Board of Directors, Part 1 - 09/10/2024

Wed 09 October 2024, 09:00 - 13:40

Trust HQ Boardroom and MS Teams

Agenda

09:00 - 09:25
25 min

1. Patient Story

09:25 - 09:30
5 min

2. Formalities

- 1a DRAFT Agenda BoD Part 1 09 October 2024.pdf (3 pages)
- 1b Draft Minutes BOD Part 1 31 07 2024.pdf (19 pages)
- 1c Action Log BoD PART 1 September 2024 DCS.pdf (2 pages)

09:30 - 09:35
5 min

3. Chair's Comments

09:35 - 09:45
10 min

4. CEO Report

- 4. CEO report OCT DCH.pdf (8 pages)

09:45 - 09:55
10 min

5. Board Assurance Framework and Corporate Risk Register

- 5ai. DCH Board Assurance Framework Board 9 October 24.pdf (6 pages)
- 5aii. BAF DCH Board 9 October 2024.pdf (13 pages)
- 5b. FINAL Corporate Risk Register Sept 2024.pdf (35 pages)

09:55 - 10:05
10 min

6. Strategy Transformation and Partnership Committee Assurance Report

- Escalation Report WTC August 2024.pdf (1 pages)
- STP Committee in Common Assurance Report DCH - DCS.pdf (3 pages)

10:05 - 10:15
10 min

7. Strategy Launch and Implementation

- 6.2 Board JS Launch and Implementation.pdf (6 pages)
- 3b. Appendix 1 - Culture Communications and Engagement Plan.pdf (9 pages)

10:15 - 10:25
10 min

8. One Transformation Approach Progress Update

- 6.3 One Transformation Approach September 24 Update v2.0.pdf (19 pages)

10:25 - 10:35
10 min

9. Our Dorset Provider Collaborative Update

- 6.4. DCH Board ODPC 25th Sept 2024.pdf (10 pages)

10:35 - 10:45
10 min

10. Quality Committee Assurance Report

- Escalation Report QC September 2024 - DD CL.pdf (2 pages)

10:45 - 10:55
10 min

11. Maternity Safety report

- 7.2a. maternity front sheet Aug 2024 Board.pdf (2 pages)
- 7.2b. Maternity Board September 2024_.pdf (22 pages)

10:55 - 11:05
10 min

12. Learning from Deaths Report Q1

- 7.3 Q1 2024 25 Learning from Deaths Report Board.pdf (21 pages)

11:05 - 11:15
10 min

13. National Patient Survey Results

- 7.4a. Front Sheet and Report _NIS REPORT AND ACTION PLAN 20240723.pdf (2 pages)
- 7.4b. NS_INPATIENT_REPORT AND ACTION PLAN_2023.pdf (11 pages)

11:15 - 11:25
10 min

14. Health Inequalities

- 7.5a. Front Sheet and Report Health Inequalities.pdf (2 pages)
- 7.5b DHC-DCH Health Inequalities Workstream Update Paper_DHC Board FNL 240924.pdf (3 pages)

11:25 - 11:40
15 min

Break

11:40 - 11:50
10 min

15. Finance and Performance Committee Assurance Report

- Assurance Report Template - DCH - FPC September 2024 - DU.pdf (2 pages)

11:50 - 12:00
10 min

16. Balanced Scorecard

12:00 - 12:10
10 min

17. Finance Report

- 8.3a. Front Sheet DCH Finance FPC September 2024.pdf (2 pages)
- 11b. DCH Finance Report M5.pdf (15 pages)

12:10 - 12:20
10 min

18. Operational Resilience and Capacity Plan (Winter) 2024/25

- 8.4a. Winter Plan 2024-2025 FPC Front Sheet.pdf (3 pages)
- 8b. Winter Plan 2024-2025 FINAL DRAFT.pdf (31 pages)

12:20 - 12:30
10 min

19. People and Culture Committee

- People and Culture Committee in Common Assurance Report DCH fw.pdf (3 pages)

12:30 - 12:40
10 min

20. Guardian of Safe Working

- 9.2a. GoSW 2425 Q1 Annual Report Front Page.pdf (2 pages)
- 9.2b. GoSW_MAINPAPER 2425 Q1 (002).pdf (6 pages)
- 8c. GoSW_APPENDICES 2425 Q1 (002).pdf (3 pages)

12:40 - 12:50
10 min

21. Workforce Race Equality Standard & Workforce Disability Equality Standard

- 9.3a. WRES Frontsheet 2024 for Board 9 Oct 2024.pdf (2 pages)
- 9.3a. Workforce Race Equality Standard Report 2024 FINAL.pdf (10 pages)
- 9.3b. WDES Frontsheet 2024 for Board 9 Oct 24.pdf (2 pages)
- 9.3b. Workforce Disability Equality Standard Report 2024 FINAL.pdf (13 pages)

12:50 - 13:00
10 min

22. Risk and Audit Committee Assurance Report

- Escalation Report RAC September 2024 SP.pdf (1 pages)

13:00 - 13:10
10 min

23. Risk and Audit Committee Terms of Reference

- 10.2a DHC DCH Audit Committee Terms of Reference Board Oct 24.pdf (2 pages)
- 10.2b. Appendix One DCH Audit Committee TOR Final Oct 24.pdf (7 pages)

13:10 - 13:20
10 min

24. Scheme of Delegation Review and update

- 10.3a. Board 09.10.24 - Scheme of Delegation review and update.doc.pdf (5 pages)
- 10.3b. Appendix 1 - Scheme of Delegation 2024 updates.pdf (1 pages)

13:20 - 13:30
10 min

25. Charitable Funds Committee Assurance Report

- 10.4 DCH Charitable Funds Committee - Escalation Report (18.9.24).pdf (3 pages)

13:30 - 13:35
5 min

26. Consent Section

26.1. ICB Board Report

- 13.1 ICB Board Report to Partners Part One 050924.pdf (2 pages)

26.2. Premises Assurance Model

- 13.2a. PAM September 2024 FPC.pdf (3 pages)
- 9b. PAM FPC appendix 1.pdf (9 pages)

26.3. Emergency Preparedness, Resilience & Response (EPRR) Annual Assurance Report 2024

- 13.3a. Front Sheet - EPRR Core Standards Sep 2024.pdf (2 pages)
- 13.3b. EPRR Core Standards Self-Assessment and Assurance Statement Aug 2024.pdf (84 pages)

13:35 - 13:40 5 min

27. Questions from the Public

13:40 - 13:40 0 min

28. Any other business

Meeting of the Board of Directors (Part 1) of Dorset County Hospital NHS Foundation Trust Wednesday 9th October 2024 at 9.00am to 1.40pm Board Room, Trust Headquarters, Dorset County Hospital, Dorchester and via MS Teams

AGENDA

Ref	Item	Format	Lead	Purpose	Timing
1.	**Patient Story**	Presentation	Dawn Dawson Vikki Tweedy	Information	9.00-9.25
2.	**FORMALITIES** to declare the meeting open.	Verbal	David Clayton-Smith Trust Chair	Information	9.25-9.30
	a) Apologies for Absence: Anita Thomas	Verbal	David Clayton-Smith	Information	
	b) Conflicts of Interests	Verbal	David Clayton-Smith	Information	
	c) Minutes of the Meeting dated 31st July 2024	Enclosure	David Clayton-Smith	Approve	
	d) Matters Arising: Action Log	Enclosure	David Clayton-Smith	Approve	
3.	**Chair's Comments**	Verbal	David Clayton-Smith	Information	9.30-9.35
4.	**CEO Report**	Enclosure	Matthew Bryant	Information	9.35-9.45
5.	**Board Assurance Framework** and **Corporate Risk Register** (September RAC)	Enclosure	Jenny Horrabin Dawn Dawson	Assurance	9.45-9.55
6.	**Strategy, Transformation and Partnership**				
6.1.	**Working Together Programme Committee Assurance Report And Strategy, Transformation and Partnership Committee Assurance Report**	Enclosure	David Clayton-Smith	Assurance	9.55-10.05
6.2.	**Strategy Launch and Implementation** (September SPTC)	Enclosure	Nick Johnson	Assurance	10.05-10.15
6.3.	**One Transformation Approach Progress Update** (September SPTC)	Enclosure	Nick Johnson	Assurance	10.15-10.25
6.4.	**Our Dorset Provider Collaborative Update** (September STPC)	Enclosure	Nick Johnson (Ben Print)	Assurance	10.25-10.35
7.	**Quality**				
7.1.	**Quality Committee Assurance Report**	Enclosure	Claire Lehman	Assurance	10.35-10.45
7.2.	**Maternity Safety Report** (September QC)	Enclosure	Dawn Dawson (Jo Hartley)	Assurance	10.45-10.55

7.3.	**Learning from Deaths Report Q1** (September QC)	Enclosure	Alastair Hutchison (Julie Doherty)	Approval	10.55-11.05
7.4.	**National Patient Survey Results** (July QC)	Enclosure	Dawn Dawson	Assurance	11.05-11.15
7.5.	**Health Inequalities Report**	Enclosure	Dawn Dawson (Helena Posnett)	Assurance	11.15-11.25
Coffee Break 11.25-11.40					
8.	**Finance and Performance**				
8.1.	**Finance and Performance Committee Assurance Report**	Enclosure	Dave Underwood	Assurance	11.40-11.50
8.2.	**Balanced Scorecard**	Enclosure	Adam Savin Executives	Assurance	11.50-12.00
8.3.	**Finance Report**	Enclosure	Chris Hearn	Assurance	12.00-12.10
8.4.	**Operational Resilience and Capacity Plan (Winter) 2024/25** (September FPC)	Enclosure	Andy Miller	Approval	12.10-12.20
9.	**People and Culture**				
9.1.	**People and Culture Committee Assurance Report**	Enclosure	Frances West	Assurance	12.20-12.30
9.2.	**Guardian of Safe Working** (September PCC)	Enclosure	Nicola Plumb (Jill McCormick)	Assurance	12.30-12.40
9.3.	**Workforce Race Equality Standard & Workforce Disability Equality Standard** (September PCC)	Enclosure	Nicola Plumb	Approval	12.40-12.50
10.	**Governance**				
10.1.	**Risk and Audit Committee Assurance Report**	Enclosure	Stuart Parsons	Assurance	12.50-1.00
10.2.	**Risk and Audit Committee Terms of Reference** (September RAC)	Enclosure	Jenny Horrabin	Approval	1.00-1.10
10.3.	**Scheme of Delegation Review and update** (September RAC)	Enclosure	Chris Hearn	Approval	1.10-1.20
10.4.	**Charitable Funds Committee Assurance Report**	Enclosure	Dave Underwood	Assurance	1.20-1.30
11.	**CONSENT SECTION**				All items 130-1.35
	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.				
11.1.	**ICB Board Report**	Enclosure	David Clayton-Smith	Information	
11.2.	**Premises Assurance Model** (September FPC)	Enclosure	Chris Hearn	Approval	
11.3.	**Emergency Preparedness, Resilience & Response (EPRR) Annual Assurance Report 2024** (September FPC)	Enclosure	Anita Thomas	Assurance	

12.	**Questions from the Public**	Verbal	David Clayton-Smith		1.35-1.40
	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				
13.	**Any Other Business** Nil notified	Verbal	David Clayton-Smith	Information	1.40
14.	**Date and Time of Next Meeting**				
	The next part one (public) Board of Directors' meeting of **Dorset County Hospital NHS Foundation Trust** will take place at **9am** on **Tuesday 10th December 2024** in **Trust HQ Boardroom and via MS Teams.**				
	Resolution Regarding Press, Public and Others: To agree, as permitted by the National Health Service Act 2006 (as amended), the Trust's Constitution and the Standing Orders of the Board of Directors, that representatives of the press, members of the public and others not invited to attend to the next part of the meeting be excluded due to the confidential nature of the business to be transacted.				

Quorum:
The quorum of the meeting as set out in the Standing Orders of the Board of Directors is below:
"No business shall be transacted at a meeting unless at least one-half of the whole number of the Chairman and members (including at least one member who is also an Officer Member of the Trust and one member who is not) is present."

Part 2 Items

- Chair's Comments
- CEO Update
- Reablement Facility and Keyworker Housing Update
- Mutually Agreed Resignation Scheme
- Clinical Coding Workforce Strategy
- Electronic Health Record

Consent Items:

- Contracts:
  - Radiology Reporting Routine Hexarad
  - East Dorset Renal Satellite Unit – Staff

Minutes of a public (Part 1) meeting of the Board of Directors of Dorset County Hospital NHS Foundation Trust held at 8.45am on 31st July 2024 at Board Room, Trust Headquarters, Dorset County Hospital and via MS Teams videoconferencing.

Present:		
David Clayton-Smith	DCS	Trust Chair (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
Alastair Hutchison	AH	Chief Medical Officer
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
Nicola Plumb	NP	Joint Chief People Officer
Anita Thomas	AT	Chief Operating Officer
Stephen Tilton	ST	Non-Executive Director
David Underwood	DU	Non-Executive Director
In Attendance:		
Sarah Anton	SA	Corporate Governance Officer (Observing)
Abi Baker	AB	Deputy Trust Secretary (Minutes)
Caroline Barnes	CB	Creative Health Specialist (item BoD24/044)
Ciara Darley	CD	Senior Programme Manager (item BoD24/051 via videoconference)
Julie Doherty	JD	Deputy Medical Director and Responsible Officer (item BoD24/070 via videoconference)
Jo Hartley	JHa	Head of Midwifery (item BoD24/057 via videoconference)
Paul Lewis	PL	Deputy Director Strategy, Transformation and Partnerships (item BoD24/051 via videoconference)
Adam Nicholls	AN	Clinical Divisional Director, Urgent and Integrated Care Division (via videoconference)
Lynn Paterson	LP	Freedom to Speak Up Guardian (item BoD24/063)
Suzy Rushbrook	SR	Arts in Hospital Manager (item BoD24/044)
Audrey Ryan	AR	Clinical Divisional Director, Family Services and Surgical Division
Members of the Public:		
Judy Crabb	JC	Governor (via videoconference)
Kathryn Harrison	KH	Lead Governor (via videoconference)
Jean-Pierre Lambert	JPL	Governor (via videoconference)
Tim Limbach	TL	Governor (via videoconference)
Apologies:		
Nil		

BoD24/044	**Patient Story**	
Baker,Abi 03/10/2024 16:29:16	SR introduced the item, outlining that the Trust had one of the longest running hospital arts programmes in the country at 37 years, and that only 80 out of 280 Trusts had an arts programme. The arts programme had two elements: curation and participation. Today's presentation would focus on the latter, which was becoming more active again following a pause during Covid-19.	

As a Creative Health Specialist CR was working on the Mary Anning Unit as part of a one-year pilot programme which hoped to demonstrate the value of creative health. CR described creative health as creative activities which had benefits for health and wellbeing, and which complimented clinical pathways. These were high-quality, well-designed activities that met patients where they were and covered a variety of artforms including visual arts and crafts, dancing and singing.

CR presented a powerful story about a patient named Robert. Robert was admitted to the Mary Anning Unit from home as he had dementia, his family were struggling to cope with his needs as he could be agitated, aggressive and anxious. Robert was mobile, able to dress and feed himself and communicate, but was isolated and experiencing occupational deprivation. Robert had been in hospital for 100 days and CR met with him for 12 Mondays.

CR described that in her work with Robert she saw him as intelligent, curious, expressive, personable and lyrical. CR's work with Robert included folding paper aeroplanes which improved dexterity, writing postcards about what they have enjoyed and found challenging, socialising with other patients in the day room, and nature-based drawing. During her time with Robert CR saw longer periods of deeper engagement and concentration, increased recognition of CR and increased confidence in taking part. CR encouraged patients to eat their meals at a table in the day room, which improved hydration and communication.

CR described the occupational benefits of creative health and that this work gave staff a better understanding of a patient's background and home life. Other benefits included Robert being more animated, improved self-esteem, increased pride, improved language, spending more time awake, mobile and engaged. Creative health offered increased occupation and helped patients feel valued for the skills they bring. It also improved the perception of healthcare to patients families and provided assurance about how their loved ones were being cared for.

CR described that she was winning hearts and minds of staff on the unit, who recognised the value that she brought to patients and now gave her lists of patients who they felt would benefit from her work. The work helped staff to see patients in a different light and the day room now felt more welcoming for patients. CR felt that the work had increased expectations of what was possible and of what patients could achieve.

Board members thanked CR for her presentation and commended the work of creative health, particularly for older patients with frailty and other comorbidities. DD felt it would be useful to consider how spaces in the hospital could be utilised effectively to meet social needs and offer activity space to get patients out of their beds. A number of Board members shared their personal experiences of loved ones in places similar to the Mary Anning Unit.

The meeting heard that this work supported and prepared patients to leave hospital sooner than they might otherwise have done. Whilst creative

	health was not a cure, it certainly contributed to a more purposeful and enjoyable life. MBr posited two comments for Board colleagues consideration relating to creative care being the kind of care that should be provided in a hospital, and that this was what anyone would want for themselves or their loved ones. Board members raised points relating to the reduced level of one-to-one time that clinicians had with patient and the increased bed occupancy, but the need to support clinicians to think beyond the transactional interactions and to provide a more personal approach to care. It was also highlighted that the comfort that creative health offered to family members should not be underplayed. Consideration was given to the various ways in which creative health solutions could be offered to patients and CR highlighted that she was undertaking training with volunteers and for staff working across dementia pathways to be creative health ambassadors. The Board discussed how this work could be prioritised in the current financial climate. MBr considered a number of elements, including the need to focus on this area if it was something the Board believed in, the harm that long-term busyness in the hospital can cause, and how the work could be funded and undertaken in varied ways. The option of charitable funding may be explored in the short term, but there may come a point in the longer term when the work could need core NHS funding. Executives were asked to consider how creative health work could be supported in the present climate and to provide an update at the next Board meeting.	**Execs**
	Resolved that: the Patient Story be heard and noted.	
BoD24/045	**Formalities**	
	The Chair declared the meeting open and quorate and welcomed governors to the meeting.	
BoD24/046	**Conflicts of Interest**	
	There were no conflicts of interest declared in the business to be transacted on the agenda.	
BoD24/047	**Minutes of the Meeting held on the 29th May 2024**	
	The Minutes of the meeting dated 29th May 2024 were approved as an accurate reflection of the meeting, subject to a minor clarification on page 9 of the minutes.	
	Resolved: that the minutes of the meeting held on 29th May 2024 were approved.	
BoD24/048	**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.	
BoD24/049	**Chair's Comments**	
	DCS highlighted the current changeable and challenging times. He asked Board members to remember the focus on patients and the good that was happening at the Trust and across the Dorset system. Secondly DCS noted a slight change in the structure of the agenda, in recognition of the fact that committees were the Board functioning outside of the Board meeting. As such escalation reports from the committees would each be a standalone item, followed by any reports that had been presented at the committee. It was hoped this would produce a more rounded focus on those topics.	
	Resolved: that the Chair's comments be noted.	
BoD24/050	**CEO Update**	
	MBr took the report as read, bringing two key areas to the attention of the Board. Firstly, the continued positive progress in a number of areas, including the development of the Joint Strategy, effective partnership working, focus on infrastructure, and encouraging progress in new models of care. The operating context for the Trust at this time remained busy with the hospital being consistently full, with high acuity and a relatively full intensive care unit, which was affecting flow, discharge, and planned care. Secondly, the challenging financial environment was highlighted. A full discussion of the month three financial position would take place later in the meeting, but the financial context in the system was proving challenging. MBr noted a letter had been sent to eleven systems who were in the second highest tier of financial regulatory intervention, which included the Dorset system. The Board needed to be aware of the risk of possible further regulatory intervention in to the system's finances. Asked about the disaggregation of public health resource across the Dorset system from April 2025, MBr explained that the decision had been made within the local authority landscape and noted the different populations and rurality of the two local authorities in Dorset. The move to separate public health services from a shared service to each local authority would offer the ability to tailor public health services to the needs of the different populations. It would also support the ambition to root public health at a place level. The positive outcome of the recent CQC inspection in to services for Special Education Needs and Disabilities (SEND) was highlighted. The need to continue to improve some elements, such as waiting times in A&E for patients with mental health or neurodevelopmental needs was recognised.	
	Resolved: that the CEO Update be noted.	

BoD24/051	Joint Strategy	
	NJ outlined that the presentation of the Joint Strategy for approval today concluded the development work and was a milestone in the federated work of the two Trusts. Thanks were extended to PL, CD, Sally Northeast and Harad Burn who all contributed to the development of the strategy. There were two elements for consideration today; formal approval of the strategy, and discussion of the implementation plan. NJ reflected that all good partnerships were founded on a shared purpose and commitment to a shared outcome and that the joint strategy provided this foundation for the federated work of Dorset County Hospital (DCH) and Dorset HealthCare (DHC). It was co-developed and produced with staff and partners over a period of six months and set out a new vision, mission, and objectives. The vision is “for healthier lives, empowered citizens, thriving communities” and the mission is “to work in partnership to provide high quality, compassionate services and to nurture an environment where people can be their best”. Four core objectives had been set focusing on care, communities, colleagues, and sustainability, each with measures of progress would develop and iterate over the lifecycle of the strategy. The recommendation for Board today was to approve the strategy. NJ confirmed that some question marks on pages 62 and 64 were typographical errors and would be removed. EJ commended figure one (page 32) as one of the best infographics she had seen of the interconnectedness between national and local plans. MBI commended the clear and robust engagement plan for the strategy. Board members approved the Joint Strategy. In terms of implementing the strategy, NJ reflected that the development of the strategy marked the end of the beginning and focus now needed to turn to three key questions; how to bring it to life for colleagues, how to deliver it, and how to track progress. The implementation plan would be launched in September and would include culture and engagement and consideration of the programmatic approach and culture shifts to support the delivery of the strategy. Enabling plans would also be developed, as well as metrics to support oversight of the strategy. NP noted the work was a reset of how the Trust described itself and how it wanted to provide care and that the test of the strategy would be how colleagues felt it was relevant in their day-to-day roles and for the people they encountered. The Board heard that at present there was no plan to change the values of each Trust, but that further consideration of this position may be needed in the future. Board members reflected that the work would be in bringing the strategy to life for colleagues and that the clinical enabling plan would play a big role in this. There was a word of caution to support staff through the implementation process as it may be unsettling for some.	

