply those recommendations to senior non-medical workforce (by March 2024).
- Analyse data to understand pay gaps by protected characteristic and put in place an improvement plan. This will be tracked and monitored by NHS boards. Reflecting the maturity of current data sets, plans should be in place for sex and race by 2024, disability by 2025 and other protected characteristics by 2026.
- Implement an effective flexible working policy including advertising flexible working options on organisations' recruitment campaigns. (March 2024).

High impact action 4: Develop and implement an improvement plan to address health inequalities within the workforce

- Line managers and supervisors should have regular effective wellbeing conversations with their teams, using resources such as the national NHS health and wellbeing framework. (by October 2023).
- Work in partnership with community organisations, facilitated by ICBs working with NHS organisations and arm's length bodies, such as the NHS Race and Health Observatory. For example, local educational and voluntary sector partners can support social mobility and improve employment opportunities across healthcare (by April 2025).

High impact action 5: Implement a comprehensive induction, onboarding and development programme for internationally-recruited staff

- Before they join, ensure international recruits receive clear communication, guidance and support around their conditions of employment ; including clear guidance on latest Home Office immigration policy, conditions for accompanying family members, financial commitment and future career options (by March 2024).
- Create comprehensive onboarding programmes for international recruits, drawing on best practice. The effectiveness of the welcome, pastoral support and induction can be measured rom, for example, turnover, staff survey results and cohort feedback (by March 2024).
- Line managers and teams who welcome international recruits must maintain their own cultural awareness to create inclusive team cultures that embed psychological safety (by March 2024).
- Give international recruits access to the same development opportunities as the wider workforce. Line managers must proactively support their teams, particularly international staff, to access training and development opportunities. They should ensure that personal development plans focus on fulfilling potential and opportunities for career progression (by March 2024).

High impact action 6: Create an environment that eliminates the conditions in which bullying, discrimination, harassment and physical violence at work occur

- Review data by protected characteristic on bullying, harassment, discrimination and violence. Reduction targets must be set (by March 2024) and plans implemented to improve staff experience year-on-year.
- Review disciplinary and employee relations processes. This may involve obtaining insights on themes and trends from trust solicitors. There should be assurances that all staff who enter into formal processes are treated with compassion, equity and fairness, irrespective of any protected characteristics. Where the data shows inconsistency in approach, immediate steps must be taken to improve this (by March 2024).
- Ensure safe and effective policies and processes are in place to support staff affected by domestic abuse and sexual violence (DASV). Support should be available for those who need it, and staff should know how to access it. (By June 2024)
- Create an environment where staff feel able to speak up and raise concerns, with steady year-on-year improvements. Boards should review this by protected characteristic and take steps to ensure parity for all staff (by March 2024).
- Provide comprehensive psychological support for all individuals who report that they have been a victim of bullying, harassment, discrimination or violence (by March 2024).
- Have mechanisms to ensure staff who raise concerns are protected by their organisation.

4.0 The Strategy: Where we want to be

This strategy takes an evidence-based and multi-disciplined approach to embed a culture of inclusion and belonging at Dorset HealthCare and Dorset County Hospital. Inclusion is everyone's business, and all of our people have a collective responsibility to action this strategy and achieve our vision, where *"we work together as one community to provide outstanding quality of care, in an environment where diverse voices are not only heard but valued, where differences are celebrated as sources of strength, and where discrimination has no place".* The four pillars of this strategy have been developed as a result of our data and where we need to focus our attention. Our Inclusion and Belonging Action Plan will hold us to account and enable us to measure our progress, with the aim of completion of all actions by 2025.

4.1 How will we measure our progress?

- Increasing parity across the WDES and WRES indicators where we have inequality in those underrepresented groups.
- Continue to reduce our GPG, with a specific target for reduction by 2024.
- Report on our Disability and Ethnicity Pay Gaps from 2024, with specific targets for reduction (if there is a pay gap) by 2025.
- Increase representation of underrepresented and marginalised groups in the roles identified by our WRES, WDES and GPG reporting by 2025.
- Improvements in the accuracy of our data with the creation of an internal diversity dashboard and a Dorset-wide system diversity dashboard by 2024.
- Increased disclosure of diversity data at all levels of the organisation, with a particular focus on reducing *'Unknown'* and *'Prefer not to say'* by improving psychological safety and transparency regarding benefits of disclosure.
- 100% of line managers completing Conscious Inclusion Training.
- 100% of new starters completing an Inclusion module as part of their mandatory training/onboarding.
- Chief executives, chairs and board members to have specific and measurable EDI objectives to which they will be individually and collectively accountable by 2024.
- Setting a reduction target for incidents involving bullying, harassment, discrimination and violence and implementation of an action plan by 2024, to improve staff experience year-on-year to ensure those impacted are listened to and supported.
- Monitor diversity data of staff leaving Dorset HealthCare and Dorset County Hospital.

The strategy focuses fostering inclusion throughout the important stages that our people go through during their time with us from attraction, recruitment, onboarding, development, retention and separation. The four pillars include:

The following section highlights some key actions we will take under each pillar – please see the appendix for our detailed Inclusion and Belonging Action Plan.

4.2 Conscious Inclusion and Collective Responsibility

Activity under this pillar focuses on awareness, education and training so that all our people understand their role in creating an inclusive culture, where they demonstrate compassion and conscious inclusion towards each other, and all voices are heard.

By setting clear standards of behaviour and proactively involving all staff, we will be able to foster an inclusive and equitable environment. Inclusion is not solely the responsibility of the People and Culture Directorate or the EDI team but a shared commitment that extends to all levels and directorates, especially our line managers. Our diversity is one of our greatest assets and inclusion is the key to unlocking its full potential. By taking collective responsibility for inclusion, we all will actively challenge discrimination and bias, whether these are behaviours are subtle or overt. We will stand united against exclusion.

How will we achieve this?

Awareness, Education and Training	• Conscious Inclusion training. • Mandatory training for all staff on Inclusion. • Active Bystander training.
EDI Steering Group and Staff Networks	• Review membership of EDI Steering Groups to ensure representation across areas and perspectives. • Support Staff Networks with their activity to raise awareness and increase knowledge. • Staff Network Chairs to act as Cultural Ambassadors to ensure diverse perspectives are influencing key decisions. • Staff Network Allyship Programmes.
Addressing Violence, Aggression and Discrimination	• Task and Finish Group to create an action plan to improve staff experience year-on-year. • Review disciplinary and employee relations processes. • Set reduction targets. • Enable staff to speak up and raise concerns. • Provide comprehensive psychological support for victims.

4.3 Inclusive Resourcing and Talent Development

Inclusive resourcing means we actively seek candidates who have diverse backgrounds and perspectives and reduce any barriers they may face in applying for roles at Dorset HealthCare and Dorset County Hospital. We firmly believe that recruitment processes should be designed to reduce the influence of bias and discrimination, while getting the most suitable candidate for a role. We acknowledge that building an inclusive workplace must start with the way we attract and select talent. Following this, we commit to nurturing and developing that talent by providing equitable opportunities for growth and development to all our staff and, where we identify underrepresentation, we commit to taking positive action to address inequalities. By doing so, we will add value to our organisation and retain our people so they can provide an outstanding quality of care to our patients.

How will we achieve this?

Inclusive Resourcing

- Conscious Inclusion training for hiring managers.
- Diverse panels, starting with all roles Band 6 and above.
- Review resourcing and recruitment process to ensure inclusion is embedded throughout with a focus on where we are losing talent during the recruitment cycle.

Inclusive Talent Development

- Widening Participation within local communities, aligned to the NHS Long Term Workforce Plan.
- Talent Pathways for underrepresented and marginalised groups.
- Positive action programmes for marginalised groups.

4.4 Equity by Design (policy, processes, practices)

We aim to embed Equity by Design when shaping our policies, processes and practices. By doing so, we will be able to identify systemic biases and remove any barriers that prevent our people from accessing the opportunities they need to thrive or having more negative experiences.

How will we achieve this?

Equality Impact Assessment

- Review and revise existing Equality Impact Assessment framework to ensure EIAs are fully embedded as a decision-making tool for processes impacting staff and patients.

Decision-making

- Decision-making should be data-driven, progress should be measured and dealt with informally or formally to account for any impact on underrepresented groups.
- Diverse perspectives should be included in decisions impacting our people (e.g., representative panels at grievance or disciplinary hearings and Staff Networks providing comment on policies and strategies).

4.5 Inclusive Leadership

Leaders set the tone and culture for their organisation. The actions under this pillar focus on encouraging our leaders and line managers to demonstrate compassion and conscious inclusion. These behaviours are vital in creating an inclusive culture at Dorset HealthCare and Dorset County Hospital. For us, Inclusive Leadership means actively seeking out and embracing diverse viewpoints as we recognise this will empower our staff to deliver great care and patient experience. As highlighted in the Messenger Review, we agree that principles of EDI should be embedded as the personal responsibility of every leader and every member of staff. We will encourage our leaders and line managers to actively challenge bias and discrimination to reduce inequitable experiences and to actively listen, learn and role-model inclusive behaviours.

How will we achieve this?

Inclusion Objective	• Every board and executive team member to have an inclusion objective that is SMART and be assessed against these as part of their annual appraisal process.
Data	• Our board to review relevant data to establish EDI areas of concern and prioritise actions. Progress will be tracked and monitored via the Board Assurance Framework. • Commit to publishing all pay gap data to encourage a culture of transparency.
Recipricol Mentoring Programmes	• Board and executive team to take part in the third cohort of our recipricol mentoring programme.
Inclusive Leadership Training	• Leading for Inclusion and Health Equity Programme. • Roll out of Conscious Inclusion and Inclusive Leadership Programme in collaboration with Dorset County targeted at all line managers and aspiring line managers.

5.0 Conclusion

This strategy takes an action-oriented approach to firmly embed a culture of inclusion and belonging at Dorset HealthCare and Dorset County Hospital. It will provide a baseline from which we can utilise our data to measure our progress – we are currently at an intersection of our past achievements and our future aspirations, and it is going take all staff with a collective responsibility to bring this strategy to life. Together, we can create an environment where diverse voices are not only heard but valued, where differences are celebrated as sources of strength, and where discrimination has no place.

Closing Thoughts by Nicola Plumb, Joint Chief People Officer

Thank you for reading our Inclusion and Belonging Strategy 2023-2025. The evidence clearly confirms that having a diverse workforce where everyone feels a sense of belonging delivers the best care for our patients. The benefits of an inclusive culture are vast – with improvements in retention, innovation, engagement and productivity. Inclusive environments are also linked to psychological safety, and this is essential for staff morale which, in turn, leads to improved patient care and outcomes. But most importantly, it is the right thing to do.

We are committed to Dorset HealthCare and Dorset County Hospital being organisations where there is no inequity of experience for our people, where opportunities are fairly allocated, where discrimination has no place so our people can thrive.

6.0 Strategy Ownership and Governance

This Inclusion and Belonging Strategy is one of the deliverables from our overarching workforce strategies and a detailed action plan for each Trust has been developed to support this strategy (please see Appendix).

Progress on the development, implementation and impact of this strategy will be reported to the People Committee, ensuring it is meeting the organisational need and delivering tangible performance improvements.

Evaluation of the interventions that are delivered will provide the quality assurance in relation to the impact they are having. Regular reviews will be put in place to ensure the design and delivery of the frameworks and programmes detailed within this strategy are fit for purpose and having the right impact.

Appendix 1: Overarching Inclusion and Belonging Action Plan 2023-2025 for Dorset HealthCare

Our Overarching Inclusion and Belonging Action Plan is a high-level overview of the actions we have committed to. It will be supplemented with a detailed plan that includes milestones and target dates to ensure we are continually held to account for delivery of this plan.

Pillar	Action	WRES (Indicator)	WDES (Metric)	GPG (Pillar)	EDS2 (Domain)	EDI Improvement Plan (Metric)
Conscious Inclusion and Collective Responsibility	Zero tolerance approach to reduce bullying, harassment, discrimination and violence to ensure staff feel safe to come to work, including a statement from our Chief Executive regarding this	**5, 6**	**4a, 4b, 4c, 4d**		**2b**	**6**
	Continue work with the SAFE Team and Dorset Police	**5**	**4a**		**2b**	**6**
	Continue to work with FTSUG for reporting	**5, 6**	**4b, 4c, 4d**		**2b**	**6**
	Set up Task and Finish Group to ensure incidents of harassment, bullying or abuse are reported and staff are supported	**5, 6**	**4a, 4b, 4c, 4d**		**2b**	**6**
	Identify themes and hotspots for colleague-on-colleague harassment, bullying or abuse	**6**			**2b**	**6**
	Continue review of Ulysses data	**6**	**4d**			**6**
	Develop new policy in collaboration with the staff network on 'managing allegations of discrimination and abuse'	**6**	**4a, 4b, 4c, 4d**		**2b**	**6**
	Launch the Respect and Resolution policy (this is the new combined grievance and dignity at work policy)	**6**	**4b**		**2b**	**6**

	Work closely with the Disability Staff Network to engage with staff and understand needs		**7**			
	Active bystander training	**8**	**4a, 4b, 4c, 4d**			**6**
	Staff engagement: EDI team to manage and feedback themes from networks and review of scores by Directorate		**9a**		**2d**	
	Continue to support, develop and engage with the Women's Staff Network Group including external engagement across a range of activities to empower female colleagues and develop growth of groups			**Culture & Engagement**		
	Review membership of EDI Steering Group to ensure representation across areas and perspectives					
	Staff Network Allyship Programmes					
Inclusive Resourcing and Talent Development	Improve diverse panel compositions and interview questions through collaboration with staff networks	**2**	**2**	**Improve workforce supply**		**2**
	Redesign and deliver recruitment and selection training to all recruiting Managers including knowledge of unconscious bias and reasonable adjustments	**2**	**2**			**2**
	Promote all opportunities across the workforce, with a particular focus on the take up of development opportunities by females, ethnic minority staff and staff with a disclosed disability to ensure an equitable workforce.	**4, 7**	**5**	**Learning & Development**		**2**
	Increase in staffing levels more reflective of diversity of local	**9**	**10**			**2**

	communication and regional/national labour markets					
	Review advertising and shortlisting processes for all Board appointments	**2**	**2**			**2**
	EDI question at every interview	**2**	**2**			**2**
	Further rollout of Reciprocal Mentoring programmes	**4, 7**	**5**	**Learning & Development**		**2**
	Further rollout of positive action programs (Beyond Difference) in partnership with Dorset Integrated Care System	**4, 7**	**5**	**Learning & Development**		**2**
	Embed career conversations as part of the annual performance appraisal process	**4, 7**	**5**			**2**
	Introduce transparency to promotion, pay and reward processes			**Improve workforce supply**		**2**
	Continue to develop flexible working options and workforce strategies to improve recruitment and retention of staff including supporting female staff to return to work following maternity or adoption leave. HR advisory team are running workshops – to promote a flexible working policy			**Improve workforce supply**		**2**
	We will review our on-boarding data ‘shortlisting to interview to appointment’ and explore any gender, race and disability inequalities	**2**	**2**	**Improve workforce supply**		**2**
Equity by Design (policy,	Year on year reduction in the percentage of ethnic minority and Disabled staff involved in disciplinary procedures	**3**	**3**			

processes, practices)	Promote the Wellbeing Service and Plans to all staff		**6**			**4**
	Occupational Health to support staff who have a disability and require reasonable adjustments, Promote Access to Work on DORIS		**8**			
	Launch awareness campaign for a Just and Learning Culture		**3**			
	Monitor the application of other policies and procedures, such as flexible working, maternity leave, adoption leave and Health and Wellbeing, and return to work after a long-term absence, which could impact on female staff disproportionately			**Improve workforce supply**		
	Encourage women who have been away from the workplace through raising a family, caring role or long-term ill health to return to work through a range of enticements including hybrid/home working, awareness of Trust policy and practices that are supportive of the specific needs of women			**Pay & Reward**		
	Encourage the uptake of Shared Parental Leave			**Pay & Reward**		
	Review and revise existing Equality Impact Assessment framework to ensure EIAs are fully embedded as a decision-making tool for processes impacting staff and patients					
	Work with Health Inequalities Lead to reduce health inequalities in the workplace					**4**

Inclusive Leadership	Conscious inclusion training for line managers and our HR team	**3, 7**	**4b, 4d**		**3a, 3b, 3b**	**1**
	Review EDI content in the new manager's induction programme	**7**	**4b**			
	Include an EDI objective in yearly appraisals to ensure every leader demonstrates their commitment to inclusion and fairness	**8**	**5**		**3a, 3b, 3b**	**1**
	Raise awareness of supporting colleagues with a disability and reasonable adjustments as part of the new manager induction process		**8**			
	Senior management team and Board to engage with all staff networks		**9a, 9b**		**3a, 3b, 3b**	**1**
	Commit to publishing all pay gap data to encourage a culture of transparency and set targets if there are gaps. Analyse data to understand pay gaps by protected characteristic and put in place an improvement plan. This will be tracked and monitored by our board. Reflecting the maturity of current data sets, plans should be in place for gender and race by 2024, disability by 2025 and other protected characteristics by 2026.					**3**
	Roll out Conscious Inclusion training for all line managers to support internationally recruited staff and staff from underrepresented groups.					**5**

Appendix 2: Overarching Inclusion and Belonging Action Plan 2023-2025 for Dorset County Hospital

Our Overarching Inclusion and Belonging Action Plan is a high-level overview of the actions we have committed to. It will be supplemented with a detailed plan that includes milestones and target dates to ensure we are continually held to account for delivery of this plan.

Pillar	Action	WRES (Indicator)	WDES (Metric)	GPG (Pillar)	EDS2 (Domain)	EDI Improvement Plan (Metric)
Conscious Inclusion and Collective Responsibility	Measurable Zero Tolerance approach to reduce bullying, harassment, discrimination and violence to ensure staff feel safe to come to work, including a statement from our Chief Executive regarding this	**5, 6**	**4a, 4b, 4c, 4d**		**2b**	**6**
	Develop and implement a staff on staff reporting system with FTSUG to improve data quality to support action	**5, 6**	**4b, 4c, 4d**		**2b**	**6**
	Set up Task and Finish Group to ensure incidents of harassment, bullying or abuse are reported and staff are supported	**5, 6**	**4a, 4b, 4c, 4d**		**2b**	**6**
	Identify themes and hotspots for colleague-on-colleague harassment, bullying or abuse	**6**			**2b**	**6**
	Continue review of Datix data	**6**	**4d**			**6**
	Develop new policy in collaboration with the staff network on 'managing allegations of discrimination and abuse'	**6**	**4a, 4b, 4c, 4d**		**2b**	**6**
	Develop a Respect and Resolution policy (this is the new combined	**6**	**4b**		**2b**	**6**

	grievance and dignity at work policy) to align with DHC					
	Improve the support neurodivergent staff to be their best at work		**7**			
	Active bystander training	**8**	**4a, 4b, 4c, 4d**			**6**
	Staff engagement: EDIB team to manage and feedback themes from networks, groups, individuals and review of scores by Directorate		**9a**		**2d**	
	Increase support, development and engagement with the Pride Network			**Culture & Engagement**		
	Review membership of EDIB Steering Group to ensure representation across areas and perspectives					
	Set up Task and Finish Group to comply with the sexual safety charter and develop a sexual safety initiative in DCH	**5, 6**	**4a, 4b, 4c, 4d**		**2b**	**6**
	Ensure all staff-on-staff reporting is handled fast, fair, transparent and is recorded in an (EDIB) measurable way with all staff handling cases trained to identify harassment, bullying or abuse in a multidisciplinary way	**5, 6**	**4b, 4c, 4d**		**2b**	**6**
	Developing and implementing a Safe-Space policy for DCH	**5, 6**	**4a, 4b, 4c, 4d**	**Culture & Engagement**	**2b**	**6**
Inclusive Resourcing and Talent Development	Improve diverse panel compositions and interview questions through collaboration with staff networks	**2**	**2**	**Improve workforce supply**		**2**
	Redesign and implement recruitment and selection training including knowledge of unconscious bias, reasonable adjustments and gender topics	**2**	**2**			**2**

	Promote all opportunities across the workforce, with a particular focus on the take up of development opportunities by all staff with protected characteristic to ensure an equitable workforce.	**4, 7**	**5**	**Learning & Development**		**2**
	Increase in staffing levels more reflective of diversity of local communication and regional/national labour markets	**9**	**10**			**2**
	Review advertising and shortlisting processes for all Board appointments	**2**	**2**			**2**
	Design and implement mandatory EDIB questions for every interview	**2**	**2**			**2**
	Review and redesign ethical recruitment process with clear standards especially for communication	**2, 4, 7**	**2, 5**			**2**
	Embed career conversations as part of the annual performance appraisal process	**4, 7**	**5**			**2**
	Introduce transparency to promotion, pay and reward processes			**Improve workforce supply**		**2**
	Continue to develop flexible working options and workforce strategies to improve recruitment and retention of staff including supporting all (with a focus on female) staff to return to work following maternity or adoption leave. HR advisory team running workshops – to promote a flexible working policy			**Improve workforce supply**		**2**
	We will review our on-boarding data 'shortlisting to interview to appointment' and explore any inequalities regarding to protected characteristics	**2**	**2**	**Improve workforce supply**		**2**

Equity by Design (policy, processes, practices)	Year on year reduction in the percentage of ethnic minority and Disabled staff involved in disciplinary procedures	**3**	**3**			
	Developing and integrating a long-term accommodation strategy to offer staff affordable and accessible housing without facing discrimination with focussing on all protected characteristics	**4,7**	**2,5**	**Improve workforce supply**	**2b**	**2**
	Implement a comprehensive induction, onboarding and development programme	**4,7**		**Improve workforce supply**		**5**
	Developing to integrate all protected characteristics in the same way as WRES & WDES into policies and add them as measurable data to all procedures like recruitment, HR and education	**2**	**2**			**2**
	Occupational Health to support staff who have a disability and/or long-term health condition and require reasonable adjustments, Promote Access to Work		**8**			
	Launch awareness campaign for a Just and Learning Culture		**3**			
	Monitor the application of other policies and procedures, such as flexible working, maternity leave, adoption leave and Health and Wellbeing, and return to work after a long-term absence, which could impact on female staff and staff with other protected characteristics disproportionately			**Improve workforce supply**		

	Encourage people who have been away from the workplace through raising a family, caring role or long-term ill health to return to work through a range of enticements including hybrid/home working, awareness of Trust policy and practices that are supportive of the specific needs of women			**Pay & Reward**		
	Encourage the uptake of Shared Parental Leave			**Pay & Reward**		
	Integrate additional gender options in our recruitment, HR and administrative processes.			**Improve workforce supply**		**2**
	Review and revise existing Equality Impact Assessment framework to ensure EIAs are fully embedded as a decision-making tool for processes impacting staff and patients					
Inclusive Leadership	Conscious Inclusion and Inclusive Leadership training for all line managers and all our HR & recruitment team members as essential	**3, 7**	**4b, 4d**		**3a, 3b, 3b**	**1,5**
	Gender awareness training for all HR, recruitment staff and executives as essential	**3, 7**	**4b, 4d**	**Improve workforce supply**	**3a, 3b, 3b**	**1,5**
	Review EDIB content in the new manager's induction programme	**7**	**4b**			
	Include an EDIB objective in yearly appraisals to ensure every leader demonstrates their commitment to inclusion and fairness	**8**	**5**		**3a, 3b, 3b**	**1**
	Raise awareness of supporting colleagues with a disability and reasonable adjustments as part of the new manager induction process		**8**			

	Senior management team and Board to engage with all staff networks – sponsors understand their role and commitment and including it as essential objective		**9a, 9b**		**3a, 3b, 3b**	**1**
	Commit to publishing all pay gap data to encourage a culture of transparency and set targets if there are gaps. Analyse data to understand pay gaps by all protected characteristic and put in place an improvement plan. This will be tracked and monitored by our board. Reflecting the maturity of current data sets, plans should be in place for gender and race by 2024, disability by 2025 and other protected characteristics by 2026.					**3**

Freedom to Speak Up & Whistleblowing Report Q3 & Q4 2023/24
Front Sheet

1. Report Details			
Meeting Title:	Board of Directors, Part 1		
Date of Meeting:	31st July 2024		
Document Title:	Freedom to Speak Up & Whistleblowing Report Q3 & Q4		
Responsible Director:	Nicola Plumb – Chief People Officer Emma Hallett – Deputy Chief People Officer	Date of Executive Approval	9th May 2024 (EH)
Author:	Lynn Paterson - Freedom to Speak Up Guardian		
Confidentiality:	No		
Publishable under FOI?	Yes		
Predetermined Report Format?	No		

2. Prior Discussion		
Job Title or Meeting Title	**Date**	**Recommendations/Comments**
People and Culture Committee	20/05/2024	Noted

3. Purpose of the Paper	To provide a bi-annual update on the Freedom to Speak Up (FTSU) cases and activities and formal whistleblowing disclosures made in Quarter 3 and 4 (October 2023-March 2024) and outline plans moving forward.						
	Note (✓)	**X**	*Discuss (✓)*		*Recommend (✓)*		*Approve (✓)*	

4. Executive Summary

This update provides a summary of the activities of the FTSU work and formal Whistleblowing disclosures between October 2023 and March 2024 (Q3 and Q4). **There were 187 cases reported to the guardian during this period and no formal whistleblowing disclosures.**

We welcome concerns raised as part of our commitment to a culture of speaking out safely. The number of concerns raised through the FTSU process in Q3 and 4 was significantly higher than the previous two quarters. The increase in activity is likely due to having 'Speak Up' month during October 2023 and the onset of targeted listening events.

Concerns involving elements that indicate a risk of adverse impact of worker wellbeing was the most prominent theme. These are mainly in relation to repeated incivility towards staff.

Over 95% of the concerns raised were acknowledged within 72 hours and actions for resolution agreed within 3 weeks.

Development activities such as the Trust's Dignity & Respect at Work (DRW) workshops and the Inclusive Leadership Programme have raised awareness about acceptable and unacceptable behaviour. The monthly Organisational Development (OD) bulletin is regularly used to reiterate the messages about speaking up as well as signposting staff to training opportunities.

	Next steps include more visiblity in the messaging from shared learning of cases and to continue to drive the speak up culture through attendance at team meetings, via the Champions Network and ESR training modules.
5. Action recommended	The Board is recommended to: 1. **NOTE** the update

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

Title of Meeting	**Board of Directors, Part 1**
Date of Meeting	**31 July 2024**
Report Title	**Bi-annual Freedom to Speak Up and Whistleblowing Report**
Author	**Lynn Paterson, Freedom To Speak Up Guardian**

1.0 Introduction

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

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

1.3 The FTSUG is supported by a network of FTSU Champions, which have now greatly increased in numbers from 16 to 34. Champions work to ensure colleagues understand and can access routes to speaking up and provide a confidential source of signposting. This model follows the recommendations of the NGO and Care Quality Commission.

1.4 This report also covers whistleblowing activity. The review provides a summary of the formal whistleblowing disclosures made within the previous 6 months and lessons learned.

1.5 The relevant policy to follow for those wishing to make a formal whistleblowing disclosure is the Freedom to Speak Up: Raising Concerns (Whistleblowing) policy (EM63). The policy signposts individuals to those who can support them to raise informal and formal concerns.

2.0 Reporting Speaking Up Cases

2.1 The FTSUG submits quarterly speaking up data online via the NGO Portal. This is published nationally by the NGO alongside all other NHS Trusts' data.

2.2 Quarter 3 and Quarter 4 saw an 87% increase in cases from the last reporting period (100 to 187), as such, an in-depth comparison between Q1 and Q2 with Q3 and Q4 may be erroneous. This positive trend is likely attributed to increased awareness during Speak Up month falling in October in addition to the onset of targeted listening events.

2.3 FTSU data for Q3 and Q4:

Total concerns raised	Q3	Q4	TOTAL
	85	102	187
Raised anonymously	17	0	17
Elements of bullying	10	24	34
Elements of patient safety	33	29	62
Element of risk to worker safety	28	24	52
Element of risk to worker wellbeing	69	74	143
Other/Inappropriate behaviours	40	54	94
Risk of detriment for speaking up	27	38	65

2.4 The staff role for reporting the highest number of concerns is Registered Nurses, accounting for 26% of cases. This mirrors the national picture due to nursing being the largest workforce. Health Care Support Workers and Clinical Support Workers each accounted for 18% of cases, closely followed by Administrative and Clerical roles accounting for 17% of cases.

2.5 Predominant bands reporting concerns are Band 7's and Band 2's equally accounting for 17% of the cases.

2.6 The majority of cases needed escalation to facilitate a resolution, with manager behaviour and colleague behaviour attributing to many of the concerns raised.

2.7 Any staff raising a patient safety concern are strongly advised to complete a datix and guided to complete this anonymously if deemed appropriate.

2.8 The FTSU key performance indicators are set at >95% of concerns being acknowledged within 72 hours and actions for resolution agreed within 3 weeks. This has been achieved.

2.9 No formal whistleblowing disclosures have been made in the period covering this review. The last formal whistleblowing disclosure made within the Trust was in July 2020. This is lower than elsewhere within the Dorset region. Whilst there have been no formal whistleblowing disclosures made in this period, there has been an increase in issues raised via the FTSUG. It is positive that staff can raise issues using this mechanism rather than the formal whistleblowing process.

3.0 Emerging Themes

3.1 Elements that indicate a risk of adverse impact of worker wellbeing was again the most prominent theme, this is consistent with Q1 & Q2. These cases are primarily in relation to incivility towards staff and poor behaviour. Staff wellbeing support information is provided in these cases, and the Trust's DRW Programme recommended. The FTSUG is now collaborating with OD colleagues and is facilitating the DRW Programme.

3.2 Incidents including poor communication and staff not being provided with feedback feature as a recurrent theme. Managers need to provide clarity for their staff and close the communication gap which can create an environment of instability and distrust.

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

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

3.4 Q3 and Q4 shows an increase in concerns raised anonymously, primarily from a targeted listening event and staff are encouraged to raise a concern by any means they feel most comfortable.