	DCS thanked colleagues for the work in creating the joint strategy and for the discussions today, noting the significant point this marked in the federated working.	
	Resolved: that the Joint Strategy be approved.	
BoD24/052	**Strategic Risks and Corporate Risk Register**	
	JeH outlined that alongside the development of the joint strategy, work had been undertaken to review the risks to the strategic objectives, which built on work from recent joint Board Development Sessions. To do this the strategic objectives had been mapped to committees, existing risks from each Trust had been mapped across to the new strategic objectives, and initial scoring of risks had been undertaken. The objectives and risks had been presented to their appropriate committee for comment and review and the paper had been updated and was presented today for approval. Moving forward, work to develop a joint risk appetite would be undertaken. The Board Assurance Framework would also be developed with a view to this being a live document and would be presented to committees in September. Whilst the risks were presented to Board for approval, the work would be to undertake mitigating actions to keep risks reduced. As chair of Risk and Audit Committee SP had seen a first draft of the Board Assurance Framework and felt it would allow Board colleagues to see live mitigations to risks. Board members thanked JeH for her work in developing the strategic risks and Board Assurance Framework. The Board discussed SR5 and agreed that the reference to health inequalities only was too narrow and should be broader to include population health and health inequalities. Board members agreed that the score for SR6 should be 20, not 25, in recognition of the mitigations and controls. The Board approved the **Strategic Risks** subject to the above two amendments. The **Corporate Risk Register** was presented to the Board for noting and had been presented at Risk and Audit Committee in June. It outlined the ongoing operational risks and provided an update on those. DD had sought additional assurance in getting live updates on the risks and in addressing overdue actions and was assured this was now in place. The Board discussed the risk relating to clinical coding which impacted finance, performance, people, and safety. Executives confirmed that the matter was discussed regularly and that regular updates were presented to Finance and Performance Committee and Quality Committee and had recently been to People and Culture Committee in relation to the	

	recruitment element. Further discussion would take place outside the meeting about the content of the risk on the register.	
	Resolved: that the Strategic Risks be approved, and the Corporate Risk Register noted.	
BoD24/053	**Finance and Performance Committee Report**	
	ST took the report as read, highlighting the below areas for the Board's attention: • A number of items for approval at the Part Two Board meeting • Review of the Finance and Performance Committee in Common terms of reference, with discussion about the number of Non-Executive Director (NED) members • Non-compliance with the Freedom of Information Act as previously discussed at a number of forums. JeH had developed a plan to address this. Further discussion to be had in Part Two about this. • The Cost Improvement Plan (CIP) was highlighted as a key risk, recognising that the next time the committee meets it would be halfway through the financial year. There was a need to continue to apply pressure to meet the CIP. A deep dive in to both DCH and DHC CIP would be presented to the first Finance and Performance Committee in Common • Positive progress in reducing agency spend • Q2 cyber security report, noting the risk of diverting resources to other projects. Full discussion of the cyber security report in Part Two • Cash position continued to be a concern, but the position was more positive than it had been	
	Resolved that: the Finance and Performance Committee Report be received and noted.	
BoD24/054	**Balanced Scorecard**	
	<u>Performance</u> AT recognised a concern about missing performance targets and noted that a contributing factor to this was that the targets kept changing. The report therefore included the targets set in March as a useful guide. • The Trust was not consistently meeting standards around cancer performance. A significant increase in cancer referrals (40% increase compared to the baseline year of 2019/2020) • Theatre utilisation performance was achieving internal targets, but with some improvement still required. Ongoing estates work was impacting this performance metric. • The number of patients remaining in hospital with no criteria to reside was higher than it should be, with 18% of patients in hospital having no criteria to reside • Increased acuity in the hospital impacting performance metrics <u>Quality</u> DD highlighted: • Continued performance below target in relation to Electronic Discharge Summaries (EDS). A task and finish group had been set	

	up to understand the cause of this and to understand any potential harms to patients. • Special cause variation in emergency readmission. A review in to this would be presented to September Quality Committee. • Thematic analysis of Friends and Family Test feedback showed a need to improve communication with patients, particularly with regards to clinic letters <u>People</u> NP highlighted: • Appraisal rates and mandatory training rates were below target. A further deep dive in to the causes would be returned to People and Culture Committee. <u>Finance</u> CH highlighted: • He would update in the finance report item, but the capital expenditure was broadly in line with plan at month three. This was generally unprecedented and was usually behind plan. The current position demonstrated pressure on the capital plan this year, which was overcommitted for the year as detailed in the Finance and Performance Committee escalation report. This was being closely monitored through the Capital Planning and Space Utilisation Group. An initial year-end projection of performance would be taken to September's Finance and Performance Committee, with the final position expected to be clear in December. MBr discussed elective recovery funding (ERF) within the system. He outlined that the Trust was doing lots of good work, but because of some of the important and necessary estates work that was being undertaken, the Trust was not performing well in terms of theatre utilisation. This impacted the ERF that the Trust might receive. The Dorset system needed to achieve 109% performance and was trying to achieve 111%, while the DCH plans were projecting 104% or 107% at a stretch. The Board should be aware of this, noting that whilst there was a lot of good work going on, the Trust's performance was not necessarily seen externally in a wholly positive light. MBr assured NEDs that the Executive team were very much focused on this and there was good engagement from the necessary clinical teams. Asked about the utilisation of South Walks House AT recognised that there could be quiet periods in all outpatient areas, particularly Wednesday afternoons and Fridays which were reserved for governance and audit work respectively. Consideration was being given to which other teams could provide services from South Walks House and an update on the progress to increase outpatient capacity would be presented to the September Board meeting.	**AT**
	Resolved that: the Balanced Scorecard be received and noted.	
BoD24/055	**Finance Report**	

	CH presented the month three position against the financial plan, highlighting: • The Trust submitted a break-even plan for the financial year, with a phased approach to the plan over the course of the year including a phased efficiency programme (CIP) and the workforce review. Operational capacity and performance metrics were associated with this. • Month three saw a £1.5m deficit, broadly in line with plan • Year to date deficit of £5.2m, £371,000 behind plan. Industrial action was the primary driver of the £371,000 variance, with high drug costs and inflationary pressures also being factors • CIP was a significant pressure, with a target of 5% of expenditure budgets equating to £14.3m. £6.3m was fully identified, with a further £5.7m being finalised and £2.3m unidentified. The Value Delivery Board continued to meet to track and monitor progress of the CIP. A deep dive in to DCH and DHC CIP would be presented to the first Finance and Performance Committee in Common. • Agency spend had reduced over the last six months, with a spend of £500,000 in month. This figure was three times higher a year ago. • Cash position stood at £9.7m which was ahead of plan due to receipt of cash from the system at the end of the last financial year in order to deliver a breakeven position. Cash remains a high risk for the Trust and is being closely monitored.	
	Resolved: that the Finance Report be received and noted.	
BoD24/056	**Quality Committee Report**	
	CL highlighted the following from the June report: • Receipt at Quality Committee of annual reports presented for the Board today, including on Safeguarding Children and Young People, Infection, Prevention and Control, and Clinical Audit Assurance Report. • Good evidence of triangulation of issues across Board sub-committees • 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 • Deep dives in to the Mary Anning Unit and EDS compliance • Receipt of the annual organ donation report EJ highlighted the following from the July report: • 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 a letter from NHS England relating to patient safety and quality. An assurance report against that letter would be returned to committee.	

	• Review of the revised strategic risks • Update on JAG accreditation provided assurance that all current actions were on track to be completed before the revisit in October EJ noted she had undertaken a walkaround in maternity recently which had been a positive experience. EJ confirmed that in the absence of a quorate meeting DD and AH had confirmed by email their approval of those items that had required approval by the Quality Committee. Post-meeting notes were included in the July minutes where relevant.	
	Resolved: that the Quality Committee report be received and noted	
BoD24/057	**Maternity Update**	
	JHa highlighted the following key points from the maternity report: • Carbon monoxide (CO) bookings were slightly above target, but smoking at time of delivery was on target. • One incident of third-degree tear in month • Post-partum haemorrhage (PPH) over 1500ml was below target but this was normal variation • No incidents of moderate harm • Two RCAs remain, one of which was the MNSI case. The second case was a neonatal case awaiting sign off of the final letter. • Three incidents of baby loss in month. • Neonatal staffing continued to be a high risk due to the requirement of a supernumerary coordinator. • Good progress being made with using the Birmingham Symptom Specific Obstetric Triage System (BSOTS) • Two models of resuscitaires had been identified and were being trialled • Two complaints received in June • Workforce data included in the report. The primary reason for staff sickness was mental health, but this was not related to work. An improvement in sickness rates in midwives, maternity support workers and Special Care Baby Unit (SCBU) staff. • NHS Resolution had accounted that there was no longer an expectation for obstetric anaesthetists who are not on the obstetric rota to attend multi-professional emergency training. Despite this, this continued to be a risk of the Maternity Incentive Scheme (MIS) and had been escalated to the Clinical Director and Leads for anaesthetics for a solution. Whilst the cause of mental health issues might not be directly work related, DU asked whether they might be brought on by the pressured nature of the work in maternity. JHa reflected that an individual's ability to manage in their private life was greatly influenced by their work and assured the Board that this was something she took seriously and where necessary she worked with staff to support them with restructured working patterns, family-friendly working arrangements, and providing access to counselling or midwifery advocates.	

	DD updated on the progress of the CQC action plan and that team were preparing for the next visit to review the service. This had an away day for the maternity senior leadership group in which the national midwife lead for NHS England had given an introduction. MBr sought further detail about the performance of admissions to the neonatal critical care unit. JHa described that the most recent Neonatal Network report positively showed the Trust below the 5% target. However there had since been an increase, noting that the small numbers for the Trust made a big difference. Every baby over 37 weeks admitted to the unit was reviewed by a multi-professional team to identify any learning from the admission, but often the admission could not be avoided. Quality Committee would continue to monitor this.	
	Resolved: that the Maternity Update be received and noted.	
BoD24/058	**Safeguarding Children and Adults Annual Report**	
	The report was presented for approval to publish as it was a regulatory requirement. DD outlined that the report provided assurance that the Trust was meeting the requirements in regulatory activity from the CQC and the Children's Act. The report had been to Quality Committee where it was recommended to Board for approval. DD highlighted the following: • The team had started the year in a difficult position with a lack of resilience, but were now more resilience with an enhanced skill set • Progress with domestic violence work with a health domestic violence advocate now in post • Good progress with coworking with Child and Adolescent Mental Health Service (CAMHS), paediatrics and the emergency department. • Areas of focus include digital systems so as to be able to see family members linked to a child on a Child Protection Plan. With regards to DD's final point, DU observed that the lack of progress to support digital systems that supported safeguarding processes was a reflection of two things. Firstly, the limited resource in digital and secondly the decision to focus on ensuring the right specification for the proposed Electronic Health Record, rather than engaging the current supplier to upgrade their system. The Board approved the report.	
	Resolved: that the Safeguarding Children and Adults Annual Report be received and noted.	
BoD24/059	**Infection Prevention and Control Annual Report**	
	The report was presented for approval to publish as it was a regulatory requirement.	

	DD noted that the report set out compliance with 10 criteria of the Health and Social Care Act and had been reported through Quality Committee. Of note, DD highlighted: • PSIRF had been embedded in the team since 1st January 2024 and was used to review all cases • A move from living in a pandemic to living with Covid-19 • Good compliance with audits • Compliance with the mandatory requirement for surgical site surveillance • The Infection Prevention and Control team spent a lot of time working with frontline clinicians, providing training, and supporting Board walkarounds. The Board approved the report.	
	Resolved: that the Infection Prevention and Control Annual Report be received and noted.	
BoD24/060	**Clinical Audit Annual Assurance Report**	
	AH noted that the report had been written by a member of staff who had recently retired and so he had not had a chance to speak to her about it before she left and there were some details in the report were not accurate. AH outlined that the report, which had been to Quality Committee and Risk and Audit Committee, described the mechanisms that exist for supervising and recording both local and national audits and the appendix describes the outcomes of the audits. The Trust generally performed well in national and local audits, but an effort was being made to improve the audit process so that they were more aligned to the divisional risk register. Clinical audit had been an area of focus for SP as chair of Risk and Audit Committee. He noted that the Clinical Effectiveness Committee had improved the process, but there was still some way to go. SP confirmed that he had previously asked about whether the Trust should have participated in some audits that it had not, as detailed on page 314 onwards. As chair of Quality Committee CL would like to see further detail next year around the outcomes, learning and consequences of clinical audit. The Board heard that the report was an internal assurance report, rather than a regulatory requirement and so was presented today for noting. AH clarified that the strategic aims for 2023/24 detailed in section five did not quite describe the breadth of ambition for the coming year but were in fact accurate. The Board considered whether Quality Committee needed to sign a final version of the report with any amendments or clarifications. EJ felt that Quality Committee provided sufficient due diligence that it did not need to see a revised version of the report. DCS summarised that the report was slightly incomplete and there were some areas that the Board requested to see in the 2024/25 version. Clinical audit was overseen by Quality Committee in the normal run of	

	business and that the Board was happy to accept this internal document. Board members agreed with this.	
	Resolved: that the Clinical Audit Annual Assurance Report be noted.	
BoD24/061	**People and Culture Committee Report**	
	MB highlighted the following: • Reports presented to the Board today for noting or approval include the Leavers and Retention Report, Medical Revalidation Report, Workforce Health and Wellbeing Report, and Joint Inclusion Strategy. • Several positive indicators including reduced agency spend, reduced vacancy rates, and reduced turnover • A small increase in absence rates, particularly in short term sickness • An increase in the number of Freedom to Speak Up (FTSU) concerns raised • A reduction in some key performance metrics, including appraisal rates MB had undertaken walkaround in the education centre last week and had a number of positive, detailed conversations with staff. DCS requested that the committee provide a greater focus on improving appraisal rates.	
	Resolved: that the People and Culture Committee Report be noted.	
BoD24/062	**Joint Inclusion and Belonging Strategy**	
	NP outlined that: • Other than the overarching Joint Strategy, this was the first joint strategy between the two Trusts and had been developed through a collaborative approach. • Some infographics relating to DCH needed to be added in order to make the data more accessible. • Some data looked different in different sections of the strategy, as they were pulled at different times e.g. the WRES and WDES data were from 2023, but current workforce data was pulled from July 2024 • The strategy brought together in to one place all the reporting requirements of the Trust. The priorities aligned to the national requirements, whilst the required actions aligned to what was needed locally, • Consideration would need to be given to how to prioritise actions, possibly by the People and Culture Committee in Common • The overarching workforce approach would be reviewed at the end of the financial year, and the strategy was expected to carry forward as part of other frameworks Board members offered a word on caution on having too many different strategies operating concurrently and noted concerns about the time period the strategy covered, 2023 to 2025, noting it was now July 2024. NP explained that the strategy was first developed in 2023 by DHC, but	

	that it was paused to allow work to be undertaken jointly with DCH. NP recommended that the strategy be approved up to 2025 with the expectation that it would roll forward after that point. It was suggested that the strategy be updated to cover the period 2024 to 2026, and that the dates of actions in the strategy be updated as necessary to enable this. MBr reflected that the strategy was more powerful as a set of intentions over a period of time and that sufficient time was given to the strategy to allow some of those pieces of work to come to fruition, such as Board participation in the reciprocal mentoring programme. The Board approved the strategy.	
	Resolved: that the Joint Inclusion and Belonging Strategy be approved.	
BoD24/063	**Freedom to Speak Up Update**	
	LP outlined that quarters three and four of 2023/24 saw an increase of FTSU cases from the previous quarter to 187 cases. This could be attributed to a number of factors, including FTSU month, communication activity, and targeted listening events. No formal whistleblowing disclosures were received in the period. Most FTSU cases included the theme of wellbeing, often this related to incivility and poor communication. Consideration was given as to whether a high level of FTSU cases was a good thing or not; did it indicate a good culture of speaking up or highlight that there were concerns. LP described more robust triangulation, in which she attended weekly patient safety huddles, met with NP, regional network, DU as FTSU Champion, and MBr. There was a great deal of activity being undertaken to improve the FTSU offer and looking ahead, LP would like to develop the active side of the role, as she was currently in a reactive space. NP thanked LP for her work to build the awareness of the role. DU echoed thanks and reflected that the Trust had signs of a healthy FTSU culture and did not feel there was such a thing as too much speaking up. MBr reiterated that as FTSU Guardian LP had the absolute right to roam through the organisation and that she could speak to any Board member at any time. The Board discussed the ways in which the outcomes of LP's work could be learned from, including presenting to operational meetings and groups, and updating the intranet with anonymised case studies.	
	Resolved: that the Freedom to Speak Up Update be received and noted.	
BoD24/064	**Workforce Health and Wellbeing Review**	
Baker,Abi 03/10/2024 16:29:16	The report was taken as read with NP highlighting the limited time that staff had to engage with the wellbeing offer and the Board should consider how to improve working conditions to support wellbeing in the workplace. Board members reflected on the resource challenge and how this could be supported in the current climate, noting the benefits that could be gained	

	from greater collaboration and funding across the system. The importance of appraisals in helping people feel valued and respected was noted as a contributing factor to improving wellbeing at work. A new health and wellbeing strategy would be developed to support this work and could be expected in the new financial year.	
	Resolved: that the Workforce Health and Wellbeing Review be received and noted.	
BoD24/065	**Risk and Audit Committee Report**	
	SP highlighted the following: • Recommendation of the Annual Report and Accounts and associated documents to Board for approval. This has been received at the Extraordinary Board meeting in June • Positive audit results from internal and external auditors. • Work had commenced on the 2024/25 internal audit programme, with scope to add in any areas that arise throughout the year as needed.	
	Resolved: that the Risk and Audit Committee Report be received and noted.	
BoD24/066	**Working Together Committee In Common Report**	
	DCS highlighted: • The transfer of flagship four, admission avoidance, into the integrated neighbourhood programme • The intention for the Working Together Programme committee in common to develop in to a Strategy, Transformation and Partnership Committee in Common	
	Resolved: that the Working Together Committee In Common Report be received and noted.	
BoD24/067	**Committee Effectiveness Review and Terms of Reference**	
	JeH noted that the terms of reference (TOR) for approval at this stage were those for the Quality Committee and Risk and Audit Committee, which were not being included in the processes for new joint committees at this time. Areas for development as highted in the Committee Effectiveness Review were included in the TORs for new joint committees. Reflecting on last week's meeting, the Board discussed the quorum of Quality Committee, with JeH noting that this had been the first time the committee was not quorate in a considerable amount of time and that she would be considered if the quorum did not stipulate the need for either Chief Medical Officer (CMO) or Chief Nursing Officer (CNO) attendance. NEDs broadly agreed that either the CMO or CNO should form part of the quorum for Quality Committee, on the basis that this was good governance, that it prevent any reputation risk by not having either present, and would prevent the need for two deputies to attend as and when the committee became a committee in common. DD felt that the executive membership of the committee was too narrow and could be broadened, and that the Directors of Nursing could form part of the quorum.	

	MBr proposed that the Board approve the Quality Committee TOR as presented today, and that it could be reviewed at a later date if the quorum was not working as intended. He recognised that executive concerns about quorum related to extenuating circumstances only and that the importance of the committee was completely recognised. The Board approved the TOR for Quality Committee and Risk and Audit Committee.	
	Resolved: that the Committee Effectiveness Review and Terms of Reference for Quality Committee and Risk and Audit Committee be approved.	
BoD24/068	**Committees in Common Terms of Reference**	
	The TOR for three committees in common were presented for review and approval: • Finance and Performance Committee in Common • Strategy, Transformation and Partnership Committee in Common • People and Culture Committee in Common Discussions and work around a Quality Committee in Common were underway and a decision about this committee was yet to be made, with a provisional move to a committee in common in quarter four. The TORs had been presented to the appropriate committee in each Trust for review and comment. No disagreements had been made about the scope of each committee, but this could be kept under review as the committees became embedded to ensure that they provided NEDs with the assurance they needed. A number of discussions had taken place regarding the number of NEDs in membership for each committee, with the final position being that there would be three NEDs per Trust on each committee, but that one or two of these could be joint NEDs. The benefit that NEDs provided in a breadth of knowledge was noted. DCS asked how we would ensure that committees in common were not twice as long as a single committee. JeH described that the governance structure beneath each committee would support with some of the weight of committees, and that an improvement in the quality of reports would support more efficient discussions at committees. The committees in common would initially be scheduled for three hours. Reflecting on the discussions today, MBr voiced that the move to committees in common was the right thing to do particularly in relation to the challenging context for the Trusts. However, how it would not be known if the way to conduct those meeting was the right way until it was trialled. In terms of practicalities more needed to be done in the organisation of agendas and quality control of papers to support the work of the committees in common. MBr reflected that this was an improvement journey and that it would not be perfect immediately. Considering his own experience with committees in common, MBr noted there would likely be a lot of macro synergy which would help with the time commitment.	

	ST echoed this, stressing that it was incumbent on the executives and anyone preparing papers to ensure that the executive summaries were sufficient to provide all the necessary detail required for the NEDs, with additional information included as needed in the main paper. The development of committees in common allowed a unique opportunity to ensure that the progress of the strategy could be the focus, rather than operational detail.	
	Resolved: that the Committees in Common Terms of Reference be approved.	
BoD24/069	**Charitable Funds Committee Report**	
	DU highlighted the following: • A £318,000 legacy fund for the redevelopment of the Prince of Wales ward was not currently being used for the purpose intended. The committee has requested a report on the funding and development position. The Head of Charity is to speak to the executor of the legacy to explain the position, mitigations and delivery of the redevelopment, and will discuss the matter with CH. The issue would be reviewed for any lessons to be learned. • Total income received at end of June totalled almost £238,000 which sufficiently covered the costs of the charity to the end of the year • £475,000 had been received in commitment and pledges towards to £2.5m capital appeal. The work of the DCH 100 Jurassic Challenge was noted, with £111,000 raised for the appeal. • Decision made to support the restructure of the charity team to support the capital appeal.	
	Resolved: that the Charitable Funds Committee Report be received and noted.	
BoD24/070	**Medical Revalidation Report**	
	JD presented the Medical Revalidation Report, noting : • The positive progress in the year • Over the coming year the intention was to reduce the number of missed or incomplete appraisals, and to streamline administrative processes for locally employed doctors. • The turnover of appraisers, and the continual need to identify medical appraisers and work this in to their job plans. • The intention to improve processes for case investigation and management, particularly for practice nurses and early decisions makers. This might include establishing a decision-making group or performance advisory panel to ensure better recording of decisions made. • The intention to embed the fair and just culture practices in work The Board approved the report.	
	Resolved: that the Medical Revalidation Report be approved.	
BoD24/071	**Questions from the Public**	

	JPL commended the work on the Joint Strategy and asked how the finances of implementation would be coordinated, particularly to develop a medium-term financial forecast. MBr described the tight grip and control the Trust had on finances and the need to work with system partners through the current situation. The achievement of the strategic ambitions would positive affect the financial viability of care in a positive way and would support the objective of financial sustainability, but this needed to be done with partners across the system, including the ICB who held the ring on the medium term financial plan. MBr described this as a work in progress. TL noted the poor appearance of the exterior of the hospital and asked if funding to improve this could be considered. MBr advised that the executive team would take this away for discussion. Public Governor, Mike Byatt, had submitted a question about digital strategy ahead of the meeting and a response had been provided by the Chief Information Officer. The full question and answer would be circulated to Board members and Governors outside of the meeting, in lieu of reading them verbatim. *Post meeting note: question and answer circulated 01 August 2024.*	**Execs**
	CONSENT SECTION	
	The following items were taken without discussion. No questions had been previously raised by Board members prior to the meeting.	
BoD24/072	**Leavers and Retention Report**	
	Resolved: that the Leavers and Retention Report be received and noted.	
BoD24/073	**People Plan Annual Progress Review**	
	Resolved: that the People Plan Annual Progress Review be received and noted.	
BoD24/074	**Working Together Programme Highlight Report**	
	Resolved: that the Working Together Programme Highlight Report be received and noted.	
BoD24/075	**DCH SubCo Q4 Performance Report**	
	Resolved: that the DCH SubCo Q4 Performance Report be received and noted.	
BoD24/076	**ICB Part 1 Board Minutes**	
	Resolved: that the ICB Part 1 Board Minutes be received and noted.	
BoD24/077	**Any Other Business**	
	None raised.	

BoD24/078	**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.**	

Action Log – Board of Directors Part 1

Presented on: 09 October 2024

Minute	Item	Action	Owner	Timescale	Outcome	Remove? Y/N
Meeting dated: 31st July 2024						
BoD24/044	**Patient Story**	Executives to consider how creative health work could be supported in the current financial climate.	Execs	September 2024	Suzy Rushbrook and Simon Pearson to attend JEMT 29/10/2024 to discuss creative strategy.	
BoD24/054	**Balanced Scorecard**	An update on the progress to increase outpatient capacity, particularly at South Walks House, to be presented to the September Board meeting.	AT	September 2024	See below. Verbal update to be provided in meeting.	
BoD24/071	**Questions from the Public**	Executives to consider how to fund improvements to the exterior of the hospital	Execs	September 2024	Added to JEMT forward plan for 28/08	
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	Scheduled for December's board meeting.	
BoD24/016	**Board Subcommittee Escalation Reports**	A review of the Charitable Funds Committee Terms of Reference to be undertaken	JeH	September 2024	In progress	

Actions from Committees…(Include Date)						

Actions to Committees…(Include Date)						

BoD24/054: update on South Walks House outpatient capacity

DEPARTMENT	ROOMS	APRIL	MAY	JUNE	JULY
SWH	ROOMS	77%	80%	82%	82%
	VIRTUAL ROOMS	35%	44%	46%	46%
	TREATMENT SUITE				30%

Report to	Dorset County Hospital Board of Directors, Part 1	
Date of Meeting	Wednesday 09 October 2024	
Report Title	Chief Executive Officer Report	
Prepared By	Sally Northeast, Associate Director of Communications and Public Engagement	
Accountable Executive	Matthew Bryant, Chief Executive	
Paper relates to	**Dorset County Hospital**	X
	Dorset HealthCare	-
	Joint	-
Action Required	**Approval**	-
	Assurance	-
	Information	X

Alignment to Strategic Objectives	Does this paper contribute to our strategic objectives	
Care	Yes	
Colleagues	Yes	
Communities	Yes	
Sustainability	Yes	
Implications	Describe the implications of this paper for the areas below	
Board Assurance Framework		
Financial		
Statutory & Regulatory		
Equality, Diversity & Inclusion		
Co-production & Partnership		

Executive Summary

Strategic update – national picture

Darzi Independent Investigation of the NHS in England

In September Professor Lord Ara Darzi reported on the findings of his rapid independent investigation into the state of the NHS. This was commissioned by the Secretary of State for Health and Social Care to set out the nature and extent of the issues facing the service.

Covid inquiry

On 10 September the inquiry published its first Every Story Matters record which details public experiences during the Covid-19 pandemic.

Resolution following industrial action

We welcome hugely the conclusion of the junior doctors' industrial action. The offer from the government for junior doctors in England represents a pay deal worth 22.3% more on average over two years.

Strategic update – local focus

Winter planning letter and urgent and emergency care improvement

As is normal at this stage of the year, we have received the winter planning letter from NHS England which recognises that urgent and emergency care will be under considerable pressure as we enter the colder months.

Seasonal vaccination programmes

NHS England have launched the seasonal flu, COVID-19 and Respiratory Syncytial Virus (RSV) autumn/ winter vaccination programme. The main flu and COVID-19 vaccination programmes will start from 3 October 2024 and are expected to be completed by 20 December 2024, with flu vaccinations available until 31 March 2025. A targeted outreach programme to improve uptake of COVID-19 vaccinations in underserved communities will continue until 31 January 2025.

New gender specialist centre for children and young people

Following the publication of the Cass report in April 2024, NHS England has set out how it will deliver transformed gender healthcare services for children and young people.

They will continue to support up to six additional new specialist regional centres between 2024 and 2026 on a phased basis. The next service to become operational will be in Bristol in November 2024.

Working together

Launching and delivering our joint strategy

Following approval of the joint strategy at both boards, it has now been launched and is available on both trust websites and intranets. Sessions to engage with colleagues on the strategy kicked off at the end of September with Team Brief events at both trusts.

Working together
Launching and delivering our joint strategy

Following approval of the joint strategy at both boards, it has now been launched and is available on both trust websites and intranets. Sessions to engage with colleagues on the strategy kicked off at the end of September with Team Brief events at both trusts.

Dorset County Hospital

Ridgeway Ward transformed into a dedicated unit for patients having elective orthopaedic surgery
Dorset County Hospital (DCH) has opened a new dedicated unit for people having orthopaedic surgery.

New Hospital Programme project jumps final approval hurdle
We are delighted that we have now received formal notification from the Treasury that our New Hospitals Programme (NHP) funding for the new emergency department and critical care unit has been approved.

Patients praise standards of care at Dorset County Hospital
Patients have praised the standard of care experienced at Dorset County Hospital (DCH).
The latest adult inpatient survey, carried out by the Picker Institute on behalf of the Care Quality Commission, captured the views and experiences of 590 patients who stayed a minimum of one night as an inpatient at DCH during November 2023.

Recommendation

The Board of Directors is requested to:

- Receive the report for **information**

Chief Executive Officer Report

Introduction

This report provides the Board with an overview of the strategic developments across the NHS and more locally across the Dorset Integrated Care System, and within our federation.

Strategic update – national picture

Darzi Independent Investigation of the NHS in England

In September Professor Lord Ara Darzi reported on the findings of his rapid independent investigation into the state of the NHS. This was commissioned by the Secretary of State for Health and Social Care to set out the nature and extent of the issues facing the service.

The report concluded that the NHS is 'in a critical condition'. Specifically, it looked at this in relation to:

- Increased waiting lists
- Increased waiting times
- Reduced patient satisfaction
- Mortality rates for cancer and cardiovascular disease
- Some particular areas of concern in relation to quality
- Where the NHS spends its money and how much the nation spends on healthcare

Five main factors were identified impacting on the performance of the NHS:

- Austerity and the lack of capital funding
- The impact of the changes associated with the Health and Social Care Act 2012
- The pandemic and recovery
- Failing to put sufficient emphasis on listening to the patient voice and engaging with staff
- The overall deterioration in the health of the nation over the past 15 years, including some of the social determinants of health

It suggests the following need to be picked up as part of the government's 10 year plan for health, due to be published in the spring:

- Re-engagement of staff and re-empowerment of patients
- Reform to ensure the current structure can deliver
- Use of the NHS's budget to contribute to the nation's prosperity (for example, through better support for the British pharmaceutical industry)
- Improved use of technology
- Supporting the shift to care closer to home by changing financial flows (including supporting expansion of primary care and community services)

We recognize the findings of the Darzi report and know that they show up every day for patients seeking to access care, and also for our staff working in services that are facing these challenges.

We welcome the candid and honest way in which the Darzi investigation discusses the problems facing the NHS and the ambition to address these via the 10 year plan. I am

confident that the strategic objectives we have developed over recent months in our trusts align well with the national direction we are starting to see emerge.

We are focused on improving access, quality and outcomes through a switch to preventative community-based care, supported by digital technology. Most of all we want to see the service user and colleague voice at the heart of all we do and are focusing strongly on this at a local level. In addition to our own work, partners like Dorset Mental Health Forum are instrumental in helping bring the voices of lived experience into our work.

Covid inquiry

On 10 September the inquiry published its first Every Story Matters record which details public experiences during the Covid-19 pandemic.

This record brings together people's healthcare experiences and is published as 10 weeks of public hearings for the Module 3 investigation 'Healthcare systems' begin. It covers the experiences of healthcare professionals and patients across both primary care and hospital, as well as emergency and urgent care, end-of-life care, maternity care, shielding, Long Covid and more.

This first record is the product of more than 32,500 people's stories submitted online to the inquiry, as well as the themes taken from 604 detailed research interviews.

The 222-page record, developed from the largest public engagement exercise ever undertaken by a UK public inquiry, sets out a wide range of experiences of the pandemic including:

- Patients found accessing healthcare during the pandemic extremely difficult and stressful
- Bereaved families and friends faced significant challenges in supporting their loved ones at the end of life
- Healthcare professionals found that planning for care in the event of a pandemic was poor and the speed of the response to the emergency was too slow, leading to lost lives and huge strain in the workforce
- An absence of good quality, well-fitting personal protective equipment (PPE) left staff, patients and carers feeling vulnerable
- Restrictions placed on visiting maternity and other healthcare services left patients and loved ones feeling isolated
- Long Covid continues to have a dramatic and damaging impact on many people's lives
- People considered clinically vulnerable were advised to shield for open-ended and often long periods of time, leaving them feeling isolated, lonely and fearful

We welcome the ongoing public inquiry, but also recognise that for many of our staff, as well as members of the public affected by Covid-19, the subject matter brings back many difficult memories, and we are offering support for colleagues.

Resolution following industrial action

We welcome hugely the conclusion of the junior doctors' industrial action. The offer from the government for junior doctors in England represents a pay deal worth 22.3% more on average over two years.

With a turnout of 69%, two-thirds voted in favour of the offer and one third against.

The government has also committed to work with the BMA to review wider issues affecting the workforce, including:

- Streamlining the way junior doctors report additional hours they work
- Reviewing the number and frequency of rotations, in recognition of how disruptive the system can be for junior doctors, their partners, and families
- Working with NHS England to review training numbers to tackle training bottlenecks that already exist and the planned expansion of medical school places

Strategic update – local focus

Winter planning letter and urgent and emergency care improvement

As is normal at this stage of the year, we have received the winter planning letter from NHS England which recognises that urgent and emergency care will be under considerable pressure as we enter the colder months.

It stresses that we need to stick to our agreed financial plans – for Dorset the £20M deficit plan – and we know that will be very challenging. Our focus needs to be on:

- Carefully planning for the expected demand and creating the capacity needed
- Supporting people to stay well eg through vaccination programmes for flu and Covid-19. We will particularly be encouraging all eligible staff to get their vaccinations when available to protect our patients as well as themselves and their families.
- Maintaining patient safety and experience by working together as a system providing the right care in the right place at the right time and working to reduce waiting times, which are longer than we would want

Across the south-west region there has been a significant focus on the preparation for winter, and in particular on supporting ambulance handover times. NHS leaders across the south-west have been working on five areas for an improvement focus:

- A set of internal actions within the South West Ambulance Service
- Arrangements for system co-ordination of urgent and emergency services across Integrated Care Systems
- Sharing best practice for community alternatives to hospital admission
- Arrangements for hospital access
- Supporting timely emergency department handovers

These were shared at a recent South West Winter Risk meeting, and their adoption will be supported by the establishment of a regional improvement network for the south west. This will focus on urgent and emergency care and will be led by Peter Lewis, Chief Executive of Somerset Foundation NHS Trust.

Alongside this within the Dorset system key initiatives for winter include:

- Seven-day working in our system transfer of care hubs
- Improving access to same day emergency care
- Increasing use of virtual wards
- Introducing care co-ordination hubs supported by specialist paramedics
- Reviewing intermediate care pathways and assessment arrangements for patients

- Enhanced communication with the public

In our own services we are already seeing early evidence of an increase in demand, and we continue to focus on the above changes and supporting our teams to provide safe care and maintain flow.

We particularly recognise the role of primary care and the impact of winter pressures on GPs. The inclusion of the GP Alliance in our new Strategy, Transformation and Partnerships committee in common helps to ensure the primary care voice is part of the trust's work at the most senior level.

Seasonal vaccination programmes

NHS England have launched the seasonal flu, COVID-19 and Respiratory Syncytial Virus (RSV) autumn/ winter vaccination programme. The main flu and COVID-19 vaccination programmes will start from 3 October 2024 and are expected to be completed by 20 December 2024, with flu vaccinations available until 31 March 2025. A targeted outreach programme to improve uptake of COVID-19 vaccinations in underserved communities will continue until 31 January 2025.

In Dorset there is a mixed delivery model for the vaccination programmes including general practice and primary care networks, community pharmacies and the three provider trusts.

A detailed communications plan supports the programme, underpinned by a new vaccination website, www.staywelldorset.nhs.uk/vaccinations. This is in addition to Dorset HealthCare's dedicated COVID-19 vaccination web pages providing detailed information on vaccination clinics, booking systems, walk-in clinics and frequently asked questions.

Strengthening our focus on inclusion and belonging

With the backdrop of the violent riots in the summer, which we know shocked and affected many colleagues, we continue to strengthen and share our messages about inclusion and belonging across both trusts.

Following the timely approval of our joint Inclusion and Belonging Strategy at both Boards, we will be engaging colleagues more with this work so that everyone can play their part in fostering an inclusive and welcoming environment.

As well as continuing to work with members of our colleague networks over the past few months, I have been delighted to join the South West Equality, Diversity and Inclusion Delivery group as the chief executive representative from the Dorset Integrated Care System. I am working closely with Patricia Miller (NHS Dorset ICB, Chief Executive) who is the overall chief executive lead for this group for the region.

As two boards we spent an important development day focused on Equality, Diversity and Inclusion, where we discussed our aspirations for our population, our organisations and what this means for our board working. We were supported by experts in the field to look at the diversity of our own boards, how we listen to each other's voices and to consider where our biases and gaps are. This is a really important stage in our board considering how to bring the ambition of our strategy to life.

New gender specialist centre for children and young people

Following the publication of the Cass report in April 2024, NHS England has set out how it will deliver transformed gender healthcare services for children and young people.

They will continue to support up to six additional new specialist regional centres between 2024 and 2026 on a phased basis. The next service to become operational will be in Bristol in November 2024.

All new referrals into the specialist gender services will be made through mental health or paediatric services and young people referred into the service will have their wider health and care needs considered. This means the role undertaken by Dorset Healthcare NHS FT will change, and services will form part of this referral pathway.

NHS England has also published plans for a review into adult gender services. This review will look at the effectiveness, appropriateness and stability of each current service to inform an updated service specification.

Working together

Launching and delivering our joint strategy

Following approval of the joint strategy at both boards, it has now been launched and is available on both trust websites and intranets. Sessions to engage with colleagues on the strategy kicked off at the end of September with Team Brief events at both trusts.

Detailed work has taken place to map out all the places where the strategy is shared, including recruitment, induction, training, team and leadership and team development. The new strategy will be embedded through these routes and an engagement programme to help colleagues understand it and shape next steps will be led by the executive team and leaders across both trusts.

Work is also underway to develop the enabling strategies for clinical and quality, people, digital, finance and infrastructure to set out more detail on how we will achieve our objectives.

Meanwhile much work is already underway, as can be seen in the work to develop Integrated Neighbourhood Teams, Access Wellbeing services, and the models of care developed through the Working Together programme, such as the revised frailty model we offer.

Committees in common

In September 2024 Dorset County Hospital and Dorset Healthcare launched their first committees in common for People and Culture, Finance and Performance and Strategy, Transformation. This forms part of the process of aligning the boards and oversight across both organizations.

To support the formation of the committees in common we completed a recruitment process for new joint non-executive director positions and have appointed three joint non-executives who will sit on both boards.

These are Eiri Jones (currently deputy chair at DCH who will join the board of DHC); Frances West (currently deputy chair at DHC who will join the board of DCH); and David Underwood (currently a NED at DCH who will become a NED at DHC).

Dorset County Hospital

Ridgeway Ward transformed into a dedicated unit for patients having elective orthopaedic surgery

Dorset County Hospital (DCH) has opened a new dedicated unit for people having orthopaedic surgery. Existing ward space has been transformed into the Ridgeway Elective Orthopaedic Unit, which includes a new admissions lounge for people coming in for orthopaedic surgery and a therapy suite to support patients with their recovery.

Funded by NHS England, the £1.4million scheme is the second phase of a programme to reduce waiting times for appointments and surgery, which included the creation of the Outpatient Assessment Centre at South Walks House in Dorchester town centre.

New Hospital Programme project jumps final approval hurdle

We are delighted that we have now received formal notification from the Treasury that our New Hospitals Programme (NHP) funding for the new emergency department and critical care unit has been approved. This is the final approval hurdle and means that work can now start in earnest.

The news comes against the backdrop of a national pause of any further NHP projects after the government announced a review of the programme.

Patients praise standards of care at Dorset County Hospital

Patients have praised the standard of care experienced at Dorset County Hospital (DCH).

The latest adult inpatient survey, carried out by the Picker Institute on behalf of the Care Quality Commission, captured the views and experiences of 590 patients who stayed a minimum of one night as an inpatient at DCH during November 2023.

Questions in the survey asked for feedback on the patients' journeys from admission to hospital, treatment and discharge.

The results revealed that 99% felt they were treated with respect and dignity; 98% had confidence and trust in the doctors and 80% rated their overall experience highly.

DCH scored above the Picker average for staff explaining reasons for changing wards at night; not having to wait long to get to a bed on a ward; being given enough information about their care and treatment while on a virtual ward and standards of hospital food.

Areas for improvement included being given more information about medicines at discharge; knowing what will happen with their care post discharge; involving families and/or carers in discussions about leaving the hospital and being asked about the quality of their care whilst in hospital.

Report to	Trust Board	
Date of Meeting	9 October 2024	
Report Title	Board Assurance Framework Quarter 1-2	
Prepared By	Jenny Horrabin Joint Director of Corporate Affairs	
Accountable Executive	Jenny Horrabin Joint Director of Corporate Affairs	
Previously Considered By	Joint Executive Management Meet Team – 3 September 2024 Audit Committee – 17 September 2024 Assigned risks considered by responsible Committees w/c 16 and 23 September 2024	
Action Required	**Approval**	X
	Assurance	-
	Information	-

Alignment to Strategic Objectives	Does this paper contribute to our strategic objectives	
Care	Yes	
Colleagues	Yes	
Communities		No
Sustainability		No
Implications	Describe the implications of this paper for the areas below	
Board Assurance Framework	This report relates to the full BAF	
Financial	No financial implications arising from the BAF	
Statutory & Regulatory	There is a regulatory requirement to have a BAF in place	
Equality, Diversity & Inclusion	There are no specific EDI implications arising from this report	
Co-production & Partnership	We will consider system risks and alignment to the system BAF as part of the development of the BAF.	

Executive Summary

Executive Summary

The Joint Strategy 'Working together, improving lives' was approved 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 continued and these were approved by the DHC and DCH Boards on the same dates.

The Audit Committee is responsible for reviewing the levels and effectiveness of the assurances that the Board receives in respect of the identified strategic risks, ensuring that they are relevant and timely and that this contributes to the effectiveness of then overall system of internal control. Individual Committees have responsibility for oversight of specific risks.

New Template and Review Process

The Board Assurance Framework has now been developed against the approved strategic risks. A new template has been developed to show 'a risk on a page' with an overview of all risks.

- Each risk has been assigned to an Executive Lead who has signed off the BAF for their assigned risk.
- The BAF as reviewed and agreed by the Joint Executive Management Team on 3 September 2024.
- Each risk has also been assigned to a committee and has been reviewed during September 2024, prior to presentation to the Board on 9 October 2024.

Current Position

The highest risks identified within the assurance framework (based on the mitigated risk score) are:

- SR3: Workforce Capacity
- SR6: Finance

Gaps in controls and assurance are identified across all strategic risks and clear actions to address these have been identified. The responsible Committees will consider if any further assurance may be required in respect of individual risk areas.

There were three amendments arising from the Committee reviews:

- People and Culture Committee requested an additional action relating to staff networks and this has been included.
- Strategy Transformation and Partnerships Committee requested a change in the assurance rating from neutral to negative in respect of the HER programme. This amendment has been made.
- Finance and Performance Committee requested a review of the controls and assurance in respect of fire safety. An update has been included.

Further Developments

Further developments are planned for the next reporting cycle:

- Key metrics will be assigned to each risk.
- Each strategic risk will be cross-referenced into the Corporate / Organisation Risk Register.
- Further work is required to develop a joint risk appetite, building on the work undertaken at the joint Board Development Workshops.
- A new template has been developed for all board reporting which includes a requirement to cross reference all reports to specific BAF risks (or to state that there are no implications). This will be rolled out during September and October 2024.

New Template

A new template has been developed for the Board Assurance Framework, with a consistent framework across both Trusts. This template has been developed to show 'a risk on a page' with an overview of all risks.

- Each risk has an unmitigated, mitigated (as at September 2024) and target score using the 5x5 scoring matrix previously reported. The unmitigated score is the level of risk before any mitigating actions are taken. The mitigated score is the level of risk with the controls and assurance in place and the implementation of the identified actions.
- Controls and assurances are identified in terms of:
    - Priority Strategies and Plans
    - Risk controls and Plans
    - Oversight Governance and Engagement
- Each assurance has been assessed as Positive / Neutral / Negative. Where there is a gap in control or assurance this has been categorised as 'neutral'.
- Each of the three categories above have an overall assessment based on the controls and assurances in place as Red / Amber / Green. Where there is an assessment of Amber or Red there will be a corresponding action to improve the level of control and/or assurance.
- Each action is marked as:
    - On Plan (Green)
    - Behind Schedule' (Amber)
    - Significantly behind schedule (Red)
    - Complete (Grey)

Recommendation

The Board is requested to:

- Receive the Board Assurance Framework as at September 2024 and be assured of its contents

DCH Trust Board 9 October 2024
Board Assurance Framework

1. Introduction

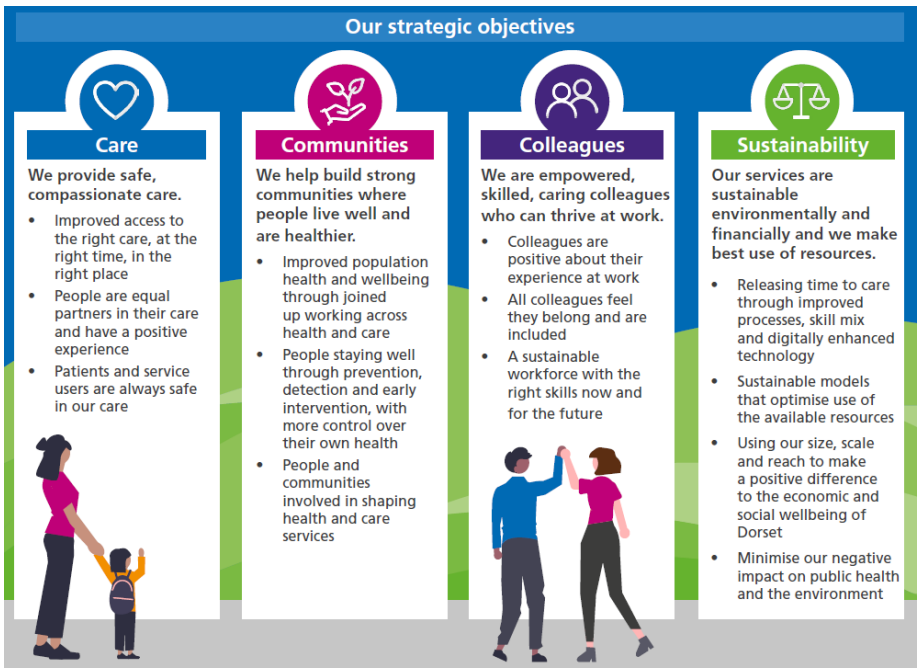
The Board Assurance Framework, together with the Corporate Risk Registers (Clinical and Non-Clinical) and local risk registers provide the framework for the management of risks across the Trust.

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.

The Audit Committee is responsible for reviewing the adequacy and effectiveness of the assurances that the Board receives in respect of the identified strategic risks, ensuring that they are relevant and timely and that this contributes to the effectiveness of the overall system of internal control. Individual Committees have responsibility for oversight of specific risks.

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 this was approved by both Boards in July / August 2024.



Alongside the development of the Joint Strategy work on developing the Joint Principal Risks to achieving the Joint Strategic Objectives was undertaken and the risks were approved by

both Boards in July / August 2024. The process to arrive at the Joint Risks was ser out in the report to the Boards.

3. New Template and Review Process

A new template has been developed for the Board Assurance Framework, with a consistent framework across both Trusts. This template has been developed to show 'a risk on a page' with an overview of all risks.

- Each risk has an unmitigated, mitigated (as at September 2024) and target score using the 5x5 scoring matrix previously reported to the Committee. The unmitigated score is the level of risk before any mitigating actions are taken. The mitigated score is the level of risk with the controls and assurance in place and the implementation of the identified actions.
- Controls and assurances are identified in terms of:
    - Priority Strategies and Plans
    - Risk controls and Plans
    - Oversight Governance and Engagement
- Each assurance has been assessed as Positive / Neutral / Negative. Where there is a gap in control or assurance this has been categorised as 'neutral'.
- Each of the three categories above have an overall assessment based on the controls and assurances in place as Red / Amber / Green. Where there is an assessment of Amber or Red there will be a corresponding action to improve the level of control and/or assurance.
- Each action is marked as:
    - On Plan (Green)
    - Behind Schedule' (Amber)
    - Significantly behind schedule (Red)
    - Complete (Grey)
- All actions are currently 'on plan' for delivery by the target date.

In terms of the review process:

- Each risk has been assigned to an Executive Lead who has signed off the BAF for their assigned risk(s).
- The BAF was reviewed and agreed by the Joint Executive Management Team on 3 September 2024.
- The BAF was reviewed by the Audit Committee on 17 September 2024.
- Each risk has also been assigned to a committee and has been reviewed during September 2024, prior to presentation to the Board on 9 October 2024. It should be noted that risk SR2 Capacity and demand was updated between the Risk and Audit Committee review and the Finance and Performance Committee review to provide more granular detail.
- There were two amendments arising from the Committee reviews:
    - People and Culture Committee requested an additional action relating to staff networks and this has been included.
    - Strategy Transformation and Partnerships Committee requested a change in the assurance rating from neutral to negative in respect of the EHR programme. This amendment has been made.
    - Finance and Performance Committee requested a review of the controls and assurance in respect of fire safety. An update has been included.

4. Current Position

The highest risks identified within the assurance framework (based on the mitigated risk score) are:

- SR3: Workforce Capacity
- SR6: Finance

Gaps in controls and assurance are identified across all strategic risks and clear actions to address these have been identified. The responsible Committees will consider if any further assurance may be required in respect of individual risk areas.

5. Further Developments

Further developments are planned for the next reporting cycle:

- Key metrics will be assigned to each risk. Where possible these will be the metrics developed for each strategic objective, facilitating clearer alignment to the achievement of strategic objectives.
- Each strategic risk will be cross-referenced into the Corporate / Organisation Risk Register. Further work is required to map these risks.
- Further work is required to develop a joint risk appetite, building on the work undertaken at the joint Board Development Workshops. This will be complied via survey during September 2024 (postponed from August 2024) using the Good Governance Institute approach GGI-Board-Guidance-on-risk-appetite-2020 (1).pdf.
- A new template has been developed for all board reporting which includes a requirement to cross reference all reports to specific BAF risks (or to state that there are no implications). This will be rolled out during September and October 2024.