3.5 More robust triangulation of data has been established, to help identify hotspots, particularly in relation to patient safety and staff turnover/retention. Weekly Patient Safety Huddles take place with attendance from FTSUG and relevant stakeholders, in addition to regular meetings with safeguarding and Southwest FTSUG's. Monthly local intelligence meetings between HR, Workforce Business Partners (WBPs), Education, Recruitment and the OD Team have now been operational for almost a year. This collaboration is incredibly helpful in providing context around issues and then identifying how to support and who to progress matters to. From some of the feedback established via the FTSU route, HR have instigated a more robust development plan for their advisors.

4.0 Next Steps

4.1 The FTSUG would like to have time to develop the more active aspects of the role particularly establishing routes within the organisation to share the learning that comes from the cases raised.

4.2 The fear of 'detriment' as a result of speaking up still features as a theme, predominantly when staff are raising concerns about their manager. The need to reiterate the messages around 'zero tolerance' on detriment, as stated in the policy continues. A dedicated FTSU internet page will help reiterate this message and include staff case studies which will contribute to shared learning.

4.3 The Champions Network is increasing with regular meetings and drop-in sessions to share ideas for promotional activities and raising awareness of speaking up. Promoting their role and how they can be accessed needs further exploration.

4.4 The FTSUG continues to drive a stronger 'speaking up' culture by attending team/department/governance meetings, staff networks, induction and preceptorship training in addition to meet and greets with the night staff regularly. Considering the national and local focus on nurturing a culture of openness and transparency, it is hoped that FTSU training will be mandated to align with our local partners.

4.5 Discussions will continue in identifying and tackling barriers to speaking up and learning to achieve improvements. This area was the main theme of speak up month. The FTSUG continues to ally with staff networks to raise awareness of the speak up process and increase visibility in these areas.

4.6 Contact is firmly established with the FTSUG at DHC with regular face to face meetings providing peer supervision, sharing ideas and highlighting opportunities to collaborate on future work. Bespoke FTSU training was provided at the Joint Board Development Workshop presented by both DCH and DHC FTSUG's.

5.0 Conclusion

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

5.2 As a system, we need to improve communications locally and be more visible in terms of messaging about our values and civility. It is reassuring that staff mainly appear to be employed in a role they enjoy; however, wellbeing is being impacted by incivility. Managers should be role models and be the flagship for our Trusts values. Training programmes including DRW will give staff the confidence to challenge uncivil and unprofessional behaviour as it arises and the Management Matters Programme will reinforce skills such as conflict resolution, compassionate leadership and motivating and maintaining morale within their teams.

6. Recommendation

The Board is recommended to note this update and the ongoing work of the FTSUG.

Report Front Sheet

1. Report Details			
Meeting Title:	Board of Directors, Part 1		
Date of Meeting:	31 July 2024		
Document Title:	**Workforce Health and Wellbeing Review**		
Responsible Director:	Nicola Plumb, Joint Chief People Officer	Date of Executive Approval	10 June 2024 (EH)
Author:	Mark Greening, Health & Wellbeing Lead		
Confidentiality:	No		
Publishable under FOI?	Yes		
Predetermined Report Format?	No		

2. Prior Discussion		
Job Title or Meeting Title	**Date**	**Recommendations/Comments**
People and Culture Committee	17/06/2024	Noted

3. Purpose of the Paper	To provide the committee with a summary of the health and wellbeing support provided to staff and the plans in place to embed and extend this offer.							
	Note (✓)	✓	*Discuss (✓)*		*Recommend (✓)*		*Approve (✓)*	

4. Key Issues

The health and wellbeing of our staff continues to be a key priority. It is well documented that poor mental and physical wellbeing directly affects patient safety, sickness absence rates, staff retention and agency spend. Health and wellbeing must have a collective focus so it becomes an integral part of every function, role and practice across the Trust. Caring for the wellbeing of our people enables them to care for the wellbeing of our patients.

We already have a comprehensive staff health and wellbeing (HWB) offer and there is ongoing work to embed this to ensure increased staff awareness. Having already embraced aspects of the NHS HWB Framework (a high-level culture change toolkit) to inform our offer, we now need to build on this to truly create a HWB culture.

To underpin the culture change required, we are forming a robust strategy based on both the NHS HWB Framework and the NHS People Promise. During 24/25 we propose utilising the seven elements of the framework alongside the People Promise pillars to create impact across the organisation.

Key challenges for continuous improvement of staff HWB support are that we have limited dedicated resources, pressure on funding streams and an ongoing need to drive cultural change for increased local ownership and organisational impact.

Continued collaborative working across ICB but more particularly with DHC, the People Promise Exemplar Programme and new HWB Strategy will support improvements to staff HWB provision and overall staff experience.

Baker Abi 30/07/2024 12:31:42

5. Action recommended

The Board is recommended to:

NOTE this paper and the updates herein

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		**Yes**		The National Staff Survey results are used as one way of gauging staff experience within the Trust alongside other data sets and alongside agreed actions provide assurances to the CQC for Well-Led Domain.
Risk Link			**No**	*f yes, please state the link to Board Assurance Framework and Corporate Risk Register risks (incl. reference number). Provide a statement on the mitigated risk position.* *(Please delete as appropriate)*
Impact on Social Value		**Yes**		A key Social Value Principle: Working together across DCH and with our Dorset system partners to improve health and well-being and reduce avoidable inequalities across our community. Principles: Recognised as a Good Employer, Champion Diversity & Inclusion, Involve Our Community.
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	People - focusing on making DCH a great place to work: Looking after and investing in our staff, developing our workforce to support outstanding care and equity of access and outcomes, creating an environment where everyone feels they belong, they matter and have a voice. Working to reduce sickness absence and increase productivity. Excellent staff experience creates excellent patient and service user experience.		
	Place	Building a better and healthier place for our patients and population – staff feel valued and supported which impacts on HWB.		
	Partnership	Working together to ensure outstanding services, accessible to our patients and population – staff are supported and developed which links to providing safe and effective services to patients.		
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**		DCH staff are part of the local Dorset community. Effective talent and appraisal processes support a healthier workforce where staff feel valued and supported.
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**		Staff who feel supported to develop their careers & have development opportunities are likely to be more productive at work. Identifying potential & growing talent of existing staff provides improved value for money (using strengths & skills)
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**	

Board of Directors
Health & Wellbeing Activity Update

Executive Summary

The health and wellbeing of our staff continues to be a key priority. It is well documented that poor mental and physical wellbeing directly affects patient safety, sickness absence rates, staff retention and agency spend. Health and wellbeing must have a collective focus so it becomes an integral part of every function, role and practice across the Trust. Caring for the wellbeing of our people enables them to care for the wellbeing of our patients.

We already have a comprehensive staff health and wellbeing (HWB) offer and there is ongoing work to embed this to ensure increased staff awareness. Having already embraced aspects of the NHS HWB Framework (a high-level culture change toolkit) to inform our offer, we now need to build on this to truly create a HWB culture.

To underpin the culture change required, we are forming a robust strategy based on both the NHS HWB Framework and the NHS People Promise. During 24/25 we propose utilising the seven elements of the framework alongside the People Promise pillars to create impact across the organisation.

The strategy will focus on:

- Improving personal HWB (physical and mental)
- Healthy relationships with colleagues
- Fulfilment at work
- Manager and leader behaviours and practice
- Environment
- Data insights
- Professional wellbeing support

To impact effectively on staff wellbeing, it is necessary for us all to take proactive action.

Key challenges for continuous improvement of staff HWB support are that we have limited dedicated resources, pressure on funding streams and an ongoing need to drive cultural change for increased local ownership and organisational impact.

Continued collaborative working across ICB but more particularly with DHC, the People Promise Exemplar Programme and new HWB Strategy will support improvements to staff HWB provision and overall staff experience.

The Committee is asked to Discuss & Approve this paper.

1. Where are we now

1.1 Employee Assistance Programme (EAP)

The service provided by our EAP provider Vivup has been embedded further into organisational knowledge. Managers for the first quarter of 2024 are the main referral method into Vivup (over 40%) showing an increase in their knowledge of the support available and the route into this. Our numbers of referrals into the Vivup triage process have increased this year.

Counselling numbers peaked during January which is not unusual and part of a national picture of increased access to counselling. Since then we have maintained a steady flow of both telephone and onsite counselling service access.

We have subscribed to Vivup's Your Care platform which provides a self-help route for staff to manage and understand their own health and wellbeing, and data is generated to provide insights into the range of staff wellbeing needs, which aids our HWB planning.

1.2 HWB Staff Intranet pages & HWB Folders

Our newly developed intranet pages have been visited over 3650 times since launch early this year - more than any other intranet page at DCH. Our professionally crafted visual identity has assisted in ensuring staff can find what they need through the identification of the wellbeing logo and bright green colour chart which in turn complements that of our EAP.

Our analogue folders have now been delivered across the trust to provide more accessible support information to staff, and our wellbeing TV will shortly be re-erected in the Damers restaurant staff area, following a period of refurbishment. There is already a Wellbeing TV in the Terrace Café and another planned for the Education Centre.

These are all key routes to raising staff awareness about the full range of HWB support available.

1.3 Trauma Risk Management (TRiM)

TRiM is a trauma-focused peer support system designed to help people who have experienced a traumatic, or potentially traumatic, event. Our TRiM process has been launched and is now available to departments across the Trust. Staff can find easy access to learn about TRiM and the referral process via a newly created intranet page and portal.

Risk assessment scores can now be completed using a new electronic form to collate and retain the work of each intervention and to minimise the work on our TRiM Practitioners and Managers.

1.4 Wellbeing classes and financial support

Since the beginning of the year, staff have been able to access free Yoga and Pilates classes and Shiatsu Massage sessions. We have continued our financial support offer with free food (leftover food from Damers), foodbank referrals and food shopping vouchers. Within the next few months we will begin work with a Dorchester-based financial support/advisory organisation who will be available to support staff in matters of finance. Each November we have staff engagement activities which focus on the financial support available to staff.

1.5 Health & Wellbeing Coaches (HWCs)

We currently have 62 HWCs and are recruiting again in June to expand the Community of Practice (CoP). This CoP is intended to provide robust support to staff and goes beyond the parameters of the recommended national 'champions' programme. We provide an enhanced skillset so they can support colleagues through their Mental Health and Suicide First Aid training and many are also TRiM Practitioners, providing wider awareness of trauma-based needs.

1.6 Menopause, Men's Health and other support

We are launching a new 'Menopause Advocates' programme in the Trust and continue with awareness-raising activities. A menopause-friendly menu is planned for Damers Restaurant.

Work is ongoing to address Men's Health and other areas including stress, anxiety and depression and muscular skeletal related issues.

1.7 Civility & Respect

National data from the Civility Saves Lives team gives clear and simple warnings about the impact on productivity, output, quality of service and patient risk. There is strong evidence that incivility significantly impacts on the wellbeing of staff and their feeling of value.

Our Dignity and Respect at Work programme continues to raise awareness about unacceptable behaviours and how to challenge these. The programme is being used as a model for delivery by NHS Dorset.

1.8 HWB Steering Group (HWBSG) & HWB Guardian

The HWBSG continues to meet quarterly to provide oversight for staff HWB support and is chaired by the Deputy Chief People Officer. The HWB Lead meets regularly with the HWB Guardian who acts as a critical friend. These routes provide support and governance to ensure we are continuously improving our staff HWB offer.

2.0 The key challenges

Key challenges for continuous improvement of staff HWB support are that we have limited dedicated resources, pressure on funding streams and an ongoing need to drive cultural change for increased local ownership and organisational impact.

2.1 HWB Personnel

The HWB team within OD consists of the HWB Lead and a full-time, charity-funded HWB Administrator (Fixed Term Contract up to October 2025). The HWB Lead supports wider OD work such as facilitating the Dignity & Respect at Work Programme, Trust Induction (Trust Values & ways of working) session and is regularly called on to support staff mediation and individual/ team development needs. This results in the dedicated resource being diluted, driving the need for peer and line manager support to be improved.

Building the HWC CoP and ensuring TRiM is running effectively (with sufficient trained Practitioners & Managers) are key to building peer support resources in the HWB arena.

Increasing line manager skills to better support staff HWB needs is gradually happening through our Management Matters programme, but offering relevant development sessions at pace and scale is still a key challenge due to limited resources.

2.2 HWB Funding

Dedicated HWB funds remain a concern. We are entering our final (fourth) year of free EAP provision via Vivup. The next financial year (2025/6) will require us to start paying an annual fee (currently being costed). Continued access to Your Care, if approved, will require an annual investment of circa £4K. The charity funding currently being used for yoga classes etc. is limited and whilst there is an application process to pursue, the outcome is not guaranteed.

Additionally, if trauma-related HWB support is identified through the TRiM process, we currently have no guaranteed budget to fund this. Whilst provision of appropriate support could be sourced through Vivup, provisional costing is at circa £2K per person. As we have no data yet on potential annual need, we cannot calculate the anticipated yearly spend. One of our 'next steps' actions is further collaboration with Dorset Healthcare (DHC) to identify how best to support this need.

3.0 Next Steps

3.1 Ongoing Collaborative Working

Wellbeing Leads across the system have continued to work together since July 2023 by meeting regularly to join up on ideas and share working practices and ideas, as well as collaborating where possible and useful. The Trust TRiM Coordinator (HWB Lead) also meets monthly with the Coordinators at DHC and UHD to discuss practice and where there might be opportunities to work together.

In June, we are meeting with DHC colleagues, including the DHC-based ICB Clinical Psychologist Lead, Meherzin Das, to explore how we can join forces to meet the trauma-related needs escalated through the TRiM process at both Trusts.

A more general staff HWB meeting in July between DHC and DCH will establish where it may be possible to work together more directly on wellbeing projects which translate between our Acute and MH Trusts.

The Wellbeing Strategies for both Trusts will be explored at the July meeting, to ascertain where the synergies and differences are, build on the successful work already established and agree a way forward to make the most of collaborate approaches.

3.2 People Promise Exemplar Programme (PPEP)

People Promise exemplar organisations (a mix of acute, community and mental health providers) were launched last year through a pilot programme. NHS England is working with this group to deliver interventions set out in the People Promise, which was created by thousands of staff who were asked what they felt would make the NHS feel like a great place to work.

DCH and DHC now have a shared PPEP team, active since April, which is working on the correlation between staff engagement, productivity, and retention. Key drivers are

flexible working, health and wellbeing and ensuring a sense of belonging and work has started in earnest to improve the staff experience.

3.3 Wellbeing Strategy

It is proposed that we adopt a Wellbeing Strategy aimed at focussing on the culture at DCH. The strategy must reflect the staff which it serves along with the issues it faces and the wider organisational culture. The proposal is for the strategy to align with the seven NHS Wellbeing Elements and the NHS People Promise pillars. We anticipate that collaborative efforts between DCH and DHC will underpin this approach and ensure that all of our managers and leaders, at whatever level, are committed to the required culture change to positively influence staff experience in the HWB arena.

The strategy will focus on:

- Improving personal HWB (physical and mental)
- Healthy relationships with colleagues (civility, respect & care)
- Fulfilment at work (inspiring & supporting our diverse staff)
- Manager and leader behaviours and practice **(**how they define, implement and embody a positive health and wellbeing culture)
- Environment (physical spaces & resources to help our staff rest, recover and succeed)
- Data insights (how we understand needs and measure effectiveness)
- Professional wellbeing support (the teams and services we rely on)

4. Conclusion

Acknowledging the continued need for a focus on our wellbeing offer, it is proposed that we adopt a new Wellbeing Strategy (in development, and in collaboration with DHC) that focuses on creating a wellbeing thread through everything we do, not just HWB-specific activities.

Embracing the seven elements of the NHS HWB Framework, aligned to the People Promise themes, will support the culture change we need for a more holistic approach to staff HWB.

Through collaborative efforts and adoption of the national framework, we can improve staff HWB provision and overall staff experience at both Trusts.

1. Recommendation

The Board is recommended to: **NOTE** the proposal.

Name and Title of Author: Mark Greening, Health & Wellbeing Lead,
Date: 07th June 2024

INTEGRITY | RESPECT | TEAMWORK | EXCELLENCE

NHS
Dorset County Hospital
NHS Foundation Trust

Escalation Report

Committee: Risk and Audit Committee

Date of Meeting: 18th June 2023

Presented by: Stuart Parsons

Significant risks / issues for escalation to Board for action	• The Annual Report and Accounts were recommended to the Board for approval and signature and publication following their laying before parliament. • The Letter of Representation was recommended to the Board for signature. • The Quality Account was recommended to the Board for approval and signature.

Key issues / other matters discussed by the Committee	The committee considered the following items:
	• Compliance with the new Code of Governance
	• Compliance with the new NHS Provider License
	• Annual Report and Accounts including:
	  ○ Annual Governance Statement
	  ○ ISA 260 Report (VFM, Management Over-ride, Going Concern)
	  ○ Annual Audit Report (Annual Report and Accounts)
	  ○ Draft External Audit Opinion (Prior to Council of Governors)
	  ○ Draft Letter of Representation
	• Quality Account
	• Internal Audit Progress Report noting:
	  ○ Commencement of work on the 2024/25 audit programme.
	  ○ The Data Security and Protection Toolkit Audit had provided moderate assurance.
	  ○ The Head of Internal Audit Opinion had not identified any significant control weaknesses.
	• The Anticrime Report and self-assessment were received, noting all areas were on track to deliver compliance with the standards and completion of the functional standards submission.
	• The Annual Clinical Audit Assurance Report was received.
	• Losses and Special Payments were noted.

Decisions made by the Committee	• The Annual Report and Accounts were recommended to the Board for approval and signature and publication following their laying before parliament. • The Letter of Representation was recommended to the Board for signature. • The Quality Account was approved and is recommended to the Board. • The Terms of Reference and Work Plan were approved.
Implications for the Corporate Risk Register or the Board Assurance Framework (BAF)	• The Corporate risk register was reviewed.

Items / issues for referral to other Committees	•

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 3rd June 2024

Presented by: David Clayton-Smith

Significant risks / issues for escalation to Committee / Board for action	• The transfer of Flagship 4 (Admission Avoidance) into the Integrated Neighbourhood Programme.

Key issues / matters discussed at the Committee	The committee in common considered the following items:
	• Working Together Highlight Report and Risk Register noting:
	  ○ The Road Map and Risk Register had been refreshed.
	  ○ The potential capacity impact of the Electronic Healthcare Records programme on future digital developments and prioritisation and mitigation via the One Transformation approach.
	• Detailed discussion of Flagship 4 and the significant contribution of data analysis and community engagement in driving targeted access to services and population health improvements.
	• Pharmacy Case Study Update.
	• An update noting that DCH and DHC were working in a federated manner and the further review of the Memorandum of Understanding between the two trusts.
	• The Communications and Engagement Plan was noted.
	• The Support Services Proposal outlining the principles and approach to the reviews was noted.
	• The committee noted the impact of the general election on the approval of the joint strategy.
	• The proposal to develop joint committees and subsequent discussion of the timelines and committee memberships was noted.
	• Review of the Working Together Programme with the NHS Forward Plan.

Decisions made by the Committee	• The Committees endorsed the transfer of Flagship 4 into the Integrated Neighbourhood Programme. • The committee supported the approach to the Support Services reviews.
Implications for the Corporate Risk Register or the Board Assurance Framework (BAF)	Nil new.

Items / issues for referral to other committees	• Nil

Report Front Sheet

1. Report Details			
Meeting Title:	Board of Directors, Part 1		
Date of Meeting:	31 July 2024		
Document Title:	Committee Effectiveness Review 2023/24		
Responsible Director:	Jenny Horrabin, Director of Corporate Affairs	Date of Executive Approval	23/07/2024
Author:	Trevor Hughes, Head of Corporate Governance Abi Baker, Deputy Trust Secretary		
Confidentiality:	No		
Publishable under FOI?	Yes		
Predetermined Report Format?	No		

2. Prior Discussion		
Job Title or Meeting Title	**Date**	**Recommendations/Comments**
Prior consultation and discussion by committee members	February – March 2024	• Terms of Reference to be updated and committee work programmes to be reviewed and agreed as per governance review recommendations for the establishment of joint committees with DHC.
Finance and Performance Committee	20/05/2024	Recommended to Board for approval
People and Culture Committee	20/05/2024	Effectiveness review noted and that this would inform the development of the committee in common.
Quality Committee	20/05/2024	Recommended to Board for approval
Risk and Audit Committee	18/06/2024	Effectiveness review noted

3. Purpose of the Paper	The purpose of the report is to present the outcome of the annual committee review of effectiveness process. Approval of the Terms of Reference for the Quality Committee and Risk and Audit Committee for the coming year is also recommended. The Terms of Reference for the Finance and Performance; People and Culture; and Strategy, Transformation and Partnership Committees in Common will be presented to the Board under separate cover for approval.							
	Note (✓)	✓	Discuss (✓)		Recommend (✓)		Approve (✓)	✓
4. Key Issues	Good governance practice determines that committees of the Board of Directors should undertake an annual review of their effectiveness in order to inform changes to their terms of reference, priorities and work programmes for the forth coming year, so demonstrating effective leadership and supporting development and delivery of the overall strategy objectives. Two governance reviews have been undertaken in year:							

1. A review of committee arrangements across DCH and DHC recommending a phased approach to the implementation of joint committee working to support the executive model and collaboration between the two trusts.
2. A review of governance arrangements within DCH below committee level to strengthen ward to Board reporting.

The committee reviews have been undertaken this year within the context of these governance reviews.

Each committee has undertaken a review of effectiveness using an appreciative enquiry approach and the model questionnaire contained within the Audit Committee Handbook 2014. Key findings are summarised as:

People and Culture Committee:
Areas of good practice

- The Committee is definitely clear on its role and seeks insight appropriately.
- The work plan has a clear programme aligned to agreed overarching objectives.
- The BAF is regularly reviewed and the committee receives the corporate risk register.
- Escalation Reports provide timely escalation of risks to Board.
- Clear evidence of actions being passed to other committees where appropriate.

Areas for development

- There is a question about the level of detail that is provided and whether this is suitably strategic.
- Reports need to better reflect how they mitigate strategic risks
- BAF needs to be prioritised when on the agenda to allow time to be assured on mitigations.
- Risk escalation process is not always exercised in a timely manner sufficient to allow time for assurance.
- Timing pressures lead to reduced emphasis on assurance and triangulation.
- Lots of routine reporting detracts from strategic focus.
- Poor timeliness of paper circulation.
- Whilst there has been some improvement on the Executive summaries, these could be further improved with clear and concise requirements, challenges or areas of improved performance.
- Too many oral updates on the action log in the meeting.
- Executive workload routinely requires rescheduling of action due dates.
- Monthly meetings are too frequent and drive discussion of the detail rather than the strategy.

Finance and Performance Committee:
Areas of good practice

- Clear evidence of actions being passed to other committees where appropriate.
- There is always good and thorough discussion which demonstrates that committee members are well prepared.

Areas for development

- Reports need to better reflect how they mitigate strategic risks
- BAF to be prioritized on committee agenda to allow for adequate

discussion of mitigating actions.

- Risk escalation process is not always exercised in a timely manner sufficient to allow time for assurance.
- Focus on operational and finance performance rather than strategic direction.
- Communication of committee decisions to staff / managers could be better articulated.
- Timing pressures lead to reduced emphasis on assurance and triangulation.
- Lots of routine reporting detracts from strategic focus.
- Poor timeliness of paper circulation.
- Whilst there has been some improvement on the Executive summaries, these could be further improved with clear and concise requirements, challenges or areas of improved performance.
- Too many oral updates on the action log in the meeting.
- Executive summaries still do not draw out the key points for the committee's attention.
- Executive workload routinely requires rescheduling of action due dates.

Quality Committee:

Areas of good practice

- Flexible approach to workplan allows for timely discussions.
- There has been good review of the strategic risks.
- Chairs knowledge has been invaluable to the performance of this committee.
- Opportunities for Board members to have relevant CPD to support continued effective functioning.
- There is always good and thorough discussion which demonstrates that committee members are well prepared.

Areas for development

- Sometimes the meetings remain operationally focused following pandemic and operational pressures. Need to be more strategically focused.
- BAF needs to be prioritised to allow more time to be assured on the mitigations.
- The maternity report executive summary needs to be more concise and explicit in the matters for the committee's attention.
- Agendas are always full so may need to consider less meetings with longer length.
- Poor timeliness of paper circulation.
- Whilst there has been some improvement on the Executive summaries, these could be further improved with clear and concise requirements, challenges or areas of improved performance.
- Too many oral updates on the action log in the meeting.
- quantity is seen as assurance over the quality of what is being presented

In terms of the areas for development there are three key themes:

To improve the focus of the papers: The standard of a all papers will form part of the governance review taken place over quarter 2. This will include further guidance and support on the executive summaries to ensure that the key issues are drawn out. The structure below the Committee is under review with the aim of operational issues being considered at a level below the Committee, enabling the

	Committee to be more strategically focussed. This should also negate the need for longer meetings as the reports enable members to focus on key issues. Administration of the Committee: Increased rigour to be introduced and enforced for all Committees. Late papers will only be accepted at the discretion of the Chair. Increased focus will be given to the review of the action log to ensure that written updates are provided where the item is not covered by an agenda item Board Assurance Framework: This will be added to the start of the agenda to ensure that the key strategic risks are prioritised. **Risk and Audit Committee:** Areas of good practice • The focus on keeping the BAF up to date and refreshed assures us that this is a working document. • The committee receives regular reports from internal and external auditors as well as from our Finance teams and Strategic Estates & Transformation Teams that set out clearly the effectiveness of internal control systems. • Effective communication is enabled through Board escalation reports and passing/transfer of relevant issues from one subcommittee to another where appropriate. • BDO attend every meeting and meet with the committee chair. • The revised meeting schedule is appropriate and effective. • External auditors meet with the committee chair regularly. Areas for development • The other committees need to allow more time for the mitigations to be discussed at their respective meetings. • Sometimes the BAF is too low on committee agendas and the time-keeping does not always allow sufficient time for full discussion. • The new Clinical Effectiveness Committee needs time to develop to improve the score in this area. • Poor timeliness of paper circulation. • Action deadline slippage In line with the recommendations approved by the Board following the two governance reviews, the Terms of Reference of Quality Committee and Risk and Audit Committee remains unchanged for the period intervening until a joint committee with DHC is established later in the year, where appropriate.
5. Action recommended	The Board is recommended to: 1. **NOTE** the outcome of the committee effectiveness review areas of good practice and areas for improvement. 2. **APPROVE** that the Terms of Reference of Quality Committee and Risk and Audit Committee remain unchanged pro temp.

6. Governance and Compliance Obligations			
Legal / Regulatory Link	**Yes**		Committees of the Board are required to undertake an annual review of their effectiveness
Impact on CQC Standards	**Yes**		Supports delivery of the Well Led standard
Risk Link	**Yes**		Committees seek assurances on controls and mitigations to manage risks to delivery of the Strategy which informs their programmes of work

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	Committees monitor the Trust's performance and delivery of the Strategy which informs their programmes of work		
	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**	
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**	

TERMS OF REFERENCE
QUALITY COMMITTEE

Constitution

The Board of Directors ("the Board") hereby resolves to establish a committee to be known as the Quality Committee ("the Committee"). The committee is a Non-Executive committee of the Board and has no executive powers other than those specifically delegated to it via these Terms of Reference.

Authority

The committee is invested with the delegated authority to act on behalf of the Board of Directors. The limit of such delegated authority is restricted to the areas outlined in the Duties of the committee. The committee is empowered to investigate any activity within its Terms of Reference, and to seek any information it requires from staff, who are requested to co-operate with the committee in the conduct of its inquiries.

The committee is authorised by the Board of Directors to obtain independent legal and professional advice and to secure the attendance of external personnel with relevant experience and expertise, should it consider this necessary.

The committee is authorised to establish sub-committees and working groups to support its work subject to Terms of Reference that shall be approved by the Quality Committee, but shall not delegate the powers conferred upon it by these Terms of Reference to any other body without the express authorisation of the Board.

Purpose

The purpose of the committee is to maintain oversight of the clinical strategies; scrutinising delivery of quality care and strategy outcomes in order to provide assurance to the Risk and Audit Committee and to the Board that risks to delivery of the clinical strategies are being managed appropriately. This would support the signing of the Annual Governance Statement and Quality Accounts. The committee will ensure that all aspects of quality governance, patient safety and experience are subject to scrutiny in order to provide assurance to the Board.

Additionally, the committee has responsibility for scrutinising and assuring delivery of relevant aspects of the Trust's 'Place' objective and ensuring that associated risks are adequately mitigated; supporting the identification and promotion of shared learning, best practice and outstanding care.

Membership

Membership of the committee will be appointed by the Board and shall consist of

three Non-Executive members; one of which will be a clinical Non-Executive who will be appointed as Chair and the following:

Chief Strategy, Transformation and Partnerships Officer ~~Director of Strategy, Transformation and Partnerships~~
Chief Nursing Officer
Chief Medical Officer
Chief Operating Officer

Deputies

Executive members are expected to nominate suitable deputies to attend committee meetings in their place, should circumstances prevent members' own attendance.

In Attendance

Senior clinical divisional representatives will be required to attend the committee in order to provide an Escalation Report of key issues arising from divisional leadership / governance meetings. Other members of Trust staff, including other Directors and Non-Executive Directors, may be invited to attend to present and/or discuss particular items on the agenda, and up to three Governors will be invited to observe the meeting. Patients and/or carers may be invited to attend meetings of the committee to discuss particular items.

The Head of Corporate Governance or his/her nominee shall act as secretary to the committee.

Quorum

The committee shall be deemed quorate if there is representation of a minimum of two Non-Executive Directors and two Executive Directors (one of which must be the Chief Nursing Officer or Chief Medical Officer). A duly convened meeting of the committee at which a quorum is present shall be competent to exercise all or any of the authorities, powers and duties vested in or exercised by the committee.

Frequency of Meetings

The committee shall meet not less than 10 times per financial year. The Chair may request an extraordinary meeting if he/she considers one to be necessary.

Members the committee must attend at least eight of all meetings each financial year but should aim to attend all scheduled meetings.

Duties

The committee has the following primary duties and functions:

1. To approve the trust's clinical strategies and Quality Priorities; scrutinising performance against Quality Account priorities.
2. To provide assurance to the Board of adherence to all of the areas of CQC work within the 5 domains reflecting the Key Lines of Enquiry;
3. To receive key regulatory and other inspection reports and scrutinise delivery of any associated action plans.
4. To provide a forum for scrutiny of any of the trust's clinical quality indicators;
5. To provide assurance to the Board that clinical quality risk is being managed and to ensure that risks are escalated to the Board as appropriate.
6. To guide and instruct the direction of clinical audit on behalf of the Board where performance, incidents or strategic clinical risks are identified in order to provide assurance of improvement and effectiveness of mitigations to the Board.
7. To consider any national and/or strategic drivers that may impact on the quality agenda at the trust.
8. To review the learning from complaints, incidents (serious incidents and Never Events) and claims and ensure all associated action plans are delivered and completed.
9. To monitor the development and implementation of the trust's Quality Improvement Strategy

General

The committee will:

1. Review the adequacy of the trust's clinical strategies and monitor delivery of outcomes;
2. Monitor strategic risks within the Board Assurance Framework and the Corporate Risk Register to ensure that risks are being managed and mitigated sufficiently, and that risks are escalated appropriately.
3. Receive details of all Serious Incidents, escalating to the Board where appropriate and receive assurance around the actions taken to prevent recurrence.
4. Monitor on-going compliance with contractual, National and Care Quality Commission standards and seek assurance that any areas of weakness are being addressed.
5. Monitor on-going compliance with the Well Led element of the CQC standards as they relate to the Board to ensure maintenance/improvement of the trust's governance risk rating.
6. Monitor compliance in relation to safeguarding children and adults.
7. Ensure procedures stipulated by professional regulators of chartered practice (i.e. General Medical Council and Nursing and Midwifery Council) are in place and are complied with to a satisfactory standard.
8. Monitor the impact of Cash Releasing Efficiency Programmes and significant service changes on quality.

9. Receive updates on an exception basis against key strategies that are approved by the committee and those that are approved by the Board where deemed appropriate, escalating to the Board as necessary

Clinical Governance:

1. Undertake in-depth reviews of the Clinical Quality Indicators reported to the Board.
2. Undertake scrutiny of the Quality Accounts to provide assurance to the Board and Risk and Audit Committee of their accuracy prior to approval.
3. Oversee the implementation and monitoring of the research programme and that the governance framework is implemented and monitored.
4. Approve and monitor the outcomes and learning arising from the Clinical Audit Plan and review the findings of all audits and the adequacy of the management responses. The committee will seek assurances as to quality improvements and how clinical risks have been identified and informed the Clinical Audit Plan.
5. Monitor the patient experience through receipt of information relating to patient surveys, complaints, claims, PALS contacts and incidents.

In consideration of reports, the committee will review the improvement required, availability of resources and outcomes.

Policy Approval

1. Approve strategies that are within the remit of the committee and are deemed appropriate for committee approval by the Board, as provided for in the trust's Standing Orders.
2. Ratify policies approved by the sub-committees that report to this committee on behalf of the Board, ensuring that due process has been followed.

Maintaining Board Oversight

In line with recommendations outlined in the NHSE/I review of Board Non-Executive Director Board Champion roles undertaken in 2021 and the subsequent guidance published in December 2021 *Enhancing Board Oversight: A new approach to NED champion roles,* the following responsibilities were remitted by the Board in January 2022 to be discharged by the Quality Committee:

- Hip fractures, falls and dementia
- Palliative and end of life care
- Resuscitation
- Learning from Deaths
- Safeguarding
- Safety and Risk
- Lead for children and young people

Reporting

The Chair of the committee will report in writing to the Board at the Board meeting that follows the committee meeting via an Escalation Report. This report will summarise the main issues of discussion and the Chair of the committee will ensure that attention is drawn to any issues, risks or decisions that require escalation to the Board or Executive team for action.

The Chair of the committee will also attend the Risk and Audit Committee to provide assurance on the committee's processes and the work that it has undertaken.

The committee will receive Escalation Reports from the sub-committees that it formally establishes that record key issues and decision making and escalation of risks and issues for the Board's attention. The committee has established the following sub-Committees:

- Clinical Outcomes and Effectiveness Committee
- Mental Health Steering Group
- Medicines Committee
- Infection Prevention and Control Committee
- Safeguarding Committee
- Patient Safety Committee
- End of Life Committee
- Patient Experience and Public Engagement Committee
- Research and Development Steering Group
- Health Inequalities Group
- Reproductive Health Clinical Governance Committee

The committee will also receive Escalation Reports from divisional leadership / governance meetings and divisional representation at committee will be required.

Administration

The Quality Committee will be serviced by the Corporate Governance Team who will agree the agenda and committee Work Plan with the Chair of the committee.

Review

These Terms of Reference will be reviewed in 12 months unless there is a requirement to do so earlier.

Appraisal

The committee will carry out an annual appraisal of its performance and effectiveness in line with the requirements of the Audit Committee Handbook 2018 (fourth Edition – January 2018) and will report this to the Board of Directors

Approved by Quality Committee – 21 May 2024
Ratified by the Board –

TERMS OF REFERENCE
RISK AND AUDIT COMMITTEE

Constitution

The Board of Directors (the Board) hereby resolves to establish a committee to be known as the Risk and Audit Committee (the committee). The committee is a Non-Executive committee of the Board and has no executive powers, other than those specifically delegated in these Terms of Reference.

Authority

The committee is authorised by the Board to investigate any activity within its Terms of Reference. It is authorised to seek any information it requires from any employee and all employees are directed to co-operate with any request made by the committee. The committee is authorised by the Board to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary.

The committee is authorised to establish short life working groups to undertake specific pieces of work and the committee shall establish Terms of Reference accordingly. The committee may not delegate the powers conferred upon it by these Terms of Reference to any other body without the express authorisation of the Board.

Purpose

The principle purpose of the Risk and Audit Committee is to ensure that there are effective systems of financial and corporate governance, risk management and internal controls in place within the trust and to provide assurance to the Board on the same. This includes financial, clinical, operational and compliance controls and risk management and corporate governance systems. The committee is also responsible for maintaining an appropriate relationship with the trust's auditors. To this end, the committee will seek assurances from Board committees regarding the scrutiny and oversight of the strategy and risks to achievement of the Strategic Objectives within the Board Assurance Framework and Corporate Risk Register; escalating these to the Board as necessary.

Membership

The committee shall be appointed by the Board from amongst the Non-Executive Directors of the trust and shall consist of not less than three members (including the Chair), one of whom shall possess recent, relevant financial experience, the Chairs of other Board committees and the following:

- Chief Finance Officer
- Deputy CEO / Chief Strategy, Transformation and Partnerships Officer
- ~~Director of Strategy, Transformation and Partnerships~~
- Chief Operating Officer
- Chief Medical Officer and or Chief Nursing Officer

- Chief Executive Officer (Annual Governance Statement and Accounts only)

Deputies

Executive members are expected to nominate suitable deputies to attend committee meetings in their place, should circumstances prevent members' own attendance.

Attendance

The following will normally be in attendance:

- Head of Internal Audit
- A representative from External Audit
- Local Anti-Fraud Specialist.
- Head of Corporate Governance (Minutes and to support the Chair)

The Chairs of the Quality, Finance and Performance and People and Culture Committees will attend to report on the assurance that their committees have obtained in relation to the monitoring and management of governance and risk in the areas of their responsibility and delegated authority at least annually.
At least once a year, the committee shall meet privately with the External and Internal Auditors.

The Chief Executive and other Executive Directors may be invited to attend when the committee is discussing areas of risk or operation that are the responsibility of that Director.

Up to three members of the Council of Governor will be invited to observe the meeting.

Quorum
The committee shall be deemed quorate if there is representation of a minimum of two Non-Executive Directors and two Executive Directors (one of which must be the Chief Nursing Officer or Chief Medical Officer). A duly convened meeting of the committee at which a quorum is present shall be competent to exercise all or any of the authorities, powers and duties vested in or exercised by the committee.
The Chair of the organisation shall not be a member of the committee.

Frequency

Meetings shall be held at least four times a year. The Chair of the committee may convene additional meetings as they deem necessary. The External Auditor or Head of Internal Audit may also request a meeting if they consider that one is necessary.

Members the committee must attend at least three of all meetings each financial year but should aim to attend all scheduled meetings.

Duties

The duties of the committee are as follows:

Governance, Risk Management and Internal Control

The committee shall ensure effective system of integrated governance, risk management and internal control is in place across the whole of the organisation's activities (both clinical and non-clinical), that supports the achievement of the organisation's objectives.

In particular, the committee will review the adequacy and effectiveness of:

- All risk and control related disclosure statements (in particular the Annual Governance Statement), together with any accompanying Head of Internal Audit statement, External Audit opinion or other appropriate independent assurances, prior to endorsement by the Board
- The underlying assurance processes that indicate the degree of achievement of corporate objectives, the effectiveness of the management of principal risks and the appropriateness of the above disclosure statements
- processes to ensure appropriate information flows to the Risk and Audit Committee from Executive management and other Board committees in relation to the trust's overall internal control and risk management position in liaison with the Quality, Finance and Performance and People and Culture Committee Chairs.
- The policies for ensuring compliance with relevant regulatory, legal and code of conduct requirements and related reporting and self-certification
- The policies and procedures for all work related to fraud and corruption as set out in Secretary of State Directions and as required by the NHS Counter Fraud Authority.
- The process for declarations of interest and gifts and hospitality

In carrying out this work the committee will primarily utilise the work of internal audit, external audit and other assurance functions, but will not be limited to these sources. It will also seek reports and assurances from Executive Directors and managers as appropriate, concentrating on the over-arching systems of integrated governance, risk management and internal control, together with indicators of their effectiveness.

The committee will use the Board Assurance Framework to drive its programme of work and that of the audit and assurance functions that report to it. The committee will ensure that the Board Assurance Framework acts as a key driver of committee and operational plans and that it is appropriately informed by operational risks arising through the Corporate Risk Register and that mitigations are adequately identified to ensure delivery of the trust's strategy.

Internal Audit

The committee shall ensure that there is an effective internal audit function that meets mandatory NHS Internal Audit Standards and provides appropriate independent assurance to the Risk and Audit Committee, Chief Executive and Board. This will be achieved by:

- Consideration of the appointment and ongoing provision of the Internal Audit service, the cost of the audit and any questions of resignation and dismissal.

- Review and approval of the Internal Audit Strategy and more detailed programme of work, ensuring that this is consistent with the audit needs of the organisation as identified by the Board Assurance Framework.
- Consideration of the major findings of internal audit work (and management's response) and ensure co-ordination between the Internal and External Auditors to optimise audit resources.
- Ensuring that the Internal Audit function is adequately resourced and has appropriate standing within the organisation.
- Annual review of the effectiveness of internal audit.

Counter Fraud

The committee shall satisfy itself that the organisation has adequate arrangements in place for countering fraud and shall approve the Annual Counter Fraud Work Plan and review the outcomes of counter fraud work.

External Audit

The committee shall review the work and findings of the External Auditor and consider the implications and management's responses to their work. This will be achieved by:

- Develop and agree with the Council of Governors the criteria for the appointment, re-appointment and removal of the External Auditors.
- Make recommendations to the Council of Governors in relation to the above.
- Approval of the remuneration and terms of engagement of the External Auditor, supplying information as necessary to support statutory function of the Council of Governors to appoint, or remove, the auditor.
- Discussion and agreement with the External Auditor, before the audit commences, of the nature and scope of the audit as set out in the Annual Plan, and ensure coordination, as appropriate, with other External Auditors in the local health economy.
- Discussion with the External Auditors of their local evaluation of audit risks and assessment of the trust and associated impact on the audit fee.
- Review all External Audit reports and any work carried outside the annual audit plan, together with the appropriateness of management responses.
- Review and monitor of the external auditor's independence and objectivity and the effectiveness of the audit process, taking into account relevant UK professional and regulatory requirements.
- Ensure there is a clear policy in place for the engagement of External Auditors to undertaken non audit services.

Other Assurance Functions

The Risk and Audit Committee shall review the findings of other relevant significant assurance functions, both internal and external to the organisation, and consider the implications to the governance of the organisation. These will include, but will not be limited to, any reviews by Regulators/Inspectors (e.g. NHS Improvement, CQC, NHS Resolution, etc.), and professional bodies with responsibility for the performance of staff or functions (e.g. Royal Colleges, accreditation bodies, etc.)

In addition, the committee will review the work of other Board committees within the organisation, whose work can provide relevant assurance to the Risk and Audit Committee's own scope of work.

In reviewing the work of the Quality Committee, and issues around clinical risk management, the Risk and Audit Committee will wish to satisfy itself on the assurance that can be gained from the clinical audit function.

Management

The committee shall request and review reports and positive assurances from directors and managers on the overall arrangements for governance, risk management and internal control. They may also request specific reports from individual functions within the organisation (e.g. clinical audit) as they may be appropriate to the overall arrangements.

Financial Reporting

The Risk and Audit Committee shall monitor the integrity of the financial statements of the trust and any formal announcements relating to the trust's financial performance.

The committee should ensure that the systems for financial reporting to the Board, including those of budgetary control, are subject to review as to completeness and accuracy of the information provided to the Board.

The Risk and Audit Committee shall review the annual report and financial statements before submission to the Board, focusing particularly on:

- The wording in the Annual Governance Statement and other disclosures relevant to the Terms of Reference of the Committee.
- Changes in, and compliance with, accounting policies, practices and estimation techniques.
- Unadjusted mis-statements in the financial statements.
- Significant judgements in preparation of the financial statements.
- Significant adjustments resulting from the audit.
- Letter of Representation.
- Qualitative aspects of financial reporting.

Quality Reporting

The Risk and Audit Committee shall monitor the integrity of the trust's Quality Report and any formal announcements relating to the trust's clinical outcomes and quality standards.

The committee should ensure that the systems for quality monitoring and reporting to the Board are subject to review as to completeness and accuracy of the information provided to the Board.

The Risk and Audit Committee shall review the annual Quality Report before submission to the Board.

Reporting

The Chair of the committee will report in writing to the Board, at the Board meeting that follows the committee meeting via an Escalation Report. This report will summarise the main issues of discussion and decision making and the Chair of the committee will ensure that attention is drawn to any risks or issues that require escalation to the Board or Executive for action.

The committee will report to the Board annually on its work in support of the Annual Governance Statement, specifically commenting on the fitness for purpose of the Assurance Framework, the completeness and embeddedness of risk management in the organisation, the integration of governance arrangements, the appropriateness of evidence that shows the organisation is fulfilling regulatory requirements relating to its existence as a functioning business and the robustness of the processes behind the Quality Accounts.

The committee will receive Escalation Reports from the Health and Safety Group that records key issues and decision making and escalation of risks and issues for the committee's attention.

Administration

The Risk and Audit Committee will be serviced by the Corporate Governance team who will agree the agenda and committee Work Plan with the Chair of the committee.

Review

These Terms of Reference will be reviewed in annually unless there is a requirement to do so earlier.

Appraisal

The committee will carry out an annual appraisal of its performance and effectiveness in line with the requirements of the Audit Committee Handbook 2018 (fourth Edition – January 2018) and will report this to the Board of Directors via an Annual Report.

Approved by Risk and Audit Committee –
Ratified by the Board –

DHC Trust Board – 31July 2024

DHC Trust Board – 7 August 2024

Committee in Common Terms of Reference

Author	Jenny Horrabin - Joint Director of Corporate Affairs
Lead Director	Jenny Horrabin – Joint Director of Corporate Affairs
Purpose of Report	To approve the Terms of Reference for the Committees in Common: • Finance and Performance • Strategy, Transformation and Partnerships • People and Culture

Executive Summary

On 31 January 2024 / 7 February 2024 the Boards of DCH and DHC respectively considered the outcomes of that governance review and determined that: they endorsed the recommendation from the Working Together Programme Committee in Committee and formally agreed to approve Option 3 - to implement a combination of joint Board subcommittees with Dorset County Hospitals and Trust only committees.

The Working Together Committee in Common approved the creation of four Committees in Common:

- Finance and Performance (Q3)
- Strategy, Transformation and Partnerships (Q3)
- People and Culture (Q3)
- Quality Governance (Q4)

The Terms of Reference have been approved by the relevant Committees at each Trust and are presented for Board approval as set out in the table below:

Committee	Committee Approval	Board Approval
Finance and Performance	DCH – 22 July 24 DHC – 23 July 24	DCH 31 July 24 DHC 7 Aug 24
Strategy Transformation and Partnerships	DCH – 22 July 24 DHC – 23 July 24	DCH 31 July 24 DHC 7 Aug 24
People and Culture	DCH – 22 July 2024 DHC – Exec Workforce Group – May 24	DCH 31 July 24 DHC 7 Aug 24

The main comments arising from consideration by the Terms of Reference at each Committee related to the NED membership. The Terms of Reference have been updated to reflect the latest discussion that there will be three NEDS from each Trust on each Committee, but at least one and no more than two of these NEDS may be Joint NEDS for both DCH and DHC. We are currently considering the appointment to Joint NED roles and this will be more formally considered through the appropriate governance routes at each Trust. To provide assurance on process and transition planning: • The Business Calendars for each Committee will be reviewed and presented to the first meeting of each Committee in Common. • A transition plan is being developed to ensure that that all actions are either closed or transferred to the new Committee and that all areas are covered as we transition to new Committee Terms of Reference during 2024/25. • Legal advice has been sought from Hill Dickinson LLP on the Terms of Reference to ensure that the technical aspects of operating a Committee in Common are adhered to.	

Recommendation	The Board is requested to:
	
	• Approve the Terms of Reference for the following Committees in Common:
	  ○ Finance and Performance (Q3)
	  ○ Strategy, Transformation and Partnerships (Q3)
	  ○ People and Culture (Q3)
	• Note the process and timeline for review of all Committees in Common during 2024/25.
	• Receive assurance on the planned transition arrangements

DHC Trust Board – 31July 2024

DHC Trust Board – 7 August 2024

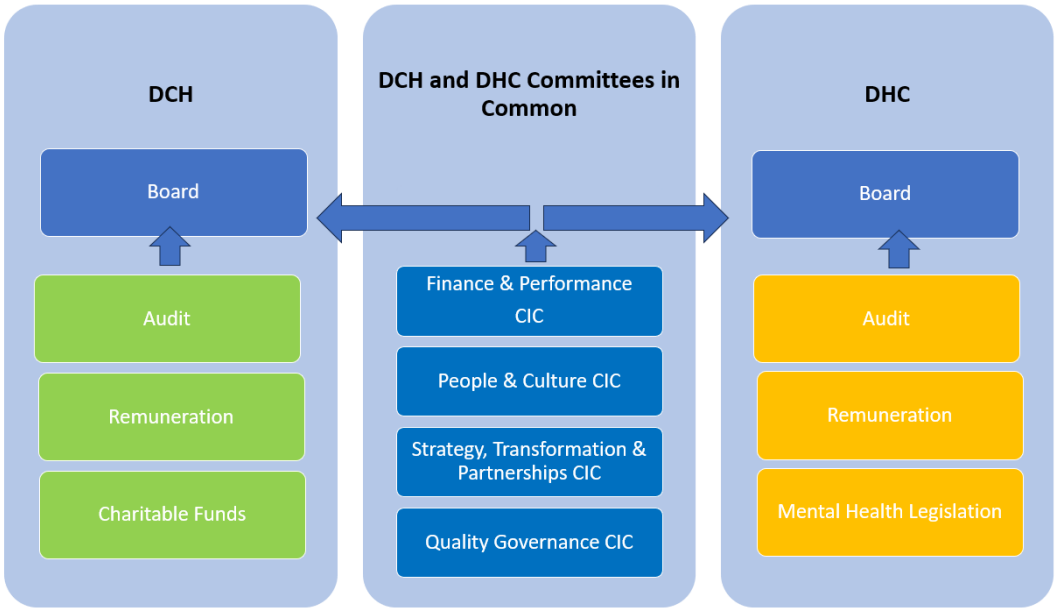
Committee in Common Terms of Reference

1 Board Subcommittee Review and Terms of Reference

1.1 Following the appointment of joint Chair and joint Chief Executive Officer, and the establishment of the Working Together Committee in Common (CiC) and Programme Board, a review of the governance arrangements across Dorset County Hospital (DCH) and Dorset Healthcare (DHC) was commissioned to promote collaboration across the activities of Boards and their committees in both trusts, reduce duplication and to identify areas of shared learning.

1.2 On 31 January 2024 / 7 February 2024 the Boards of DCH and DHC respectively considered the outcomes of that governance review and determined that: they endorsed the recommendation from the Working Together Programme Committee in Committee and formally agreed to approve Option 3 - to implement a combination of joint Board subcommittees with Dorset County Hospitals and Trust only committees.

1.3 The Working Together Committee in Common approved the creation of four Committees in Common as set out in the diagram below at its meeting on 3 June 2024:



1.4 This paper provides an overview of three Committees with the review of the Terms of Reference (Table 1), the timeline for approval and implementation (Table 2) and a Table showing Executive Membership across all Committees in Comm (Table 3). The Quality Committee review is scheduled for Q3 of 24/25. For each Trust there is a 'mirrored' Terms of Reference that has been presented to the relevant Committee for review and approval prior to presentation to the respective Boards for ratification. The timeline is set out in Table 2, The Terms of Reference for review by this Committee are:

- Finance and Performance Committee (Appendix 1)
- Strategy Transformation and Partnerships Committee (Appendix 2)

- People and Culture Committee (Appendix 3)

1.5 Legal advice has been sought from Hill Dickinson LLP on the Terms of Reference to ensure that the technical aspects of operating a Committee in Common are adhered to.

1.6 The main comments arising from consideration by the Terms of Reference at each Committee related to the NED membership. The Terms of Reference have been updated to reflect the latest discussion that there will be three NEDS from each Trust on each Committee, but at least one and no more than two of these NEDS may be Joint NEDS for both DCH and DHC. We are currently considering the appointment to Joint NED roles and this will be more formally considered through the appropriate governance routes at each Trust.

1.7 Once approved the Business Calendars for each Committee will be reviewed and presented to the first meeting of each Committee in Common. A transition plan is being developed to ensure that that all actions are either closed or transferred to the new Committee and that all areas are covered as we transition to new Committee Terms of Reference during 2024/25.

2. Recommendation

The Board is requested to:

- Ratify the Terms of Reference for the following Committees in Common:
  - Finance and Performance (Q3)
  - Strategy, Transformation and Partnerships (Q3)
  - People and Culture (Q3)
- Note the process and timeline for review of all Committees in Common during 2024/25.
- Receive assurance on the planned transition arrangements

Table 1: Overview of Committees in Common

Committee	People and Culture	Finance and Transformation	Strategy, Transformation
Scope	• People and Organisational Development Strategies and Plans • Workforce related performance indicators • Key strategic workforce related equality and diversity compliance requirements, including relevant equality, diversity and inclusion legislation. • Staff Survey and other engagement survey results • Guardian of Safe Working • Freedom to Speak Up arrangements • Workforce planning (including workforce safeguards). • Health and wellbeing of the workforce • Risks relevant to work of the Committee • Policies relevant to Committee	• Operational Performance • Financial Planning • Financial Performance • Capital Planning and Performance • Business Cases and Investments • Procurement • Estates, health and safety, fire and water compliance • EPRR Subsidiary Co / Joint ventures • Oversight of finance and performance where lead provider on MH collaboratives • Risks relevant to Committee • Policies relevant to Committee	• Strategy and Strategic Performance • One Transformation Approach (including Working Together Programme) • Provider Collaboratives and Other Partnerships (including oversight of arrangements for entering into new collaboratives (with ongoing assurance where lead provider through Finance and Performance and Quality Governance Committees) • Health Inequalities • Digital • Cyber Security (with annual assurance t the Audit Committee) • Net Zero • New Hospitals programme • Risks relevant to Committee • Policies relevant to Committee
Membership	**Non-Executive** • Three Non-Executive Directors (at least one and no more than two may be Joint NEDS across DCH and DHC) **Executive** • Joint Chief People Officer • Joint Chief Nursing Officer • Chief Medical Officer **In attendance** • Director of Finance • Nominated Governor(s) • Other staff of the Trust may be requested to attend for specific matters. Where a member is unable to attend routinely an appropriate deputy who will attend on a regular	**Non-Executive** • Three Non-Executive Directors (at least one and no more than two may be Joint NEDS across DCH and DHC) **Executive** • Joint Chief Finance Officer • Joint Chief Strategy, Transformation and Partnerships Officer • Chief Medical Officer • Chief Operating Officer **In attendance** • Director of Nursing • Nominated Governor(s) • Other staff of the Trust may be requested to attend for specific matters.	**Non-Executive** • Three Non-Executive Directors (at least one and no more than two may be Joint NEDS across DCH and DHC) **Co-Opted Members** • Dorset GP Alliance • Dorset Mental Health Forum **Executive** • Joint Chief Finance Officer • Joint Chief Strategy, Transformation and Partnerships Officer • Joint Chief Nursing Officer • Joint Chief People Officer **In attendance** • Directors of Operations (or equivalent for each Directorate)

Committee	People and Culture	Finance and Transformation	Strategy, Transformation
	basis should be nominated and notified to the Chair.	Where a member is unable to attend routinely an appropriate deputy who will attend on a regular basis should be nominated and notified to the Chair.	• Director of Strategy • Director of Transformation • Nominated Governor(s) • Other staff of the Trust may be requested to attend for specific matters. Where a member is unable to attend routinely an appropriate deputy who will attend on a regular basis should be nominated and notified to the Chair

Table 2: Overview of Timelines for Approval and Implementation

Details have been provided above the timescale for review and implementation of aligned Terms of Reference or Committees in Common for each Committee. An overview is provided in the able below:

Committee	Committee Approval	Board Approval	Implementation
Finance and Performance	DCH – 22 July 24 DHC – 23 July 24	DCH 31 July 24 DHC 7 Aug 24	Q3 September 2024
Strategy Transformation and Partnerships	DCH – 22 July 24 DHC – 23 July 24	DCH 31 July 24 DHC 7 Aug 24	Q3 September 2024
People and Culture	DCH – 22 July 2024 DHC – Exec Workforce Group – May 24	DCH 31 July 24 DHC 7 Aug 24	Q3 (TBC) September 2024

Table 3: Executive Membership

Committees in Common	Frequency	JCNO	JCFO	JCPO	JCTSO	DCH COO	DHC COO	DCH CMO	DHC CMO	Total	JDoCA
People and Culture	Bi-Monthly	X		X		X	X	X	X	6	A
Finance and Performance	Bi-Monthly		X		X	X	X	X	X	6	A
Strategy, Transformation & Partnerships	Bi-Monthly	X	X	X	X					4	A
Quality Governance	Bi-Monthly	X				X	X	X	X	5	A

Dorset County Hospital NHS Foundation Trust **Finance and Performance Committee-in-Common** **TERMS OF REFERENCE Final Draft for Approval**	
1. Committees in Common	• The Dorset County Hospital NHS Foundation Trust is putting in place a governance structure, which will enable it to work together with the Dorset HealthCare University NHS Foundation Trust to implement change. • Each Trust has agreed to establish a committee which shall work in common with the other (**Committee in Common** or **CiC**), but which will each take its decisions independently on behalf of its own Trust. • Each Trust has decided to adopt terms of reference in substantially the same form, except that the membership of each CiC will be different. • The CiC shall meet together with the associated committee from Dorset HealthCare University NHS Foundation Trust as the **Dorset Trust Finance and Performance CiCs**
2. Duties	• The Committee-in-Common has been established by the Board of Dorset County NHS Foundation Trust as a committee with these terms of reference, to be known as the Dorset County Hospital Finance and Performance CiC. • These terms of reference set out the membership, remit, responsibilities and reporting arrangements of the Dorset County Hospital Finance and Performance CiC. It is supported in its work by other committees established by the Board. • The Dorset County Hospital Finance and Performance CiC is authorised to investigate any activity within these terms of reference. It is authorised to seek any information it requires from any member of staff and all members of staff are directed to cooperate with any request made by the Committee-in-Common. • The Dorset County Hospital Finance and Performance CiC is authorised to obtain external legal or other independent professional advice if it considers this necessary, taking into consideration any issues of confidentiality and the Trust's standing financial instructions. • The Dorset County Hospital Finance and Performance CiC is a committee of the Trust and therefore can only make decisions binding Dorset County Hospital NHS Foundation Trust. None of the Trusts other than Dorset County Hospital NHS Foundation Trust can be bound by a decision taken by Dorset County Hospital Finance and Performance CiC. • The Dorset County Hospital CiC will form part of a governance structure to support collaborative leadership and relationships with system partners and follow good governance in decision making (as set out in the updated Code of Governance for NHS Provider Trusts). The Dorset County Hospital Finance and Performance CiC will have regard in their decision-making to the triple aim duty of better health and wellbeing for everyone, better quality of health services for all individuals and sustainable use of NHS resources.
Role and Purpose	• Paragraph 15(2) and (3) of Schedule 7 of the National Health Service Act 2006 allows for any of the functions of a Foundation Trust to be delegated to a committee of directors of the Foundation Trust. This power is enshrined in Dorset County Hospital NHS Foundation Trust's Constitution.