6. Recommendations

The Board is requested to:

a) Receive the Board Assurance Framework as at September 2024 and be assured of its contents

Dorset County Hospital
NHS Foundation Trust

Dorset County Hospital NHS Foundation Trust
Board Assurance Framework - September 2024

Dorset County Hospital NHS Foundation Trust

Board Assurance Framework Overview - September 2024	Strategic Objectives				Responsibility		Score				
Strategic Risks	Care	Communities	Colleagues	Sustainability	Committee	Executive	Unmitigated Score	Mitigated Sept 24 Score	Mitigated Nov 24 Score	Mitigated Jan 24 Score	Target Score
SR1: Safety and Quality 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				**Quality Governance**	Chief Nursing Officer	**16**	12			**9**
SR2: 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		**People and Culture**	Chief People Officer	**15**	**12**			**6**
SR3: 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 and safe sustainable services within our resources	X		X		**People and Culture**	Chief People Officer	**15**	**15**			**9**
SR4: 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	**Finance and Performance**	Chief Operating Officer	**16**	**9**			**6**
SR5: 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	**Finance and Performance**	Chief Finance Officer	**16**	12			**9**
SR6: 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	**Finance and Performance**	Chief Finance Officer	**16**	16			**12**
SR7: 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	**Strategy, Transformation & Partnerships**	Chief Strategy Transformation and Partnerships Officer	**12**	**9**			**6**
SR8: 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	**Strategy, Transformation & Partnerships**	Chief Strategy Transformation and Partnerships Officer	**16**	**12**			**6**
SR9: 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	**Strategy, Transformation & Partnerships**	Chief Strategy Transformation and Partnerships Officer	**20**	**12**			**6**
SR10 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	**Strategy, Transformation & Partnerships**	Chief Strategy Transformation and Partnerships Officer	**15**	12			**9**

Dorset County Hospital NHS Foundation Trust

Strategic Objective	Strategic Risk	Overseeing Committee
Care	**SR1: Safety and Quality** **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**	Quality Committee

Executive Lead	Risk Score	Consequence	x	Likelihood	=	Score
Chief Nursing Officer	Unmitigated	4	x	4	=	16
	Mitigated	4	x	3	=	12
	Target	3	x	3	=	9

Controls *What we have in place to support delivery of the objective*	Assurance *Source of assurance - including internal (e.g. audits, policy monitoring, etc.) and external (e.g. regulators, internal audit, etc.)*	*Outcome of assurance*	Assessment *(See assessment guidance)*
Priority Programmes and Strategies			
Quality Priorities 24/25 (each have a subject matter expert owner)	Board approved 24/25 Quality Priorities incl in the Quality Account 23/24	Positive	
PSIRF Response Plan	Board approved PSIRF Response Plan, updates to Quality Committee (QC)	Positive	Green
Contractual obligations 24_25	KPI monitoring and Quality Dashboard	Neutral	
Maternity Incentive Scheme (MIS)	Maternity, Quality Committee, LMNS oversight and reporting	Neutral	
Patient flow Transformation Programme	Programme Board, Monthly reporting and Integrated Corporate Dashboard	Neutral	
Risk Controls and Plans			
Quality Priority Improvement Plan (inc agreed standards and measurement)	Quarterly Quality Priorities Report to QC (progress against KPIs)	Positive	
Patient Experience Metrics and Improvement Plans	Patient Experience monthly, quarterly and Annual Complaints Report (inc local surveys and metrics), Friends and Family Test National Surveys, Patient Story to Board, 15 Steps Challenge	Neutral	
PSIRF implemented to improve patient safety and Patient Safety Plan	PSIRF Operational and Exec Huddles, Patient Safety Committee oversight of Patient Safety Plan and Quality priorities	Positive	Amber
Patient Flow Transformation Programme	Programme Board - progress against milestones. Compliance with Winter Planning guidance	Neutral	
Quality Governance Committee Framework	Quality Reports and Dashboards	Neutral	
Oversight Arrangements for Governance & Engagement			
Quality Committee	Assurance Reports to Board	Positive	
Patient Safety Committee	Patient Safety Incidents Report and Assurance Reporting to Quality Committee	Positive	Green
PSIRF Oversight Group	Patient Safety Incidents oversight to Patient Safety Committee	Neutral	

Actions to Improve Controls and Assurance *(Required for any areas assessed Amber or Red)*	Lead	Target Date	Progress Summary
PSIRF Response Plan to refreshed and reviewed for 24/25	CS	Dec-24	On Plan
Establish Quality Assurance Group and annual reporting plan	Jhow	Sep-24	On Plan
Implementation of new Complaints and Concerns Policy in line with PHSO standards	Jhow	Mar-25	On Plan
Completion of CQC self assessments and actions plans	Jhow	Mar-25	On Plan
Completion of MIS	Jhow	Feb-25	On Plan

Dorset County Hospital NHS Foundation Trust

Strategic Objective	Strategic Risk	Overseeing Committee
Care Colleagues	**SR2: 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.**	People and Culture

Executive Lead	Risk Score	Consequence	x	Likelihood	=	Score
Chief People Officer	Unmitigated	5	x	3	=	15
	Mitigated	4	x	3	=	12
	Target	3	x	2	=	6

Controls *What we have in place to support delivery of the objective*	Assurance *Source of assurance - including internal (e.g. audits, policy monitoring, etc.) and external (e.g. regulators, internal audit, etc.)*	*Outcome of assurance*	Assessment *(See assessment guidance)*
Priority Programmes and Strategies			
Joint Inclusion & Belonging Strategy	Board approved Joint Inclusion and Belonging Strategy and Plan Cultural maturity assessment - internal audit - result awaited	Neutral	Amber
Leadership and Management Development Programme	Staff survey /Pulse Survey / FTSU Quarterly Report / Employment Relations	Neutral	
DCH People Strategy to 2025	WRES & WDES/EDS2/Gender Pay Gap / Staff Survey / Pulse Survey	Neutral	
EDS 2 in development	EDS 2 being developed - gap in assurance and control	Neutral	
Programme of staff engagement activity	Further assurance required to formalise programme and measure effectiveness	Neutral	
People Plan Priorities 2024/25	Workforce report to People and Culture Committee on progress against key	Positive	
Risk Controls and Plans			
Freedom to Speak Up Policy	Freedom to Speak Up bi-annual and annual reports	Neutral	Amber
Joint Inclusion and Belonging Action Plan	Further assurance required - reprioritisation of priorities and timeframes	Neutral	
People & Culture Committee in Common (DCH & DHC)	Assurance / Escalation Report to Board	Positive	
Oversight Arrangements for Governance & Engagement			
People & Culture Committee in Common (DCH & DHC)	Assurance / Escalation Report to Board	Positive	Amber
Equality and Inclusion Group sexual safety working group trade union partnership form	Assurance Reports to People and Culture Committee	Positive	
Staff Networks	Annual EDI Report and Minutes to be reported to PCC from Sept 24	Neutral	

Actions to Improve Controls and Assurance *(Required for any areas assessed Amber or Red)*	Lead	Target Date	Progress Summary
Re-prioritise Joint Belonging and Inclusion Action plan and timeframe - to PCC Sept 24	NP	Oct-24	On Plan
Establishing the Culture and inclusion Reference Group	NP	Nov-24	On Plan
Finalising the governance sub-structure to Joint People and Culture Committee	JH / NP	Nov-24	On Plan
Continue work to support and strengthen FTSU with stronger joint working arrangements	NP/DD	Dec-25	On Plan
Joint People Plan to be developed (aligned to Joint Strategy and ICS People Plan)	NP	Mar-25	On Plan
Strengthen executive involvement in staff networks	CG	Nov-24	On Plan
Complete roll out of system conscious inclusion and inclusive leadership training	EH	Mar-25	On Plan

Dorset County Hospital NHS Foundation Trust

Strategic Objective	Strategic Risk	Overseeing Committee
Care Colleagues	**SR3: 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 and safe sustainable services within our resources**	People and Culture

Executive Lead	Risk Score	Consequence	x	Likelihood	=	Score
Chief People Officer	Unmitigated	5	x	3	=	15
	Mitigated	5	x	3	=	15
	Target	3	x	3	=	9

Controls *What we have in place to support delivery of the objective*	Assurance *Source of assurance - including internal (e.g. audits, policy monitoring, etc.) and external (e.g. regulators, internal audit, etc.)*	*Outcome of assurance*	Assessment *(See assessment guidance)*
Priority Programmes and Strategies			
DCH People Strategy to 2025 Dorset ICS People Plan and NHS Long Term Workforce Plan	Workforce Metrics in Integrated Performance Report / Staff Survey and Pulse Surveys / Internal Audit Report - Recruitment	Neutral	Amber
Workforce Planning framework	Workforce Metrics in IPR - other assurance reporting to be developed	Neutral	
Apprenticeship & Widening Participation Programme	Regular report from Education Team to People and Culture Committee	Positive	
People Promise Retention Exemplar Programme	Progress to NHSE and Board	Neutral	
Risk Controls and Plans			
Annual Workforce Plan and Priorities	Workforce Metrics Report to People and Culture Committee on progress against	Positive	Amber
Learning Needs Analysis	Annual Education Quality Self-Assessment / Learning Needs Analysis	Neutral	
		Neutral	
Oversight Arrangements for Governance & Engagement			
People & Culture Committee	Assurance / Escalation Report to Board	Positive	Amber
Workforce Programme System Groups (Recruitment, Widening Participation)	Escalation Report to ICB People Committee (reports to ICB)	Neutral	
Safer Staffing Review	Staff Staffing Report to Board	Positive	
Recruitment Control Panel	Weekly Reporting to Executives and System	Positive	

Actions to Improve Controls and Assurance *(Required for any areas assessed Amber or Red)*	Lead	Target Date	Progress Summary
Joint People Plan to be developed (aligned to Joint Strategy and ICS People Plan)	EH	Jun-25	On Plan
Full implementation of Workforce Planning Framework	NP	Dec-24	On Plan
More clarity on system implementation long term workforce plan - awaiting regional framework and will respond	NP	Dec-24	On Plan
Roll out of recruitment training for managers with focus on diversity and inclusion	EH	Mar-25	On Plan
Develop Talent Management and Succession Planning Approach	EH	Jun-25	On Plan
Finalising the governance sub-structure to Joint People Committee	NP / JH	Nov-24	On Plan

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Dorset County Hospital NHS Foundation Trust

Strategic Objective	Strategic Risk	Overseeing Committee
Care Communities Sustainability	**SR4: 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**	Finance and Performance

Executive Lead: Chief Operating Officer

Risk Score	Consequence	x	Likelihood	=	Score
Unmitigated	4	x	4	=	16
Mitigated	3	x	3	=	9
Target	3	x	2	=	6

Controls *What we have in place to support delivery of the objective*	Assurance *Source of assurance - including internal (e.g. audits, policy monitoring, etc.) and external (e.g. regulators, internal audit, etc.)*	*Outcome of assurance*	Assessment *(See assessment guidance)*
Priority Programmes and Strategies			
Patient Flow Program (Internal to DCH with partners)	Regular updates against key plans and outcomes via F&P reporting	Positive	
UEC Review (Newton) with System partners	To be confirmed in Sept 24	Neutral	Amber
Operational Plan 24/25 (in accordance with national planning guidance and inc Elective Recovery Fund - ERF)	Reported to F&P and Board (including risks to achievement of plan)	Neutral	
Risk Controls and Plans			
Elective Recovery activities	Work underpinning is within Divisional Performance and F&P reports / regional ov	Neutral	
UEC Improvement Plan	Work underpinning is within Divisional Performance and F&P reports	Neutral	Amber
Performance Management Framework (and resulting deep dive reviews)	Performance Report to F&P and Board and Deep Dives / Internal Audit Reports	Neutral	
Seasonal surge plan	Surge plan reported to F&P with monitoring via Performance Report	Neutral	
Oversight Arrangements for Governance & Engagement			
Finance and Performance Committee	Assurance Reports to Board	Positive	
System Planned Care Delivery Group /Elective Performance Management Group (EPMG) /Productivity weekly meetings	Performance Report to F&P and Board	Positive	
UEC System meetings - weekly/monthly/Qtrly and Seasonal Surge Planning	Surge plan reported to F&P with monitoring via Performance Report	Positive	Green
Divisional Performance Meetings	Performance Report to F&P and Board and Deep Dives	Positive	

Actions to Improve Controls and Assurance *(Required for any areas assessed Amber or Red)*	Lead	Target Date	Progress Summary
Use of Performance Management Framework to increase oversight where performance identified for improvement - year end review of performance	AT	May-25	On Plan
UEC (Newton) diagnostic stage to be completed and next steps clarified	AT	Nov-24	On Plan
Cold debrief on seasonal surge plan in Q4	AT	Mar-25	On Plan

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Dorset County Hospital NHS Foundation Trust

Strategic Objective	Strategic Risk	Overseeing Committee
Care Colleagues Sustainability	**SR5: 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**	Finance and Performance

Executive Lead	Risk Score	Consequence	x	Likelihood	=	Score
Chief Finance Officer	Unmitigated	4	x	4	=	16
	Mitigated	4	x	3	=	12
	Target	3	x	3	=	9

Controls *What we have in place to support delivery of the objective*	Assurance *Source of assurance - including internal (e.g. audits, policy monitoring, etc.) and external (e.g. regulators, internal audit, etc.)*	*Outcome of assurance*	Assessment *(See assessment guidance)*
Priority Programmes and Strategies			
New Hospital Programme	NHP Business Case, programme approved and build progressing	Positive	
Joint Estates Strategy to be developed - not yet in place	Not yet in place	Neutral	Amber
Capital Programme	Monitoring to Finance and Transformation (Performance) Committee	Positive	
Risk Controls and Plans			
Estates compliance functions	Compliance reports in estates Function and reported to compliance groups Further assurance required on fire safety	Neutral	
Backlog maintenance plan	On track and reported to Capital Investment Meeting	Positive	Amber
Oversight Arrangements for Governance & Engagement		Neutral	
Finance and Transformation (Performance) Committee for estates planning and compliance and Strategy Transformation and Partnerships Committee for transformation (from Sept 24)	Escalation reports to Board	Neutral	Amber
Capital Investment Meeting	Gap in assurance - reporting to Committee to be strengthen	Neutral	
Estates related compliance groups in place (water, fire, health and safety)	Gap in assurance - reporting into F&P from Sept 24	Neutral	
New Hospital Programme Board	Programme approved, NHP Programme Board report to STP Committee & NHSE	Positive	

Actions to Improve Controls and Assurance *(Required for any areas assessed Amber or Red)*	Lead	Target Date	Progress Summary
Develop Joint Estates Strategy	CH	Jul-25	On Plan
Strengthen assurance reporting on estates planning and compliance	CH	Dec-24	On Plan
Review of compliance functions by newly appoint Joint Director of Estates and Facilities	DM	Dec-24	On Plan
Review of fire safety compliance and governance by newly appoint Joint Director of Estates and Facilities	DM	Nov-24	On Plan

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Dorset County Hospital NHS Foundation Trust

Strategic Objective	Strategic Risk	Overseeing Committee
Sustainability	**SR6: 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**	Finance and Performance

Executive Lead: Chief Finance Officer

Risk Score	Consequence	x	Likelihood	=	Score
Unmitigated	4	x	4	=	16
Mitigated	4	x	4	=	16
Target	4	x	3	=	12

Controls *What we have in place to support delivery of the objective*	Assurance *Source of assurance - including internal (e.g. audits, policy monitoring, etc.) and external (e.g. regulators, internal audit, etc.)*	*Outcome of assurance*	Assessment *(See assessment guidance)*
Priority Programmes and Strategies			
5% efficiency delivery required of which recurrent delivery at min 60% and <20% classed as high risk by end August 2024	Oversight via Value Delivery Board, Divisional Performance meetings and Finance & Performance Committee	Positive	
Operational plan 2024/25 break even delivery	Oversight via Finance Reporting to Finance & Performance Committee and Senior Leadership Group and Trust Board	Negative	Amber
Medium Term Financial P - underlying position recovery and improve future sustainability inc cash focus	Medium Term Financial Plan to Finance and Performance Committee	Neutral	
Risk Controls and Plans			
Operational workbook completion supported by Transformation & Finance with EQIA process updates - Trust CIP Tracker master for recording, CFO led support review meetings with all areas	Value Delivery Board Executive SRO oversight, reporting to Finance & Performance Committee accountability frameworks, internal audit assurance	Neutral	
Regular budget meetings, enhanced budget manager training, recovery plans required for all overspending areas	Finance Reporting to Divisional Performance Meetings, Finance and Performance Committee & Trust Board	Neutral	Amber
System wide working & development - System Investment Group & System Recovery Group	Reports to System Investment Group & System Recovery Group, plus regular NHSE regional engagement / Oversight Framework rating	Neutral	
Oversight Arrangements for Governance & Engagement			
Finance and Performance Committee	Escalation Reports to Board, Finance Report to Committee and Board	Neutral	
Value Delivery Board (VDB) - CFO Chair & Executive SROs in place per identified themed area, EQIA process being enhanced	Internal audit report HFMA checklist assessment and CIP process audit conducted	Neutral	Amber
System wide working - System Recovery Group, CEO Escalation meeting	Financial oversight reports internally and System ICB	Negative	

Actions to Improve Controls and Assurance *(Required for any areas assessed Amber or Red)*	Lead	Target Date	Progress Summary
Efficiency deep dive to be presented to FPC Sept 2024	CH / CA	Sep-24	On Plan
Review of prior year non recurrent efficiency delivery for recurrent potential, challenge non recurrent status for agency and productivity schemes	CA	Sep-24	On Plan
Daily cash monitoring and appropriate mitigations including income maximisation, timely debt collection etc	CA	Sep-24	On Plan
Recovery plans in place for all overspending areas - target areas include non clinical bank review, NCTR patients, theatre utilisation, escalation beds, external securit	CH	Sep-24	On Plan
Enhanced of EQIA Process	CA	Nov-24	On Plan

Dorset County Hospital NHS Foundation Trust

Strategic Objective	Strategic Risk	Overseeing Committee
Communities Sustainability	**SR7: 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.**	Strategy, Transformation & Partnerships

Executive Lead

Chief Strategy Transformation and Partnerships Officer

Risk Score	Consequence	x	Likelihood	=	Score
Unmitigated	4	x	3	=	12
Mitigated	3	x	3	=	9
Target	3	x	2	=	6

Controls *What we have in place to support delivery of the objective*	Assurance *Source of assurance - including internal (e.g. audits, policy monitoring, etc.) and external (e.g. regulators, internal audit, etc.)*	*Outcome of assurance*	Assessment *(See assessment guidance)*
Priority Programmes and Strategies			
Joint Forward Plan, supports NHS system focus on the same priorities	ICB-led Provider Relationship meetings, ICB Membership	Positive	Green
Our Dorset Provider Collaborative	Our Dorset Provider Collaborative(PC) Board / PC Report to Board / Plan for	Positive	
One Transformation Approach (including Integrated Neighbourhood Teams and Flagships Programmes)	One Transformation Approach - Flagship Programme reporting to Joint Transformation and Improvement Board (JTIB) and Finance and Transformation	Positive	
Risk Controls and Plans			
Compliance with NHS Provider Licence and Code of Governance re duty to collaborate	Provider Licence and Code of Governance Compliance Report to Audit Committee annually	Positive	Amber
Five pillars from Joint forward plan - aligned of all programmes	Joint Strategy aligned to Joint Forward Plan / Ongoing assurance not in place -	Neutral	
Portfolios of change - INT / MH / Sustainable services / working together / operational redesign	Reporting to JTIB and to STP Committee from September 2024	Positive	
Oversight Arrangements for Governance & Engagement			
ICB and ICP Membership	Chair member of ICP, CEO member of ICB - updates and minutes to Board bi-monthly	Positive	Amber
Finance and Transformation Committee to Aug 24 and Strategy, Transformation and Partnership Committee - from	Escalation Reports to Board	Neutral	
Working Together Portfolio Board and Working Together Committee in Common	Escalation Reports from Working Together CIC to Board - to Aug 24	Positive	

Actions to Improve Controls and Assurance *(Required for any areas assessed Amber or Red)*	Lead	Target Date	Progress Summary
Framework for ensuring all proposals demonstrate alignment to the ICS Objectives / Joint Forward Plan	PL	Jan-25	On Plan
Strengthen reporting to Board in respect of provider collaboratives and partnership working	PL	Nov-24	On Plan

Dorset County Hospital NHS Foundation Trust

Strategic Objective	Strategic Risk	Overseeing Committee
Care Communities Sustainability	**SR8: 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.**	Strategy, Transformation & Partnerships

Executive Lead

Chief Strategy Transformation and Partnerships Officer

Risk Score	Consequence	x	Likelihood	=	Score
Unmitigated	4	x	4	=	16
Mitigated	4	x	3	=	12
Target	3	x	2	=	6

Controls *What we have in place to support delivery of the objective*	Assurance *Source of assurance - including internal (e.g. audits, policy monitoring, etc.) and external (e.g. regulators, internal audit, etc.)*	*Outcome of assurance*	Assessment *(See assessment guidance)*
Priority Programmes and Strategies			
Joint Strategy	Approved Strategy - metrics to be developed	Neutral	Amber
One Transformation Approach (including Integrated Neighbourhood Teams and Flagships Programmes)	One Transformation Approach - Flagship Programme reporting to Joint	Positive	
New Hospital Programme	Programme approved, NHP Programme Board report to STP Committee & NHSE	Positive	
Electronic Health Record (EHR) Programme (Outline Business Case - OBC)	DHC Board approved OBC. Further approvals by NHSE / Cabinet Office	Neutral	
Risk Controls and Plans			
Strategy Implementation Plan	Approved plan in place - assurance to be via bi-annual delivery reports, strategy dashboard to STP Committee- not yet in place	Neutral	Amber
Five pillars from Joint forward plan - aligned of all programmes	Joint Strategy aligned to Joint Forward Plan / Ongoing assurance not in place - need more robust assurance on alignment and monitoring	Neutral	
Enabling plans; Clinical & Quality, People, Digital, Finance and Infrastructure	Assurance not in place - plans to be developed	Neutral	
Joint Improvement Framework approach	Approved Joint Improvement Framework approach - to be implemented	Neutral	
Implementation of Patient Care Race Equality Framework (PCREF)	Self-assessment against national organisational competencies - reporting to STP Committee / Underlying governance structures to be reviewed to ensure robust	Neutral	
Oversight Arrangements for Governance & Engagement			
Portfolio Boards - Flagships, Integrated Neighbourhood Teams and Working Together Portfolio Boards	Transformation Reports	Positive	Green
Joint Transformation Improvement Board	One Transformation Highlight Reports	Positive	
Working Together Committee in Common (to Aug 24) and STP Committee from Sept 24	Escalation Reports to Board	Positive	

Actions to Improve Controls and Assurance *(Required for any areas assessed Amber or Red)*	Lead	Target Date	Progress Summary
Joint Strategy - Develop the Strategy Dashboard (including metrics to measure reduction in health inequalities)	PL	Nov-24	On Plan
Joint Improvement Framework. Develop the outline plan until Mar 25	PL	Oct-24	On Plan
Joint Strategy. Produce and get approval for the Enabling Plans	PL	Mar-25	On Plan
Implement robust governance and reporting for PCREF	PL	Dec-24	On Plan

Dorset County Hospital NHS Foundation Trust

Strategic Objective	Strategic Risk	Overseeing Committee
Communities Sustainability	**SR9: 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.**	Strategy, Transformation & Partnerships

Executive Lead	Risk Score	Consequence	x	Likelihood	=	Score
Chief Strategy Transformation and Partnerships Officer	Unmitigated	5	x	4	=	20
	Mitigated	4	x	3	=	12
	Target	3	x	2	=	6

Controls *What we have in place to support delivery of the objective*	Assurance *Source of assurance - including internal (e.g. audits, policy monitoring, etc.) and external (e.g. regulators, internal audit, etc.)*	*Outcome of assurance*	Assessment *(See assessment guidance)*
Priority Programmes and Strategies			
Joint digital strategy DCH/DHC	NHSE Digital Maturity Assessment (DMA), NHSE What Good Looks Like (WGLL)	Neutral	
EHR Programme (OBC)	DCH Board approved OBC. Further approvals by NHSE / Cabinet Office	Negative	Amber
Risk Controls and Plans			
Digital risks monitored and reported	Monthly Report to Digital Transformation and Assurance Group (DTAG)	Neutral	
Cyber security (NHSE Cyber Essentials, Information Security Management framework ISO27001)	Internal Audit Review	Neutral	Amber
Data Security & Protection Toolkit	Submission via Finance and Performance Committee and audited by BDO, reviewed by SIRO	Positive	
Oversight Arrangements for Governance & Engagement			
Strategy Transformation and Partnerships Committee - From Sept 2024	TOR approved - Reporting to Board from October 2024	Neutral	
EHR Programme Board	EHR Report into Board	Neutral	
Digital Transformation & Assurance Group	Monthly reporting includes risks, cyber, projects	Neutral	Amber
Digital Services Leadership Group (recently implemented - with only digital team representation)	Governance and reporting to be developed	Neutral	
Information Governance Group (also covers cyber)	Bi-monthly report to Finance and Performance Committee, STP from Sept 24	Positive	

Actions to Improve Controls and Assurance *(Required for any areas assessed Amber or Red)*	Lead	Target Date	Progress Summary
Joint digital strategy to be developed and submitted for Board approval	SD	Mar-25	On Plan
NHSE Review of outline business case (OBC) followed by EPR Investment Board/Cabinet Office	EHR Prog	Oct-24	On Plan
Implementation of Federated Data Platform (NHSE Mandate)	SD	Mar-26	On Plan
Development of Infrastructure roadmap to support joint digital strategy	SD	Mar-25	On Plan
Implement DCH/DHC EHR Advisory Group	SD	Sep-24	On Plan
Implement digital services governance by joining with DCH Digital Transformation & Assurance Group)	SD	Dec-24	On Plan

Dorset County Hospital NHS Foundation Trust

Strategic Objective	Strategic Risk	Overseeing Committee
Care Sustainability	**SR10 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**	Strategy, Transformation & Partnerships

Executive Lead	Risk Score	Consequence	x	Likelihood	=	Score
Chief Strategy Transformation and Partnerships Officer	Unmitigated	3	x	5	=	15
	Mitigated	3	x	4	=	12
	Target	3	x	3	=	9

Controls *What we have in place to support delivery of the objective*	Assurance *Source of assurance - including internal (e.g. audits, policy monitoring, etc.) and external (e.g. regulators, internal audit, etc.)*	*Outcome of assurance*	Assessment *(See assessment guidance)*
Priority Programmes and Strategies			
Joint DCH/DHC Digital Strategy (inc cybersecurity)	NHSE Digital Maturity Assessment & NHSE What Good Looks Like (WGLL)	Positive	
Secure email accreditation	ISO 27001 compliance linked to secure email accreditation (DCB1596)	Positive	Amber
EHR Programme (delivery of enterprise unified patient record platform)	DCH Board approved OBC. Further approvals by NHSE / Cabinet Office	Neutral	
Risk Controls and Plans			
Data Security & Protection Toolkit	Submission is via Finance and Performance Committee (FPC) and audited by Internal Audit BDO, reviewed by SIRO	Positive	
Regular phishing campaigns conducted, monitoring of alerts, patching and maintenance, password controls	Cyber security audit conducted by BDO (Aug 23), reported to IGG & FPC	Neutral	Amber
Cyber Security monitoring arrangements and system controls	Quarterly cyber security report to FPC	Neutral	
Oversight Arrangements for Governance & Engagement			
Information Governance Group (also covers cyber)	Bi-monthly report to Finance and Performance Committee, STP from Sept 24	Positive	
Monthly Digital Transformation & Assurance Group	Monthly reporting includes risks, cyber, projects	Neutral	Amber
Digital Services Leadership Group (recently implemented - with only digital team representation)	Governance and reporting to be developed	Neutral	
Finance and Performance Committee (Strategy Transformation and Partnerships from Sept 24)	Escalation report to Board	Positive	

Actions to Improve Controls and Assurance *(Required for any areas assessed Amber or Red)*	Lead	Target Date	Progress Summary
Joint ICB-led cyber security strategy being developed	SB	Nov-24	On Plan
Implement multifactor authentication (MFA) for all staff (in progress)	SB	Nov-24	On Plan
Development of Infrastructure roadmap to support joint digital strategy	SB	Mar-25	On Plan
Joint digital strategy (includes cyber) to be developed and submitted for Board approval	SD	Mar-25	On Plan

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ASSURANCE ASSESSMENT

GREEN	AMBER	RED
Well functioning controls in place to manage risks and deliver objective	Some key controls in place, but may not cover all risks or elements of objective	Clear gaps in controls for management of risks and delivery of objective
Assurance available for key controls	Some assurances available, but may not cover all controls	Limited or no assurance available
Assurance is overall **positive**	Assurance is overall **neutral**	Assurance is overall **negative**
	Clear actions to address gaps in controls and/or assurances	Plan not sufficient to address gaps in controls and/or assurances

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

1. Report Details			
Meeting Title:	Board of Directors, Part 1		
Date of Meeting:	09 October 2024		
Document Title:	Corporate Risk Register		
Responsible Director:	Jo Howarth Director of Nursing (Acute Services)	Date of Executive Approval	*Approved by* Dawn Dawson 04/09/2024
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	19/09/2024	Received for assurance

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 27 August 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.