	• The Dorset HealthCare University Finance and Performance CiC will together with the other Committee in Common advise, support and assure the Board of Dorset HealthCare University NHS Foundation Trust and Dorset County NHS Foundation Trust on matters related to: o reviewing financial and operational performance. This will include operational performance against both internal and external (agreed local, regional, national, regulatory, commissioning and contractual) indicators and reviewing financial performance and delivery of the Trusts financial efficiency / cost improvement plans. o scrutinising and approving enabling strategies, business cases, expenditure, procurement and financial plans in line with the Standing Financial Instructions and Scheme of Delegation. o Oversight of compliance in respect of estates, health and safety (including fire and water) and Emergency Preparedness, Response and Resilience, Subsidiary Companies and Joint Ventures.
Responsibilities	**1. Operational Performance** a) Review performance against key national, local and internal targets and indicators. b) Review exception reports and action plans for those targets and indicators where delivery is at risk. c) Review the contractual risk attached to non-achievement of national and local targets. d) Agree the composition of the performance scorecard on an annual basis **2. Financial Planning** a) Review and recommend to the Board for approval the Trust's Financial Plan, considering alignment with the Trusts strategic ambitions, national requirements, and system plans. b) Review and recommend to the Board for approval the Trust's Budget Setting Policy. c) Consider ad hoc financial issues that arise (e.g. check Private Patient Cap, estate revaluation etc.) **3. Financial Performance** a) Monitor the financial performance of the Trust, including: b) performance against plans; c) delivery of key financial duties; d) any variances against plans, risks to delivery and the adequacy and effectiveness of associated recovery and action plans; e) the development of key financial metrics; and f) the delivery of the Cost Improvement Plan g) Scrutinise arrangements for a working capital facility and other long terms loans if required, and investment of surplus cash. h) Consider such other matters and take such other decisions of a generally financial nature as the Board of Directors shall delegate to it. **4. Capital Planning and Performance** a) Oversee the development and management of the rolling capital programme including scrutiny of the prioritisation process, forecasting and remedial action, and report to the Board of Directors accordingly. b) Review and recommend to the Board for approval the Capital Plan / Programme prior to submission to the Trust Board for approval. **5. Business Cases and Investments** a) Review and approve business cases for investment and investment in accordance with the Trust's Standing Financial Instructions and Scheme of Delegation and Reservation of Powers to the Board,

	ensuring that outcomes and benefits are clearly defined and measurable and support achievement of the Trust's objectives and make recommendations to the Board for approval as appropriate. b) Periodically assess the benefits realisation of business cases and major projects through post-implementation reviews, ensuring that potential learning is shared for future investment and delivery. c) Approve the Treasury Policy in line with national guidance. d) Scrutinise arrangements for a working capital facility and other long terms loans if required, and investment of surplus cash. **6. Procurement** a) Approval of the Procurement Strategies and Plans. b) Ensure compliance with procurement legislation. c) Maintain oversight of contractual matters and approve contract awards in accordance with the Standing Orders and Standing Financial Instructions. **7. Other** a) Review arrangements in respect of estates, health and safety, fire and water and ensure compliance with regulatory and statutory requirements. b) Maintain oversight of the arrangements in place for Emergency Planning, Response and Resilience, including approval of annual submissions and monitoring of actions required to ensure compliance. c) Where the Trust is the lead provider as part of a provider collaborative receive assurance and provide oversight of matters related to finance and performance d) Where the trust establishes either a subsidiary company or a joint venture, the Finance and Performance Committee will be responsible for maintaining oversight of the activity and governance arrangements surround each respectively. The committee will ensure that the Trust's Standing Financial Instructions and Scheme of Delegation reflect the delegated authorities provided under each arrangement and seek assurances of compliance on behalf of the Board. The committee will require the following after a meeting of any subsidiary company or Joint Venture Board: • Summary of activities undertaken and decisions made • A report assuring statutory compliance with applicable regulations and submission of statutory returns • Timely escalation of identified risk and mitigating actions agreed. **8. Governance** a) Seek assurance on behalf of the Trust Board for the response to finance and performance risks which appear on the Board Assurance Framework and Corporate Risk Register b) Receive assurance on the timely review and approval of the policies relevant to the work of the Committee.
Accountability Arrangements	• The Dorset County Hospital Finance and Performance CiC is accountable to the Board of Dorset County Hospital NHS Foundation Trust. • The Committee Chair will provide an assurance report following each meeting to the Board of Directors of Dorset County Hospital NHS Foundation Trust. • Dorset County Hospital Finance and Performance CiC shall provide such other reports and communications briefings as requested by Dorset County Hospital NHS Foundation Trust's Board for inclusion on the agenda of Dorset County Hospital NHS Foundation Trust's Board meeting.

Membership / Attendance	**Non-Executive** • Three Non-Executive Directors (at least one and no more than two may be Joint NEDS across DCH and DHC) and one of whom will either be the Chair or the Vice Chair of the Committee **Executive** • Joint Chief Finance Officer • Joint Chief Strategy, Transformation and Partnerships Officer • Chief Medical Officer • Chief Operating Officer **In attendance** • Director of Nursing • Nominated Governor(s) • Other staff of the Trust may be requested to attend for specific matters. • Where a member is unable to attend routinely an appropriate deputy who will attend on a regular basis should be nominated and notified to the Chair.
Chair	When the Dorset County Hospital Finance and Performance CiC meets with the associated committee from Dorset HealthCare University NHS Foundation Trust as committees in common (**Dorset Trust Finance and Performance CiCs**), one person nominated from the Members of each of the CiCs shall be designated the Chair and one from the other Trusts CiC membership as the Vice Chair. The Chair and Vice Chair shall preside over and run the common meetings with the roles then rotating on an annual basis between the Trusts members.
Quorum	Members of the Dorset County Hospital Finance and Performance CiC have a responsibility for the operation of the Dorset County Hospital People and Culture CiC. They will participate in discussion, review evidence and provide objective expert input as part of the **Dorset Trust Finance and Performance CiCs** to the best of their knowledge and ability, and endeavour to reach a collective view. Each Member of the Dorset County Hospital Finance and Performance CiC shall have one vote. The Dorset County Hospital Finance and Performance CiC shall reach decisions by consensus of the Members present. The quorum shall be three (3) Members. This must include at least two Non-Executive Directors from the Trust (which may include Joint NEDS acting for both Trusts) and an Executive Director. If any Member is disqualified from voting due to a conflict of interest, they shall not count towards the quorum for the purposes of that agenda item.
Administrative Support	Administrative support will be provided by the Executive Assistant to the Joint Chief Finance Officer. Agenda and papers will be circulated one week prior to the meeting.
Frequency of Meeting	• The Dorset County Hospital Finance and Performance CiC shall meet with the associated committee from Dorset HealthCare University NHS Foundation Trust as the **Dorset Trust Finance and Performance CiCs** and discuss the matters delegated to them in accordance with their respective Terms of References. • Subject to the below, Dorset County Hospital Finance and Performance CiC meetings shall take place bi-monthly. • Any Trust CiC Member may request an extraordinary meeting of the **Dorset Trust Finance and Performance CiCs** (working in common) on the basis of urgency etc. by informing the Chair. In the event it is identified

	that an extraordinary meeting is required the Chair shall give five (5) Working Days' notice to the Trusts.
Conflict of Interest	• Members of the Dorset County Hospital Finance and Performance CiC shall comply with the provisions on conflicts of interest contained in Dorset County Hospital NHS Foundation Trust Constitution/Standing Orders and NHS Conflicts of Interest guidance. For the avoidance of doubt, reference to conflicts of interest in Dorset County Hospital NHS Foundation Trust Constitution/Standing Orders also apply to conflicts which may arise in their position as a Member of the Dorset County Hospital Finance and Performance CiC. • All Members of the Dorset County Hospital Finance and Performance CiC shall declare any new interest at the beginning of any Dorset County Hospital Finance and Performance CiC meeting and at any point during a **Dorset Trust Finance and Performance CiCs** meeting if relevant.
Date Approved	• Reviewed by Joint Executive Management Team 2 July 2024 • Approved by Finance and Performance Committee 22 July 2024 • Ratified by Dorset County University NHS Foundation Trust Board of Directors 31 July 2024
Date Review	31 March 2025

Dorset County Hospital NHS Foundation Trust
Strategy, Transformation and Partnerships Committee-in-Common

TERMS OF REFERENCE Final Draft for Approval

Committees in Common	• The Dorset County Hospital NHS Foundation Trust is putting in place a governance structure, which will enable it to work together with the Dorset HealthCare University NHS Foundation Trust to implement change. • Each Trust has agreed to establish a committee which shall work in common with the other (**Committee in Common** or **CiC**), but which will each take its decisions independently on behalf of its own Trust. • Each Trust has decided to adopt terms of reference in substantially the same form, except that the membership of each CiC will be different. • The CiC shall meet together with the associated committee from Dorset HealthCare University NHS Foundation Trust as the **Dorset Trust Strategy, Transformation and Partnerships CiCs**
Duties	• The Committee-in-Common has been established by the Board of Dorset County NHS Foundation Trust as a committee with these terms of reference, to be known as the Dorset County Hospital Strategy, Transformation and Partnerships CiC. • These terms of reference set out the membership, remit, responsibilities and reporting arrangements of the Dorset County Hospital Strategy, Transformation and Partnerships CiC. It is supported in its work by other committees established by the Board. • The Dorset County Hospital Strategy, Transformation and Partnerships CiC is authorised to investigate any activity within these terms of reference. It is authorised to seek any information it requires from any member of staff and all members of staff are directed to cooperate with any request made by the Committee-in-Common. • The Dorset County Hospital Strategy, Transformation and Partnerships CiC is authorised to obtain external legal or other independent professional advice if it considers this necessary, taking into consideration any issues of confidentiality and the Trust's standing financial instructions. • The Dorset County Hospital Strategy, Transformation and Partnerships CiC is a committee of the Trust and therefore can only make decisions binding Dorset County Hospital NHS Foundation Trust. None of the Trusts other than Dorset County Hospital NHS Foundation Trust can be bound by a decision taken by Dorset County Hospital Strategy, Transformation and Partnerships CiC. • The Dorset County Hospital CiC will form part of a governance structure to support collaborative leadership and relationships with system partners and follow good governance in decision making (as set out in the updated Code of Governance for NHS Provider Trusts). The Dorset County Hospital Strategy, Transformation and Partnerships CiC will have regard in their decision-making to the triple aim duty of better health and wellbeing for everyone, better quality of health services for all individuals and sustainable use of NHS resources.
Role and Purpose	• Paragraph 15(2) and (3) of Schedule 7 of the National Health Service Act 2006 allows for any of the functions of a Foundation Trust to be delegated to a committee of directors of the Foundation Trust. This power is enshrined in Dorset County Hospital NHS Foundation Trust's Constitution.

	• The Dorset HealthCare University Strategy, Transformation and Partnerships CiC will together with the other Committee in Common advise, support and assure the Board of Dorset HealthCare University NHS Foundation Trust and Dorset County NHS Foundation Trust on matters related to: o oversight of delivery of the Trusts strategic objectives and priorities and the One Transformation Approach (consisting of four portfolios: Place and Neighbourhood; Sustainable Services; Mental health and; Working Together) o ensuring that addressing health inequalities are embedded in the One Transformation Approach. o maintaining oversight of the programmes of work in respect of digital; net zero; new hospitals programme and quality improvement and ensuring alignment with the strategic objectives and priorities and the One Transformation Approach. o maintaining oversight of all collaboratives and partnership arrangements, ensuing alignment with the strategic objectives and priorities and the One Transformation Approach
Responsibilities	**1. Strategy and Strategic Performance** a) Receive assurance on delivery of the Trusts strategic objectives and priorities and achievement of key strategic metrics and milestones. b) Consider risks and issues and where is necessary, ensure recovery plans are in place and oversee delivery of these plans. **2. One Transformation Approach** a) Ensure that the Trust has a robust process in place for the identification and delivery of individual schemes within the One Transformation Approach, including the establishment of a gateway process. b) Approve the One Transformation Approach portfolio and priority projects considering strategic fit; clinical prioritisation; addressing health inequalities; affordability and deliverability. c) Monitor delivery of the One Transformation Approach / projects and seek assurance on the benefits realisation through the transformation programmes and achievement of agreed outcomes, with a particular focus on addressing health inequalities. d) Monitor escalated risks and mitigations in place in respect of the One Transformation Approach. e) Maintain oversight of the Quality Improvement Programme and monitor delivery of projects and achievement of outcomes f) Specific oversight of the Working Together Programme (as part of the One Transformation Approach) to: o Ensure the implementation of all duties and obligation within the agreed Memorandum of Understanding, including overseeing the review process. o Maintain oversight of the Working Together Programme to ensure achievement of collaborative working practices across DCH and DHC that improve resilience and optimise the use of resources, productivity, and efficiency across both organisations. o Scrutinise risks and mitigations to delivery of the strategic aims of the Working Together Programme, reporting or escalating these to the respective Boards and monitor areas of good practice, benefits realised and learning across both organisations and with key partners and stakeholders. o Approve the alignment of policy where this reduces duplication of effort, reduce costs or simplifies decision-making.

	3. Provider Collaboratives and Other Partnerships a) Approve and recommend to the Board any agreements or Memorandums of Understandings that the Trust enters into in respect of partnerships and collaboratives. *b)* Maintain oversight of the Provider Collaboratives and / or partnerships that the Trust is engaged in, with a particular focus on the different role the Trust plays in each partnership / collaborative and any risks arising from this and monitor delivery of projects and achievement of outcomes. *Where we are the lead provider monitoring of contractual performance will fall within the scope of the Finance and Performance Committee. Monitoring of quality and safety will fall within the scope of the Quality (Governance) Committee.* **4. Health Inequalities** a) Maintain oversight of the work undertaken by the Trust to address health inequalities to improve the health of our population and ensure that national guidance and requirements are adhered to and this is embedded in the One Transformation Approach. b) For DHC only – maintain oversight of the implementation and development of the Patient and carer Race Equality Framework (PCREF) **5. Digital and Cyber Security** a) Approve Digital Transformation Strategies and Plans, ensuing these are aligned to strategic objectives and the One Transformation Approach b) Receive assurance on plans in place to manage risks associate with cyber security. **6. Net Zero** a) Approve Green / Net Zero Strategies and Plans, ensuing these are aligned to strategic objectives and the One Transformation Approach and meet all statutory and regulatory requirements. b) Maintain oversight of the Green / Net Zero Programme and monitor delivery of projects and achievement of outcomes. **7. New Hospitals Programme** a) Maintain oversight of the New Hospitals Programme and monitor delivery of projects and achievement of outcomes. **8. Governance** a) Seek assurance on behalf of the Trust Board for the response to strategy, transformation and partnership risks which appear on the Board Assurance Framework and Corporate Risk Register b) Receive assurance on the timely review and approval of the policies relevant to the work of the Committee.
Accountability Arrangements Baker Abi 30/07/2024 12:31:14	• The Dorset County Hospital Strategy, Transformation and Partnerships CiC is accountable to the Board of Dorset County Hospital NHS Foundation Trust. • The Committee Chair will provide an assurance report following each meeting to the Board of Directors of Dorset County Hospital NHS Foundation Trust. • Dorset County Hospital Strategy, Transformation and Partnerships CiC shall provide such other reports and communications briefings as requested by Dorset County Hospital NHS Foundation Trust's Board for

	inclusion on the agenda of Dorset County Hospital NHS Foundation Trust's Board meeting.
Membership / Attendance	**Non-Executive** • Three Non-Executive Directors (at least one and no more than two may be Joint NEDS across DCH and DHC) and one of whom will either be the Chair or the Vice Chair of the Committee **Co-Opted Members** • Dorset GP Alliance • Dorset MH Forum **Executive** • Joint Chief Finance Officer • Joint Chief Strategy, Transformation and Partnerships Officer • Joint Chief Nursing Officer • Joint Chief People Officer **In attendance** • Directors of Operations (or equivalent for each Directorate) • Director of Strategy • Director of Transformation • Associate Chief Medical Officer - Transformation • Nominated Governor(s) • Other staff of the Trust may be requested to attend for specific matters. • Where a member is unable to attend routinely an appropriate deputy who will attend on a regular basis should be nominated and notified to the Chair.
Chair	When the Dorset County Hospital Strategy, Transformation and Partnerships CiC meets with the associated committee from Dorset HealthCare University NHS Foundation Trust as committees in common (**Dorset Trust Strategy, Transformation and Partnerships CiCs**), one person nominated from the Members of each of the CiCs shall be designated the Chair and one from the other Trusts CiC membership as the Vice Chair. The Chair and Vice Chair shall preside over and run the common meetings with the roles then rotating on an annual basis between the Trusts members.
Quorum	Members of the Dorset County Hospital Strategy, Transformation and Partnerships CiC have a responsibility for the operation of the Dorset County Hospital People and Culture CiC. They will participate in discussion, review evidence and provide objective expert input as part of the **Dorset Trust Strategy, Transformation and Partnerships CiCs** to the best of their knowledge and ability, and endeavour to reach a collective view. Each Member of the Dorset County Hospital Strategy, Transformation and Partnerships CiC shall have one vote. The Dorset County Hospital Strategy, Transformation and Partnerships CiC shall reach decisions by consensus of the Members present. The quorum shall be three (3) Members. This must include at least two Non-Executive Directors from the Trust (which may include Joint NEDS acting for both Trusts) and an Executive Director. least one Non-Executive Directors from the Trust and an Executive Director. If any Member is disqualified from voting due to a conflict of interest, they shall not count towards the quorum for the purposes of that agenda item.

Administrative Support	Administrative support will be provided by the Executive Assistant to the Joint Chief Finance Officer. Agenda and papers will be circulated one week prior to the meeting.
Frequency of Meeting	• The Dorset County Hospital Strategy, Transformation and Partnerships CiC shall meet with the associated committee from Dorset HealthCare University NHS Foundation Trust as the **Dorset Trust Strategy, Transformation and Partnerships CiCs** and discuss the matters delegated to them in accordance with their respective Terms of References. • Subject to the below, Dorset County Hospital Strategy, Transformation and Partnerships CiC meetings shall take place bi-monthly. • Any Trust CiC Member may request an extraordinary meeting of the **Dorset Trust Strategy, Transformation and Partnerships CiCs** (working in common) on the basis of urgency etc. by informing the Chair. In the event it is identified that an extraordinary meeting is required the Chair shall give five (5) Working Days' notice to the Trusts.
Conflict of Interest	• Members of the Dorset County Hospital Strategy, Transformation and Partnerships CiC shall comply with the provisions on conflicts of interest contained in Dorset County Hospital NHS Foundation Trust Constitution/Standing Orders and NHS Conflicts of Interest guidance. For the avoidance of doubt, reference to conflicts of interest in Dorset County Hospital NHS Foundation Trust Constitution/Standing Orders also apply to conflicts which may arise in their position as a Member of the Dorset County Hospital Strategy, Transformation and Partnerships CiC. • All Members of the Dorset County Hospital Strategy, Transformation and Partnerships CiC shall declare any new interest at the beginning of any Dorset County Hospital Strategy, Transformation and Partnerships CiC meeting and at any point during a **Dorset Trust Strategy, Transformation and Partnerships CiCs** meeting if relevant.
Date Approved	• Reviewed by Joint Executive Management Team 2 July 2024 • Approved by Strategy, Transformation and Partnerships Committee 22 July 2024 • Ratified by Dorset County University NHS Foundation Trust Board of Directors 31 July 2024
Date Review	31 March 2025

Dorset County Hospital NHS Foundation Trust **People and Culture Committee-in-Common** **TERMS OF REFERENCE Final Draft for Approval**	
Committees in Common	• The Dorset County Hospital NHS Foundation Trust ('Dorset County Hospital') is putting in place a governance structure, which will enable it to work together with the Dorset HealthCare University NHS Foundation Trust to implement change. • Each Trust has agreed to establish a committee which shall work in common with the other (**Committee in Common** or **CiC**), but which will each take its decisions independently on behalf of its own Trust. • Each Trust has decided to adopt terms of reference in substantially the same form, except that the membership of each CiC will be different. • The CiC shall meet together with the associated committee from Dorset HealthCare University NHS Foundation Trust as the **Dorset Trust People and Culture CiCs**
Duties	• The Committee-in-Common has been established by the Board of Dorset County NHS Foundation Trust as a committee with these terms of reference, to be known as the Dorset County Hospital People and Culture CiC. • These terms of reference set out the membership, remit, responsibilities and reporting arrangements of the Dorset County Hospital People and Culture CiC. It is supported in its work by other committees established by the Board. • The Dorset County Hospital People and Culture CiC is authorised to investigate any activity within these terms of reference. It is authorised to seek any information it requires from any member of staff and all members of staff are directed to cooperate with any request made by the Committee-in-Common. • The Dorset County Hospital People and Culture CiC is authorised to obtain external legal or other independent professional advice if it considers this necessary, taking into consideration any issues of confidentiality and the Trust's standing financial instructions. • The Dorset County Hospital People and Culture CiC is a committee of the Trust and therefore can only make decisions binding Dorset County Hospital NHS Foundation Trust. None of the Trusts other than Dorset County Hospital NHS Foundation Trust can be bound by a decision taken by Dorset County Hospital People and Culture CiC. • The Dorset County Hospital CiC will form part of a governance structure to support collaborative leadership and relationships with system partners and follow good governance in decision making (as set out in the updated Code of Governance for NHS Provider Trusts). The Dorset County Hospital People and Culture CiC will have regard in their decision-making to the triple aim duty of better health and wellbeing for everyone, better quality of health services for all individuals and sustainable use of NHS resources.
Role and Purpose	• Paragraph 15(2) and (3) of Schedule 7 of the National Health Service Act 2006 allows for any of the functions of a Foundation Trust to be delegated to a committee of directors of the Foundation Trust. This power is enshrined in Dorset County Hospital NHS Foundation Trust's Constitution.

	• The Dorset County Hospital People and Culture CiC will together with the other Committee in Common advise, support and assure the Board of Dorset HealthCare University NHS Foundation Trust and Dorset County NHS Foundation Trust on matters related to the production and delivery of strategies and plans related to people, culture and organisational development and to oversee key performance indicators relevant to the scope of the work of the Committee. The scope of the Committee will include matters related to Equality, Diversity and Inclusion, annual reporting and compliance with regulatory and legislative requirements.
Responsibilities	**1. Strategies and Transformational Change** a) Oversee progress on the development and delivery of People and Organisational Development Strategies, taking into account relevant best practice and ensuring alignment with the Trust's strategic priorities and objectives. b) Maintaining oversight of workforce changes as a result of transformational change and oversee the aspects of significant service changes relevant to the scope of the Committee. **2. Plans and Performance** a) Receiving and approving relevant People and Organisational Development plans and ensuring that they are consistent with the Trust's strategies and identifying and monitoring where further actions are required. b) Reviewing workforce related performance indicators and ensuring there are plans in place to address key risk areas and monitoring implementation of these plans. c) Maintain oversight of key strategic workforce related equality and diversity compliance requirements, including relevant equality, diversity and inclusion legislation. d) Analysing national and local reports on significant workforce matters and monitoring implementation and resulting action. **3. Culture, Engagement & Education** a) Providing oversight of the delivery of key improvement actions in response to the annual Staff Survey and other engagement survey results and ensuring these are aligned to the People Plan. b) To receive and review quarterly and annual reports of the Guardian of Safe Working c) Provide oversight of Freedom to Speak Up arrangements and ensure the promotion and continuance of a healthy speak up culture and identification and embedding of any learning arising. d) Ensure that effective arrangements are in place to secure the availability of a competent and appropriately qualified workforce to deliver healthcare for the Trust (including workforce safeguards), including education, learning and development. e) Provide oversight of the arrangements in place for the health and wellbeing of the workforce, including monitoring key metrics associated with this. **4. Governance** a) Seek assurance on behalf of the Trust Board for the response to people risks which appear on the Board Assurance Framework and Corporate Risk Register b) Receive assurance on the timely review and approval of the policies relevant to the work of the Committee.

Accountability Arrangements	• The Dorset County Hospital CiC is accountable to the Board of Dorset County Hospital NHS Foundation Trust. • The Committee Chair will provide an assurance report following each meeting to the Board of Directors of Dorset County Hospital NHS Foundation Trust. • Dorset County Hospital CiC shall provide such other reports and communications briefings as requested by Dorset County Hospital NHS Foundation Trust's Board for inclusion on the agenda of Dorset County Hospital NHS Foundation Trust's Board meeting.
Membership / Attendance	**Non-Executive** • Three Non-Executive Directors (at least one and no more than two may be Joint NEDS across DCH and DHC) and one of whom will either be the Chair or the Vice Chair of the Committee **Executive** • Joint Chief People Officer • Joint Chief Nursing Officer • Chief Medical Officer **In attendance** • Director of Finance • Nominated Governor(s) • Other staff of the Trust may be requested to attend for specific matters. • Where a member is unable to attend routinely an appropriate deputy who will attend on a regular basis should be nominated and notified to the Chair.
Chair	When the Dorset County Hospital People and Culture CiC meets with the associated committee from Dorset HealthCare University NHS Foundation Trust as committees in common (**Dorset Trust People and Culture CiCs**), one person nominated from the Members of each of the CiCs shall be designated the Chair and one from the other Trusts CiC membership as the Vice Chair. The Chair and Vice Chair shall preside over and run the common meetings with the roles then rotating on an annual basis between the Trusts members.
Quorum	Members of the Dorset County Hospital People and Culture CiC have a responsibility for the operation of the Dorset County Hospital People and Culture CiC. They will participate in discussion, review evidence and provide objective expert input as part of the **Dorset Trust People and Culture CiCs** to the best of their knowledge and ability, and endeavour to reach a collective view. Each Member of the Dorset County Hospital People and Culture CiC shall have one vote. The Dorset County Hospital People and Culture CiC shall reach decisions by consensus of the Members present. The quorum shall be three (3) Members. This must include at least two Non-Executive Directors from the Trust (which may include Joint NEDS acting for both Trusts) and an Executive Director. If any Member is disqualified from voting due to a conflict of interest, they shall not count towards the quorum for the purposes of that agenda item.
Administrative Support	Administrative support will be provided by the Executive Assistant to the Joint Chief People Officer. Agenda and papers will be circulated one week prior to the meeting.

Frequency of Meeting	• The Dorset County Hospital People and Culture CiC shall meet with the associated committee from Dorset HealthCare University NHS Foundation Trust as the **Dorset Trust People and Culture CiCs** and discuss the matters delegated to them in accordance with their respective Terms of References. • Subject to the below, Dorset County Hospital People and Culture CiC meetings shall take place bi-monthly. • Any Trust CiC Member may request an extraordinary meeting of the **Dorset Trust People and Culture CiCs** (working in common) on the basis of urgency etc. by informing the Chair. In the event it is identified that an extraordinary meeting is required the Chair shall give five (5) Working Days' notice to the Trusts.
Conflict of Interest	• Members of the Dorset County Hospital People and Culture CiC shall comply with the provisions on conflicts of interest contained in Dorset County Hospital NHS Foundation Trust Constitution/Standing Orders and NHS Conflicts of Interest guidance. For the avoidance of doubt, reference to conflicts of interest in Dorset County Hospital NHS Foundation Trust Constitution/Standing Orders also apply to conflicts which may arise in their position as a Member of the Dorset County Hospital People and Culture CiC. • All Members of the Dorset County Hospital People and Culture CiC shall declare any new interest at the beginning of any Dorset County Hospital People and Culture CiC meeting and at any point during a **Dorset Trust People and Culture CiCs** meeting if relevant.
Date Approved	• Reviewed by Joint Executive Management Team 2 July 2024 • Approved by People and Culture Committee 22 July 2024 • Ratified by Dorset County University NHS Foundation Trust Board of Directors 31 July 2024
Date Review	31 March 2025

INTEGRITY | RESPECT | TEAMWORK | EXCELLENCE

NHS
Dorset County Hospital
NHS Foundation Trust

Escalation Report

Executive / Committee: Charitable Funds Committee

Date of Meeting: 23 July 2024

Presented by: Dave Underwood

Significant risks / issues for escalation to Committee / Board for action	• **Charitable Funding – Project Report: Prince of Wales Ward redevelopment** – as outlined below. To note the risk of using the charitably funded redeveloped ward for the service's business continuity purposes, which does not reflect the purpose for which the funds were intended.
Key issues / matters discussed at the Committee	**DCHC Charitable Funds Committee (23.7.24)** • **Charitable Funding – Project Report (Dumiso Ncube, Service Manager) Prince of Wales Ward redevelopment.** This project was funded from a major £318K legacy received in 2018 for the benefit of DCH Renal Unit. The redevelopment of the ward was intended to provide a new Home therapies suite and overall improvements to the ward. The project report detailed a range of issues with the Prince of Wales ward's redevelopment including construction of side rooms not fit for purpose which needed rectifying (at the Trust's cost) and which delayed the project completion. Currently the unit is now having to be used for business continuity purposes due to the demise of the Covid Isolation Pod due to structural issues. Therefore, with regard to the intention of the donated funds the unit is not currently being used for the purpose intended. The committee requested a final account for the project's expenditure be provided to understand the quantum of the legacy's funds which have been expended on the project. It was agreed that the Charity Chair and Head of Charity will then meet with the Trust's Chief Finance Officer to discuss the matter. This position also needs to be reported by the Head of Charity to the Executor of the legacy, to explain the issues, current situation and intended mitigations to ensure the purpose of the donated funds is delivered. Dumiso Ncube will provide a summary report for these purposes. The Trust will also need to review the delivery of this project to identify lessons learnt to avoid similar issues with other capital projects. • **DCH Charity Finance/Income 24/25 reports (M2&M3)** M2 (May) and M3 (June) reports 2024/25 were received. Total income as of end May £202,389. Unrestricted funds were £251,272, providing a surplus of £31,272 against the reserves target of £220,000. Total income to date as of end June £237,322. Unrestricted funds were £268,445, providing a surplus of £48,445 against the reserves target of £220,000.

	• **£2.5M Capital Appeal (ED/CrCU)** progress report received. £475K income/pledges to date as of end June 2024. DCH100 Jurassic Coast Challenge (May) raised £111,543. Major fundraising events planning in progress including An Evening with Kate Adie (Sep); Sunflower Trail events (Aug); Online Art Auction; Hinton St Mary Estate Gala Event (Summer 25) and Summer Shows (Sherborne Classic Cars/Melplash Show/Dorset County Show) Grants funding, corporate and donor engagement programme ongoing. Valerie Pitt-Rivers CVO, founder of DCH Arts in Hospital, has kindly agreed to be Arts Patron for the appeal.
Decisions made by the Committee	• Decision made ex-committee (23.7.24) by DCH Charity Strategy Group, to support the DCH Charity Team restructure proposal and associated budgets for 24/25 and 25/26 (forecast).
Implications for the Corporate Risk Register or the Board Assurance Framework (BAF)	• Nil
Items / issues for referral to other Committees	• Nil

Report Front Sheet

1. Report Details			
Meeting Title:	Board of Directors, Part 1		
Date of Meeting:	31 July 2024		
Document Title:	**Medical Revalidation Annual Report**		
Responsible Director:	Alastair Hutchinson, Chief Medical Officer	Date of Executive Approval	03/06/24
Author:	Dr Julie Doherty, Responsible Officer		
Confidentiality:	No		
Publishable under FOI?	Yes		
Predetermined Report Format?	Yes		

2. Prior Discussion		
Job Title or Meeting Title	**Date**	**Recommendations/Comments**
People and Culture Committee	17/06/2024	Received and recommended to Board

3. Purpose of the Paper	In line with the Framework of Quality Assurance (FQA) for Responsible Officers and Revalidation the Trust is required to submit an annual report and statement of compliance, approved by the Trust Board and signed by the CEO prior to submission to NHSE/I. This report is relevant to all Doctors excluding Doctors in Training.							
	Note (✓)	✓	*Discuss (✓)*		*Recommend (✓)*		*Approve (✓)*	✓

4. Executive Summary

All doctors are required to have an annual appraisal that covers a doctor's whole practice, which takes account of all relevant information relating to the doctor's fitness to practice (for their work carried out in the organisation and for work carried out for any other body in the appraisal period & for which they need a licence to practice), including information about complaints, significant events and outlying clinical outcomes. The annual appraisal is a requirement of the 5-year revalidation cycle.

The Trust continues to meet all statutory duties in relation to medical revalidation and Responsible Officer regulations.

Of the 319 Drs connected to DCHFT at 31 March 2024, 305 were due to hold an appraisal in the time they remained connected. Of these 305:
269 held a completed grade I appraisal (i.e an appraisal was held on or within 28 days of the appraisal anniversary) = 88.2%
32 had an approved missed / incomplete appraisal i.e grade 2 = 10.5%. Most of these will have subsequently held their appraisal in line with their approved postponement date.
4 doctors had an unapproved missed appraisal = 1.3%

20 Doctors revalidated. Two were deferred and rescheduled dates have been set. There were no non-engagement recommendations.

	A Higher-Level Responsible Officer (HLRO) peer review visit is expected during 2024 Areas of focus for 2024/25: • Establishing a formal Decision-Making Group or equivalent to support 'Responding to concerns' • A review of our case investigation and management systems to support EDI and 'Just Culture' / 'Fair to Refer'
5. Action recommended	The Board is asked to: 1. **NOTE and APPROVE** the Medical Revalidation Report.

6. Governance and Compliance Obligations				
Legal / Regulatory Link		**Yes**		Statement of Compliance to be signed by CEO once approved in preparation for submission to NHSE/I. RO holds statutory role in medical regulation.
Impact on CQC Standards		**Yes**		Well-led
Risk Link		**Yes**		Adhering to requirements of annual appraisals to support revalidation
Impact on Social Value			**No**	
Trust Strategy Link		**How does this report link to the Trust's Strategic Objectives?** *Please summarise how your report will impact one (or multiple) of the Trust's Strategic Objectives (positive or negative impact). Please include a summary of key measurable benefits or key performance indicators (KPIs) which demonstrate the impact.*		
Strategic Objectives	People	RO is accountable for the local clinical governance processes, focusing on the conduct and performance of doctors, including evaluating a doctor's fitness to practise, and liaising with the GMC over relevant procedures.		
	Place			
	Partnership			
Dorset Integrated Care System (ICS) Objectives		**Which Dorset ICS Objective does this report link to / support?** *Please summarise how your report contributes to the Dorset ICS key objectives.* *(Please delete as appropriate)*		
Improving population health and healthcare			**No**	
Tackling unequal outcomes and access			**No**	
Enhancing productivity and value for money			**No**	
Helping the NHS to support broader social and economic development			**No**	
Assessments		**Have these assessments been completed?** *If yes, please include the assessment in the appendix to the report..* *If no, please state the reason in the comment box below.* *(Please delete as appropriate)*		
Equality Impact Assessment (EIA)			**No**	
Quality Impact Assessment (QIA)			**No**	

Designated Body Annual Board Report and Statement of Compliance

Period covered: 1 April 2023 – 31 March 2024

Report author: Dr Julie Doherty, RO & Deputy CMO

The report sets out the information and metrics that a designated body is expected to report upwards, to assure their compliance with the regulations and commitment to continual quality improvement in the delivery of professional standards.

The content of the template is updated periodically (latest version found at NHS England » Quality assurance).

Section 1 – Qualitative/narrative
Section 2 – Metrics
Section 3 - Summary and conclusion
Section 4 - Statement of compliance

Section 1 Qualitative/narrative

1A – General

The board/executive management team of **Dorset County Hospital NHS Foundation Trust** can confirm that:

1A(i) An appropriately trained licensed medical practitioner is nominated or appointed as a responsible officer.

Action from last year:	Nil
Comments:	Dr Julie Doherty is the RO for DCHFT DCHFT has a split Chief Medical Officer (CMO) / RO role. This is managed by good communication and regular 1:1 meetings between the CMO and RO. We are aware of the comments within the Morecambe Bay report relating to RO / CMO functions & responsibilities. Professor Alastair Hutchison is the CMO. He has access to GMC Connect and there is resilience within the team should the RO be on unexpected or extended leave. We continue to regularly review whether this split CMO / RO role remains appropriate for DCHFT. Alternative options considered

	include for the RO role to be within the remit of the CMO and duties delegated to a revalidation officer or for other duties of the CMO to be delegated to an AMD to provide time for the CMO to fulfil RO duties.
Action for next year:	Options for RO role being presented to Board 31 July 2024

1A(ii) Our organisation provides sufficient funds, capacity and other resources for the responsible officer to carry out the responsibilities of the role.

Yes / No:	Yes & remains under regular review
Action from last year:	Funding for appraisal to sit within CMO budget, providing more clarity and facilitating appraiser activity within job plans.
Comments:	Successful move of funding as above. This also facilitates recruitment of appraisers from a pool of retired consultants. Admin support to RO is under regular review. There is limited capacity within the admin budget & team, such that admin duties are regularly reviewed to provide the most effective support to appraisal & revalidation systems. We are continually looking to recruit new appraisers within divisions as some relinquish such duties or leave post. Payment for appraisal role is in line with other Trusts.
Action for next year:	Ongoing recruitment drive to attract & retain appraisers. Discussion at Board on 31 July 2024 regarding resource allocation to RO

1A(iii)An accurate record of all licensed medical practitioners with a prescribed connection to our responsible officer is always maintained.

Action from last year:	Nil
Comments:	Compliant. The revalidation administrator support the maintenance of an accurate record of connections to DCHFT. Prescribed connections are checked for accuracy & appropriateness. Discussions are held with RO and on occasions the GMC if there is any doubt regarding whether a Dr has a prescribed connection.
Action for next year:	Nil

1A(iv) All policies in place to support medical revalidation are actively monitored and regularly reviewed.

Action from last year:	Complete the changes required to the Medical Appraisal policy and seek ratification via LNC & PCC
Comments:	Medical appraisal policy reviewed, updated & ratified. Published on intranet 13/03/24. Review date 1 Dec 2026.
Action for next year:	Nil unless changes identified.

1A(v) A peer review has been undertaken (where possible) of our organisation's appraisal and revalidation processes.

Action from last year:	To invite the HLRO to conduct a visit during 2024
Comments:	Invitation sent (Feb 2024) and awaiting visit date
Action for next year:	Action plan will be put forward pending outcome of peer review process

1A(vi) A process is in place to ensure locum or short-term placement doctors working in our organisation, including those with a prescribed connection to another organisation, are supported in their induction, continuing professional development, appraisal, revalidation, and governance.

Action from last year:	Nil
Comments:	Locum / short term placement Drs are given an introduction to departments. Drs are encouraged & supported to engage in departmental governance & educational meetings. Internal Scope of Practice form available to support provision of feedback for locums. Medical Appraisal Policy updated in respect of appraisal offers and requirements for connection to DCHFT as their designated body

Action for next year	Nil

1B – Appraisal

1B(i) Doctors in our organisation have an annual appraisal that covers a doctor's whole practice for which they require a GMC licence to practise, which takes account of all relevant information relating to the doctor's fitness to practice (for their work carried out in the organisation and for work carried out for any other body in the appraisal period), including information about complaints, significant events and outlying clinical outcomes.

Action from last year:	Continue to monitor appraisal rates. Continue QA of appraisal.
Comments:	All Drs connected to DCHFT are expected to hold an annual appraisal. Appraisal rates are monitored with a view to continued improvement and a target of >90%. Reasons for missed / postponed appraisals are recorded (Appendix 1). Appraisal inputs & outputs are quality assured via audit. Of the 319 Drs with a prescribed connection to DCHFT during this appraisal year, 305 were due to hold an appraisal in the time they were connected to us (14 left the Trust prior to their appraisal anniversary). Of these 305 doctors, 269 had a completed appraisal in line with their appraisal anniversary or within 28 days of such (Grade 1 = 88.2%). 32 had an approved incomplete or missed appraisal (Grade 2 = 10.5%). This figure includes approved postponements and doctors new to the Trust (including from overseas) who did not provide an appraisal history for the previous year & will have been provided with an appraisal anniversary date on employ at DCHFT. Most, if not all, of these doctors will have subsequently held an appraisal. 4 doctors left the Trust without completing their appraisal giving an unapproved incomplete or missed appraisal rate of 1.3%
Action for next year:	Consider ways to reduce the approved incomplete / missed appraisal rate.

1B(ii) Where in Question 1B(i) this does not occur, there is full understanding of the reasons why and suitable action is taken.

Action from last year	Ongoing review of process for scrutiny & monitoring of appraisal rates
Comments:	Compliance with annual appraisal monitored and reviewed at the monthly appraisal meetings attended by the RO / CMO and appraisal lead. QA and governance overseen at RAGG. Reasons for missed / postponed appraisals are recorded via postponement forms with requests scrutinised via the RO or appraisal lead.
Action for next year:	Liaison with divisional directors to improve management of postponement of appraisal relating to workforce capacity or absence of appraisers. Support doctors within local investigation processes to hold an appraisal in line with their appraisal anniversary.

1B(iii) There is a medical appraisal policy in place that is compliant with national policy and has received the Board's approval (or by an equivalent governance or executive group).

Action from last year:	Complete the changes required to policy and seek ratification via LNC & PCC
Comments:	Medical appraisal policy reviewed, updated & ratified. Published on intranet 13/03/24. Review date 1 Dec 2026.
Action for next year:	Nil unless changes required prior to Dec 2026

1B(iv) Our organisation has the necessary number of trained appraisers[1] to carry out timely annual medical appraisals for all its licensed medical practitioners.

Action from last year:	Funding for medical appraisal within CMO budget for greater clarity and to facilitate appraiser role within agreed job plans
Comments:	Funding now within CMO budget. There is still a turnover of medical appraisers such that we need to continue our drive to recruit and retain new appraisers. As a general guide, each appraiser is allocated 6 appraisals per annum.

[1] While there is no regulatory stipulation on appraiser/doctor ratios, a useful working benchmark is that an appraiser will undertake between 5 and 20 appraisals per year. This strikes a sensible balance between doing sufficient to maintain proficiency and not doing so many as to unbalance the appraiser's scope of work.

Action for next year:	Continued enlistment of support from Divisional Directors (DDs) to identify medical appraisers from departments & encourage consultants / specialist Drs to take on the role.

1B(v) Medical appraisers participate in ongoing performance review and training/ development activities, to include attendance at appraisal network/development events, peer review and calibration of professional judgements (Quality Assurance of Medical Appraisers or equivalent).

Action from last year:	Continue regular audit for QA. To continue to promote the value of appraisal amongst Drs To continue to seek IT / digital support for inputs to appraisal (currently limited by resource within the digital team)
Comments:	We hold quarterly appraiser meetings for peer support. The meetings are supplemented by a newsletter which includes updates from ROAN meetings and the GMC ELA. Appraisers attend formal update training every 3 years (with reminders when expired). The RO and appraisal lead conduct audits for QA (inputs and outputs) with feedback to appraisers individually. Appraisers are invited to meet with the RO should they wish face to face feedback or if there are any concerns regarding performance or feedback from appraisees. ASPAT (tool used to measure quality of appraisal outputs): Mean score for this year = 45/50. Range of scores 32-50 Outcome of audit of quality of appraisal 2023/24 discussed at RAGG and quarterly appraiser meeting. Value of appraisal discussed at opportunities available e.g. LED Induction Resource limitations within digital team such that unable to progress IT / AI solutions to support appraisal at the current time.
Action for next year:	Provision of ongoing peer support & CPD opportunities for medical appraisers

1B(vi) The appraisal system in place for the doctors in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group.

Action from last year:	Ongoing monitoring & QA of appraisal

Comments:	Inputs and outputs from Appraisal are quality assured as noted above. The Board receive an annual report on medical appraisal and revalidation. RAGG now meets twice a year. The group conducts self-assessment against the Principles of Effective Clinical Governance for the Medical Profession. Outcomes from QA of appraisal are discussed. At the last meeting the proposed actions for DCHFT from a review of learning from Morecambe Bay were discussed.
Action for next year:	The HLRO visit for peer review will provide another source of QA

1C – Recommendations to the GMC

1C(i) Recommendations are made to the GMC about the fitness to practise of all doctors with a prescribed connection to our responsible officer, in accordance with the GMC requirements and responsible officer protocol, within the expected timescales, or where this does not occur, the reasons are recorded and understood.

Action from last year:	Continue to submit recommendations to the GMC on time.
Comments:	All recommendations made on time. Number of Doctors revalidated this year: 20 (+2 for Weldmar as RO for both designated bodies) Number of deferrals: 2 Number of non-engagement recommendations: 0 Decisions are recorded and recommendations notified to the Dr.
Action for next year:	Nil

1C(ii) Revalidation recommendations made to the GMC are confirmed promptly to the doctor and the reasons for the recommendations, particularly if the recommendation is one of deferral or non-engagement, are discussed with the doctor before the recommendation is submitted, or where this does not happen, the reasons are recorded and understood.

Action from last year:	Nil

Comments:	Doctors are informed of RO recommendations via email to the doctor at the time of submission via GMC Connect or PReP IT. Recommendations to defer are discussed with the doctor either face to face or via email well before that recommendation is submitted. Deferrals may be a joint agreement between Dr and RO depending on the reason for deferral. Reasons for deferral and actions the doctor needs to complete to enable a recommendation to revalidate to be made are set out clearly and provided in writing (usually via email).
Action for next year:	Nil

1D – Medical governance

1D(i) Our organisation creates an environment which delivers effective clinical governance for doctors.

Action from last year:	Continue self -assessment at RAGG and take steps to complete actions identified
Comments:	We engage in self-assessment (with lay member challenge at RAGG) against the Principles set out in 'Effective Clinical Governance for the Medical Profession'. Copies of self – assessments available.
Action for next year:	Nil

1D(ii) Effective systems are in place for monitoring the conduct and performance of all doctors working in our organisation.

Action from last year:	Nil
Comments:	Systems are in place for monitoring the conduct and performance of all doctors working at DCHFT. Concerns regarding conduct / performance are identified and managed at departmental or divisional level and escalation pathways are in place. FtP concerns are discussed with the GMC ELA and PPA as appropriate. The Trust has local polices (such as disciplinary, whistleblowing, grievance, bullying..) and uses MHPS.

	There is a weekly Medical HR meeting involving the Head of People Services, CMO, RO and DDs where concerns are discussed and summaries recorded. Following on from National high profile cases (Letby & Morecambe Bay) an action plan is under development which includes the setup of a more formal Decision Making Group (DMG or equivalent), Quality Surveillance Group and introduction of an Employer Relations Report to Board
Action for next year:	Produce & agree final TOR for a DMG +/- PAG (Performance Advisory Group) Establish and evaluate the DMG Introduction of an Employer Relations Report to Board

1D(iii) All relevant information is provided for doctors in a convenient format to include at their appraisal.

Action from last year:	Look to identify ways to support Drs in collating supporting information and reduce the burden of appraisal. By this means we hope to change perception (reported by some Drs) of appraisal & enhance its value.
Comments:	Guidance on supporting information provided to appraisees by appraiser, appraisal lead, RO and administrator for revalidation. Risk data, complaints & compliments available from the Trust. Scope of Practice (internal and external available) to support information sharing. Unfortunately we have not been able to secure additional IT / AI support for appraisal inputs at this time.
Action for next year:	Nil

1D(iv) There is a process established for responding to concerns about a medical practitioner's fitness to practise, which is supported by an approved responding to concerns policy that includes arrangements for investigation and intervention for capability, conduct, health and fitness to practise concerns.

Action from last year:	Nil
Comments:	Maintaining High Professional Standards is the approved policy used for responding to concerns. Fitness to Practice issues are discussed at the RO / CMO / GMC ELA meetings which are held quarterly. The GMC ELA is available for informal / formal discussion by MS Teams / telephone between meetings.

	Practitioner Performance Advice (PPA) service is an additional support for the CMO / deputy CMO (RO). Regular meetings are scheduled with the Trust's allocated advisor from PPA
Action for next year:	Nil

1D(v) The system for responding to concerns about a doctor in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group. Analysis includes numbers, type and outcome of concerns, as well as aspects such as consideration of protected characteristics of the doctors and country of primary medical qualification.

Action from last year:	Establish a peer support group for case investigators at DCHFT Include protected characteristics in analysis reports
Comments:	Case investigator training took place in March 2024. WE have yet to establish a per support group. PPA have produced an organisational report. We are setting a date to discuss this and plan further work around EDI and a fair culture.
Action for next year:	Peer support for case investigators – carry over Analysis of PPA Organisational Report

1D(vi) There is a process for transferring information and concerns quickly and effectively between the responsible officer in our organisation and other responsible officers (or persons with appropriate governance responsibility) about a) doctors connected to our organisation and who also work in other places, and b) doctors connected elsewhere but who also work in our organisation.

Action from last year:	Nil
Comments:	MPIT forms (national process) are used. Telephone conversations or virtual meetings via MS Teams have occurred where there were higher level concerns potentially likely to impact on patient safety / outcomes. There is documented evidence of discussions and decision making / outcomes
Action for next year:	Nil

1D(vii) Safeguards are in place to ensure clinical governance arrangements for doctors including processes for responding to concerns about a doctor's practice, are fair and free from bias and discrimination (Ref GMC governance handbook).

Action from last year:	nil
Comments:	HR policies include an Equal Opportunities Impact Assessment & statement. We are working through self -assessment of the Principles in the GMC handbook as outlined above at RAGG There is discussion and challenge at the RO/CMO/ GMC ELA meetings. PPA have produced an organisational report. We are setting a date to discuss this and plan further work around EDI and Fair Culture
Action for next year:	Analysis of PPA organisational report

1D(viii) Systems are in place to capture development requirements and opportunities in relation to governance from the wider system, e.g. from national reviews, reports and enquiries, and integrate these into the organisation's policies, procedures and culture. (Give example(s) where possible.)

Action from last year:	N/A
Comments:	See above (1D ii) regarding learning from national events e.g. Letby & Morecambe bay
Action for next year:	As per 1D ii

1D(ix) Systems are in place to review professional standards arrangements for all healthcare professionals with actions to make these as consistent as possible (Ref Messenger review).

Action from last year:	N/A

Comments:	See 1Dii which encompasses all healthcare professionals with regards Quality Surveillance Group (QSG) The Trust has an established leadership development programme which is frequently being built upon. This gives due regard to EDI. Trust values are integrated into appraisal systems. Teams have regular meetings between senior medical, nursing and managerial leads.
Action for next year:	Embedding of QSG Evaluation of leadership programmes across the Trust

1E – Employment Checks

1E(i) A system is in place to ensure the appropriate pre-employment background checks are undertaken to confirm all doctors, including locum and short-term doctors, have qualifications and are suitably skilled and knowledgeable to undertake their professional duties.

Action from last year:	Nil
Comments:	In addition to pre-employment check there are systems to share information once a doctor has been offered a contract with DCHFT: Sharing of information regarding new doctors entering employ occurs via MPIT forms from RO to RO. Such forms are also used to share concerns (RO to RO) which arise during employment at DCHFT of any doctors who also practice elsewhere (e.g locum doctors; doctors with private practice) HPANs (Health Professional Alert Notices) may also be used to share significant concerns about a doctor who has disconnected from DCHFT and not yet made a connection to a new Designated Body. GMC processes also allow appropriate information sharing when there are Fitness to Practice concerns. Information sharing processes adhere to Caldicott principles. RO and CMO share the role of Caldicott guardian and attend relevant update training. (GMC handbook Principles 4e & f). Doctors in training posts and their equivalent LED have clinical supervision and in most instances (for LED / all for those with a national training number) educational supervision.
Action for next year:	Nil

1F – Organisational Culture

1F(i) A system is in place to ensure that professional standards activities support an appropriate organisational culture, generating an environment in which excellence in clinical care will flourish, and be continually enhanced.

Action from last year:	N/A
Comments:	The Trust values and organisational culture support a strive for excellence in clinical care. Some departments / teams have engaged in a Culture Survey i.e. perinatal care
Action for next year:	Consider leadership support in promoting positive clinical environments and actioning recommendations from culture survey analysis

1F(ii) A system is in place to ensure compassion, fairness, respect, diversity and inclusivity are proactively promoted within the organisation at all levels.

Action from last year:	N/A
Comments:	Promoted within Trust values and within policies. Behaviours not aligned with Trust values are challenged.
Action for next year:	As per 1Fi

1F(iii) A system is in place to ensure that the values and behaviours around openness, transparency, freedom to speak up (including safeguarding of whistleblowers) and a learning culture exist and are continually enhanced within the organisation at all levels.

Action from last year:	N/A
Comments:	Promoted within Trust values and within policies. Behaviours not aligned with Trust values are challenged. Learning culture demonstrated in a variety of ways including learning from incidents; M&M; FERF

Action for next year:	Nil

1F(iv) Mechanisms exist that support feedback about the organisation' professional standards processes by its connected doctors (including the existence of a formal complaints procedure).

Action from last year:	N/A
Comments:	Feedback from connected doctors occurs in a number of ways including exit interviews, complaints and appeals processes & procedures. Feedback on Trust disciplinary processes has previously been received (2021) from non-medical staff via 'Lived Experience Interviews' For doctors there has been informal feedback from those going through performance management and FtP processes. We are aware that delays in such processes contribute to feelings of anxiety & uncertainty. With this in mind the Trust has trained additional case investigators.
Action for next year:	Nil

1F(v) Our organisation assesses the level of parity between doctors involved in concerns and disciplinary processes in terms of country of primary medical qualification and protected characteristics as defined by the Equality Act.

Action from last year:	N/A
Comments:	PPA Organisational report is to be discussed and analysed to provide further information on E&D issues.
Action for next year:	Agree actions arising from the analysis

1G – Calibration and networking

1G(i) The designated body takes steps to ensure its professional standards processes are consistent with other organisations through means such as, but not restricted to, attending network meetings, engaging with higher-level responsible officer quality review processes, engaging with peer review programmes.

Action from last year:	N/A
Comments:	Peer review has been invited and we are awaiting a date from HLRO. RO, CMO and appraisal lead engage in ROAN meetings
Action for next year:	To be determined pending outcome of HLRO peer review

Section 2 – metrics

Year covered by this report and statement: 1April 2023 - 31March 2024.

All data points are in reference to this period unless stated otherwise.

2A General

The number of doctors with a prescribed connection to the designated body on the last day of the year under review. This figure provides the denominator for the subsequent data points in this report.

Total number of doctors with a prescribed connection on 31 March 2024 = **319**	

2B – Appraisal

The numbers of appraisals undertaken, not undertaken and the total number of agreed exceptions is as recorded in the table below.

Total number of appraisals completed	**269**
Total number of appraisals approved missed	**46** (includes 14 leavers who were not scheduled to hold an appraisal prior to leaving; some drs new to Trust and who had appraised prior to arriving or new drs who had not provided an appraisal history for the past year and who were allocated a new appraisal anniversary)
Total number of unapproved missed	**4**

2C – Recommendations

Number of recommendations and deferrals in the reporting period.

Total number of recommendations made	22 (+2 for Weldmar Hospicecare -DCH provides RO services to this DB)

Total number of late recommendations	0
Total number of positive recommendations	20 (+2 Weldmar)
Total number of deferrals made	2
Total number of non-engagement referrals	0
Total number of doctors who did not revalidate	2

2D – Governance

Total number of trained case investigators	**14**
Total number of trained case managers	**3**
Total number of new concerns registered	**3** (+1 Dr employed by DCH with formal case investigation performed at another organisation)
Total number of concerns processes completed	**1**
Longest duration of concerns process of those open on 31 March	**20 months** Includes both informal and formal performance management issues over a period
Median duration of concerns processes closed	**8 months**
Total number of doctors excluded/suspended	**1**
Total number of doctors referred to GMC	**3** (includes 1 Dr referred by DCH; 1 Dr referred by patient and 1 Dr already having undertakings with the GMC)

2E – Employment checks

Number of new doctors employed by the organisation and the number whose employment checks are completed before commencement of employment.

Total number of new doctors joining the organisation	155

	37 excluding Drs inTraining
Number of new employment checks completed before commencement of employment	154

2F Organisational culture

Total number claims made to employment tribunals by doctors	0
Number of these claims upheld	0
Total number of appeals against the designated body's professional standards processes made by doctors	0
Number of these appeals upheld	0

Section 3 – Summary and overall commentary

This comments box can be used to provide detail on the headings listed and/or any other detail not included elsewhere in this report.

General review of actions since last Board report
Funding for appraisal now sits within CMO budget, providing more clarity and facilitating appraiser activity within job plans. The Medical appraisal policy has been reviewed, updated & ratified. Published on intranet 13/03/24. Review date 1 Dec 2026. A HLRO peer review visit is to be conducted during 2024 – we await a date from NHSE (SW).
Actions still outstanding
Establish a peer support group for case investigators at DCHFT Include protected characteristics in analysis reports
Current issues
Retention and replacement of medical appraisers remains a challenge. We continue to audit inputs to and outputs from medical appraisal. Feedback from appraisal is positive for the majority. When responding to concerns regarding doctors, we need to ensure that our case investigation and management processes are fair (Fair to Refer https://www.gmc-uk.org/-/media/documents/fair-to-refer-report_pdf-79011677.pdf ; Just Culture https://www.england.nhs.uk/patient-safety/patient-safety-

culture/a-just-culture-guide/). We plan some work looking into actions and decision making, starting with an analysis of our PPA Organisational report.

Actions for next year (replicate list of 'Actions for next year' identified in Section 1):

1. Ongoing recruitment drive to attract & retain appraisers.

i) Continued enlistment of support from Divisional Directors (DDs) to identify medical appraisers from departments & encourage consultants / specialist Drs to take on the role.

ii) Provision of ongoing peer support & CPD opportunities for medical appraisers

2. Consider ways to reduce the approved incomplete / missed appraisal rate.

i) Liaison with divisional directors to improve management of postponement of appraisal relating to workforce capacity or absence of appraisers. Support doctors within local investigation processes to hold an appraisal in line with their appraisal anniversary

3. Produce & agree final TOR for a DMG (Decision Making Group) +/- PAG (Performance Advisory Group)

4. Establish and evaluate the DMG

5. Establish a peer support group for case investigators at DCHFT

6. Perform an analysis of the PPA Organisational report for DCHFT

7. Introduction of an Employer Relations Report to Board

8. Consider leadership support in promoting positive clinical environments and actioning recommendations from culture survey analysis

i) Evaluate the Clinical Leads Development programme

Overall concluding comments (consider setting these out in the context of the organisation's achievements, challenges and aspirations for the coming year):

We comply with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013).

We continue to learn from national event reporting and our teams engage in RO and Appraiser networking meetings.

Section 4 – Statement of Compliance

The Board/executive management team have reviewed the content of this report and can confirm the organisation is compliant with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013).