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 June 2024 to 31 August 2024.

Date information	Initial Risk Score at time of addition	Risk Register Reference	Risk Title	Risk Description	Primary Reporting Committee
Date risk added to register. 06/06/2024 Next review date: 09/08/2024 Proposed date for risk to be managed: 31/03/2025	16 (Major (4) x Likely (4))	1903	Medical Equipment - Age of Washers in EDU	*Washers in Endoscopy Decontamination Unit are over 10 years old:* *EDU Washer 1 3H100255 Jan-14* *EDU Washer 2 3H100256 Jan-14* *EDU Washer 3 3H100257 Jan-14* *Washer 2 3H100256 (chamber 2a) was scheduled for a repair 06/06/2024 due to connectivity issues. The engineer has confirmed that this washer has reached its maximum capacity of cycles (maximum capacity per washer is 25,000 - this washer has reached 32,767) and it's at end of life.* *As all our machines are of a similar age and usage so this issue will likely happen to the rest at some point in the near future.* *EDU Washer 1 3H100255* *EDU Washer 3 3H100257* *Still in working order but department now have reduced capacity for normal activity. Senior management informed and awaiting updates from TDOC support.*	Finance and Performance Responsible Executive: Chris Hearn BAF reference: Place
Date risk added to register. 18/06/2024 Next review date: 18/09/2024 Proposed date for risk to be managed: 30/09/2024	16 (Major (4) x Likely (4))	1909	Fire Risk - Unauthorised Battery Disposal	*During the investigation of a fire in a waste bin outside of the MSCP a black bin bag was identified within the ground floor lift lobby next to an abandoned patient chair. On further examination the bag was full of used batteries that have been left by someone currently unknown, the risk to fire was evident given the condition of some of the batteries.* *The batteries were removed and disposed of with immediate effect following their discovery. The current risk rating reflects the risk prior to discovery.* ***This is likely to be lowered on next review.***	Finance and Performance Responsible Executive: Chris Hearn BAF reference: Place
Date risk added to register. 03/07/2024	15 (Moderate (3) x Certain (5))	1911	Digital - Reasonable Adjustment Flag	*Reasonable Adjustment Flag – DAPB4019 Requirement is to:* • *Identify - consult and consent approach*	Finance and Performance Responsible Executive:

Date information	Initial Risk Score at time of addition	Risk Register Reference	Risk Title	Risk Description	Primary Reporting Committee
Next review date: 01/09/2024 Proposed date for risk to be managed: 31/03/2025				• *Record - must be consistent and include SNOMED codes* • *Flag – using alerts which allow for SNOMED codes* • *Share – using flag + patient registers. Email triggered to designated recipients following specific events, eg admitted, in ED.* • *Meet – meet the requirements of the patient* • *Review and update - registers include review dates.* *The current Trust clinical systems cannot fully comply with the technical requirements of this ISN and the Trust is unable to fully meet its requirements under the Equality Act to provide reasonable adjustments to patients.* *Current mitigations include alerts to the LD Team, written patient documents, use of This is Me and manual PAS flags however these do not fully meet the requirements of the digital ISN.*	Ruth Gardiner BAF reference: Place
Date risk added to register. 03/07/2024 Next review date: 01/09/2024 Proposed date for risk to be managed: 31/03/2025 Baker,Abi 03/10/2024 16:29:16	15 (Moderate (3) x Certain (5))	1912	Digital - Unsent EDS (Electronic Discharge Summary) issues	*Ongoing issue of EDSs not being sent in accordance with contractual obligations. Investigations shows that there are 3 reasons for the delays:* • *Digital issues* • *Not all depts use VitalPAC,* • *EDS's not being completed in a timely way by the Clinicians.* *Until these 3 reasons are addressed either with system upgrade or system user compliance GP surgeries will not receive patient EDS (Electronic Discharge Summaries) in a timely manner, which poses a clinical safety risk.* *Reports currently being generated by ICE. These notify each ward of incomplete EDS's that need to be actioned and are displayed in date order with alerts as the EDS's get older.* A Task and Finish Group is in place to improve mitigations and performance.	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
Date risk added to register. 03/07/2024 Next review date: 01/11/2024 Proposed date for risk to be managed: 31/03/2025	15 (Moderate (3) x Certain (5))	1913	Digital - TPP SystmOne - EPR core unit	*The Trust's SystmOne unit is mainly used as a read only electronic patient record. As it is a SystmOne unit, it receives Tasks from Primary Care and other providers and system generated messages in relation to patients who have been under the Trusts care.* *There are currently a number of tasks that are unactioned which relate either to patient care (e.g. medication requests, test result follow up, clinical queries) or administration tasks relating to the integrity of the record, (e.g. demographic changes, record merge requests).* *In addition, there are a variety of issues to explore in relation to system users, ADT feeds, assigning a system privacy officer and Caldicott guardian and the specifications for teams using the system to accept referrals as well as other considerations.* *Regular meetings have been set up with the Interim CIO, Interim Head of Systems, Development, and Digital Transformation, Chief Nursing Information Officer, Data Quality Lead and the NHS Dorset digital team. From these meetings an action plan has been formulated to gain further information on the risk and to explore how best to resolve it, including finding suitable resource to manage open tasks.*	Finance and Performance Responsible Executive: Ruth Gardiner BAF reference: Place
Date risk added to register. 08/07/2024 Next review date: 01/09/2024 Proposed date for risk to be managed: 31/12/2024	12 (Major (4) x Possible (4))	1914	Safety - ED Crowding	*ED crowding and use of escalation occurs when the department has reduced flow and continuing attendances. over the last 12-18 months there has been increasing waits for beds often in access of 24 hrs which has caused the ED to become bedded and the ED escalation areas to be in constant use.* *Currently mitigated through the use of the Portesham Unit as additional beds while plans for enhancing flow through the Assessment areas are agreed and implemented. No use of the ED corridor since the introduction of the additional capacity in mid-August.* *UEC recovery plan/ ICS recovery plan/ Joint SOP*	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
				with SWAST/ alternative pathways with ICS system partners/ Patient flow and transformation board/ future NHP and Emzone project/ UTC implementation.	
Date risk added to register. 12/07/2024 Next review date: 30/08/2024 Proposed date for risk to be managed: 31/12/2024	16 (Major (4) x Likely (4))	1917	Safety - Introduction of Right Care, Right Person	*The introduction of Right Care, Right Person by the police will change the working practice of the Police in relation to their support and interventions where patients abscond from health services.* *Whilst changes to the delivery of support from the police has not yet been agreed or implemented, changes are already being experienced by clinical teams in the responses they receive from 999 call handlers which is creating some confusion.* *Right Care Right Person and working groups, chaired by the ICB are in place to look at policy changes.* *Information being collated on any incidents that occur where Police decline to support, and these are being fed through to the local inspector to address - case reviews are being commenced where a patient has come to harm as a result of absconsion and non-attendance.* *Strategic Mental Health Legislation Multi-Agency Group is in place and policy issues relating to support of mental health patients are escalated through this meeting.* *Executive team has raised the issue with Dorset ICB at the provider relationship meeting.*	Finance and Performance Responsible Executive: Anita Thomas **SYSTEM RISK** BAF reference: Place BAF reference: Partnership
Date risk added to register. 12/07/2024 Next review date: 31/08/2024 Proposed date for risk to be managed: 31/03/2025	16 (Major (4) x Likely (4))	1919	Digital - Electronic Health Record - Insufficient Digital Resource to support EHR readiness and implementation	*The next stage of the EHR programme related to readiness and then procurement and completion of a full business case, does not have adequate resourcing for DCH to complete all anticipated work to ensure e DCH can contribute to and participate as an active partner for the programme.* *Trust Board approval of the OBC is subject to further assurance on readiness and resourcing. Resources may need to be diverted from other strategic or BAU work with consequential risks to other projects or to operational provision*	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
Date risk added to register. 18/07/2024 Next review date: 20/09/2024 Proposed date for risk to be managed: 31/03/2025	15 (Moderate (3) x Certain (5))	1920	Digital - EndoForm in DPR not being sent electronically to GP's	*Over 2 years ago the new reporting system for flexible cystoscopies was set up into DPR. We would type the patient report directly into the Eform and it was planned to then be electronically sent to the GP via the DPR system. We found out 6 months after the launch that this was not the case, via GP complaints.* *No harm has come to the patients that were reviewed.* *We have been asking since then for the link to be set up but have been told on numerous occasions it wasn't a priority.* *To mitigate until a digital solution is found, we ensure each report is printed and sent to the GP via the postal system.*	Finance and Performance Responsible Executive: Ruth Gardiner BAF reference: Place BAF reference: Partnership
Date risk added to register. 22/07/2024 Next review date: 02/09/2024 Proposed date for risk to be managed: 21/10/2024	16 (Major (4) x Likely (4))	1922	Safety - Provision of Vascular Access Service	*There is no vascular line access service currently provided by the trust.* *This has previously been mitigated by using Anaesthetic Associates and occasionally 2 theatre practitioners that have been trained.* *One Anaesthetic Associate has left the Trust, and the other is no longer to carry out this service as it falls outside their remit due to a changing of their conditions of practice.* *Presently utilising gaps in the emergency list where an appropriately trained person can carry out the access.* *Not all Anaesthetists are trained to do this. Using the 2 trained theatre staff is not always possible due to it not being part of theatres establishment.*	Finance and Performance Responsible Executive: Anita Thomas BAF reference: Place
Date risk added to register 01/08/2024 Next review date: 02/09/2024 Proposed date	8 (Major (4) x Unikely (2))	1927	Safety - Paediatric Reporting of diagnostic images - lack of capacity	*No resilience for Paediatric Reporting across Dorset - this specifically affects Suspected Physical Abuse (SPA) legal cases. No current provision to report these cases at DCH.* *Contact made to all trusts and networks across the south, all experiencing similar issues with resilience due to lack of Paediatric Radiologists.*	Quality Committee Responsible Executive: Jo Howarth **SYSTEM RISK** BAF reference: Place

Date information	Initial Risk Score at time of addition	Risk Register Reference	Risk Title	Risk Description	Primary Reporting Committee
for risk to be managed: 31/12/2024				*Escalated to ICB, Wessex Imaging Network and Execs* ***THIS WAS ADDED ON 01/08/2024 as HIGH RISK*** ***Reviewed 27/08/2024*** ***This risk report is superseded by a service level agreement with Birmingham's Children's Hospital to report our SPA cases (30/08/24). The risk was reduced accordingly***	
Date risk added to register. 13/08/2024 Next review date: 13/09/2024 Proposed date for risk to be managed: 31/03/2025	15 (Moderate (3) x Certain (5))	1940	Estates - Head & Neck Management Office	*Head & Neck Operational and nursing management office currently based within the top floor of the Transport hub.* *This has previously been descripted as 'not fit for use' and is having impact on the staff within the office due to noise levels, air circulation.* • *Offer to work in alternative locations to staff where possible (hot desking)* • *Offer to work from home where/ when possible* • *Purchase of personal fans* • *Windows fully open (not correctly from H&S point of view)* • *Winter - Purchase of bottled water to avoid having no water in building* • *Headphones are regularly used by members of the teams to have music playing to manage with the increased background noise.*	Finance and Performance Responsible Executive: Chris Hearn BAF reference: Place

1. Introduction

1.1 This report provides an update to the report presented to the June 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. (Moderate risk score 9 (Moderate (3) x Possible (3) previously HIGH risk 16))

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 As an update:

- Policy was ratified by the Finance and Performance Committee (FPC) in June 2024.
- 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. SOPS have been drafted.

2.1.3 Spot checks on the vehicles and licences will continue to be undertaken, with finding being reported back to the Estates and Facilities Compliance Group. Escalations will be to the Health, Safety, Fire and Security Group, for exception reporting to the Risk and Audit Committee as

appropriate.

3. System Wide Risks

3.3 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 This is not on the risk register at Dorset Healthcare, however it has been raised by DCH with the ICB, who will raise this with their Health Inequalities lead.

3.4 **456 Patient Transport Provision & Urgent Patient Transfers (Moderate risk score 12 (4 Major x 3 Possible) was previously HIGH scored 16))**

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

3.4.3 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. In the main, these journeys now relate to outpatient appointments, and have low harm impact.

3.4.4 As this is now below the Corporate Risk Register threshold, it will be moved back to Division and be excluded from the next report, unless the risk score increases.

3.5 461 Risk of harm to patients that are MFFD remaining in hospital. (Moderate risk score 12 (4 Major x 3 Possible) previously HIGH 16)

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.

3.5.3 Length of stay is down in aggregate in comparison with 2023/24 with pathways 0 and 1 leading this improvement. The more complex patients however demonstrate an increasing length of stay which is acknowledged by the System partners due to the out of hospital offer not fitting certain cohorts of patients such as delirium, younger frail and behavioural concerns.

3.5.4 The System has engaged with support offers from BCF Support and PPL to review and recommend changes to the D2A offer. The system has further agreed a Strategic Partner (Newton) to review the entire UEC pathway and propose improvements (and associated savings). This latter partner will build on the work of the former which has been taking place since April 2024.

3.5.5 Funding from ICB to LAs for Better Care Funding (discharge and admission avoidance work) was cut for 2024/25 and the first round of reductions in offers was felt in June, coinciding with the end of half term and leading to longer lengths of stay. A further round of cuts is proposed for September and the Trust is working with ICB and partners on mitigating the impact further for DCH patients.

3.5.6 ICB Patient Safety team has linked with the NHS Dorset Urgent and Emergency Care team to review this risk as it is recorded as a risk at DCH, NHSD (FI006) and UHD (1053).

3.5.7 As this is now below the Corporate Risk Register threshold, it will be moved back to Division and be excluded from the next report, unless the risk score increases.

3.6 866 External Multiagency Delays Resulting in Delayed Discharge of Complex Paediatric Patients (Moderate risk score 9 Moderate (3) x Possible (3) previously HIGH 15)

3.6.1 An increasing number 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 but for their own safety.

3.6.2 The risk has been reviewed and reduced following the CYP Flagship programme's:

- Introduction of a 5-day Mental Health and Neurodiversity training programme based on the

Sussex Hospital model. The purpose of this training is to improve staff skills and knowledge in supporting children and young people with mental health and neurodiversity that use our services.

- The training program includes the following:
  - Eating Disorders
  - Simulations
  - Risk Assessments
  - Safe Holding training
  - Mental Health Act/Policies/Risks
  - Neurodiversity
  - The different services available/Signposting
  - Staff wellbeing
  - Mental Health Conditions
  - Safe holding training

3.6.3 It is anticipated that a least two members of staff on each shift in ED and Kingfisher will have completed the safe holding training.

3.6.4 A 15 Step challenge recently took place in the Emergency Department and on Kingfisher ward. The feedback collected (Emergency Department) has been shared at the CYP Mental Health Parity of Esteem Workshop. We are still awaiting feedback from the young person that joined us on the 15 Step challenge on Kingfisher ward. Once we have received all the feedback, this will then be shared with Kingfisher ward and at the next workshop.

3.6.5 The CYP Complex Care Practitioner has introduced a new referral Form in the organisation.

Referral criteria is as follows:

- CYP aged between 0-25 years with complex care needs (mental health and neurodiversity with or without a physical health need).
- CYP meeting criteria 1 that are (or are anticipated to be) admitted for over 72 hours.
- Support required with the clinical, professional leadership and management of a child and young person with complex needs to ensure safe and effective care delivery.
- Support required with multi professional meetings to find a solution and create onward plans for those CYP with mental / emotional / behavioural needs who remain admitted to acute setting without ongoing physical needs.
- Support required with any delayed discharges of a child and young person who is in an unsuitable setting for their needs.

3.6.6 Facilities on Kingfisher ward
The Green Room (De-escalation Room), Ligature Light bathroom and Disabled bathroom are available for patients to use. The feedback received from young people on the 15-step challenge regarding these facilities was positive.

3.6.7 A new Risk Assessment form (Restraint) has been created and is in the process of being reviewed.

3.6.8 The service have been working closely with Dorset Healthcare in relation to frequent attenders. This work includes:

- Creating a new policy
- Developing MDT/multi-agency care plans
- Establishing a Frequent Attender/High Intensity User Working Group

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

3.7.1 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.

3.7.2 A 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.

3.7.3 A National Child Mortality Database Programme thematic report was published in July 2024, which covered data from April 2019 to March 2022, which included the theme of transition. It noted the importance of early and robust transition planning for children moving between paediatric and adult services.

3.7.4 The National Confidential Enquiry into Patient Outcome and Death (NCEPOD) published a report on transition from child into adult healthcare in June 2023. This report concluded that there is no clear pathway for the transition of children to adult healthcare services. The report also found that the process of transition and the subsequent transfer is often fragmented, both within and across specialties. The report makes several recommendations to address this issue.

3.7.5 These recommendations have been addressed in an action plan, but we remain unable to deliver all actions due to capacity. This is also a System risk and has been shared with the Patient Safety team at the ICB, who are sharing this with the Health Inequalities team.

4 Corporate Risk Register

4.1 There are currently 84 risks on the risk register that are scored 15 or above. This is down on the last Committee report from 88. Services are continuing work through their risk registers as part of their governance review processes.

4.2 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 48 risks were closed between 01.06.2024 and 27.08.2024. 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 27.08.2024
Appendices

- Heat Map (Appendix 1)
- Corporate Risk Register items (All committees) (Appendix 2)
- Risks closed between 01.06.2024 and 27.08.2024 (Appendix 3)

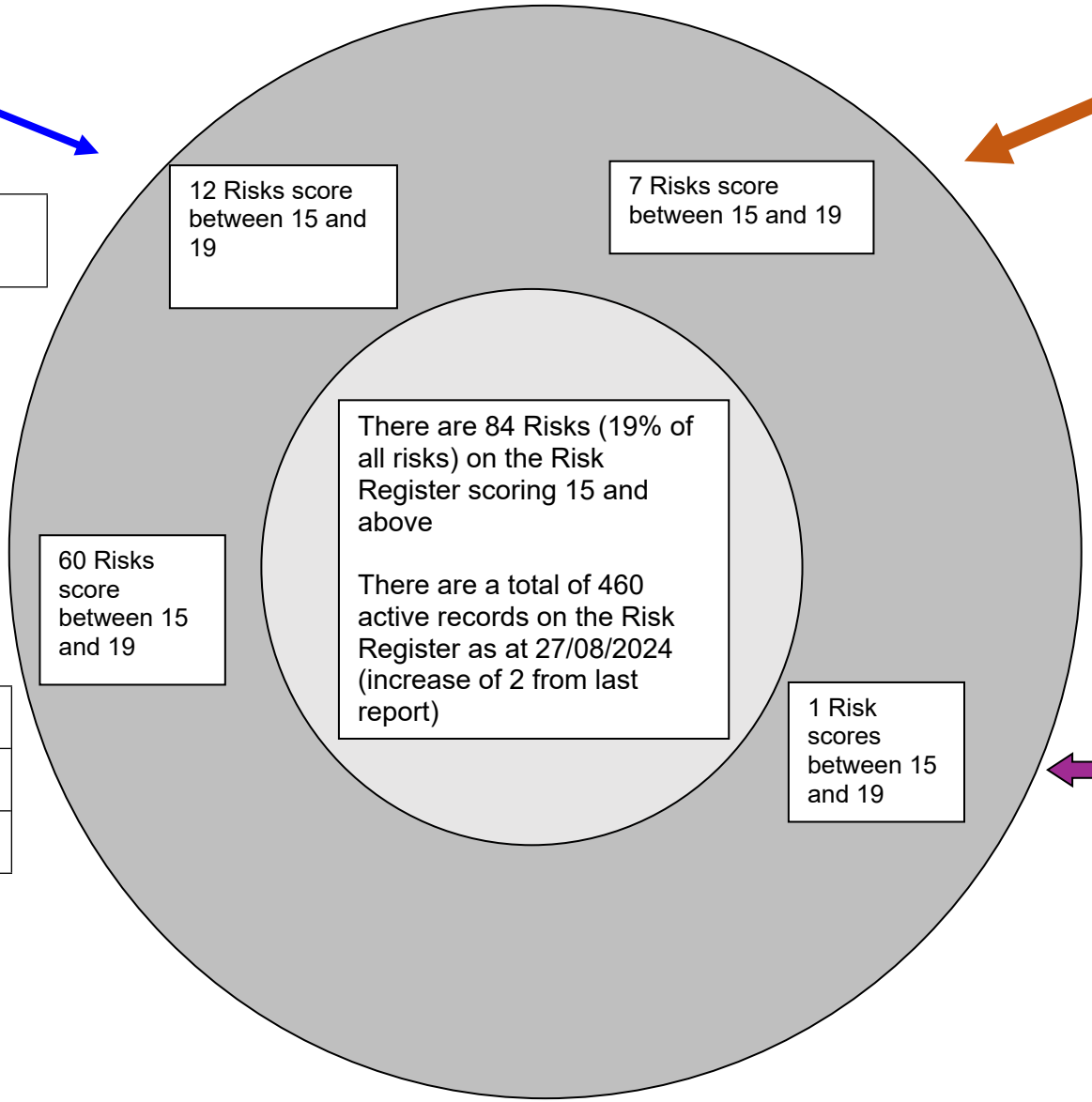
Corporate Risk Register – Risks scoring 20 or above detailed in the table