Signed on behalf of the designated body

[(Chief executive or chairman (or executive if no board exists)]

Official name of the designated body:	Dorset County Hospital NHS Foundation trust

Name:	Matthew Bryant
Role:	CEO
Signed:	
Date:	

Annual Report Appendix A

Audit of all missed or incomplete appraisals audit

Doctor factors (total) as at end March 2024	**9**
Maternity leave during the majority of the 'appraisal due window' (appraisal subsequently held)	1
Sickness absence during the majority of the 'appraisal due window' (Of which 2 have been held and 1 booked)	3
Prolonged leave during the majority of the 'appraisal due window' (1 x sabbatical & appraisal subsequently held)	1
Suspension during the majority of the 'appraisal due window'	0
New starter within 3 month of appraisal due date	0
New starter more than 3 months from appraisal due date	0
Postponed due to incomplete portfolio/insufficient supporting information: - (1 awaiting completion; 1 awaiting appraiser return / new appraiser; 1 held)	3
Appraisal outputs not signed off by doctor within 28 days	0
Lack of time of doctor (work capacity) (subsequently held)	1
Lack of engagement of doctor	0
Other Total Appraisals postponed or deferred: • 1 x (appraisal booked) paternity leave when appraisal due. • 2 x interruption to practice following career break/sabbatical (appraisal held x1 and booked x1) • 6 x due to Appraisee's Annual leave (appraisals subsequently held) • 3 x due to Study Leave. (2 booked and 1 held) • 4 x due to Special leave. (3 held and 1 booked)	**16** 1 2 6 3 4
Appraiser factors(total)	**14**
3 x Unplanned absence of appraiser (approved late appraisal) – of which 1 awaiting return of appraiser to undertake appraisal; 1 appraisal held 07/02/2024 by another appraiser and 1 appraisal held	**3**
Appraisal outputs not signed off by appraiser within 28 days	**6**
Lack of time of appraiser	0
Total Other appraiser factors (describe): 1 x appraiser failing to confirm appraisal time and rota could not be	**5**

changed last minute (Now booked) 3 x Staff shortages in appraisers department (1 rebooked and 2 now held) 1 x appraiser taking last minute annual leave (appraisal subsequently held).	1 3 1
Organisational factors • 1 x insufficient SI. Appraisal subsequently held • 2x repeated Doctor strike action. Appraisals subsequently held • 2 x due to shortage of appraisers. Appraisals subsequently held • 1 x due to first available slot in Orthopaedics rota. Appraisal subsequently held • 1 x needing to attend an urgent meeting had to cancel and rebook appraisal.	**7**
Administration or management factors	0
Failure of electronic information systems	0
Insufficient numbers of trained appraisers	0
Other organisational factors (describe) • 3 x– First available date for both appraiser/appraisee. Appraisal subsequently held x2 and 1 rebooked	**3**

Report Front Sheet

1. Report Details			
Meeting Title:	Board of Directors, Part 1		
Date of Meeting:	31 July 2024		
Document Title:	Bi-Annual Leavers and Retention Report		
Responsible Director:	Nicola Plumb, Joint Chief People Officer	Date of Executive Approval	10 June 2024 (EH)
Author:	Sam Dewar, Workforce Business Partner Michelle Tamplin, Workforce Business Partner		
Confidentiality:	N/A		
Publishable under FOI?	Yes		
Predetermined Report Format?	No		

2. Prior Discussion		
Job Title or Meeting Title	**Date**	**Recommendations/Comments**
PCC	17/06/2024	Noted

3. Purpose of the Paper	To provide a bi-annual update on Leavers and Retention.							
	Note (✓)	✓	*Discuss (✓)*	✓	*Recommend (✓)*		*Approve (✓)*	

4. Executive Summary

This report analyses Trust leavers data from 1 October 2023 to 31 March 2024 inclusive.

During this period there were 134 leavers, which is 3.51% of the substantive and fixed term workforce. This is a 20% reduction (33 less leavers) compared to the same period in the previous year and an 12% reduction (19 less leavers) compared to the previous 6 months.

Encouragingly, as with previous reports, the leavers data for this period does not indicate any concerning patterns for further investigation regarding gender, ethnicity or disability.

Our highest number of leavers continues to be those aged 56 and over with the main reason for leaving in this age group being retirement. We are however seeing an increasing number of people choosing to retire and return which is mitigating against the immediate impact and meaning we are retaining people's knowledge and skills for longer. This evidences the need to continue to ensure we have options and information available for those who may want to consider retire and return or flexible working and that we continue our focus on good succession planning, robust sustainable workforce supply pipelines and grow our own schemes.

We are also continuing to see a disproportionate number of leavers aged 25 and under, the majority of which are from the Administrative & Clerical and Additional Clinical Services staff groups and that the most declared reason for leaving is

	relocation. Although this only amounts to a small number of the overall leavers this needs to be monitored and emphasizes the need to continue to develop and promote career development opportunities and pathways so that we can provide opportunities which will both attract and retain young people in the local area. There continues to be a disproportionate number of leavers from the Administrative and Clerical roles, and this appears to be increasing. The majority being from band 2 and band 3 roles. The reasons for leaving vary, with the highest declared reason being work life balance and retirement (including some retire and returns). The Smarter Working workstream and refreshed Flexible working policy may benefit this staff group as the roles lend themselves to remote/hybrid working arrangements for example which may help with work life balance issues. Leavers with less than 12 months service remain at a similar level to previous reports. This is an area of focus identified to be part of the People Promise Exemplar Programme with continued monitoring, a focus on improving our exit interview data and consideration around how the Smarter Working workstream and flexible working might help to improve retention. People leaving to relocate out of the area has reduced in the last 6 months but still remains high so requires further monitoring. Despite a new leaver process being launched during 2023 we continue to have a similar gap in our knowledge and intelligence with around 25% still indicating 'voluntary resignation other/not known' as their reason for leaving. This suggests that a further review of the process is needed to ensure it is properly understood and embedded and that we are making it as easy and accessible as possible. The report summarises work underway to improve retention and highlights areas of particular focus for the Trust which includes the recently launched People Promise Exemplar Programme.
5. Action recommended	The Board is recommended to: 1. **NOTE** the report.

6. Governance and Compliance Obligations			
Legal / Regulatory Link		**No**	*If yes, please summarise the legal/regulatory compliance requirement. (Please delete as appropriate)*
Impact on CQC Standards		**No**	*If yes, please summarise the impact on CQC standards. (Please delete as appropriate)*
Risk Link		**No**	*f yes, please state the link to Board Assurance Framework and Corporate Risk Register risks (incl. reference number). Provide a statement on the mitigated risk position. (Please delete as appropriate)*
Impact on Social Value		**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	Positive impact by seeking to identify, monitor and make recommendations to address any retention issues or trends	
	Place	N/A	
	Partnership	N/A	
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**	By understanding the reasons people are leaving we can make improvements that mean our retention rates improve providing a stable substantive workforce with the necessary skills, experience and competence.
Tackling unequal outcomes and access		**No**	
Enhancing productivity and value for money		**Yes**	By maintaining a stable substantive workforce we will save money on agency/locum costs and provide greater continuity and stability of care.
Helping the NHS to support broader social and economic development		**No**	
Assessments	**Have these assessments been completed?** *If yes, please include the assessment in the appendix to the report..* *If no, please state the reason in the comment box below.* *(Please delete as appropriate)*		
Equality Impact Assessment (EIA)		**No**	
Quality Impact Assessment (QIA)		**No**	

Title of Meeting	**People and Culture Committee**
Date of Meeting	**17 June 2024**
Report Title	**Bi-Annual Leavers and Retention Report**
Author	**Sam Dewar, Workforce Business Partner** **Michelle Tamplin, Workforce Business Partner**

1. Introduction

1.1 This report analyses Trust leavers data from 1 October 2023 to 31 March 2024 inclusive.

1.2 Bank staff, Flexibly Employed Staff (FES) and Doctors in Training who are on rotation are excluded from the leavers data. The data also excludes 5 fixed-term staff who left as planned at the end of the fixed term contract and 19 employees who were dismissed during probation or for performance or conduct reasons.

1.3 Percentages have been calculated as a proportion of headcount in ESR using substantive staff only (permanent and fixed term). The substantive headcount as of 31 March 2024 was 3819 (excluding bank, non-executive, honorary, volunteer and locum positions).

1.4 This report analyses leavers data by age, gender, ethnic minority, disability, division, staff group, reason for leaving and by duration of employment.

1.5 The analysis within this report assists the Trust to assess and monitor progress in meeting our People Plan priorities including retaining people with the right skills to deliver outstanding care.

2. Number of leavers

2.1 Between 1 October 2023 and 31 March 2024 (inclusive) there were 134 leavers from the Trust which is 3.51 % of the substantive and fixed term workforce. This is a 20% reduction (33 less leavers) compared to the same period in the previous year and a 12% reduction (19 less leavers) compared to the previous 6 months.

3. Age

3.1 The largest age group of leavers in this period were again between aged 56-60 (20% or 27 people). As shown in Table 1 (see appendices) this % is high when compared to the composition of the workforce. This is also the case when considering all leavers aged 56 and above, with 59 people in this age range making up 44% of leavers but only 19% of the workforce. This correlates with retirement (which includes people who retire and return) being the highest declared reason for leaving at 29%.

3.2 Leavers age 25 years and under continue to be at levels higher than we would expect given their representation in the workforce. People in this age band make up 8% of the workforce but accounted for 12% of the leavers (16 leavers). The majority of these leavers were from the Administrative and Clerical (8) and Additional Clinical Services (5) staff groups and the reasons for leaving varied with 5 people not specifying a reason and the most commonly declared reason being relocation (5).

3.3 The data in table 1 also shows that the leavers % rate for those aged between 26 and 55 (inclusive) continues to be lower than the composition of the workforce indicating that retention rates in this age group are relatively good.

4. Gender

4.1 The proportion of leavers split by gender within the Trust shows that 78% of staff leavers were female while 22% were male which broadly mirrors the composition of the substantive workforce.

5. Ethnic Origin

5.1 The data in table 2 (see appendices) shows that the leavers rates by ethnic groups is broadly comparable to the composition of the workforce.

6 Disability

6.1 81% of the Trust's leavers had no declared disability, 4% had a declared disability and 15% did not declare whether they had a disability. There is no significant variation when compared to the current workforce which is comprised of 82% who declare as not disabled, 7% who have declared a disability and 11% who have not declared or prefer not to say. Of the 5 leavers who declared a disability the reasons for leaving varied and none gave their reason for leaving as being health related.

7. Leavers by Division

7.1 The data in table 3a shows that 37% (50) of leavers were from Corporate Functions, 29% (39) of the leavers were from Division A (Urgent and Integrated Care) and 34% (45) were from Division B (Family Services and Surgical). The most noticeable change from the previous 6 months being that the total number of leavers in Division A has dropped whilst the total numbers of leavers in Division B and the Corporate Functions is similar.

7.2 The Urgent and Integrated Care Division (Table 3b) saw the highest number of leavers in the Additional Clinical Services (13), Nursing & Midwifery (9) & Admin & Clerical (8) with the highest declared reasons for leaving being relocation (9), retirement (6) and better work life balance (4). For all staff groups in this Division the number of leavers has reduced except for Administrative & Clerical which remained the same. Nursing saw the biggest reduction from 21 leavers to 9.

7.3 The Family and Surgical Division (Table 3b) saw the highest number of leavers in the Additional Clinical Services (13), Administrative & Clerical (12) and Nursing &

Midwifery (12) with the highest declared reason for leaving being retirement (22), health (4) and work life balance (4). In this Division there were increases in leavers in Additional Clinical Services from 8 to 13 and Administrative & Clerical from 5 to 12 with the other staff groups either reducing or remaining at similar levels.

7.4 Within the Corporate Functions the total number of leavers was similar to the previous 6 months (increasing by 3). The most notable change being an increase in leavers in Health Informatics from 6 to 11 and a continued reduction in leavers in Estates. Looking at the reasons for leaving for staff in Health Informatics they varied with 2 stating Health, 2 work life balance, 2 better reward & 2 Promotion and the 3 Voluntary Resignation - Other.

8. Whole Trust Leavers By Staff Group

8.1 The staff groups with the highest number of leavers were Administrative & Clerical at 57 leavers (43%); Additional Clinical Services at 26 leavers (19%) & Nursing & Midwifery 23 leavers (17%).

8.2 When compared, the number of leavers from each staff group with the previous 6 months the majority of staff groups have seen a reduction in leavers (see table 4) with the exception of Administrative & Clerical (up by 18) and Healthcare Scientists (up by 2).

8.3 The Administrative & Clerical staff group leavers were from a wide range of roles, areas and bandings (band 2 to band 8b) however the majority 40 of out the 57 were from Band 2 or Band 3 roles and the reasons for leaving varied with the highest declared reasons for leaving being Work Life Balance (5), Health (4) & Retirement (4). There were 13 leavers who gave their reason for leaving as Voluntary Resignation – Other.

8.4 When comparing the % of leavers by staff group with the composition of our substantive workforce the majority are proportionate or lower than we would expect except for Administrative & Clerical which is more than double (see table 4). When looking at the reasons for leaving for the whole staff group they varied with the highest declared reason being work life balance (10), retirement (10 including 7 retire and returns), health (5) promotion (5), better Reward Package (3) and relocation (2).

8.5 For Additional Professional Scientific & Technical staff group (which includes Pharmacy and was flagged as being of concern in the previous report) we saw a significant reduction in the number of leavers to a level that is now below the composition of the workforce.

8.6 For Additional Clinical Services (which includes HCSW and was staff group flagged as being a concern in previous reports) we have seen the same number of leavers to the previous six-month period and a % that is comparable with the composition of the workforce.

8.7 For Estates & Ancillary staff group (a staff group flagged as being of concern in the last report) we have seen a further reduction in leavers and the % that is now closer to the composition of the workforce.

8.8 For Nursing and Midwifery staff group we saw a significant reduction in leavers since the previous 6 months and a % which is now well below the composition of the workforce.

8.9 It should also be noted there has been a rapid increase in Internationally Educated Nurses (IEN) within the organisation with 114 arriving during 2023 and a further 17 in early 2024 bringing the current headcount to 307. Retention in this group is being closely monitored and is improving with the current retention rate being 88.75%. There has also been a focus on providing equality of opportunity for IENs to seek promotion and we have seen increase in the number of IENs undertaking Band 6 roles which now stands at 25.

9. Leavers By Duration of Employment

9.1 61% of leavers (82) left the trust with 2+years of service (table 5). This was similar to the previous 6 month period.

9.2 38 leavers (28%) left within 12 months of commencing employment which is 1 more than in the previous 6 month period. Of these leavers 12 were in Additional Clinical Services staff group (which includes HCSW) and 20 were in the Administrative & Clerical staff group. The reasons for leaving varied with the majority indicating voluntary resignation - not known/other (17), however of those who did specify a reason they cited work life balance (6), health (5), relocation (3) and incompatible working relationships (2).

10. **Reasons for Leaving (and comparison to previous 6 month period)**

10.1 The highest given reason for leaving the Trust was due to retirement which has increased by 6% since the previous 6 months and accounted for 40 (30%) of the leavers. It should be noted however that 22 of these were retire and return which we have seen an increase in since recent changes in the NHS pension make this easier and more attractive. This means that although they are deemed as leavers due to the enforced break in service, we are still retaining the skills and knowledge of these individual for longer within the Trust.

10.2 When compared with the reasons for leaving from the previous 6 months there has been some movement (see table 6). The most notable being a decrease in people relocating down by 15% to 11% of leavers. Looking at the exit interview forms of people who have relocated they have indicated that pay levels, the cost of housing in the area, lack of development opportunities, and their spouses moving jobs were contributing factors in their decision to relocate. Although the number of people giving this reason has dropped recently it is likely that we will continue to see people moving to more affordable parts of the UK alongside increasing examples of other employers offering additional recruitment and retention payments.

10.3 We also saw a small increase in the % of people leaving for work-life balance and health both up by 2% and better reward package, promotion, travel issues and working relationships all up by 1%.

10.4 There remains an ongoing gap in our knowledge and intelligence of the reasons for leaving with 25% or 33 leavers indicating 'voluntary resignation other/not known' as the reason for leaving (which is 1 more than in the previous 6-month period). A new leaver process (an anonymous online survey) was launched in 2023 and this is now under further review so that going forward we hope to see an improvement in this along with having richer data for those who choose to respond. We must acknowledge however that as we are not able to remove this 'other' reason from ESR, and we cannot make the completion of a leaver form compulsory, that we will never eliminate it completely.

11. Summary and Next Steps

11.1 Between 1 October 2023 and 31 March 2024 (inclusive) there were 134 leavers which is 3.51 % of the substantive and fixed term workforce. This is a 20% reduction (33 less leavers) compared to the same period in the previous year and an 12% reduction (19 less leavers) compared to the previous 6 months.

11.2 Encouragingly, as with previous reports, the leavers data for this period does not indicate any concerning patterns for further investigation regarding gender, ethnicity, or disability.

11.3 **The age data continues to show that our highest number of leavers are aged 56 and over** and that this is disproportionate to the composition of the workforce. The main reason for leaving in this age group being retirement. We are however seeing an increasing number of people choosing to retire and return which is mitigating against the immediate impact and meaning we are retaining people's knowledge and skills for longer.

Next steps: We continue to ensure we have options and information available for people who may want to consider retire and return options. Additionally, to fill these retirement gaps we need to continue our work to ensure there is understanding across the Trust of the need for good succession and workforce planning which includes robust and sustainable workforce supply pipelines and grow our own schemes.

11.4 **The age data also continues to show a disproportionate number of leavers aged 25 and under,** the majority of which are from the Administrative & Clerical and Additional Clinical Services staff groups and that the most declared reason for leaving is relocation. Although this only amounts to a small number of the overall leavers this needs to be monitored and emphasizes the need to continue to develop and promote career development opportunities and pathways so that we can provide opportunities which will both attract and retain young people in the local area.

Next steps: We continue to implement our People Plan priorities to support opportunities for upskilling, placement support, growing our own strategies, flexible working policy review, introduction of new ways of working and new roles and retire and return approaches which support and promote health and wellbeing.

11.5 **There continues to be a disproportionate number of leavers from the Administrative and Clerical workforce,** and this appears to be increasing, with the majority being from band 2 and band 3 roles. The reasons for leaving vary with the highest declared reason being work life balance and retirement (including retire and returns).

Next steps: New approaches are underway to assist us in recruiting to administrative roles, including a rolling recruitment programme in Access and a business administration scholarship cohort. A potential future model could also include a cohort of generic administrative apprentices each year as a longer-term pipeline to fill support roles across the hospital. The Smarter Working workstream and refreshed flexible working policy may also benefit this staff group as the roles lend themselves to remote/hybrid working arrangements for example which may help with work life balance issues.

11.6 **Leavers with less than 12 months service** remain at a similar level to previous reports.

Next steps:

This is an area of focus identified to be part of the People Promise Exemplar Programme (see appendix table 7). We will continue to monitor this trend and will explore ways of improving our insights into the reasons for leaving as there is currently a big gap in our knowledge with the majority stating voluntary resignation other/not known as the reason for leaving.

11.7 **People leaving to relocate out of the area** has reduced in the last 6 months but still remains high.

Next steps:

We will continue to monitor this trend and will use responses from the new exit interview process to give us an insight into what if anything can be done to reduce this reason for leaving.

We are commencing our Smarter Working workstream with the aim of breaking down the barriers to flexible working conversations. In some cases (and for some roles) the consideration of remote and/or hybrid working could reduce the need for staff wanting or needing to relocate and from having to leave their role.

We have a Recruitment & Retention Premia (RRP) in place which provides the mechanism to apply additional RRP payments (on both a short- or long-term basis) where there is a robust case and sufficient evidence exists to support this. This policy will be considered in areas where retention rates are of significant concern.

We will continue to develop and promote career development opportunities and pathways so that we can provide opportunities for people to progress to higher banded roles.

11.8 **The data highlights ongoing significant gaps in our knowledge and intelligence where there is no recorded reason for leaving,**

Next steps: A new leaver process was launched in 2023 which has resulted in a small improvement in this situation. However, to ensure we are maximizing its impact, we will continue to monitor the response rates on a regular basis and will review the way we promote its completion to make it as easy and accessible as possible.

11.9 Additionally there are a range of retention initiatives underway and in development as detailed in Table 6.

12. Recommendation

12.1 That the Committee discuss and note this report.

Table 1: Leavers by age

Age	Leavers	% of Leavers	% of workforce
<20 Years	5	4%	1%
21-25	11	8%	7%
26-30	7	5%	13%
31-35	13	10%	15%
36-40	13	10%	13%
41-45	8	6%	11%
46-50	8	6%	10%
51-55	10	7%	11%
56-60	27	20%	10%
61-65	19	14%	6%
66-70	11	8%	2%
>71 Years	2	1%	1%
Total	134	100%	100%

Table 2: Leavers by ethnicity

Ethnicity	Leavers	% of Leavers	% of Workforce
White	111	83%	76%
Other	20	15%	20%
Unspecified	3	2%	4%
Total	**134**	**100%**	**100%**

Table 3a: Leavers by Division & Corporate Functions

Division/Corporate Function	Leavers	% of Leavers
Corporate functions	50	37%
Division A	39	29%
Division B	45	34%
Total	**134**	**100%**

Table 3b: Leavers by Division split into staff group

Staff Group	Division A (Urgent & Integrated Care)	Division B (Family & Surgical)
Add Prof Scientific and Technic	1	0
Additional Clinical Services	13	13
Administrative and Clerical	8	12
Allied Health Professionals	2	4
Healthcare Scientists	3	0
Medical and Dental	3	4
Nursing and Midwifery Registered	9	12
Total	**39**	**45**

Table 4: Whole Trust Leavers by Staff Group

Staff Group	Leavers	Change since previous 6 month period	% of Leavers	% of workforce
Add Prof Scientific and Technic	1	↓ 4	1%	2%
Additional Clinical Services	26	No change	19%	20%
Administrative and Clerical	57	↑ 18	43%	21%
Allied Health Professionals	6	↓ 4	4%	7%
Estates and Ancillary	11	↓ 4	8%	6%
Healthcare Scientists	3	↑ 2	2%	2%
Medical and Dental	7	↓9	5%	12%
Nursing and Midwifery Registered	23	↓ 17	17%	28%
Students	0	↓1	0%	2%
Total	**134**	**↓ 19**	**100%**	**100%**

Reduction	
No change	
Increase	

Table 5: Leavers by Length of Service with Trust

Length of Service	Leavers	% of total Leavers	Change since previous 6 months
Within 12 months	38	28%	Up by 4%
13 - 23 months	14	10%	Down by 4%
2+ years	82	61%	Down by 1%
Total	**134**	**100%**	

Reduction	
No change	
Increase	

Table 6: Movement in reason for leaving

Reason for leaving	Leavers	% of Leavers	Comparison to previous 6 months
Retirement (including 22 retire & return)	40	30%	Up by 6%
VR - Adult Dependants	2	1%	No change
VR - Better Reward Package	4	3%	Up by 1%
VR - Child Dependants	1	1%	No change
VR - Health	9	7%	Up by 2%
VR - Working Relationships	3	2%	Up by 1%
VR - Lack of Opportunities	1	1%	No change
VR - Other/Not Known	33	25%	Up by 3%
VR - Promotion	8	6%	Up by 1%
VR - Relocation	15	11%	Down by 15%
VR - Further education or training	2	1%	Down by 1%
VR - Travel issues	1	1%	Up by 1%
VR - Work Life Balance	15	11%	Up by 2%
Total	**134**	**100%**	

Reduction	
No change	
Increase	

Chart 1: Reasons for Leaving

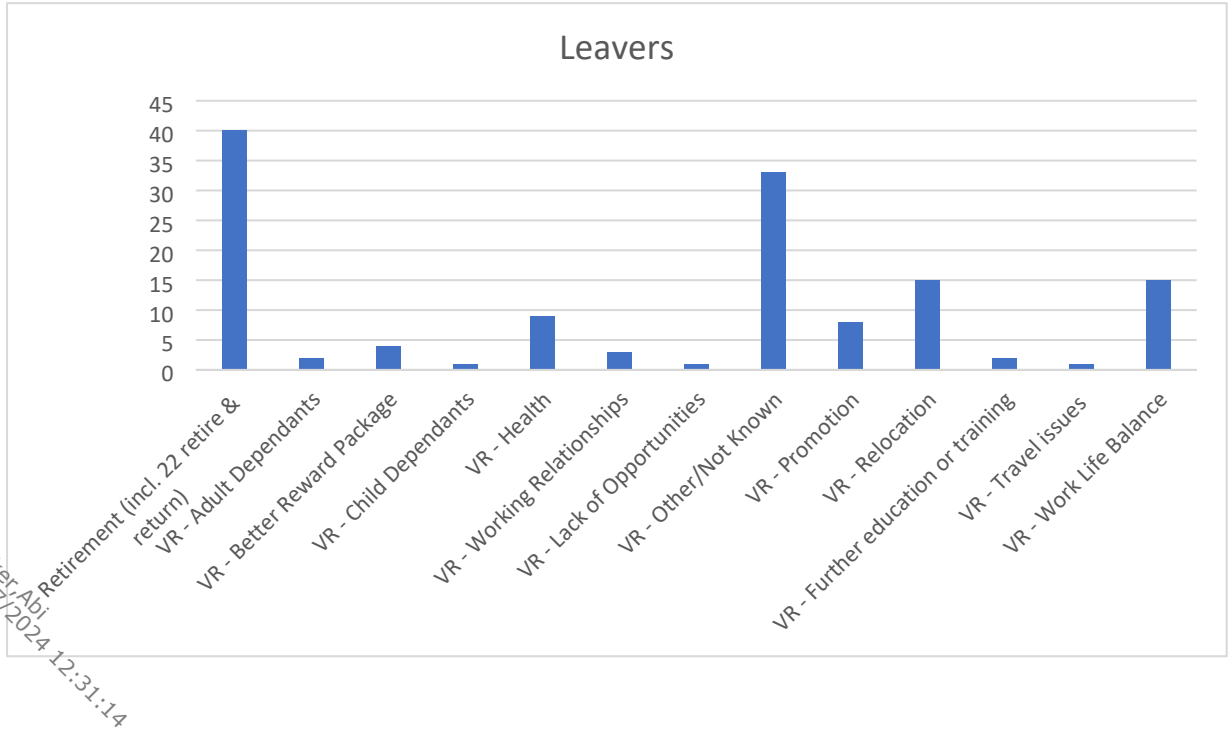


Table 7: Retention Initiatives

Staff Group	Retention Initiatives
All	New initiatives: • People Promise Exemplar Programme In 2022, NHSE launched the People Promise Exemplar programme with the aim of further embedding the People Promise in NHS Trusts. The programme was designed *'to test the assumption that optimum delivery of all NHS People Promise interventions delivered in one place simultaneously can deliver improved staff experience and retention outcomes – beyond the sum of the individual components'.* The results from the first programme cohort of Trusts have been very positive and Dorset County and Dorset HealthCare saw this as an ideal opportunity to further align the strategic workforce objectives across the two Trusts and submitted a joint application. Funding was received for a 12-month contract for a People Promise and Retention Manager and a People Promise Specialist Advisor working across both Trusts. Both roles have been recruited to and commenced from 22nd April 2024, employed by DCH. People Promise self-assessments including a review of the National Staff Survey 2023 results, retention data and stakeholder engagement have been completed to inform the development of the driver diagram for the programme. Projects and actions to be included within the programme include (but are not exhausted to) the creation and embedding of a local induction framework, the implementation and embedding of smarter working (including flexible working), a further data dive to better understand our leavers within the first two years of employment and embedding and promotion of leadership training. Next steps: The People Promise Programme Initiation Document will be presented at Joint Executive Management Team on 18 June 2024 for final approval. Existing/ongoing initiatives: • Recruitment and Retention Premia Policy introduced and being used for some of our hardest to fill roles • Review of our flexible working policy and guidance • Smarter working workstream commenced • Review of Recruitment Policy underway (to include ethnical recruitment guidance) • Review of and promotion of health and wellbeing initiatives

	• Staff Networks & staff engagement plan to promote • Pastoral Support and Practice Education support • Staff recognition and reward schemes • Staff discounts and benefits • Dedicated 'Joining Us from Overseas' page launched (with lots of advice/guidance/useful links etc) • Review of our Visa and Right to Remain arrangements completed • Improving leaver data collection, analysis, and insights • Appointment of substantive midwifery Workforce & Retention Lead. • Employability sessions for the IEN spouses
Nursing	• Stay and Thrive programme • International nurses salary and progression policy reviewed and salary justification complete resulting in fairness and equity of pay • Retention rates for IEN (International Educated Nurses) monitored regular with retention currently at 88.75%. • Project to focus on career conversations and accelerated development for international nurses complete and principles now being rolled out (with appropriate training) to whole nursing workforce • National checklists - Advanced Clinical Practice - readiness and retention framework and checklist will shape development of plans • Review of nursing positions, career pathways and career conversations • Action Learning Sets for IEN set to launched to support Band 6's in post with further rollout following trial • Accommodation policy, subsidy rates and application (under review)
Health Care Support Worker	• Support Worker Network launched • Apprenticeship pathway – direct entry and during employment Registered Nurse and Registered Nursing Associate apprenticeship annual cohorts supported. • Band 2/3 job descriptions updated in line with revised national profiles, assessment undertaking and implementation underway • HCSW celebration day & Care certificate day • Plans for launch of Band 2-4 Development Community working collaboratively across Dorset system. • Career conversations for Support workers to be rolled out.
Allied Health professionals	• Grow our own Apprenticeships in OT, Physio, Dietetics, Radiography, ODP • West Dorset Community of good practice network launched to explore rotation and joint CPD approaches etc • ACP work under nursing also extends to AHP roles • Associate Director Allied Health Professions appointed and commenced in role
Health Care Scientists	• Apprenticeships (Health Care Science Practitioners) and Trainee roles • Improved engagement with Healthcare Lead now in post (and first Healthcare Science Workshop event took place in March 2024)

Admin and Clerical	• Review of trust wide administration and business support requirements (links with digital strategy) to include review of opportunity for direct entry administrative apprenticeship cohorts
APT&S	• Introduction of new Recruitment and Retention Premia payments ad warm welcome schemes where applicable (including Pharmacy & Plaster Technician) • Pharmacy Technician & Pharmacy Services Assistant apprenticeships to build workforce resilience and career development pathways • Flexible working and remote working opportunities explored/ arrangements now implemented (Pharmacy)
Estates and Ancillary	• Creation of supervisor roles to provide career progression • Additional roles and apprenticeships created as part of 23/24 business planning • Recruitment and Retention Premia in place for some roles.
Medical and Dental	• CESR route offered in some specialties and roll out of academy approach planned • Review of system support to support service resilience. • Review of locum rates to support resilience. • Refer a Friend referral Payment (Consultant) • Warm Welcome Payment (Consultant)

Report Front Sheet

1. Report Details			
Meeting Title:	Board of Directors, Part 1		
Date of Meeting:	31 July 2024		
Document Title:	**DCH People Plan – Annual Progress Report**		
Responsible Director:	Nicola Plumb, Joint Chief People Officer	Date of Executive Approval	11 July 2024
Author:	Emma Hallett, Deputy Chief People Officer		
Confidentiality:	N/A		
Publishable under FOI?	Yes		
Predetermined Report Format?	No		

2. Prior Discussion		
Job Title or Meeting Title	**Date**	**Recommendations/Comments**
People and Culture Committee	22/07/2024	Noted

3. Purpose of the Paper	The purpose of the attached presentation is to summarise the progress made against the year two outputs and measures in the DCH People Plan							
	Note (✓)	✓	*Discuss (✓)*	✓	*Recommend (✓)*		*Approve (✓)*	

4. Executive Summary

The DCH People Plan was approved by the Board in April 2022. The three-year plan was designed in collaboration with staff, alongside the clinical plan, via a series of strategy away days. This approach encouraged teams to identify what needed to be different and helped to promote purpose, belonging and control - the heart of wellbeing and creating a great place to work.

The five principles of the DCH People Plan are as follows

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

The presentation summarises the good progress that has been made against all five principles of the People Plan.

There are less outputs and measures within the people plan in year two (23/24) reflecting that many of the workstreams will take the full three years to come to fruition. Most of the year two outputs and measures have been partially met or met, including the reduction in vacancy rate to below 5% and the reduction in time to hire. The turnover target of 7% has not been met, but turnover has reduced significantly and is on a continuing downward trajectory. Likewise with the two measures from the Staff Survey (overall engagement and opportunities to make improvement), although the targets in the People Plan have not yet been

	met, both scores have improved and sit above the average national score. The presentation also summarises the other progress made against the People Plan, including the expansion of the management matters training programme, the introduction of a medical leadership progamme, the implementation of a health and wellbeing triage and TRiM Trauma Response process, the reduction in reliance on agency workers (through recruitment, increasing bank fill rates and implementing reduced framework rates), the achievement of the government target for new apprenticeship for the fifth consecutive year and the delivery of all planned widening participation initiatives, including supported internships, the relaunch of work experience and the HCSW vocational scholarship. The presentation summarises the Y3 People Plan Priorities, many of which are a further expansion of work already underway. The other priorities for 24/25 are also listed, these include attraction, absence management and engagement. There are also several priorities that will be undertaken in collaboration with Dorset Healthcare, including implementation of the Sexual Safety Charter, a review of Local and Corporate Induction, implementation of the joint Equality, Diversity, Inclusion and Belonging strategy and activities identified as part of the joint People Promise exemplar programme. Finally, the presentation covers next steps. The People Plans of both DCH and DHC run until the end of March 2025, providing us with a timely opportunity to develop a joint People Plan, which will be an important enabler for the joint strategic objectives and organisational priorities currently being finalised.
5. Action recommended	The People and Culture Committee is recommended to: 1. **NOTE** and **DISCUSS** the presentation

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		**Yes**		Well Led Domain
Risk Link		**Yes**		Areas of under-performance in relation to the DCH People Plan could affect provision of high-quality patient services and/or to the Trust's financial position.
Impact on Social Value		**Yes**		By providing equality of access to our roles across all demographics and encouraging and enabling younger people to join our workforce
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 overall capacity and performance of the workforce, at all levels of the organisation, impacts significantly on the achievement of Trust strategic objectives.		
	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**		The overall capacity and performance of the workforce, at all levels of the organisation, impacts significantly on the achievement of Trust strategic objectives.
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**	

DCH People Plan

Annual Progress Report

Emma Hallett
Deputy Chief People Officer

- The DCH People Plan was designed in collaboration with staff, alongside the clinical plan, via a series of strategy away days
- This approach encouraged teams to identify what needed to be different and helped to promote purpose, belonging and control - the heart of wellbeing and creating a great place to work
- The DCH People Plan aligns with the previous DCH Trust strategy of People, Place and Partnership and with the NHS People Plan
- The final plan was approved by the Board in **April 2022**

Link to DCH People Plan HERE

Five People Plan Principles

1 We will look after and invest in our staff, developing our workforce to support outstanding care and equity of access and outcomes

2 We will create an environment where everyone feels they belong, they matter, and their voice is heard

3 We will improve safety and quality of care by creating a culture of openness, innovation and learning where staff feel safe themselves

4 We continue to create collaborative and multidisciplinary professional team working to maximise skills, knowledge, and respect

5 Transactional People Processes as a Strategy Enabler

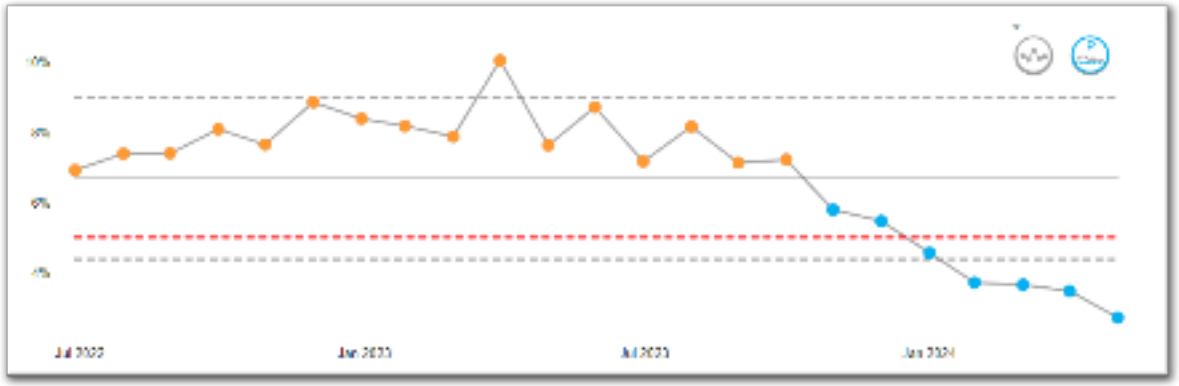
There are less outputs and measures within the people plan in year two, reflecting that many of the workstreams will take the full three years to come to fruition.

Year 2 (23/24) Outputs

Priority	Goal	Output	Outcome
We will look after and invest in our staff, developing our workforce to support outstanding care and equity of access and outcomes	Actively participate in system workforce planning Embed workforce planning by building competence at line management level	Five Year workforce plans to be implemented for all services and staff groups by March 2024	Partially achieved Workforce Planning training now in place. Workforce Planning Template and Intranet page launched. Workforce plans in place for some but not all staff groups – nursing and those with high agency use were prioritised as part of high-cost agency project.
	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	Clear career pathways developed for all professions by March 2024, linking to the apprenticeship strategy where appropriate. Priority focus to be given to AHP and HCA pathways to respond to immediate workforce shortages	Partially Achieved Central recruitment process and scholarship process for HCSWs introduced. 200 HCSWs were recruited, inducted and trained during 2023/24, reducing HCSW vacancies by 65%. AHP apprenticeships introduced. More work to be done on mapping career pathways for non-clinical roles.

Year 2 (23/24) Measures

Reduction in vacancy rate from 6.32% to below 5% by March 2024



Baker,Abi
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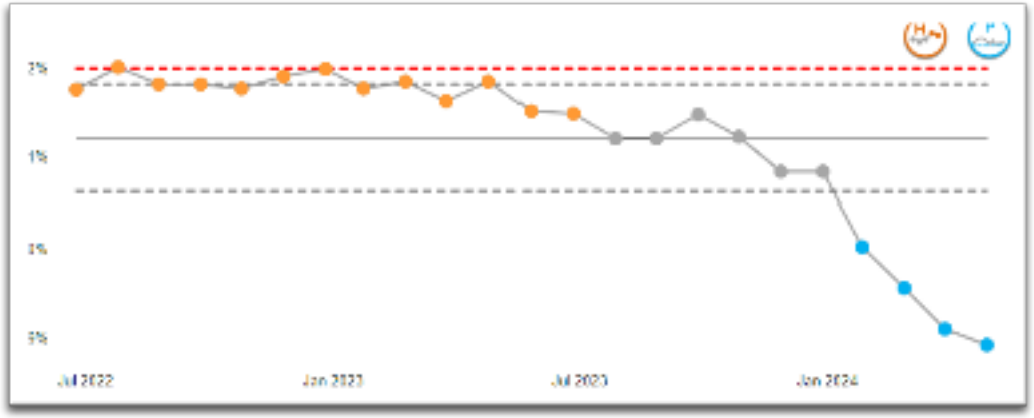
Achieved

The vacancy rate reduced to 3.65% by March, despite being at over 10% in April 2023

Reduction in turnover from 8.7% to 7% by March 2024

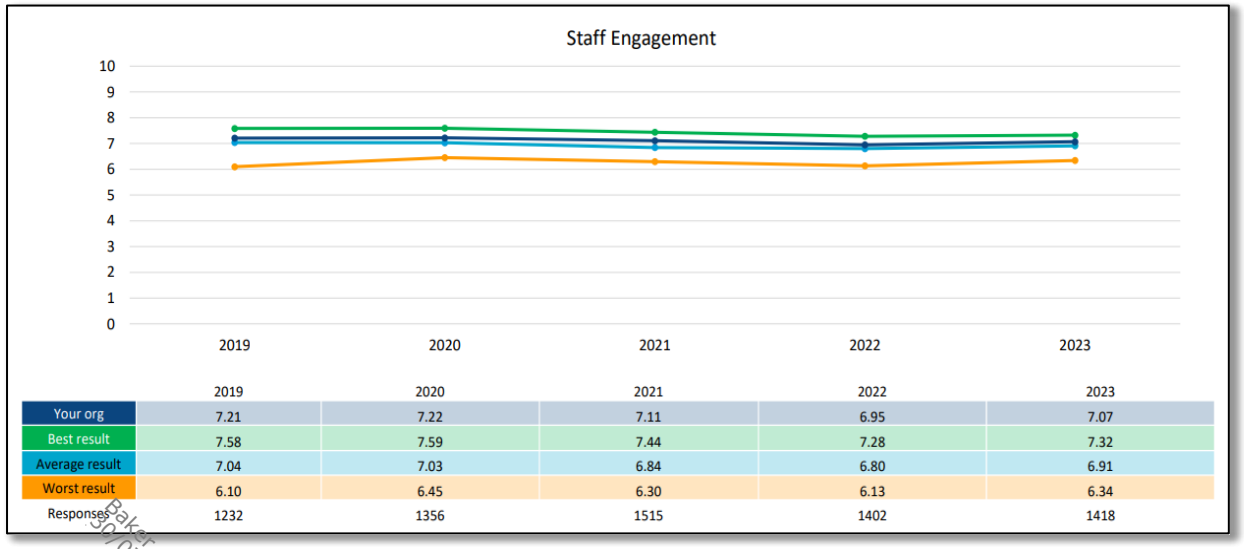


Not Achieved

The turnover rate has reduced from 12% to 8.9% and is following a downward trajectory but the 7% target set in the People Plan has not yet been met.

Year 2 (23/24) Measures

Overall engagement score in National Staff Survey will be 7.3 or above by March 2024



	2019	2020	2021	2022	2023
Your org	7.21	7.22	7.11	6.95	7.07
Best result	7.58	7.59	7.44	7.28	7.32
Average result	7.04	7.03	6.84	6.80	6.91
Worst result	6.10	6.45	6.30	6.13	6.34
Responses	1232	1356	1515	1402	1418

Not Achieved

The engagement score from the 2023 staff survey was 7.07 – but it was the first increase in two years

Improvement in National Staff Survey question relating to making improvements at work from 59% to 64% by March 2024

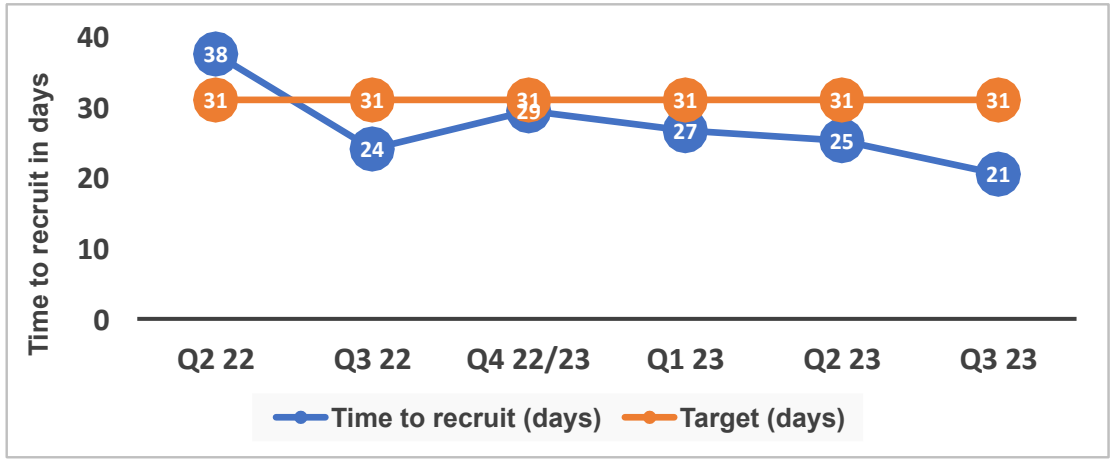
Question	2021	2022	2023	Average
I am able to make improvement happen in my area of work	58.74%	57.99%	60.55%	56.35%

Not Achieved

The score for this question from the 2023 staff survey was 60.55%, an increase of 2.56% and above average.

Year 2 (23/24) Measures

The time to hire (from vacancy to start date) to be reduced by one week for all posts by December 2023



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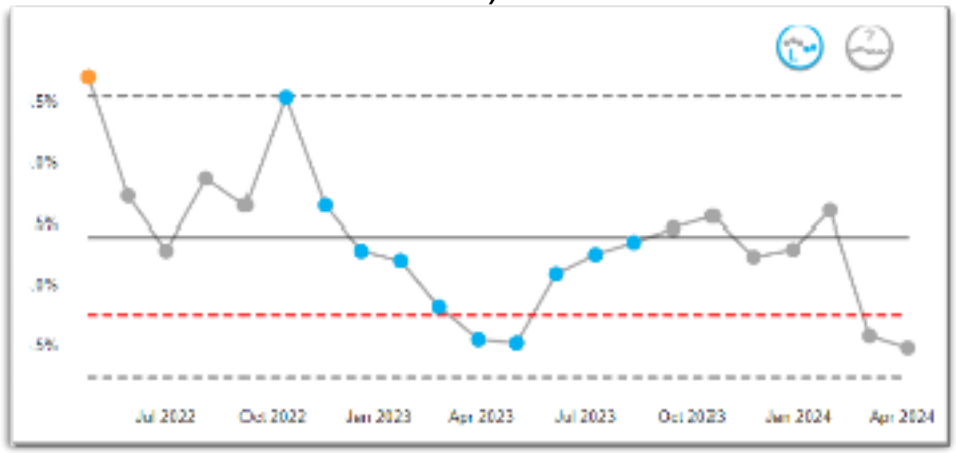
Achieved

The time to hire has reduced from 38 days to 21 days (27 days on average)

Sickness absence reduced from 4.79% to 3.75% by March 2025 (Y3 Measure)



Partially Achieved

The Sickness absence target of 3.75% is being achieved sporadically but the average is currently 4.1%

Other People Plan Progress

- Management Matters Programme – new sessions added this year, including Constructive Conversations, Workforce Planning Essentials, Risk Management, Sickness Absence Management, Bias & Interview Training and Mentoring Skills
- Medical Leadership Programme for Clinical Leads designed and commenced
- Appraisal Policy updated to underpin new and simplified appraisal process
- Implementation of a health and wellbeing triage and TRiM Trauma Response process
- 150 Staff Health and Wellbeing folders distributed to wards and departments across the Trust
- Your Care platform launched on Vivup to provide personal, emotional & financial wellbeing tools
- Health & Wellbeing Coaches pool increased
- Second Reciprocal Mentoring cohort facilitated
- Staff Network development and support increased, including dedicated budgets and new charter
- Conscious Inclusion and Inclusive Leadership modules launched

Other People Plan Progress (Cont)

- NHSE intake target for International Nurses met
- Awarded the NHS National pastoral Care Quality award
- Organised and facilitated a Trust wide Careers Fair in March 2024 – over 200 attendees
- Contributed to the reduction in reliance on agency workers (through recruitment, increasing bank fill rates and implementing reduced framework rates)
- Supported all potential conduct cases through the lens of a just and learning culture
- Revised Exit Interview form/process launched (providing access to richer data)
- Devised and implemented Recruitment and Retention Premia Policy
- BI vacancy & Staff Survey dashboards launched (to add to existing Workforce Summary Dashboard)

Other People Plan Progress (Cont)

- Apprentice government target for new starters met and exceeded for the 5th consecutive year
- All planned Widening participation initiatives for 23-24 delivered (including supported internships, relaunch of work experience, HCSW vocational scholarship)
- Undergraduate placement capacity increased by a further 14%
- Preceptorship interim quality mark award achieved
- Launched revamped support worker induction and development program with positive feedback (more focus on new to care)
- Introduction to medicine program now offered via the Duke of Edinburgh gold award and separate program for local young people interested in careers in medicine free of charge
- Successful implementation of development days for SAS and LED doctors ensuring equitable access to training

Y3 People Plan Priorities

- Further develop management and leadership development offer
- Further develop apprentice and widening access pathways
- Improve leavers data
- Implement of CESR Academy for aspirant Consultants
- Develop five-year workplans for all staff groups
- Implement medical rostering and job planning (MSSP)
- Improve pastoral support for international staff
- Design and implement Coaching and Mentoring strategy

Other Priorities

DCH

- Review internal resources supporting attraction
- Launch refreshed Absence Management Policy
- Design and implement staff engagement strategy

Joint with DHC

- Agency reduction programme
- Embed Sexual Safety Charter
- Review Local and Corporate Induction
- Equality, Diversity Inclusion and Belonging strategy
- People Promise Programme
- Appraisal, Talent management and Succession planning
- Embed the national NHSE educator strategy and Safe Learning Charter
- Increase placement capacity
- Embed workforce planning framework
- Review staff recognition programme
- Automation & AI
- Implement the TED team development tool

What Next?

Both current DCH and DHC People Plans run until end of March 2025

Overall joint strategic objectives and organisational priorities agreed

Work is underway to align the People Functions within the two Trusts

Strategic alignment underway in several areas, including EDIB and Health and Wellbeing

Joint People Plan 2025-2028

Questions?

Working Together

Dorset County Hospital NHS Foundation Trust Dorset HealthCare University NHS Foundation Trust

Working Together Programme

MONTHLY HIGHLIGHT REPORT

DCH Board of Directors, Part II – 31 July 2024
DHC Board of Directors, Part II – 07 August 2024

Author	Ciara Darley
SROs	Dawn Dawson, Nick Johnson

Executive Summary

The Working Together Programme Board (WTPB) receive a monthly highlight report. The July report is attached for information.

Key updates from the Programme include:

Working Together, Improving Lives – DCH and DHC Joint Strategy

Members of the Working Together Programme Board received a copy of the full strategy document, an outline of the development process and draft implementation plan. The Strategy was approved for onward circulation to the Boards of Directors on the 31st July and 7th August.

Joint Board Assurance Framework

The Programme Board received the Outline Board Assurance Framework for information. It has been developed alongside the Joint Strategy in the aim to avoid any unnecessary delays and outlines the process in supporting two Trusts in their strategic risk management.

Flagship Programmes

The three Flagship programmes have continued to move forwards:

Frailty

The frailty flagship is now able to evidence progress against key metrics. Most recently this includes:

- The project is currently ahead of target for unplanned admissions
- The reduction in June admissions represents a positive potential cost avoidance, recognising that there is further work required to release these costs and realise the benefit
- More alternatives to unplanned care than predicted have been also been recorded

Diabetes

Progress commences to developing the mobilisation plan for year 1, including: complex discharge pathway, targeted neighbourhood Health & Care Professionals (H&CP) support,

population health oversight and management advice, mental health H&CP Education Programme.

Children and Young People

The Gateway 3 Outline Business Case is complete and has been approved by the Working Together Programme Board. Four opportunities are currently being explored: Introduction of youth workers in ED, introduction of 'people with lived experience' to support children and young people experiencing mental health issues, and high-quality mental health training. In addition, the flagship is reviewing the 15 step challenge completed in ED.

Case Studies

Further to the 10 completed case studies currently available to colleagues within both trusts, a further two are in development:

- Weymouth Theatres – theatre handed over on 3 July, anticipated that first test lists will run in August with full roll out from September 2024
- New to Type 2 Diabetes Education – Ensuring that everyone with newly diagnosed or existing type 2 diabetes gets the same access to six hours of 'new to type two' and three hours of 'ReFocus' education.

Risk Register has been refreshed. Two risks remain to be high (rated 16).

- Risk 22: If there is insufficient workforce available to achieve the service redesign, then the ability to deliver service redesign will impacted, so the associated programme benefits will not be realised.
- Risk 14: Integration of clinical systems across the two organisations is a key enabler for a number of strategic objectives. There is a risk this cannot be achieved given IG, commercial and technical capacity.

Recommendation	The Board of Directors is invited to: 1. **Note** the highlight report

Working Together

Dorset County Hospital NHS Foundation Trust

Dorset HealthCare University NHS Foundation Trust

NHS

Working Together Programme Monthly Highlight Report – July 2024

Executive SROs	Dawn Dawson, Joint Chief Nursing Officer and Nick Johnson, Joint Chief Strategy, Transformation and Partnerships Director
Author	Ciara Darley, Senior Programme Manager
Executive Summary: This report highlights continued progress since the last reporting period.	

1. Progress since the last report	Attachments
1.1 General • **Joint Strategy Development** The Joint Strategy is due for circulation to the DCH Board on 31 July, and the DHC Board on the 7 August 2024. In the lead up to these dates, further engagement has been completed, with refinement of the vision and mission, objectives with outcomes and proposed measures and a clearer description of the delivery mechanisms. The refined strategy has a stronger emphasis on addressing inequalities, the need for a culture of continuous improvement, working in partnerships, and the service user and colleague voice. The completed draft document has been shared with members of the Working Together Programme Board for approval, ahead of circulation to the DCH Board of Directors in July, and DHC Board of Directors in August. Following approval of the strategy, emphasis will shift to launching the document and further implementation planning and mobilisation. • **Joint Board Assurance Framework** Development of the Joint Board Assurance Framework commenced in March 2024, alongside the development of the Joint Strategy, to avoid any unnecessary delays. The intention is that there will be a single set of joint strategic risks, but separate Board Assurance Frameworks for each trust as the score, controls, assurance and actions may be different across the two Trusts. Once the Joint Strategy and joint strategic risks have been approved by each Board, the full Board Assurance Framework will be developed and populated.	Enc E

1.2 Flagships

- **Frailty**
  - The primary aim is to reduce avoidable admissions for people over 70 who are living with frailty and identified as being at high risk of admission through the design of a streamlined, consistent and coherent system that reduces duplication, complexity and unwarranted variation in intermediate care pathways.
  - Progress this period includes engagement with Strategic Development and Operational Implementation Working Groups, including ICB and Social Care. Additionally, development of the approach to benefits realisation, and Frailty SystmOne virtual ward user engagement and design of process underway.
  - Progress on key metrics:
    - The project is currently ahead of target for unplanned admissions, with a reduction of 486 unplanned attendances
    - The reduction in June admissions represents a potential cost avoidance, recognising that there is further work required to release these costs and realise the benefit
    - More alternatives to unplanned care than predicted have been also been recorded

Enc B

- **Diabetes**
  - The ambition for the diabetes flagship is to support people to live well with diabetes, by building knowledge, skills and confidence
  - Progress commences to developing the mobilisation plan for year 1, including: complex discharge pathway, targeted neighbourhood Health & Care Professionals (H&CP) support, population health oversight and management advice, mental health H&CP Education Programme.
  - In addition, development of benefits realisation and impact plans, and a detailed workforce plan.

- **Parity of Esteem C&YP**
  - The ambition is to support children and young people with social, emotional and mental health needs who present with complex issues, including challenging behaviours, disordered eating/eating disorders, neurodivergence or learning disabilities needs in acute settings, by reducing unwarranted variation through creating a high quality clinical integrated pathway to care. This approach will provide a skilled multi-agency triage in ED (at the front door) that determines the right intervention to support the needs of that young person and their families
  - The Gateway 3 Outline Business Case complete and approved by the Working Together Programme Board. Four opportunities are currently being explored:
    - Introduction of Youth Workers in DCH ED
    - introduction of People with Lived Experience to support Children and Young People experiencing mental health issues
    - introduction of Family Ambassadors to support families of children and young people experiencing mental health issues
    - High-quality mental health training
  - In addition, the flagship is reviewing the ’15 step challenge’ completed in ED

1.3 Case Studies

- Ten case studies are available on the Trust's intranet sites
- Weymouth Theatres – handover to DCH complete 03 July. All IT has been ordered. Require approximately 4 weeks to organise staffing/insourcing for proposed lists. Planning for a light touch launch in August, to be fully running in September.
- New to Type 2- Diabetes Joint Educational offer – draft Case Study document and slides complete – awaiting confirmation from leads. The collaborative work is in line with NICE Guidance, highlighting the need for good education at diagnosis. The teams ensure that everyone with newly diagnosed or existing type 2 diabetes gets the same access to six hours of 'new to type two' and three hours of 'ReFocus' education.

1.4 Enablers' update since the last report

- **Comms and Engagement**
  - Progress in this period focusses on continued support to key areas of working together, including developing and editing the Trust Strategy, and communications and engagement plan ahead of submission for Board Approval.
  - Question and Answers regarding the federated model have also been added to both intranet sites
  - Work has initiated to develop a shared corporate branding

- **Workforce & Culture**

  Workstream 1 - Create a climate of collaboration to support delivery of the clinical strategy:
  - Joint strategy engagement events continued during June.
  - Joint Board Development Programme agreed.
  - Planning underway for fourth Joint SLG development session (18th July).

  Workstream 2 – Maximise Efficiency through Collaborative People Services
  - Joint Equity, Diversion, Inclusion and Belonging strategy drafted and being socialised within organisations prior to submission to Boards in July/August.
  - People Promise Exemplar Programme priorities signed off by joint EMT.
  - First joint employment policy (Flexible Retirement) drafted. Work started on the joint Organisational Change policy.
  - Individual meetings held by Chief People Officer with Senior People Team re future joint People Services model.
  - Series of meetings held with Joint Senior People and Culture leads – road map for closer joint working introduced.
  - First joint Staff Side Chair meeting set up.

- **Digital**
  - As previously reported, the digital focus continues to be on the Electronic Health Record (EHR) OBC. Development has now been completed, and submitted to SW Region before national and Treasury approval.

- A timeline for DCH/DHC Microsoft Teams collaboration has been provided to the Programme Board in June, achievement of phase one is due in September 2024.
- Steps are being taken to foster closer working across DCH and DHC digital teams and to explore opportunities for collaboration with key areas including common systems integration solution and joint procurement opportunities on Risk Management (Ulysses) system and Service Desk platform.
- Development of a joint Digital Strategy (includes Data Strategy) will begin in June with a planning phase initially around stakeholder engagement, understanding joint corporate strategic objectives, and alignment with ICB Data and Technology Strategy (due Oct/Nov). Aim is to bring to Boards & Committees in February/March 2025.