People and Culture Committee

1152	Current Digital Staffing levels present risk to both operational and strategic activities ↑

Finance and Performance

472	Community Paediatric Long waits for ASD patients ↔
1221	Tackling the backlog of elective care ↔
1749	Theatre Utilisation below 85% ↔



Quality Committee

Risk and Audit Committee

Baker, Abi
03/10/2024 16:29:16

Corporate Risk Register: RISK and AUDIT COMMITTEE **Appendix 2**

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 criterion 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: 30/09/2024 Proposed date for risk to be managed: 31/12/2024	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. Deputy Head of Paediatrics Occupational Therapy is met 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. This is not on Dorset Health Care's risk register, as they are not commissioned to provide this service, however this risk has been raised and reported to the ICB as a system risk, but resolution soon will be unlikely.
Reporting Committee Baker,Abi 03/10/2024 16:29:16	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: **Risk of harm to patients that are MFFD remaining in hospital**	**SYSTEM RISK** Responsible Executive: Jo Howarth, CNO Comments/ Mitigations
461	**12**		15	Patients stay too long in hospital due to internal delays or lack of external care capacity/inefficient process e.g. home with care or community hospital bed. Patients who remain in hospital for longer than they should are at risk of harm - falls or infection. Date risk added to register. 29/09/2021 Next review date: 31/12/2024 Proposed date for risk to be managed: 31/03/2025	Length of stay is down in aggregate in comparison with 2023/24 with pathways 0 and 1 leading this improvement. The more complex patients however demonstrate an increasing length of stay which is acknowledged by the System partners due to the out of hospital offer not fitting certain cohorts of patients such as delirium, younger frail and behavioural concerns. The System has engaged with support offers from BCF Support and PPL to review and recommend changes to the D2A offer. The system has further agreed a Strategic Partner (Newton) to review the entire UEC pathway and propose improvements (and associated savings). This latter partner will build on the work of the former which has been taking place since April 2024. Funding from ICB to Las for Better Care Funding (discharge and admission avoidance work) was cut for 2024/25 and the first round of reductions in offers was felt in June, coinciding with the end of half term and leading to longer lengths of stay. A further round of cuts is proposed for September and the Trust is working with ICB and partners on mitigating the impact further for DCH patients. **ICB provided an update 08.08.2024**. Patient Safety Team to link with the NHSD Urgent and Emergency Care team to review this risk, also recorded as a risk by the ICB ref FI006 and UHD ref 1053.
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	**9**		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	Introduced a 5-day Mental Health and Neurodiversity training programme based on the Sussex Hospital model. This training will improve staff skills and knowledge in supporting children and young people with mental health and neurodiversity that use our services. The training is for all clinical staff.

				beds on discharge from Kingfisher Ward. Date risk added to register. 24/12/2019 Next review date: 11/11/2024 Proposed date for risk to be managed: 31/03/2025	Safe Holding training is included in the Mental Health and Neurodiversity training program. We aim to have Safe Holding training mandatory (Yearly) within the organisation. This training is essential for the safety of patients/staff and will reduce risks. A new Risk Assessment form (Restraint) has been created and is in the process of being reviewed. 15 Step challenge recently took place in the Emergency Department and on Kingfisher ward. The feedback collected from the 15 Step challenge (Emergency Department) has been shared in the CYP Mental Health Parity of Esteem Workshop. Still awaiting feedback from the young person on the 15 Step challenge on Kingfisher ward. CYP Complex Care Practitioner has introduced a new referral Form in the organisation. The Green Room (De-escalation Room), Ligature Light bathroom and Disabled bathroom are available for patients to use. The feedback received from young people on the 15-step challenge regarding these facilities was positive. Children and Young People Mental Health policy has been adapted and reviewed by various staff, including Dorset Healthcare. This policy was recently approved in the Mental Health and Learning Disability Steering Group meeting and is available online to access. Introduced a weekly CYP Mental Health Project Group meeting. We have been working very closely with Dorset Healthcare around frequent attenders and we are creating a new policy, developing MDT Care plans and introduced a new Frequent Attender/High Intensity User Working Group.
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	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.

				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: 16/09/2024 Proposed date for risk to be managed: 31/12/2024	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. ICB have been notified of this risk, and it will be discussed with their Inequalities Team. The National Confidential Enquiry into Patient Outcome and Death (NCEPOD) published a report on transition from child into adult healthcare in June 2023. This report concluded that there is no clear pathway for the transition of children to adult healthcare services. The report also found that the process of transition and the subsequent transfer is often fragmented, both within and across specialties. The report makes several recommendations to address this issue. These recommendations have been addressed in an action plan, but we remain unable to deliver these actions due to lack of staff.
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	**12**		**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. Date risk added to register. 01/07/2023 Next review date: 31/10/2024 Proposed date for risk to be managed: 31/03/2025	The admission contractors (HTG) were 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. While there continues to be teething issues, they have not been of the nature of those experienced during wind down of previous contract. In the main they relate to OPD appointments and have low harm impact.
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	

		SYSTEM RISK		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: **Patient Safety Concerns and Increased Risk of Adverse Outcomes Due to Prolonged Wait Times in Community Paediatrics**	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: 22/09/2024 Proposed date for risk to be managed: 30/09/2026	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: 02.08.2024** Dorset ICB continuing to develop plans for assessment hub, profiling tool and recovery plans for existing waiting list for ASD/ADHD/ND waiters ~2600 CYP at DCH. We are working with Dorset ICB on this. Locum Consultant in post for 16 weeks covering WDA role as unable to recruit to post permanently despite being advertised 3 times. Community Paediatrics Workforce T&F group meeting commenced ASD co-ordinator newly in post. Another member of the secretarial team for community Paediatrics has resigned.	
Primary Reporting Committee		Finance and Performance Committee		**BAF objective: PLACE** • We will build sustainable infrastructure to meet the changing needs of the population. • We will deliver, safe effective and high-quality personalised care for every individual. • We will listen to our communities, recognise their different needs and help create opportunities for people to improve their own health and wellbeing. • We will utilise digital technology to better integrate with partners and meet the needs of the population. **BAF objective: PARTNERSHIP** • We will contribute to a strong, effective Integrated Care System, focussed on meeting the needs of the population. • We will ensure best value for the population in all that we do and we will create partnerships with commercial, voluntary and social enterprise organisations to address key challenges in innovative and cost-effective ways. • We will increase the capacity and resilience of our services by working with our provider collaboratives and networks and developing centres of excellence We will work together to reduce unwarranted clinical variation across Dorset • Through partnership working we will contribute to helping improve the economic, social and environmental wellbeing of local communities **BAF objective: PEOPLE** • Recruitment and Retention		

Ref:	Current Score		Previous Score	Risk Title: **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: 30/09/2024 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 31/08/24** Utilisation is still below 85% however the Trust is exceeding its improvement trajectory (as agreed with the Regional NHSE Team) and in August will be 2% over trajectory at 76%. Weymouth theatres and the new theatre schedule go into operation in September 2024, moving high volume work to a more appropriate site designed to maximise flow and create 58 additional lists over all. Weekly meetings will continue until performance over 80% is achieved sustainably.
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	16	⟺	16	The final plan for 2024/25 reflects a breakeven position for the Trust. Date risk added to register. 01/04/2024 Next review date: 30/09/2024 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. In July 2024, we delivered a month 4 deficit of £1 million after technical adjustments, an adverse performance of £0.1 million against the revised plan of £0.999 million deficit. The Trust has an efficiency delivery requirement of £14.4 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 including workforce review and productivity stretch totalling £7.5m. Without continued development of these 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 has improved since last year due to a combination of factors including system agency rate reduction and vacancy level decreases. NHSE is expecting all off framework agency spends to cease completely this quarter, if acheived the Trust aims to see a further FYE reduction of £1 million on spend. This has been achieved largely throughout quarter 1, however month 4 saw additional operational pressures where high cost Mental Health agency nursing was required. There is a risk at month 5 that further increased agency will be required due to the opening of Portisham Ward to support the extreme pressures seen in ED. Whilst 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 when required, which is forecast to be necessary in quarter 3. Ongoing mitigating solutions include review of local payment terms and driving income collection at pace will continue to be used to minimise this risk.
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: - 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: 02/09/2024 Proposed date for risk to be managed: 31/03/2025	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. Further Independent sector capacity has been made available by the ICB to support the transfer of long waiting patients, UHD have offered mutual aid in Ophthalmology and Echo capacity and a review of IS contracts and deliverability has delivered further in-house capacity.
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	

All Risk Register items closed between 01 June 2024 and 31 August 2024. **Appendix 3**

ID	Opened	Review date	Due date	Care Groups	Service of responsibility	Title	Risk Statement	Risk level (initial)	Risk level (current)	Risk level (Target)
1839	29/02/2024	17/04/2024	22/07/2024	Chief Operating Officer	Transformation – Patient Pathway Improvement Programme	24 Beds - Roof Leaks	Roof Leaks - 24 Beds	High Risk	Moderate Risk	Very low Risk
1798	18/01/2024	21/08/2024	01/08/2024	Chief Operating Officer	Transformation – Patient Pathway Improvement Programme	24 beds Ringfencing Protocol Challenges	If ward access cannot be appropriately ringfenced then orthopaedic activity will be curtailed with a risk that the orthopaedic activity identified in the business case will not be delivered. This has impacts on patient care, reputation, income, and the performance management regime for the trust as whole in its relationship with the ICB and region.	High Risk	High Risk	Low Risk
1901	04/06/2024	19/08/2024	30/09/2024	Trauma, Orthopaedics, Urology & Junior Doctors (B1a)	Orthopaedics Service	Air Conditioning Unit not working properly	Ongoing issues with the air conditioning unit installed in the new Portesham Unit	Moderate Risk	Moderate Risk	Very low Risk
1492	22/08/2022	23/07/2024	12/02/2025	Family Services (B4)	Paediatric Diabetic Service	Clinic Capacity in Paediatric Diabetes	Paediatric Diabetes patients should attend 4 clinic appointments a year to meet Best Practice Tariff requirements. We are currently not achieving this. This means that patients are receiving less education and support to manage their diabetes and are potentially having fewer adjustments made to their insulin than they require. This could lead to a higher HbA1c which may increase their risk of long term complications of diabetes. It may also affect their engagement with our service as patients have expressed dissatisfaction with their appointments being cancelled. This also increases the workload for the Diabetes Nurses and Dietitians who try to do additional patient reviews when patients aren't able to come to clinic.	Moderate Risk	Moderate Risk	Very low Risk

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ID	Opened	Review date	Due date	Care Groups	Service of responsibility	Title	Risk Statement	Risk level (initial)	Risk level (current)	Risk level (Target)
1668	10/06/2023	30/09/2024	31/12/2024	Integrated and Holistic Care (A2)	Clinical Haematology	Clinical Haematology Capacity for Dual Reporting of Bone Marrow Cases	There is currently insufficient capacity to dual report bone marrow cases in line with national guidance / UKAS accreditation requirements.	High Risk	Low Risk	Low Risk
959	15/09/2020	30/09/2024	31/12/2023	Integrated and Holistic Care (A2)	Respiratory Service	DAIRS Nurse Staffing	DAIRS Nurse Staffing	Moderate Risk	Moderate Risk	Low Risk
1203	02/02/2023	03/04/2024	31/03/2025	Chief Finance Officer	Strategic Estates	Delay for patients arriving by air ambulance during construction work for NHP scheme	The Helipad will need to be relocated to an off site location for the duration of the build, including demolition of West Annex and construction of new access road.	High Risk	Low Risk	Low Risk
1824	22/02/2024	22/02/2024	31/03/2025	Chief Nursing Officer	Across all specialties	Deprivation of Liberty Safeguards	Patients who are being deprived of their liberty under the Deprivation of Liberty safeguards are not being assessed within the timeframe set within this legal framework. This means that although Trust staff have identified they are possibly depriving a patient of their liberty using this framework, once the urgent authorization (Lasting a maximum of 14 days from date of application) the Local Authority (Supervisory Body) are not currently able to complete the necessary assessments within the timescales set within the DoLs framework. This means that the patient has no means of appeal to any deprivation, but also means that as assessments are not being completed in a timely way, many patients are discharged before assessments can be completed	Moderate Risk	Moderate Risk	Moderate Risk
1872	29/04/2024	02/09/2024	31/03/2025	Chief Information Officer	Clinical IT Systems	Digital Clinical Team - current staffing levels - risk to operational and strategic objectives	As the Trust has developed its digital maturity the number of digital clinical systems utilised has grown. Support is required by specialist clinicians, clinical informaticians/clinical digital safety specialists, who help ensure health Information Technology (IT) systems meet user requirements and adhere to patient safety standards. Currently these staff sit within the Digital services Change team and their role is split with project support and leading the training team. This allows little time to ensure we can mitigate any safety concerns of existing systems(e.g. Vital Pac, Fortrus systems). This also means we are unable to complete clinical risk management activities in a timely way.	Moderate Risk	High Risk	Low Risk

ID	Opened	Review date	Due date	Care Groups	Service of responsibility	Title	Risk Statement	Risk level (initial)	Risk level (current)	Risk level (Target)
1407	26/05/2022	16/08/2024	31/03/2025	Chief Information Officer	Digital Services (formerly IT)	DR - single point of failure	Not all applications are resilient/ mirrored to the other server r	Moderate Risk	Moderate Risk	Low Risk
1659	01/06/2023	17/06/2024		Head & Neck and Specialist Medicine (B2)	Ear, Nose and Throat (ENT) Service	ENT Deanery Gap - Junior Doctor	Removal of GPVTS post within the junior doctor allocation from the Deanery.	High Risk	Low Risk	Low Risk
1598	31/01/2023	30/09/2024	30/09/2024	Integrated and Holistic Care (A2)	Orthotics Service	Hand Therapy: Choose and Book Independent Providers	Incomplete pathways experienced by patients who opt for surgery at independent partner organisations namely Practice Plus Hospital Shepton Mallet and New Hall Hospital, Salisbury; with no hand therapy or other after care provided resulting in poor outcomes for patients. 1. Working with MSK service to agree appropriate referral process for both Newhall and Shepton Mallet independent providers for patients requiring surgery. As no after care is provided those procedures that require hand therapy should no longer be referred to these providers. Both DCH and UHD are unhappy to follow up these patients due to issues with communication of procedures and protocols, inability to communicate with the named surgeon difficulty re referring back into the service if there are issues with the surgery, dressings or infection. 2. Both UHD and DCH to escalate the problems through care groups and division 3. Current mitigation is that DCH hand therapists agree to see W Dorset local patients who have had surgery elsewhere as currently UHD are currently picking all these patients up; any issues/ risks to be logged and reported in own trust through incident reporting system, and brought back to the care group	Moderate Risk	Moderate Risk	Low Risk

ID	Opened	Review date	Due date	Care Groups	Service of responsibility	Title	Risk Statement	Risk level (initial)	Risk level (current)	Risk level (Target)
1624	27/03/2023	30/09/2024	31/03/2025	Integrated and Holistic Care (A2)	Respiratory Service	HCA Staffing Vacancies on Moreton Ward / Care Group Wards	There are 5 WTE vacancies of HCAs on Moreton ward. This leads to challenges in filling the shifts on the roster and leads to challenges with the provision of care. Additionally, there are consistently high vacancy levels in HCA establishment across all care group wards. Individuals have left to pursue other career options both within and external to the NHS.	High Risk	Low Risk	Low Risk
1202	31/01/2022	04/03/2024		Vascular and Metabolic (A1)	Cardiology Service	Heart Flow	Heart Flow is mandatory to implement. However the Trust does not have the servers and a suitable environment to support Heart Flow. The Trust needs to purchase 2xservers, then configure and install the new environment to support heart Flow.	Low Risk	Low Risk	Very low Risk
1621	14/03/2023	15/03/2023	11/04/2023	Chief Finance Officer	Finance	Helipad - Closure for NHP enabling work and construction (>2yr)	The use of the helipad during NHP enabling works (which includes the demolition of the West Annex)and NHP construction is deemed unsafe due to rota downwash and FOD/flying material hazards. Helipad closure is therefore initially scheduled for 20/03/23 to allow the commencement of these works. This presents an operational risk with the provision of a temporary helipad on the TA Centre site <1m from DCH. These risks include the time delays and logistics of an effective handover, including the movement of Helimed crew from landing site to DCH, handover and transfer back to landing site. The clinical view on the associated risks is still to be properly finalised but there is an assessment from Dr I Mew that shows the logistics/time delays of the handover for a transfer patient (time critical/specialist care) would mean that a road transfer would be as quick or quicker than via an air ambulance. If time critical/specialist care transfers become the favoured transfer method during the period of the helipad closure then there is a resourcing risk as Anaesthetists from DCH would be required to manage the transfer and accompany the patient. Potentially taking a member of the team off site for >4hrs. There is a longer-term risk of the use of the helipad post NHP completion i.e. If air ambulance emergency transfers into ED and critical patient transfers out of DCH to S'ton etc reduce in preference for road transfers, or the air ambulance crew bypassing DCH in favour of an alternative hospital then custom and practice over two years could influence the future use of the helipad.	High Risk	High Risk	Moderate Risk

ID	Opened	Review date	Due date	Care Groups	Service of responsibility	Title	Risk Statement	Risk level (initial)	Risk level (current)	Risk level (Target)
1220	08/03/2022	08/04/2022	08/04/2022	Pharmacy, Pathology and Medical Physics (A4)	Across all specialties	Homecare Service Provider resilience	CQC rating has rated some providers as inadequate for safety, leadership and requires improvement for effectiveness and responsiveness. This has led to concerns regard the ability of providers to maintain an adequate service to patients.	High Risk	High Risk	Moderate Risk
1000	21/11/2019	31/01/2023	31/03/2025	Chief Finance Officer	Finance	Inability to secure capital funding for build, or for business case development	Failure to secure capital funding – without capital this scheme will not go ahead and consequential risk that DCH cannot fully meet role as identified by Clinical Service Review and supported overwhelmingly in public consultation. Hub estimate £72m, funding route (e.g.. Health Infrastructure Plan) to be determined	Moderate Risk	Moderate Risk	Low Risk
1935	10/08/2024	31/12/2024		Integrated and Holistic Care (A2)	Dietetics and Nutrition Service	Inappropriate Management of Adult Eating Disorder Patients	There is a risk that some eating disorder patients admitted to DCH do not have an appropriately eating disorder service to support patient care.	Low Risk	Low Risk	Low Risk
776	29/11/2018	30/09/2024	30/06/2024	Integrated and Holistic Care (A2)	Adult Occupational Therapy Service	Inpatient Occupational Therapy Staffing	Currently running with the following inpatient vacancies: 1 x band 3, 2x band 6 OT, 1x band 7, 1x band 5 OT vacancies. 2 mat leaves Patient care at risk; speed of response, quality of discharges, delivery of rehabilitation limited. Staff wellbeing is a concern, with high sickness rates (especially mental health) as well as capacity to sufficiently supervise and support junior staff. High demand on services could risk inefficient working, particularly in areas/wards with no dedicated ward presence from therapies (low referring areas) Affecting the rotas (unable to sustain current rotas) and being able to do seven day working including supporting the Yeatman project	High Risk	Low Risk	Low Risk

ID	Opened	Review date	Due date	Care Groups	Service of responsibility	Title	Risk Statement	Risk level (initial)	Risk level (current)	Risk level (Target)
1021	31/12/2020	30/09/2024	28/08/2023	Integrated and Holistic Care (A2)	Stroke Service	Insufficient dietetic cover for stroke pilot at the Yeatman Hospital	There is a pilot project to set up a stroke rehabilitation unit at the Yeatman hospital. Stroke patients commonly have some difficulty in eating and drinking enough to meet their needs for nutrition and hydration with some requiring temporary or permanent artificial nutrition. This requires specialist dietetic input and the support of trained nutrition nurses both in direct patient care and also to train and support the care staff. The Yeatman pilot represents new work and is taking a significant amount of time from the DCH acute dietetic service which is a pressure for an already overstretched service of 2.6WTE dietitians. The need for specialist and dedicated dietetic support is a fundamental requirement for this stroke service and should be included as part of the resource plan.	Moderate Risk	Moderate Risk	Very low Risk
1532	24/10/2022	01/08/2024	01/08/2024	Surgery & Gastroenterology (B1b)	Gynaecology Service	Lack of Admitting Area for MTOP / MMOP Patients Across Surgical Wards	Patients who require a MTOP / MMOP procedure are often identified by the Maternity OPD. Patients are often discharged home to await date for admittance to hospital. Induction of labour is required to terminate / manage these pregnancies. In pregnancies / patients with a gestation of 12-18 weeks this is managed sensitively through the Nursing staff on Abbotsbury Ward. Gestations above 18-20 weeks are managed through Maternity.	Moderate Risk	Moderate Risk	Very low Risk
1190	11/01/2022	31/12/2024		Integrated and Holistic Care (A2)	Discharge Team Service	Lack of band 4 staff for 7 day opening of D/C Lounge	Discharge lounge asked to open 7 days a week to support flow, unable to open 7 days a week an unable to cover with own staff and bank	Moderate Risk	Low Risk	Low Risk
1529	17/10/2022	30/08/2024	20/11/2024	Family Services (B4)	Paediatrics Service	Lack of Capacity of Neurodevelopment Nursing	Neurodevelopment Nursing Team have seen a significant increase within their patient referrals over the past few months. The current nursing service is 1.0WTE band 7 Nurse who covers West Dorset with CYP with a diagnosis of a Neurodevelopment condition or is going through diagnostics. The service is supported by the Community Paediatricians who refer into the service. The Neurodevelopment Nurses have stopped taking direct referral as they have a caseload of over 120 CYP under their service which has now reached capacity to support all of the CYP. The role has developed significantly over the past few years with the service also supporting EHCPs and Schools.	High Risk	Moderate Risk	Very low Risk

ID	Opened	Review date	Due date	Care Groups	Service of responsibility	Title	Risk Statement	Risk level (initial)	Risk level (current)	Risk level (Target)
1246	27/04/2022	30/09/2024	11/07/2024	Integrated and Holistic Care (A2)	Adult Occupational Therapy Service	Lack of OT in Orthopaedics	Due to vacancies there is no qualified OT cover on either of the orthopaedic wards. This has significant consequences on patient flow and safety. Update 07/03/2024 - There is now a B6 Orthopaedic OT on the ward. There is still a vacancy of B5 and a B6.	High Risk	Low Risk	Low Risk
1054	10/03/2021	31/07/2024	20/06/2024	Family Services (B4)	Paediatrics Service	Lack of Paediatric Tissue Viability Service	We have seen an increasing demand in the number of CYP in the community that require Tissue Viability management. Currently the Trust has adult Tissue Viability Nurses in DCH and DUHFT but no service to support paediatric patients. There is no paediatric local policy, skin assessment or nutritional screening tool available for the Paediatric team to support specialist assessment, advice and support. The CCN team have been managing Chronic and Acute wounds within the community with advice from the Trust TVN team, this support has been helpful however it has been raised that the TVN team is not trained to provide advice to CYP under the age of 18 years. There is a trust risk for the purchasing of specialist equipment, regarding which service holds the budget for specialist equipment, PIN for ordering and which service in Paediatrics will provide assessment, ordering and ongoing maintenance of equipment in the community. At this point links were made with DUHFT via Neil Cleaver to find a better way to support CYP and their families with a more Robust pathway for TVN support in Paediatric Services.	High Risk	Low Risk	Very low Risk
1601	02/02/2023	31/05/2024	31/12/2024	Surgery & Gastroenterology (B1b)	Colorectal Service	Loss of Colorectal Oncology Clinics on Site	Medical Oncology clinics for colorectal cancer patients at DCH are being reduced by 50% to one per week. New patients are being referred to an alternative clinician in Poole. Dr A Harle is discontinuing her Wednesday DCH clinic from April. Dr S Prince is now receiving new colorectal referrals to be seen in Poole on a Thursday. Dr Prince will not travel to DCH for MDT or OPD. The CNS service cannot travel to Poole each Thursday due to staffing levels and clinical commitments onsite. The Poole CNS team are unable to support the clinics due to their own caseload.	Moderate Risk	Moderate Risk	Low Risk