- **Governance**
  - Proposal for Committees in Common developed, setting out timeline over 2024/25, roll out anticipated from September 2024.
  - Exercise to ensure that meeting calendars and cycle of business for 2024/25 are streamlined to ensure effective board to ward governance is ongoing.
- **Finance and Estates**
  - Key leads have been identified for each area.
  - Directorate working towards 3-5 year priorities

2. Roadmap	Attachments
• The roadmap as at July 2024 is attached	Att. 1

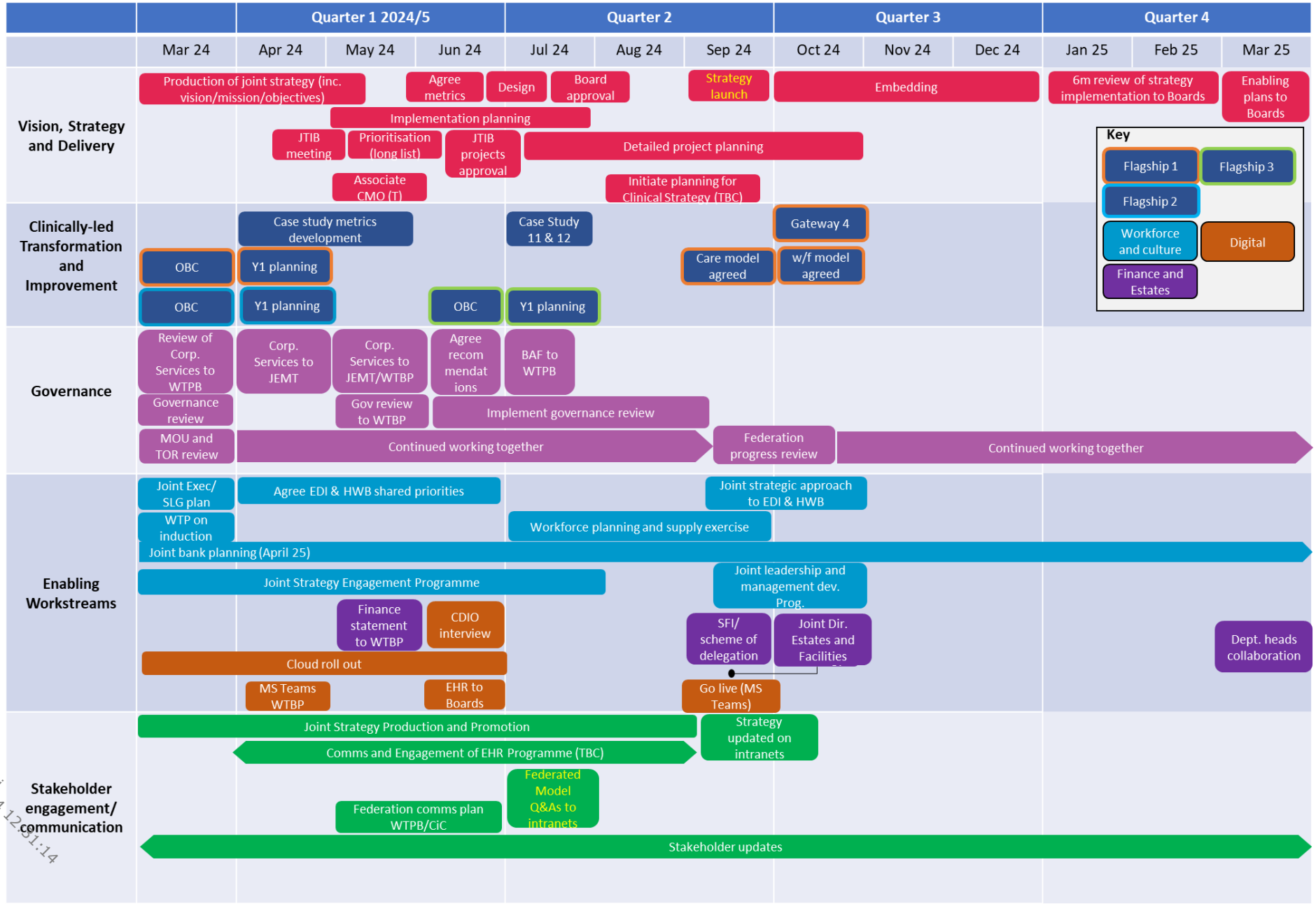
3. Key Milestones for this and the forthcoming period	Target Date	Status	Estimated completion	Planned actions next period
• **Joint Strategy to trust Boards for approval**	July/Aug 2024		Jul/Aug 2024	Delayed due to election. To go to Boards in July and August 2024
• **New to Type 2 – Diabetes Educational offer Case Study**	June 2024		July 2024	Complete, awaiting confirmation from leads.
• **Federation Progress Report**	September 2024		September 2024	
• **Initiate roll-out of new Committees in Common**	September 2024		September 2024	

4. Risk Register	Attachments

• The risk register is attached. There are currently two high risks (as below). Work is ongoing with Risk Leads to ensure proper referencing to the Corporate Risk Registers.
  • Risk 22: If there is insufficient workforce available to achieve the service redesign, then the ability to deliver service redesign will impacted, so the associated programme benefits will not be realised (16).
  • Risk 14: Integration of clinical systems across the two organisations is a key enabler for a number of strategic objectives. There is a risk this cannot be achieved given IG, commercial and technical capacity (16).
	Enc D2

5. Key topics for approval/discussion at this month's WTPB		**Decision required**	**Attachments**
•	Note the report	N	
•	Approve the Joint Strategy Document	Y	Enc E
•	Outline Board Assurance Framework	N	Enc F

Working Together Roadmap July 2024



10 July 2024

Report Front Sheet

1. Report Details			
Meeting Title:	Board of Directors, Part 1		
Date of Meeting:	31 July 2024		
Document Title:	DCH SubCo Q4 Performance Report		
Responsible Director:	Nick Johnson, Chief Strategy, Transformation and Partnership Officer, and DCH SubCo Director	Date of Executive Approval	Report approved by DCH SubCo Board 12/06/2024
Author:	Andy Harris, Superintendent Pharmacist		
Confidentiality:	No		
Publishable under FOI?	Yes		
Predetermined Report Format?	No		

2. Prior Discussion		
Job Title or Meeting Title	**Date**	**Recommendations/Comments**
DCH SubCo Board Meeting	12/06/2024	Noted
Finance and Performance Committee	22/07/2024	Noted

3. Purpose of the Paper	Quarterly performance report from the Trust's subsidiary company – DCH SubCo Ltd.							
	Note (✓)	✓	Discuss (✓)		Recommend (✓)		Approve (✓)	

4. Key Issues

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.

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.
5. Action recommended	The Board is recommended to: 1. **NOTE** the report

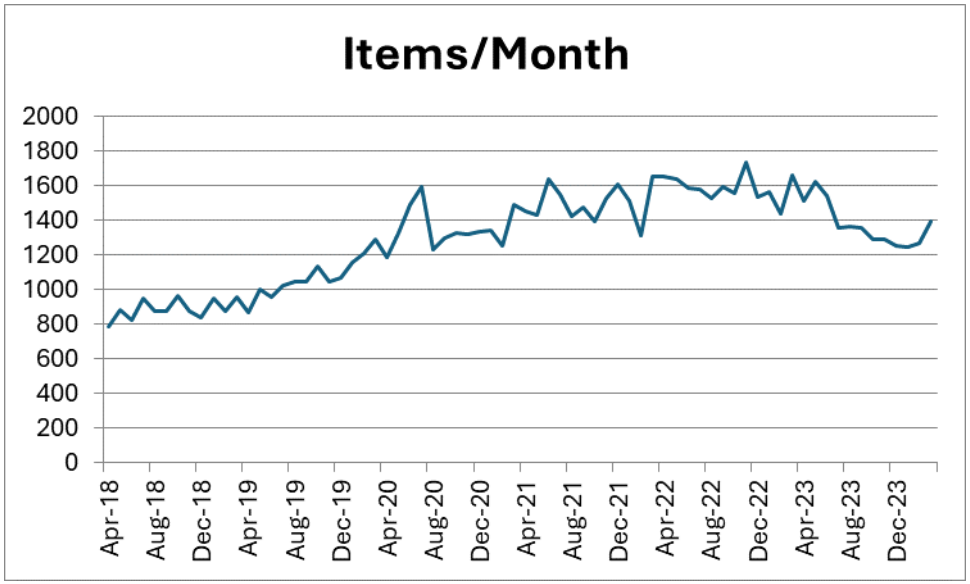
Performance Report

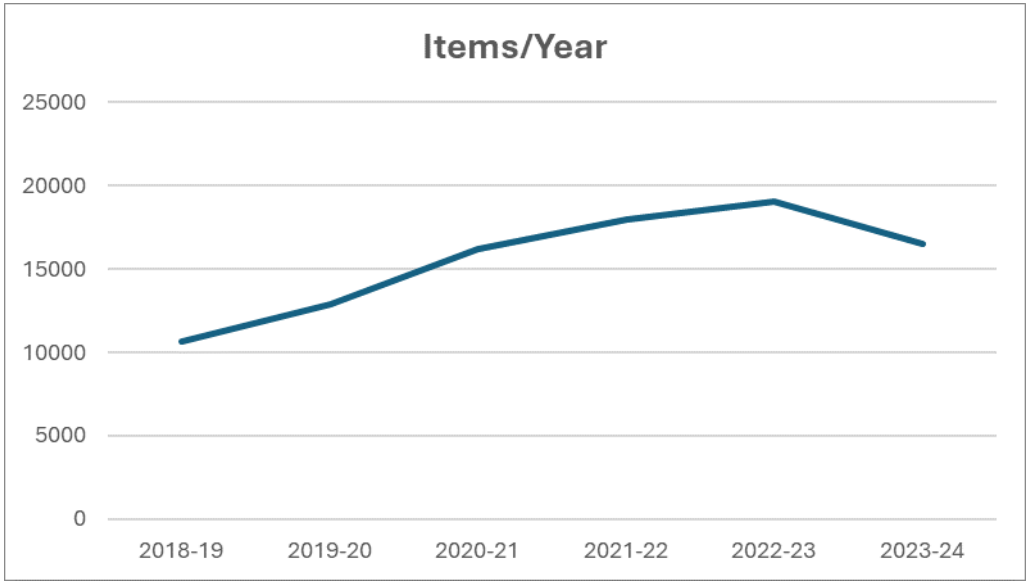
Andrew Harris
Superintendent Pharmacist
Apr 2024

Key Performance Indicators (KPIs)

	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
Total Number of Customers per Month	205	215	196	143	135	116	126	138	133	131	137	139
Total Items Dispensed	1510	1621	1545	1354	1367	1355	1292	1290	1256	1247	1272	1397
Average Items/day	83.9	81.1	70.2	64.5	62.1	64.5	58.7	58.6	66.1	56.7	60.6	69.9
No. of same day Prescriptions	291	342	333	181	273	179	158	210	196	217	172	239
No. of Advance Prescriptions	469	521	463	492	383	466	516	434	429	451	410	432

Activity levels from April 2018 to current:





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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	Jan-24	Feb-24	Mar-24
Rate of dispensing errors detected post issue	Number of errors made per total volume of prescriptions dispensed that have LEFT the department	<2.0%	<1.0%	1.0-2.0%	>2.0 %	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Near Miss Monitoring	Number of errors made per total volume of prescriptions dispensed that have NOT LEFT the department	<2.0%				0.91%	0.92%	0.88%	0.85%	0.82%	0.76%	0.71%	0.86%	0.91%	1.02%	0.77%	0.96%
Availability of service	Responsible Pharmacist Availability	0	0 to 45 mins	45 to 90 mins	> 90 mins	0	0	0	150 mins	15 mins	0	0	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 %	99.52 %	99.69 %	99.57 %
MHRA Recall Assurance	100% of all SABs alerts, MHRA and Company-Led recalls are managed in accordance	100%				100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%

	with Class status																
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%	90.3%	91.0%	91.2%
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%	(i) 93.9% (ii) 86.4%	(i) 100% (ii) 94.2%	(i) 99.3% (ii) 95.9%
Index of customer satisfaction	The patient overall satisfaction level		100% of Customers to be offered Customer Feedback Survey Monthly Reporting on KPIs to record; Total Number of Customers per Month Completion / Uptake Rate (%)			100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Number of complaints	The number of upheld complaints		1 or fewer complaints per quarter	2 or fewer complaints per	Over 2 complaints	0	0	0	0	0	0	0	0	0	0	0	0

				quarter	per quarter												
Number of non-agreed non-formulary items supplied	Number of items that appear on total non-formulary supply report	0%	0% - 0.049%	0.05% - 0.099%	> 0.1%	0	0	0	0	0	0	0	0	0	0	0	0
Controlled drug management	Correct procedure against SOPs followed at all times	100%	No Tolerance			100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Provision of financial, clinical and management information	financial, clinical and management information to be provided within 5 working days following the end of the previous month	100%	100% - 99%	98.9% - 97.5%	< 97.5 %	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Waste/Expiry management *	Waste Costs below £200 per month - Stock waste to be managed	<£200	<£200			£14.84	£0.01	£0.00	£18.29	£0.00	£0.00	£0.00	£35.45	£0.14	£0.00	£0.00	£27.96

	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
Month End Stock Value £k (i/c VAT)	299	264	286	234	217	336	234	221	294	249	265	279

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.

Minutes of the meeting of the Part 1 Public ICB (ICB) Board of NHS Dorset
Thursday 16 May 2024 at 10am
Phoebe Room at BCP Council, Civic Centre, Bourne Avenue, Bournemouth, BH2 6DY and via MS Teams

Members Present:		
	Jenni Douglas-Todd (JDT)	ICB Chair
	Rhiannon Beaumont-Wood (RBW)	ICB Non-Executive Member
	John Beswick (JB)	ICB Non-Executive Member
	Cllr Nick Ireland (NI) (part)	Leader Dorset Council
	Siobhan Harrington (SH)	Chief Executive University Hospitals Dorset NHS Foundation Trust and ICB NHS Provider Trust Partner Member
	Leesa Harwood (LH)	ICB Non-Executive Member
	Jillian Kay (JK)	Corporate Director for Wellbeing, BCP Council
	Patricia Miller (PM) (part) (virtual)	ICB Chief Executive
	Rob Morgan (RM)	ICB Chief Finance Officer
	Debbie Simmons (DSi)	ICB Chief Nursing Officer
	Kay Taylor (KT)	ICB Non-Executive Member
	Forbes Watson (FW) (part) (virtual)	GP Alliance Chair, Primary Care Partner Member
	Dan Worsley (DW)	ICB Non-Executive Member
Invited Participants Present:		
	Neil Bacon (NB)	ICB Chief Strategy and Transformation Officer
	Louise Bate (LBa) (virtual) (part)	Manager, Dorset Healthwatch
	Zoe Bradley (ZB)	Interim Chair, Dorset VCSE Board
	Cecilia Bufton (CB) (virtual) (part)	Integrated Care Partnership Chair
	David Freeman (DF)	ICB Chief Commissioning Officer
	Dawn Harvey (DH)	ICB Chief People Officer
	Matt Prosser (MP)	Chief Executive, Dorset Council
	Ben Sharland (BS) (virtual) (part)	GP Alliance Deputy Chair
	Stephen Slough (SS)	ICB Chief Digital Information Officer
	Dean Spencer (DSp) (part)	ICB Chief Operating Officer
In attendance:		
	Tina Arnold (TA) (item ICBB24/076)	ICB Infection, Prevention and Control Lead
	Liz Beardsall (LBe)	ICB Head of Corporate Governance
	Anita Counsell (AC) (item ICBB24/084) (virtual)	ICB Deputy Director of Health Inequalities
	Jane Ellis (JE)	ICB Chief of Staff
	Vanessa Howard (VH) (item ICBB24/076)	Care Home Manager
	Fran Pingarelli (FP) (item ICBB24/084 and 085)	ICB Head of Organisational Development
	Tina Ricketts (TR) (item ICBB24/085) (virtual)	Chief People Officer, UHD
	Louise Trent (LT) (minutes)	ICB Governance Support Officer
Public:		
	One member of the public was present in the room. The meeting was also available via livestream.	

Apologies:		
	Jim Andrews (JA)	Chief Operating Officer, Bournemouth University
	Matthew Bryant (MB)	Joint Chief Executive Dorset County Hospital and Dorset HealthCare NHS Foundation Trusts and ICB Board NHS Provider Trust Partner Member (member)
	Sam Crowe (SC)	Director of Public Health for Dorset and Bournemouth, Christchurch and Poole (BCP) Councils (participant)
	Paul Johnson (PJ)	ICB Chief Medical Officer (member)
	Rachel Pearce (RP)	Director of Commissioning for NHS England South (attendee)
	Jon Sloper (JS)	Interim Programme Director, VCS Assembly (participant)

ICBB24/072 Welcome, apologies and quorum

The Chair declared the meeting open and quorate and welcomed meeting presenters. There were apologies from Matthew Bryant, Sam Crowe, Paul Johnson, Rachel Pearce and Jon Sloper. The Chief Executive Officer's return was welcomed.

ICBB24/073 Conflicts of Interest

In relation to the mention of the Cass Review in the CEO's Report to the ICB Board, John Beswick flagged his role as Chief Finance Officer at Great Ormand Street Hospital which was the location of one of the two new services set up following the closure of the Gender Identity Development Service at the Tavistock and Portman NHS Foundation Trust in March 2024. There was no conflict with the item to be discussed at the ICB Board and therefore no action was required.

ICBB24/074 Minutes of the Part One Meeting held on 7 March 2024

The minutes of the Part One meeting held on 7 March 2024 were agreed as a true and accurate record.

Resolved: the minutes of the meeting held on 7 March 2024 were approved.

ICBB24/075 Action Log

The action log was considered, and approval was given for the removal of completed items.

Resolved: the action log was received, updates noted, and approval was given for the removal of completed actions.

<u>Standing Items</u>

ICBB24/076 Board Story: Hydration

The ICB Chief Nursing Officer, supported by the ICB Infection, Prevention and Control Lead and the Care Home Manager introduced the Board Story on Hydration.

F Watson joined the meeting.

The Board Story set out the elements of the Hydration programme and its benefits. Key points included:

- A hydration programme pilot had been undertaken in three care homes and a number of elderly care wards in University Hospitals Dorset (UHD). This had been effective with a further pilot which extended to additional care homes, added wards at UHD and to wards at DCH and Salisbury. The programme had also been discussed with the mid-Dorset Primary Care Network (PCN) for the potential offer within primary care.
- Care homes had introduced different initiatives for resident engagement which included provision of a wide variety of hot and cold drinks, fresh fruit and jellies and activities such as assisting with the creation of fruit kebabs and smoothies.
- Evidenced benefits included a reduction in Urinary Tract Infections (UTIs) and falls, residents appearing healthier and happier, improvement in sleeping patterns and increased engagement with staff and other residents.
- Wider benefits included staff recognition of and improvement with their own hydration needs.
- The programme development had included system-wide representation and engagement with patients, residents, and staff.

The Board congratulated the team on the programme, which had demonstrated significant benefits, and discussed the next steps for further rollout and considered ways to embed this across the system with a broader campaign in the community to support the prevention agenda. Work underway included digital promotion in GP practice waiting rooms and utilisation of pharmacies in communities. The opportunity to connect with the voluntary sector to progress wider was recognised.

Resolved: the Board noted the Hydration Board Story.

Tina Arnold and Vanessa Howard left the meeting.

ICBB24/077 Board Assurance Framework

The ICB Chief Strategy and Transformation Officer introduced the Board Assurance Framework (BAF).

The Board recognised that the Board Assurance Framework had evolved through a process which included workshops and full discussions at the Risk and Audit Committee with focus on risk appetite and key controls.

Reflections on the current iteration included the requirement to review the connectivity between risk levels and the mitigating actions, clarity between the Corporate Risk Register and the Board Assurance Framework and the need for key controls needed to be stronger and better articulated. The number of high rated risks had been discussed at the Strategic Objectives Committee and this was subject to review.

It was noted that the Corporate Risk Register had evolved over time and it would be beneficial to progress the BAF in the same way with further development as required.

Resolved: the Board noted the Board Assurance Framework.

ICBB24/078 Chief Executive Officer's Report

The ICB Deputy Chief Executive Officer (CEO) introduced the CEO's Report.

Key messages from the report included:

- The Cass review final report had been published in April, which included the ambition for regional centres to work at scale and provide support and access into local services, with two established at this stage.
- Both the Health Inequalities in 2040 report and the tobacco and vapes bill had been recognised as important developments which would require cross system action to address.
- The GP contract 1.9% uplift offer had resulted in dispute with NHSE following referendum of British Medical Association (BMA) members and conversations continued at national level. Local work to support GP resilience continued.
- The Dorset Council Special Educational Needs and Disabilities (SEND) inspection outcome was welcomed. Work continued with BCP SEND recovery and an increase in access and reductions in waiting times had been seen.
- The 2024/25 Operational Planning and recovery work continued and the work from system leaders and teams was recognised.
- The NHSE Chief Delivery Officer and National Director of Integration had visited NHS Dorset with positive feedback received alongside recognition of forthcoming potential challenges.

The Board recognised the work of the Chief Commissioning Officer during the recent duration as Acting Chief Executive Officer. This had been a challenged time and his leadership of the team and partnership working to progress the Operating Plan alongside providing assurance to NHSE was acknowledged.

With regard to priorities and risks, it was clarified that GP sustainability was reflected in the priorities as a key area for Integrated Neighbourhood Teams however the narrative could be strengthened to reflect. The Prevention, Equity and Outcomes Committee had requested that a risk for GP sustainability be included on the Corporate Risk Register.

The Full Business Case for the UHD New Hospitals Programme had received a letter of approval and the Board acknowledged the work undertaken to achieve the position.

L Bate left the meeting.

The Board discussed the approach to public communication for positive news stories. It was confirmed that weekly meetings were undertaken with the Deputy Director of Communications and Engagement and plans included the potential for creation of a brochure setting out key developments. The assessment of key messages, format and accessible language was being considered.

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

ICBB24/079 Quality Report

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

- The Child and Adolescent Mental Health Service (CAMHS) continued to be challenged on waiting list access to Tier 4 services. This remained a national issue and a revised tier 4 specification was awaited from NHSE.

- A deep dive in relation to follow up waiting lists had been undertaken by the System Quality Group (SQG).
- A No Criteria To Reside (NCTR) deep dive had also been undertaken with progress seen. Patients that remained longer on wards had the potential to deteriorate and work was underway to reduce the risk of harm.

- A System Quality Impact Assessment (SQIA) group had been established with weekly meetings held to review decisions undertaken from a system quality perspective

- The Dorset Council SEND inspection report had been published but had been embargoed during the recent local elections. The outcome had been achievement of level one, the highest level of assurance. The Board recognised and thanked all involved for the contribution from across the system and acknowledged the positive outcome.

- An Integrated Performance Report was being developed which would be available in draft format for the forthcoming ICB committee meetings. Separate reporting would continue alongside until the integrated report provided the appropriate assurance.

The Board noted the ophthalmology risk and the work underway. It was noted that the deep dive work had not been concluded and work continued across the providers to address the waiting lists and mitigate harm.

The Board queried whether the Board received confirmation that the Patient Safety Incident Response Framework (PSIRF) governance was in place across the system to progress this within the required timescales. This was monitored through the system wide safety meetings which reported to the Quality, Experience and Safety Committee (QESG).

Resolved: the Board noted the Quality Report.

ICBB24/080 Dorset ICS Finance Update

The ICB Chief Finance Officer introduced the Dorset Integrated Care System Finance Update covering the financial position for the ICB and the system.

The system had a year-end deficit position at £14.6 million which had been accepted by the NHS England National Team. The forthcoming plan included the ambition for improvement on recurrent areas. The ICB was at £17.4 million deficit which was subject to year-end audit with no issues anticipated.

A more detailed finance update would be provided in Part 2 of the meeting.

Resolved: the Board noted the Dorset ICS Finance Update.

ICBB24/081 System Performance Report

The ICB Chief Operating Officer introduced the System Performance Report.

Key points to note:

- An improvement in performance had been seen during the year with a positive position at year end.
- The Operating Plan had been submitted with achievement of 19 out of 35 standards with improvement seen in a further nine. Deteriorating areas included virtual ward utilisation, and the four-hour standard.
- The month one position showed progress with being on target for long-waiters, category two response times being above standard and an improvement on the No Criteria to Reside trajectory.
- Dementia diagnosis rates would be a recognised challenge with whole pathway review required.
- Virtual wards had seen improvement during April from the March position.

The Board noted the dementia diagnosis rates challenge with how to address going forward for achievement. It was noted that variation had been seen across Primary Care Networks with a deep dive planned to understand the position at a local level and to identify areas of good practice.

Resolved: the Board noted the System Performance Report.

ICBB24/082 Committee Escalation Reports

The Board Committee Chairs presented the committee escalation reports from the January and February meetings. All issues discussed were included in the previously circulated reports. The Chair asked the Board to focus their discussion on the key themes across the meetings to promote a more holistic and strategic discussion on the work of the committees.

Key issues included:

- Integrated Care Partnership – a review had been undertaken which included feedback on positive areas and challenges. The Integrated Care Partnership was becoming more mature and the opportunity to amplify areas of work from the ICB Board, for example, the earlier Hydration programme and the smoking partnership work, by utilising the wider connections across businesses and communities was recognised.

D Spencer left the meeting.

- People, Engagement and Culture Committee – the work plan had been approved with recognition that it would remain a work in progress. Integrated Care System workforce productivity remained an issue and would continue to be scrutinised. A recruitment and retention risk had been raised for inclusion on the Corporate Risk Register.
- Prevention, Equity and Outcomes Committee – received a presentation on the Health Inequalities Annual Report which had produced a good level of discussion. A Health Inequalities dashboard was being progressed. Areas for concern included the requirement for a risk on GP sustainability and the significant issues with dental and oral health access.
- Productivity and Performance Committee – work continued on Personal Health Commissioning (PHC) to gain assurance that work to address the issues was on track.
- Quality, Experience and Safety Committee – discussion had been undertaken on tier 4 CAMHS with a deep dive requested to understand the risks and issues. The SEND improvement plan and the Clinical Plan Implementation Plan had both been discussed in detail.
- Risk and Audit Committee – the full Corporate Risk Register and BAF content had been reviewed and approved. An update on the key management judgements as part of the year end accounts had been received ahead of the June Special meetings to receive the Annual Report and Accounts.
- Strategic Objectives Committee – the draft Digital Strategy had been received and discussed and the work undertaken to achieve this was acknowledged. A risk for the Electronic Health Record (EHR) had been approved in principle for inclusion on the register.

Resolved: the Board noted the Committee Escalation Reports.

Items for Decision

ICBB24/083 ICB People Committee Work Plan

The Chief People Officer introduced the ICB People Committee Work Plan.

The workplan had been refreshed following the People, Engagement and Culture Committee (PECC) development workshop and had been approved at the April PECC meeting. There was recognition that the work plan would continue to evolve in response to the emerging themes. Work connections with other committees had been identified to progress and strengthen focus. Operational Plan targets to strengthen the ICB's regulatory role had been reflected.

Board feedback included:

- Consideration of measurable impact in plans as programmes progressed. It was noted that a workshop had been planned with the team to address this.
- Regular review of the relevant risks from the BAF needed including on the work plan.
- The alteration of the name to PECC following the committee refresh had not been updated on the work plan.
- Consideration of engagement with communities to be reflected in the plan. This had been considered at the workshop and would be included in the papers received by the committee rather than be reported separately. Further consideration of key messages would be beneficial.
- The role for the Voluntary and Community Sector Alliance with community engagement and long-term opportunities was recognised.

The Board approved the work plan subject to the amendments above.

ACTION: LB

Resolved: the Board approved the ICB People Committee Work Plan.

B Sharland and F Watson left the meeting.

Items for Noting/Assurance/Discussion

ICBB24/084 2024-25 Equality Delivery System and Equality Objectives

The ICB Chief People Officer, supported by the ICB Head of Organisational Development and the ICB Deputy Director of Health Inequalities, introduced the previously circulated presentation on the 2024-25 Equality Delivery System and Equality Objectives. The presentation covered the highlights achieved from the NHS Equality Delivery System process, associated work and how this had informed the Equality Objectives, and the plans for the next 12 months.

Key points included what had been achieved so far, including the three deep-dives which had been conducted, the Leading of Equality and Inclusion Programme which was open to staff across the Dorset system, the ICB staff networks, and the action plan which had been developed to address key areas in 2024/25.

C Bufton left the meeting.

The Board requested more ambitious targets in the action plan. The current position and the achievement target appeared to be small increments, especially considering the areas including ethnically diverse staff experiencing bullying. The final outcome should be zero for all staff and robust targets required consideration. It was confirmed that the targets had been set with a 30% reduction however overachievement was anticipated across all areas and the target had the potential to be adjusted following discussions with Staff Networks.

There was a responsibility to the equality legislation across the ICB, NHS and system and future reporting should provide clarity on understanding the gaps and the work being undertaken to address these. There was a requirement at regional level for systems and organisations to align to the south west strategy and the direct correlation had not been reflected. The Board had previously agreed it would adopt a system wide approach to equality, diversity and inclusion, however there was not yet consistency across the system.

The Board noted the national focus on maternity with the level of deprivation for outcomes and experience and requested consideration be given to whether a deep dive into Dorset Maternity Services for national themes in local service provision would be beneficial.

ACTION: DSi

Resolved: the Board noted the report on the 2024-25 Equality Delivery System and Equality Objectives.

ICBB24/085 Integrated Care System NHS Staff Survey Results, Insights and Next Steps

The Chief People Officer, supported by the ICB Head of Organisational Development and the UHD Chief People Officer introduced the report on the Integrated Care System NHS Staff Survey Results, Insights and Next Steps.

A positive response rate had been seen overall and this had been reviewed at the ICB's People, Engagement and Culture Committee (PECC). Areas of least improvement had been equality, diversity and inclusion (EDI) and Freedom to Speak Up (FTSU) and there was recognition that work was required across the system to address these. The ICB and NHS partners undertook quarterly 'Pulse' surveys to provide ongoing regular review throughout the year with 'heatmaps' developed at team levels to identify improvement areas.

The Board discussed the importance of ensuring there was a positive culture and environment to support staff to speak up, the need for local targets for Dorset to sit alongside the national benchmarking, and the work that was underway at the ICB and NHS partners around sexual safety.

The Board recognised the survey results were NHS only with consideration required to understand the EDI agenda as a system. This should be reviewed with the Chief People Officers across the system.

Action: DH

The Board discussed the importance of system executive leadership, including the ICB Board being representative of the population that it served.

Resolved: the Board noted the report on the Integrated Care System NHS Staff Survey Results, Insights and Next Steps.

<u>Items for Consent</u>

ICBB24/086 Emergency Preparedness, Resilience and Response Annual Report

Resolved: the Board noted the Emergency Preparedness, Resilience and Response Annual Report.

ICBB24/087 Questions from the Public

There were no questions received from members of the public.

ICBB24/088 Any Other Business

The Chair thanked the team at Bournemouth, Christchurch and Poole Council for their assistance with hosting the Board in their offices.

The work of the Chief Commissioning Officer during his time as Acting Chief Executive Officer was recognised, and the Board thanked him for his hard work.

ICBB24/089 Key Messages and review of the Part 1 meeting

Following the meeting, the Chair agreed that the key messages from the meeting were that the Board:

- welcomed the Board Story on hydration, especially the outcomes for residents, their families and care home staff. The Board strongly supported the roll-out of the programme more widely, using resources across the system to support this.
- noted the quality and operational performance, and noted the year-end financial position of a £14.6 million deficit. The Board welcomed the areas of significant operational performance and noted the challenges around No Criteria to Reside, the dementia diagnosis rate and virtual wards.
- congratulated Dorset Council and the area team on its positive joint Ofsted and CQC inspection outcome regarding the local arrangements for children and young people with SEND, and welcomed the news of the sign-off of University Hospitals Dorset's New Hospitals Programme full business case.
- thanked primary care colleagues for their ongoing work in improving access, noting the challenges around general practice sustainability and reiterating the ICB's focus on primary care especially through the Integrated Neighbourhood Teams work.
- welcomed the updated on the ICB's Equality Objectives, requesting that the plan for reducing inequality was made even more ambitious and reiterating the ICB's commitment to a system-wide approach to equality, diversity and inclusion.
- celebrated the positive ICS NHS Staff Survey results, but noted the areas of improvement required especially in relation to speaking up, equality, diversity and inclusion, and sexual safety.

ICBB24/090 Date and Time of Next Meeting

The next meeting of the ICB Board would be held on Thursday 11 July 2024 at 10am, in the Boardroom, Vespasian House, Barrack Road, Dorchester, Dorset, DT1 1TS.

ICBB24/091 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:

Baker Abi
30/07/2024 12:31:14