ID	Opened	Review date	Due date	Care Groups	Service of responsibility	Title	Risk Statement	Risk level (initial)	Risk level (current)	Risk level (Target)
1535	26/10/2022	07/06/2024	01/01/2025	Chief Finance Officer	Strategic Estates	Loss of decant beds/Maud Alexander bed spaces resulting from NHP refurbishment spaces	When Maud Alex closes, DCH will lose decant beds until em zone opens. This will put operational pressure on the trust that will need to be mitigated. The time taken to refurb Em Zone could be months, or be a more complex and expensive build if phased.	Moderate Risk	Moderate Risk	Moderate Risk
1243	25/04/2022	30/08/2024	31/05/2024	Trauma, Orthopaedics, Urology & Junior Doctors (B1a)	Across all specialties	Medication not being Prescribed for Elective Patients on Admission to Hospital	Junior doctors not being allocated time to complete electronic drug prescriptions for elective patients on admission to the Trust, due to staff shortages. Previously junior doctors were allocated time to attend the Surgical Admissions Lounge to complete. This can impact on patient's not receiving their medication in a timely manner.	Moderate Risk	Moderate Risk	Low Risk
1347	23/05/2022	03/06/2024	31/03/2024	Chief Information Officer	Clinical IT Systems	Mosaic Chemotherapy system - DCH to Poole	Ongoing issues with access to the Poole chemotherapy system create delays in patient prescribing for chemotherapy introducing time consuming workarounds and use of generic passwords to enable users to continue working. This is not in line with Trust security policy	High Risk	Moderate Risk	Moderate Risk
1853	27/03/2024	01/07/2024	28/03/2025	Radiology, Outpatients & Neurophysiology (B3b)	Neurophysiology Service	Neurophyisology reporting cover	Our reporting cover is provided by Poole neurophysiology	Moderate Risk	High Risk	Low Risk
1035	03/02/2021	30/09/2024	31/03/2025	Integrated and Holistic Care (A2)	Dietetics and Nutrition Service	Nutrition Hydration Failures	The trust's nutrition and hydration policy set out our commitment to the appropriate nutrition and hydration for our patients staff and visitors. We measure our achievement against our objectives through regular audit. 2020 audits have not demonstrated adequate performance against our stated objectives including those targeted at meeting the basic nutrition and hydration needs of our patients. This is evidenced by several years of MUST audit data that has failed to demonstrate improvement in the screening and nutritional management of our most vulnerable patients.	High Risk	Moderate Risk	Very low Risk
1674	13/06/2023	30/12/2024	31/12/2024	Theatres, Anaesthetics, Critical Care & Decontamination (B3a)	Theatre Service	Obsolete Stryker Camera Stack Components	Have been informed that some components of our Stryker Camera Stacks will no longer be service or have spare parts for after December 2024.	Low Risk	Low Risk	Very low Risk

ID	Opened	Review date	Due date	Care Groups	Service of responsibility	Title	Risk Statement	Risk level (initial)	Risk level (current)	Risk level (Target)
1696	04/07/2023	30/09/2024	31/12/2024	Integrated and Holistic Care (A2)	Adult Physiotherapy Service	On call Respiratory Physiotherapy Service	Dorset County Hospital does not provide a 24/7 respiratory physiotherapy on call service to Critical Care.	Low Risk	Low Risk	Very low Risk
1417	26/05/2022	16/08/2024		Chief Information Officer	Digital Services (formerly IT)	PACS Image Backup	In the event of complete hardware failure there is no backup unable to access any historical PACS images	Moderate Risk	Moderate Risk	Low Risk
1527	14/10/2022	30/09/2024	13/10/2024	Integrated and Holistic Care (A2)	Palliative Care and End of Life Service	Palliative Care Staffing	Shortage of both nursing and medical staff for Palliative and End of Life Care within the hospital.	Moderate Risk	Low Risk	Low Risk
1579	16/01/2023	29/07/2024	31/05/2024	Theatres, Anaesthetics, Critical Care & Decontamination (B3a)	Theatre Service	Patient Transport Trolleys Replacement	DSU and Theatres use Anetic Aid QA3 for patient transport. Thirteen of our Thirty trolleys will no longer be maintained by Anetic Aid and need to be replaced. Current maintenance contract has expired.	Low Risk	Low Risk	Very low Risk
1622	14/03/2023	11/04/2023	03/10/2024	Chief Finance Officer	Finance	Programme Delays - Resulting from delays to the conclusion of RIBA stage 2&3	Delays resulting from Design Team availability/sickness and NHS industrial action has lead to 6 cancelled meetings from and extended design period of 38 weeks, creating a potential delay to the programme. Tilbury Douglas have reviewed the programme and are currently flagging a 4 week delay. Although stage 2 drawings/SOA have been signed off and accepted there are still outstanding caveats relating to staff change, storage, shell room opening schedule, patient garden, isolation rooms, diagnostic imaging CT room and bereavement	High Risk	High Risk	Low Risk
1165	14/10/2021	30/09/2024	30/04/2024	Integrated and Holistic Care (A2)	Stroke Service	Radiology, Digital Team & Service capacity to support implementation of Stroke Artificial Intelligence Solution	limited / lack of capacity due to workload for radiology to support the implementation of Rapid AI for the stroke service. This would impact on patient care regarding thrombectomy. If AI is not implemented this will result in delayed urgent treatment for Stroke patients and can prolong their recovery or reduce their ability to recover from a Stroke.	High Risk	Low Risk	Very low Risk

ID	Opened	Review date	Due date	Care Groups	Service of responsibility	Title	Risk Statement	Risk level (initial)	Risk level (current)	Risk level (Target)
1718	29/08/2023	30/08/2024	19/08/2024	Radiology, Outpatients & Neurophysiology (B3b)	Outpatients Services	Regular Opening of Clinic Rooms in Ortho OPD for Inpatients Out of Hours	Due to an increase in the number of patients requiring an in-patient bed, there have times when the clinic rooms in ortho OPD have been used for these patients out of hours. The environment and facilities do not provide and support in patient care.	Moderate Risk	Moderate Risk	Very low Risk
718	27/08/2019	30/09/2024	30/09/2024	Integrated and Holistic Care (A2)	Chemotherapy Service	Resilience of Mosaiq (SACT electronic Prescribing System)	Mosaiq (the prescribing and patient management system) continues to crash, creating a risk in terms of being able to prescribe, check, monitor and produce chemotherapy and other treatments.	Moderate Risk	Low Risk	Low Risk
1727	13/09/2023	15/08/2025	31/12/2024	Pharmacy, Pathology and Medical Physics (A4)	Blood Sciences Service - Biochemistry	Roche Cobas c8000 unreliability due to repeat intermittent erroneous results	Intermittent incorrect patient results being released to service users which could impact patient management.	Moderate Risk	Low Risk	Low Risk
1452	08/07/2022	29/08/2022	28/06/2024	Chief Finance Officer	Estates Department	Safe System of Work - Heights	Safe System of Work are a statutory requirement for Work at Heights	High Risk	Moderate Risk	Low Risk
536	01/01/2019	01/10/2023	31/07/2024	Chief Nursing Officer	Across all specialties	Slip Trips & Falls	Patients known to have falls, on sedatives or acute illness/delirium are known to be at increase risk of falls.	Low Risk	Moderate Risk	Low Risk
953	15/09/2020	30/09/2024	11/07/2024	Integrated and Holistic Care (A2)	Respiratory Service	Space - Respiratory Medicine	Insufficient space for the workload of the department, and poor layout, not making best use of the space available within the department footprint.	High Risk	Low Risk	Low Risk

ID	Opened	Review date	Due date	Care Groups	Service of responsibility	Title	Risk Statement	Risk level (initial)	Risk level (current)	Risk level (Target)
1228	17/03/2022	30/06/2023	16/03/2027	Chief Operating Officer	Site Team	Supervisory Night Sister Capacity	The supervisory night team has a requirement to have 2 members of staff on duty every night. This has been ongoing since the Covid Pandemic started in March 2020. The budget is insufficient to meet this need, and it has been met with additional hours over budget provided by as & when staff for the last 2 years to meet this need. Given the operational pressures relating to bed capacity, high clinical acuity and an increasingly junior ward nurse team, supported frequently by agency staff, there is a requirement to formalise the arrangement substantively.	Moderate Risk	Moderate Risk	Moderate Risk
1869	25/04/2024	15/05/2024	19/06/2024	Chief Operating Officer	Transformation – Patient Pathway Improvement Programme	SWH - Ventilation (Intake Plenum)	Design proposed for ventilation intake not meeting requirements of authorising engineer.	Moderate Risk	Moderate Risk	Very low Risk
801	07/11/2019	30/08/2024		Radiology, Outpatients & Neurophysiology (B3b)	Outpatients Services	Unfunded Staffing Shortfall in Outpatients	Increased requirement for temporary staff due to additional fast track clinics and capacity issues across all specialities in all outpatient areas.	High Risk	Moderate Risk	Low Risk
1503	08/09/2022	30/09/2024	11/07/2024	Integrated and Holistic Care (A2)	Stroke Service	Use Of Day Rooms for Inpatient Beds - Stroke	The Day room facilities on both the Stroke Unit and Barnes ward have been intermittently utilised throughout the summer to place inpatients as a result of the corporate demands on capacity.	Moderate Risk	Very low Risk	Very low Risk
515	08/08/2016	30/06/2024	11/07/2024	Integrated and Holistic Care (A2)	Across all specialties	Wander Alarms	Not enough wander alarms to fulfil the requirement of elderly care/stroke. Patient safety at risk	Moderate Risk	Very low Risk	Very low Risk

Working Together

Dorset County Hospital NHS Foundation Trust

Dorset HealthCare University NHS Foundation Trust

Escalation Report

Executive / Committee: Working Together Committee

Date of Meeting: Thursday 15 August 2024

Presented by: David Clayton-Smith

Significant risks / issues for escalation to Committee / Board for action	•
Key issues / matters discussed at the Committee	The committee in common considered the following items: • Working Together Highlight Report and Risk Register noting: ○ ○ • Committees in Common Terms of Reference • Joint Improvement Framework • Joint Strategy Implementation Plan • Integrated Neighbourhood Working • Children and Young People Flagship Outline Business Case • Strategic Risks and Development of the Board Assurance Framework • Review of the Working Together Programme with the NHS Forward Plan , including the ICB Forward Plan
Decisions made by the Committee	• Approval of the Federation Development Plan Update / Memorandum of Understanding
Implications for the Corporate Risk Register or the Board Assurance Framework (BAF)	• Report presenting the Strategic Risks and Development of the Board Assurance Framework
Items / issues for referral to other committees	• Nil

Strategy, Transformation and Partnership Committee in Common Assurance Report for the meeting held on 23 September 2024

Chair: David Clayton-Smith	**Executive Lead:** **Nick Johnson**	**Date of Next Meeting:** 27 November 2024
Quoracy met?	Yes	
Purpose of the report	To assure the Board on the main items discussed by the People and Culture Committee in Common and, if necessary, escalate any matter(s) of concern or urgent business which the Committee is unable to conclude.	
Recommendation	To receive the report for **assurance**	

Significant matters for assurance or escalation, including any implications for the Corporate Risk Register or Board Assurance Framework	• Receipt of the revised Board Assurance Framework and committee assigned risks, noting that there was a single set of strategic risks for both Trusts but a separate Board Assurance Framework for each Trust, due to the difference in assurances around those risks. A dynamic document that would be further developed and linked to the Corporate Risk Register for each Trust.
Key issues / matters discussed at the meeting	The committee received, discussed and noted the following reports: **Committee in Common transition report** • Marks that the organisations have moved from one committee to another and to provide assurance the transition has not lost actions or items from the workplan. • Standardised reporting with aligned front sheets but this is working progress and will evolve over time. **Strategy Launch and Implementation** • Strategy will launch on 30 September and will deliver the culture, communication and engagement plan. • Noted there are 3 main delivery initiatives. **Joint Improvement Framework** • Noted there is improvement in both organisations, using NHS Impact as guide and working with colleagues from UHD and ICB as well as primary care colleagues. • Looking ahead – there will be a board development session to share what has been delivered so far and to inform next steps • Inspire, empower and enable to support staff to make improvement. **One Transformation update** • Prioritisation of programmes has taken place using a scoring framework. This was co-produced with executives and teams

- The importance of noting the un-prioritised programmes was discussed as these could become a priority of the future.

Integrated Neighbourhood teams

- Top strategic priority and made progress since formally handed over considering the multiple stakeholders.
- Creating better experience for patients across primary and community care. Minimise duplication and encourage situation where patients only have to tell their story once.
- Query if there is the correct level of resource.

Frailty Programme Update

- Following the single point of access call there is a community assessment or SDEC in acute to keep flow.
- If managed right then we can reduce unplanned admission by 27% by 2027. Implementation has been development of virtual ward offer across DCH and DHC and are working well utilising system1. Continue to recruit to teams in those areas – working with GP to increase confidence in referrals and create a newsletter to connect teams.
- Frailty SDEC at DCH has opened
- Need to get single contact link operating

Provider Collaborative update

- Set priorities for 2425 and working to deliver those.
- ODPC board chaired by SH
- CANDO is a collaboration between DCH and UHD, success with Rheumatology and orthodontics
- Temporary workforce and agency spend – led by CS and seen reduced spend and ODPC cannot take complete ownership but helped.
- Shared service with a focus around procurement.
- Whilst in system pressure need to strengthen the focus on acute hospital access and see value release.

Reablement facility update

- Project between Dorset council and DCH to create a reablement centre at THQ – working on for a number of months and now working through detail.
- Dorset county have 3 reablement centres trying to deliver – Bridport, DCH and a site on east
- Developing principles to underpin heads of terms.
- Key areas
    - Long term lease – 125 year leaser
    - Asked for 20 year rolling break clause to buy out of agreement.

	○ Council do not want break cause in first 40 years so DCH will need to consider ○ Good progress on financial arrangements. Net neutral – offering county hall office space for those in THQ and Diabetes. Would need to provide clinical space for diabetes. ○ Moving to agreement – key decision for trust. ○ Still need to develop service model. Supporting patients 6 week post discharge and admission avoidance. **EHR** **NHP** • Summary of funding – Dorset schemes are not included in the government review and have had funding confirmed for all Dorset schemes. • ST Anns campus schemes in main work contract with Kia and are working to time and budget not concern to report • DCH in enabling works phase with some challenges with services encountered in ground which has created delays. Work done so far shows still affordable and designing the final scheme and GMP and again the schedule working to making progress hoping to make. **BAF**
Decisions made at the meeting	• Endorse the prioritisation of the One Transformation Approach
Issues / actions referred to other committees / groups	• Strategy launch update to the Board • One Transformation Approach including prioritisation framework to the Board • Electronic Health Record to part 2 of Board

Report to	Dorset County Hospital Board of Directors, Part 1	
Date of Meeting	Wednesday 09 October 2024	
Report Title	Strategy Launch and Implementation	
Prepared By	Paul Lewis Joint Director Strategy & Improvement Ciara Darley Strategy & Improvement lead	
Accountable Executive	Nick Johnson Deputy Chief Executive DCH & Joint Chief Strategy, Transformation and Partnerships Officer	
Previously Considered By	Strategy Transformation and Partnerships Committee in Common	
Action Required	**Approval**	
	Assurance	**X**
	Information	

Alignment to Strategic Objectives	Does this paper contribute to our strategic objectives	
Care	Yes	~~No~~
Colleagues	Yes	~~No~~
Communities	Yes	~~No~~
Sustainability	Yes	~~No~~
Implications	Describe the implications of this paper for the areas below	
Board Assurance Framework	Supports SR7 & 8; Collaboration and Transformation & Improvement.	
Financial	Improves through progress of Joint Strategic Objective - Sustainability	
Statutory & Regulatory	Demonstrates alignment to ICS Objectives	
Equality, Diversity & Inclusion	Improves through progress of Strategic Objective – Colleagues	
Co-production & Partnership	Improves through progress of Joint Strategic principles	

Executive Summary

This report assures the committee that following the approval of the Joint Strategy, a comprehensive launch and implementation plan is in place.

The Joint Strategy was approved by both Boards of Directors in July and August 2024. Since then, key governance structures have been established, including the revised Board Assurance Framework and updated reporting templates to align with the strategic objectives. Additionally, the new Working Together Portfolio and Joint Transformation & Improvement Board have been formed to oversee strategy implementation, providing assurance to this committee. The Joint Strategy report included the proposed culture, communications and engagement plan and this is in progress too.

The official launch will take place on 30 September 2024. After which communications will be sent to stakeholders across the system, thanking them for their contributions and sharing the approved strategy.

The three key initiatives driving the Joint Strategy's objectives are:

1. One Transformation Approach (OTA): Structured portfolios designed to deliver transformational change across both Trusts and in partnership with the ICS. Key areas include Place & Neighbourhoods, Mental Health, Sustainable Services, and the Working Together Portfolio. The OTA is now working with the Executive Team to reprioritise workstreams to align with available capacity across support, operational, and clinical services.

2. Enabling Plans: These will cover Clinical & Quality, People, Digital, Finance, and Infrastructure. Each plan will align with the Joint Strategy, outlining both how they support broader strategic work and how they internally contribute to the strategic objectives.

3. Joint Improvement Framework: This framework aims to inspire and enable continuous improvement by staff, service users, and partners. Aligned with the aspirations of the Dorset ICS and national initiatives, a working group has developed an improvement approach, which will be presented at this meeting.

Additionally, a Joint Strategy dashboard is being developed to track progress against strategic metrics, marking a new collaboration for both Business Intelligence teams.

It is proposed to update this committee every 2 months until the Enabling Plans are approved by March 2025 and then report bi-annually.

Recommendation
The Board is requested to receive the report for assurance

Strategy Launch and Implementation

1. Executive Summary

1.1. The Joint Strategy was approved in July/August 2024 by both Boards of Directors. Since then, the Implementation Plan and Culture, Communications & Engagement Plan have commenced. New governance arrangements are in place to monitor and report progress. The official launch will be 30 September 2024.

1.2. The key initiatives driving the strategy include the One Transformation Approach, Enabling Plans, and Joint Improvement Framework, all designed to deliver change across both Trusts to achieve the Strategic Objectives. The One Transformation Approach is already in progress, the enabling plans and Joint improvement framework are in development. A dashboard is being developed to monitor progress against strategic objectives.

1.3. It is proposed to update the committee every 2 months until the Enabling plans are approved by March 2025 and then move to bi-annual reporting. This seeks to give the committee proportionate assurance.

2. Introduction

2.1. The Joint Strategy, the first between the two Trusts, was approved in July/August 2024 and signalled the intent to both Dorset County and Dorset Healthcare to work in a federated way that improved the health and wellbeing of the population we serve.

2.2. This paper is designed to update the committee on progress with the strategy implementation. Progress is being made across several areas. This includes the new governance arrangements, report templates, the Board Assurance Framework, the implementation plan, the launch, the culture, communications and engagement plan and the key initiatives; One Transformation Approach, Enabling plans and the Joint Improvement Framework.

3. Main narrative

3.1. Strategy implementation is happening across several areas.

Governance

3.2. The new arrangements are now in place. Progress with implementation is discussed with a small executive-led working group on a regular basis to manage routine management. Formal updates are reported to the Working Together Portfolio chaired by Trust executives and then to the Joint Transformation & Improvement Board chaired by the CEO. For assurance updates are then reported to this committee.

3.3. The Board Assurance Framework has been updated to reflect our new strategy and is already in use.

3.4. Report templates are being rolled out to ask which strategic objective the paper relates; this will help to ensure that focus remains on achieving the strategic objectives across the trusts. For this committee the new template is in place.

Culture, communications and engagement plan.

3.5. The plan accompanied the Joint Strategy proposal that went to the Boards of Directors as an appendix. It outlined the main activity required to bring the strategy to life for our stakeholders. See Appendix 1.

3.6. The operational objective is 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. The Communications Objective is for colleagues at both trusts to understand how the joint strategy influences what they do and actively contribute to its successful delivery.

3.7. Progress in ongoing and the major components are listed. The plan has 4 main themes; Embed the strategy through an OD programme, Create and roll out the brand, Internal communication campaign and external communications campaign. Progress is ongoing.

3.8. The official launch will be on 30 September 2024. Once launched a series of actions will take place to coordinate the announcement with stakeholders. The communications will thank everyone for their contribution is developing the strategy, announce how as federated Trusts we bring our unique contribution to the Dorset ICS and our areas of focus detailed in the strategic objectives.

Enabling Plans

3.9. The enabling plans take the overall direction set by the Joint Strategy and develop the detail within each function. The plans will run for the life of the Joint Strategy, they are Clinical & Quality, People, Digital, Finance and Infrastructure. The plans will align to the vision and mission and demonstrate how they work towards the achievement of the strategic objectives.

3.10. The enabling plans will have 2 distinct parts. The first will describe how they are supporting ongoing efforts outside of their function. The second will describe what the function is doing internally.

3.11. Where possible the enabling plans complement existing or emerging plans. Progress with the plan will be reported through their usual governance routes and shared with the Working Together Portfolio for information and assurance

3.12. A proposal to start the work is due to go in the coming weeks with a view that all the Enabling Plans will be approved by March 2025.

Joint Improvement Framework

3.13. The Joint Improvement Framework (JIF) is designed to inspire, empower, and enable staff to improve across both Trusts, patients, communities and partners. The approach was endorsed by the Working Together Committee in Common and is presented as an item later in the meeting agenda. The JIF aims to foster continuous improvement in access, outcomes, experiences, and cost efficiency for patients and communities. By harnessing the collective

strength of our teams and embracing a collaborative spirit, we aim to transform into leading improvement organisations. This initiative will not only engage staff but also equip them with the tools and mindset necessary to implement meaningful changes, enhancing service resilience and sustainability. The JIF is structured around four main phases: Discover, Define, Develop, and Deliver.

3.14. Currently, the work is in the Discover phase. There is a lot of improvement work going on across both Trusts and provides another way to meet our ongoing challenges and creates hope, energy and optimism. This is exemplified by the energy and effort across both trusts in their contributions to QI week 9 – 12 September 2024. An end stage checklist will be completed for the Discover phase to check progress and agree whether the Define phase can commence. The breadth of work across both Trusts means this phase is likely to run beyond the initial month planned.

3.15. There is a newly formed Working Group with attendees from across both trusts. This group is connected to the ICB, patient and VCSE representatives. In time the group will extend its invite to Primary Care so that our Improvement Journey includes everyone.

3.16. To ensure Dorset providers are well-aligned, there is an ongoing relationship with UHD to complement their improvement approach, Patient First.

4. Conclusion

4.1. The Joint Strategy between Dorset County and Dorset Healthcare is underway, with governance structures, implementation, and engagement plans progressing as scheduled.

4.2. The official launch will be 30 September 2024.

4.3. Key initiatives, including the One Transformation Approach, Enabling Plans, and Joint Improvement Framework, are at various stages of development and rollout.

4.4. A dashboard is being developed to track progress towards strategic objectives, ensuring transparency and accountability.

4.5. Formal updates will continue to be provided every two months until March 2025, transitioning to biannual reporting once Enabling Plans are fully approved.

4.6. The Joint Improvement Framework is in the early Discover phase, with strong engagement and momentum across both Trusts.

5. Recommendations

5.1. The Board is recommended to:

a. Receive the report for **assurance**

Name and Title of Authors:
Paul Lewis Joint Director of Strategy and Improvement
Ciara Darley Strategy and Improvement lead

Date: 11 September 2024

6. Appendices

6.1. Appendix 1. Culture, Communications and Engagement plan

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

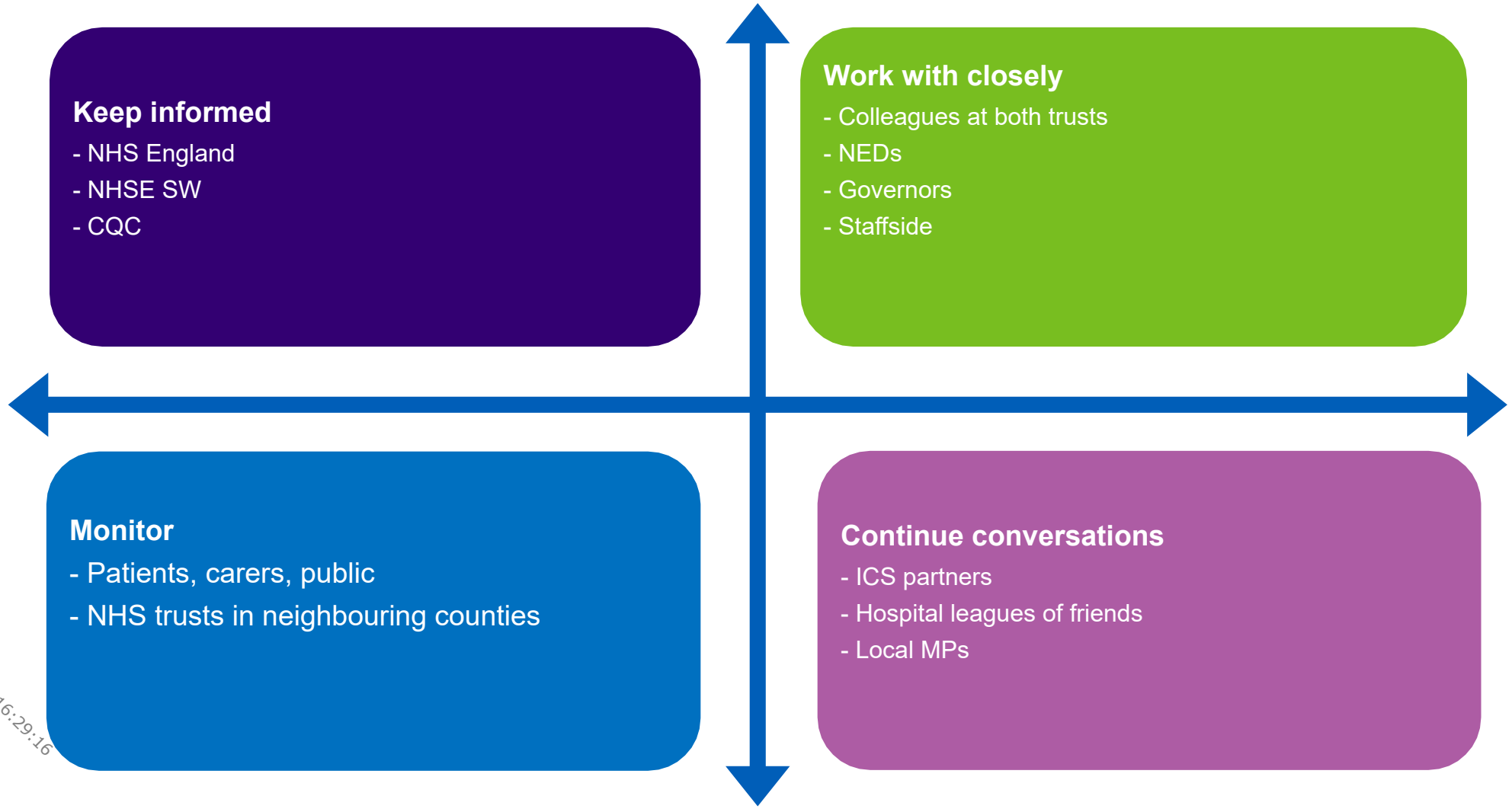
COMMUNITIES
We help build strong communities where people live well and are healthier

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	

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

Report to	Board of Directors	
Date of Meeting	Wednesday 09 October	
Report Title	One Transformation Approach Progress Update	
Prepared By	Judith Dean, Strategic Transformation Director	
Accountable Executive	Nick Johnson Deputy Chief Executive DCH & Joint Chief Strategy, Transformation and Partnerships Officer	
Previously Considered By	Joint Investment and Transformation Board September 2024 Strategy, Partnerships and Transformation Committee 25 September 2024	
Action Required	**Approval**	
	Assurance	X
	Information	

Alignment to Strategic Objectives	Does this paper contribute to our strategic objectives	
Care	Yes	
Colleagues	Yes	
Communities	Yes	
Sustainability	Yes	
Implications	Describe the implications of this paper for the areas below	
Board Assurance Framework	Supports SR1 Quality and Safety; SR3 Workforce Capacity; SR7 Collaboration and SR8 Transformation and Improvement	
Financial	OTA portfolios established to support the progress of the Joint Strategic Objective - Sustainability	
Statutory & Regulatory	Demonstrates alignment to ICS Objectives. Portfolios will support development and recognition of any statutory and regulatory requirements within their scope.	
Equality, Diversity & Inclusion	Improves through progress of Strategic Objective – Care, Communities & Colleagues	
Co-production & Partnership	Improves through progress of the OTA Portfolios and System programmes.	

Executive Summary

This paper summarises the progress on the development of the One Transformation Approach, the agreed priorities, and next steps. One Transformation Approach (OTA): Structured portfolios designed to deliver transformational change across both Trusts and in partnership with the ICS. Key areas include Place & Neighbourhoods, Mental Health, Sustainable Services, and the Working Together Portfolio. The OTA is working with the Executive Team to reprioritise workstreams to align with available capacity across support, operational, and clinical services.

Recommendation

The Board is requested receive assurance on:

- The progress made.
- Approval of the priorities and next steps for wider communication received via the Strategy, Transformation and Partnerships Committee
- Closure of the prioritisation phase of the One Transformation Approach and note that the programmes of work will move into implementation, with a six-monthly review of priorities via the Joint Transformation and Improvement Board

One Transformation Approach Progress Update

1. Context

1.1. Dorset County Hospital and Dorset Healthcare have strong records in delivering change and across both organisations there are some great examples of operational improvement, service redesign, digital innovation, transformation and new ways of working.

1.2. As demand for healthcare continues to increase, and financial and workforce pressures are experienced within organisations, and across the system, we will need to continue to improve the way we deliver our 'business as usual' while at the same time think strategically and reimagine the way in which we provide care to meet the changing needs of our population and to ensure our services are sustainably fit for the future.

1.3. This constant pressure to change means that we risk interventions being layered onto existing systems, and risks project overlaps, interdependencies and / or impact on other schemes being poorly understood.

1.4. Our single transformation and improvement approach will provide oversight of the change programmes across both Trusts, support the selection, prioritisation and control of the organisations' programmes and projects, in line with strategic objectives and capacity to deliver.

1.5. The goal being to balance the implementation of improvement and transformation work with the need to maintain operational delivery, giving visibility to senior leaders to make informed decisions and ensure resources and attention are focussed on the right initiatives and that those projects continue to maximise their value in delivering the intended impact.

2. Oversight

2.1. Delivery of our strategic objectives will be through our One Transformation Approach which adopts portfolio and outcome-based methodologies and is supported by an improvement framework to create the optimal environment for change.

2.2. This way of working ensures alignment and co-ordination of our major change projects linked to our vision, mission and strategic objectives and also encourages innovation by empowering and supporting staff to identify and make improvements themselves.

2.3. Our single approach works across directorate and organisational boundaries and is overseen by the Joint Transformation and Improvement Board who:

- Agree the prioritised portfolio of transformation and improvement programmes across Dorset Healthcare and Dorset County Hospital that balance the need for operational improvement and strategic transformation within the available resources.
- Set the ambition, expected outcomes, impact and timescales of the overarching portfolios.
- Delegate responsibility for delivery to an Executive Senior Responsible Officer

- Resolve conflict across and within individual programmes, breaking down silos and managing unintended impacts between programmes.
- Monitor and evaluate programme progress and benefits realisation.
- Provide assurance and insight to the Trust committees re. delivery of the Trust transformation and improvement programmes.

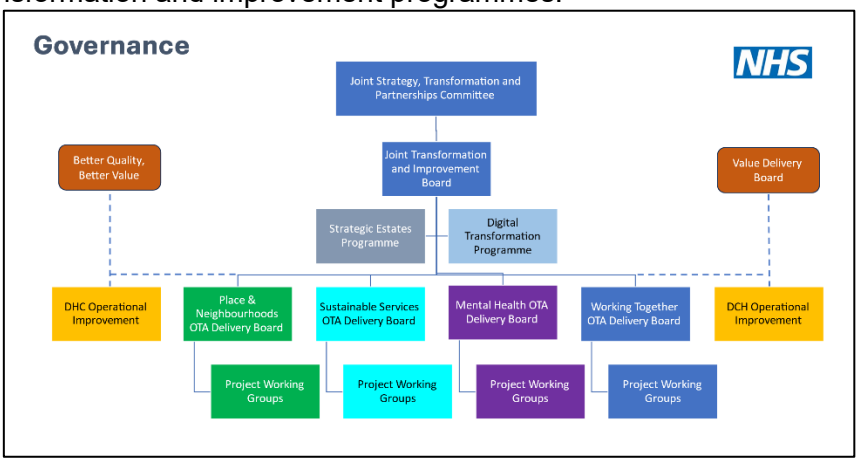


Figure 1: OTA Governance

3. Leadership

3.1. We have four transformation and improvement portfolios which drive delivery of our strategic objectives, these portfolios run alongside our improvement work, to ensure the optimal balance between transformation, continuous improvement and the need to maintain operational delivery.

3.2. Each portfolio is led by Executive SROs who will:

- Hold responsibility for ensuring delivery of the outcomes and impact for the overarching portfolio as set by the Joint Transformation and Improvement Board.
- Provide direction to the portfolio leadership triumvirate, consisting of a senior operational, clinical and transformation lead who will be jointly and separately responsible to the SROs for delivering the programme goals and outcomes.
- Work with Executive colleagues to resolve conflict across and within programmes, breaking down silos and ensuring other programmes are linked and delivered.
- Be supported by the Transformation Management Office

3.3. Supporting the SROs are the Portfolio Triumvirate Leads (a clinical, an operational and a transformation lead) who are jointly and separately accountable to the Executive SROs for delivering the portfolio outcomes within agreed timescales and resources.

3.4. The triumvirate will work together, taking responsibility for:

- Overseeing the successful planning and execution of the programme and associated projects
- Identifying, securing, and managing specialist skills, enablers and resources required to support delivery.
- Reporting detailed status updates and managing programme risks and overcoming barriers to progression
- Providing ongoing direction to the project teams.

4. Portfolios

4.1. The **Neighbourhood and Place** portfolio is seeking to:

- Adopt a population needs based approach, working with partners and communities in a Neighbourhood with Integrated Neighbourhood Teams providing integrated services that meet the needs of the population, supporting:
  - People to stay well through prevention, early detection and intervention.
  - People to stay at home, or be discharged early to recover, building knowledge and confidence to stay as healthy as possible.
  - The design of service models for children and young people that meet the mental and physical health needs across local authority and NHS services, including primary care, community services, speech and language therapy, school nursing, oral health, acute and specialised services.

- Reduce duplication, complexity, and unwarranted variation in care pathways by designing and implementing cross-organisational, streamlined, and coherent approach with access to place-based services which:
  - Provide specialist advice, guidance, and support to be able to support people to stay well and / or recover meet as many of those care and support needs locally and keep people well in their communities.
  - Provide timely access to specialist care able to respond to escalating or acute care needs.
  - Co-ordinate and integrate shorter term interventions to support transition between hospital and neighbourhood services and reduce hand-offs.

4.2. The **Mental Health** portfolio is seeking to:

- Deliver new and integrated models of primary and community mental health care with a focus on early identification and timely support to reduce escalation risks and bridge gaps in pathways.
- Promote, protect and improve our children and young people's mental health and wellbeing.
- Ensure parity of esteem through the development of a cohesive offer able to meet the physical and mental health of individuals.
- Improve flow of patients with mental health needs through both specialist mental health and acute hospital settings
- Empower individuals to self-identify their needs and access diverse interventions, which extend beyond clinical approaches.

4.3. The **Sustainable Service** portfolio is seeking to:

- Ensure continued access to more specialist, fragile, clinical services by working across organisational and agency boundaries to reduce inequalities, improve outcomes, improve pathway resilience and/or improve productivity.
- Optimise the use of estates and workforce.
- Reduce unwarranted variation in clinical care and outcomes through standardising approaches to improve patient care.
- Ensure services are designed to reduce the negative impact on public health and the environment.

4.4. The **Working Together** to realise the benefits of collaboration portfolio is seeking to develop:

- An Improvement Framework that builds a thriving and aligned framework that supports transformation and improvement across the organisations.
- Clinical, People & Culture, Finance, Digital and Estates enabling strategies.
- Greater collaboration to help simplify decision-making, increase integration and improve quality and outcomes for the people we serve.
- Streamlined support offers that remove the barriers to working across organisational boundaries.
- Optimised resources and reduced duplication and complexity

5. Operational Improvement

5.1. Recognising that transformation is not the sole focus of the organisations and we get the balance of resource allocation right to support transformation with the need to ensure resources are available to support operational teams to maintain and improve operational delivery.

5.2. The operational teams are responsible for, and need supporting capacity for:

- In year delivery of best value, best quality services that meet commissioned performance standards, within the available resources through:
- Delivery of 24/25 operational planning priorities
- Improved productivity and flow
- Increased efficiency and effectiveness
- Operational and performance improvement
- Cost avoidance, containment and reduction

5.3. While operational performance has a different reporting line, depending in the scale of change, interdependencies and resource requirements there will be some programmes which will benefit from being included in the Joint Transformation and Improvement Board discussions to ensure full visibility for senior leaders to make informed decisions and ensure resources and attention are focussed on the right initiatives and that those projects continue to maximise their value in delivering the intended impact.

5.4. Additionally, the Better Quality, Better Value and Value Delivery Boards will have a key role to play in driving opportunity identification and bringing them to the attention of the Joint Transformation and Improvement Board.

6. Prioritisation

6.1. The Working Together Programme Board and Committee in Common previously approved the prioritisation framework and agreed that it would make sense to put all existing and planned transformation and improvement plans through the process to determine the revised list of priorities.

6.2. A long list of opportunities was assessed through that framework, including DHC and DCH programmes as well as system programmes where we are the lead partner and those, where we are supporting partners.

6.3. The output of that initial prioritisation exercise was discussed by the Joint Executive Management Team in July where the Executive SROs for the individual portfolios were

asked to review and refine the outcomes and impact measures for their portfolio and then use the output from the prioritisation exercise as the basis for a discussion to determine the optimal blend of year one priorities expected to have the greatest impact on delivery the ambitions of the portfolio

6.4. Alongside this an assessment of current resource allocation was requested from each of the support services to understand the current allocation of resources against the prioritised programmes and their BAU and improvement work.

6.5. 24 prioritised programmes, across the four portfolios, were presented to the September Joint Transformation and Improvement Board. Considering the availability of the supporting resources, it was agreed that further prioritisation was required to better reflect available resources.

6.6. A further review of each programme was completed during the meeting with the following transformation programmes agreed as priorities for 24/25:

- Integrated Neighbourhood Teams
- Frailty
- Access Wellbeing
- CYP Mental Health Transformation
- Our Dorset Provider Collaborative
  - Clinical Networks
  - Temporary workforce (nursing and medical)
  - Procurement

6.7. The priority enabling programmes of work were agreed as:

- Electronic Health Records
- Joint Strategy implementation
- Joint Improvement Framework
- Support Services Review
- New Hospitals Programmes

6.8. Further detail of the portfolios and prioritised programmes can be found in appendix A, along with next steps for those programmes which have not been prioritised at this time, appendix B.

7. Next Steps

7.1. Repurpose the Working Together Programme Board, from October, to act as the Portfolio Oversight Board for the Portfolios, grouping the discussion at that Board into Place & Neighbourhoods and Mental Health portfolios and Sustainable Services and Working Together.

7.2. Establish the Joint Transformation and Improvement Delivery group, a cross-directorate, cross-organisational group, supporting the delivery of the agreed priorities within the portfolios. This group will include Portfolio triumvirates plus DCH and DHC Senior Leads from Strategy, Transformation and Partnership, Operations, People and Culture, Comms and Engagement, Nursing and Quality, Medical, Finance, Estates, Digital and Business Intelligence

7.3. Agreed priorities sent to support service leads with a request to:

- Review their work in line with these priorities and identify what changes in resource allocation is required as a result.

8. Identify what their remaining resource will be doing in terms of BAU and other change and improvement work.

8.1. Explore lead partner arrangement for CYP Mental Health Transformation programme.

8.2. Review of Operational Improvement Portfolio by Executive SROs to confirm prioritised work programmes and enabling resource requirement.

8.3. Communicate prioritisation decision more widely via Trust Senior Leadership Groups

8.4. Track implementation progress and benefits realisation.

8.5. Stand up programme delivery groups.

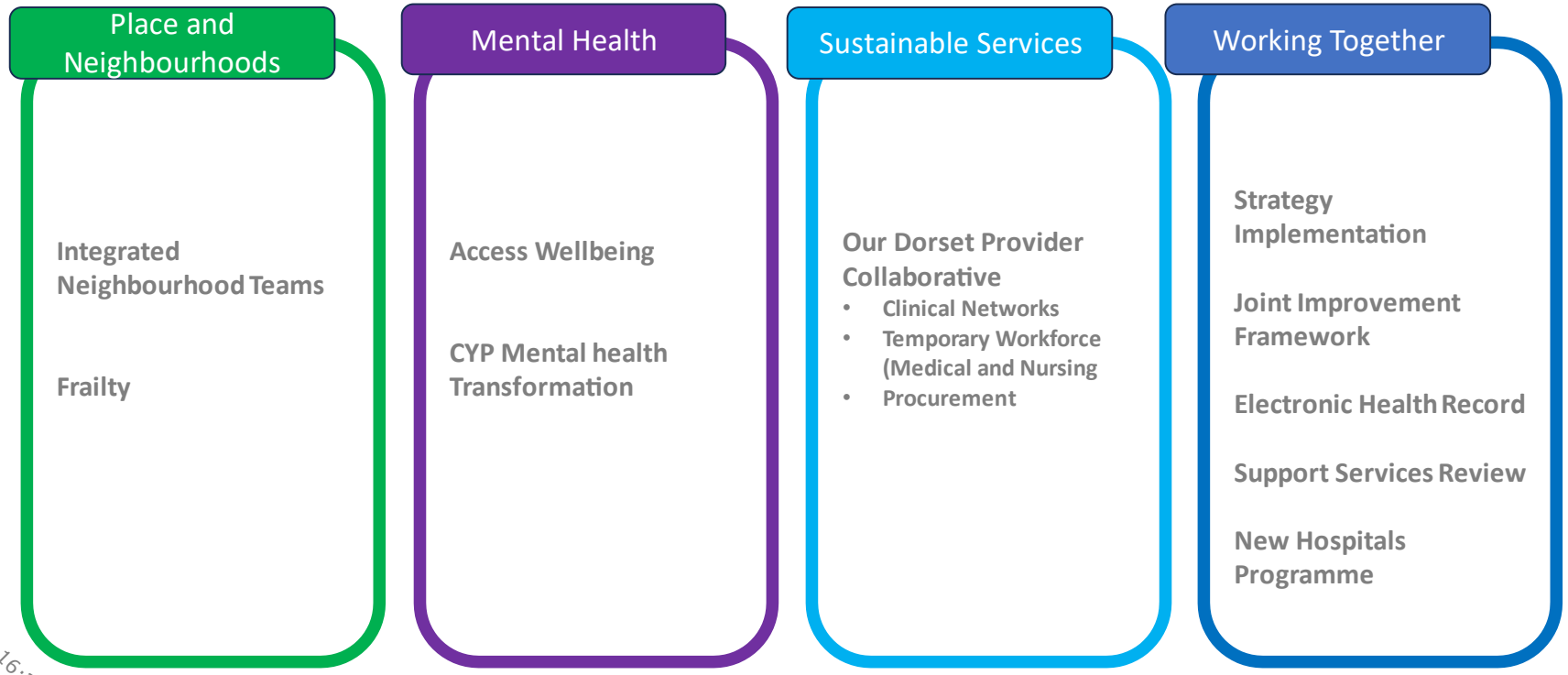
9. Recommendation

The Board is requested receive assurance on:

- The progress made.
- Approval of the priorities and next steps for wider communication received via the Strategy, Transformation and Partnerships Committee
- Closure of the prioritisation phase of the One Transformation Approach and note that the programmes of work will move into implementation, with a six-monthly review of priorities via the Joint Transformation and Improvement Board

Appendix A Prioritised Portfolio and Programmes

Prioritised Portfolios and Programmes



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Place and Neighbourhoods

Executive SRO – Dawn Dawson
Senior STP Lead – Judith Dean

What the portfolio is seeking to achieve	Expected Impact	Contributing Programmes	Portfolio Leadership Triumvirate
Adopt a population needs based approach, working with partners and communities in a **Neighbourhood** with Integrated Neighbourhood Teams providing integrated services that meet the needs of the population, supporting: • People to stay well through prevention, early detection and intervention • People to stay at home, or be discharged early to recover, building knowledge and confidence to stay as healthy as possible • Service models for children and young people that meet the mental and physical health needs across local authority and NHS services, including primary care, community services, speech and language therapy, school nursing, oral health, acute and specialised services. Reduce duplication, complexity and unwarranted variation in care pathways by designing and implementing cross-organisational, streamlined and coherent approach with access to **place-based** services which: • Provide specialist advice, guidance and support to be able to support people to stay well and / or recover meet as many of those care and support needs locally and keep people well in their communities • Provide timely access to specialist care able to respond to escalating or acute care needs. • Co-ordinate and integrate shorter term interventions to support transition between hospital and neighbourhood services and reduce hand -offs	Care (User Experience) • Improved safety and quality • Improved patient outcomes and experience Communities (Population Health) • Reduction in unplanned contacts and bed days • Improved equity of access and outcomes • Reduction in inequalities (core 20 plus 5) Compassion (Staff Experience) • Increased staff satisfaction and wellbeing Sustainability • High quality clinically and financially sustainable services • Reduction in per capita cost (system) • Improved efficiency and effectiveness	1. **Integrated Neighbourhood Team Programme** 2. **Frailty (includes virtual wards and remote monitoring (regardless of speciality) and Frailty SDEC element of pathway home hub)** **DHC / DCH programme** **System programme where we are the lead partner**	**Clinical Lead** • ICS Clinical Director **Operational Lead** • Alex Lister **Transformation Lead** • Lauren Leete

Integrated Neighbourhood Teams		Programme SRO:	Nick Johnson
Programme Mandate/ Brief	The development of Integrated Neighbourhood Teams that bring together multidisciplinary professionals from across health and care organisations to deliver services to meet the needs of their defined population by focusing on personalised care that is as far as possible anticipatory rather than reactive.		
Summary Update	• Gateway Two document approved by Programme Board • Work progressing within Weymouth and Portland and Boscombe and next 2 INT areas and approach to be agreed 11/09/24 • Draft outcome measures shown below to be further developed, and metrics confirmed over next 2 months • DHC engagement commenced • Programme resourcing requires resolution		
Programme stage	Design	Programme RAG	

Strategic Outcome	Ambition	Impact hypothesis	Impact realisation timeframe
CARE **User experience**	Impact on safety, quality, and experience	Timely access to personalised care and advice (reactive and proactive)	12-24 Months
COMMUNITIES **Improved population health**	Impact on strategic intent to reduce unplanned contacts	X% reduction in unplanned health and contacts / stays	12-24 Months
	Improved population health and equity of access and outcomes	Improved population health and reduction in health inequalities	5 years
COLLEAGUES **Staff Experience**	Improved staff health & wellbeing	X% Staff recommending the neighbourhood as a great place to work	12-24 Months
SUSTAINABILITY	Size of net financial benefit (system impact)	*£X*	12-24 months
	Improved efficiency and effectiveness	Sustainable model that optimises use of the available workforce and financial envelope	12-24 months

Frailty		Programme SRO:	Alastair Hutchison
Programme Mandate/ Brief	To reduce duplication, complexity and unwarranted variation in intermediate care pathways by designing a streamlined, consistent and coherent approach to support frail patients, identified as being at high risk of admission to avoid the need for unplanned admission where possible, by providing community based sub-acute care rather than hospital-based care, when appropriate.		
Summary Update	• Workforce gap analysis. • Culture of Collaboration opportunities identified. • Programme comms via DCH Team Brief and DHC staff newsletter • Review of impact metrics to provide more accurate insights. • Increased use of Virtual Ward beds as an alternative to unplanned admissions.		
Programme stage	Develop	Programme RAG	

Strategic Outcome	Ambition	Impact hypothesis	Impact realisation timeframe
CARE **User experience**	Impact on safety, quality & experience	5% reduction in hospital acquired harm of over 70s (inc. infections and deconditioning)	12-24 months
		10% reduction in average total LoS for acute/sub-acute episode	6-18 months
COMMUNITIES **Improved population health**	Reduce unplanned contacts & bed days	27% reduction in unplanned hospital admissions for over 70s	18-24 months
	Potential to improve equity of service access and outcomes	Increased ease and equity of access to alternatives to hospital admission	6-12 months
COLLEAGUES **Staff Experience**	Potential to improve staff health & Wellbeing	80% staff recommend the service as a great place to work (maintain or improve depending on baseline)	12-24 months
SUSTAINABILITY	Reduction in per capita cost (system)	Potential Financial Reduction from reduced stays (Gross) £20M Net saving to be calculated - costs of alternative services to be modelled	12-24 months
	Improved efficiency and effectiveness		

Mental Health

Executive SRO – Andy Dean
Senior STP Lead – Judith Dean

What the portfolio is seeking to achieve	Expected Impact	Contributing Programmes	Portfolio Leadership Triumvirate
Deliver new and integrated models of primary and community mental health care with a focus on early identification and timely support to reduce escalation risks and bridge gaps in pathways Ensure parity of esteem through the development of a cohesive offer able to meet the physical and mental health of individuals Promoting, protecting and improving our children and young people's mental health and wellbeing Improve flow of patients with mental health needs through both specialist mental health and acute hospital settings Empower individuals to self-identify their needs and access diverse interventions, which extend beyond clinical approaches.	Care (User Experience) • Increased and earlier access to MH and Wellbeing support • Improved safety and quality of life measures • Improved patient outcomes and experience Communities (Population Health) • Reduction in unplanned contacts and bed days • Improved equity of access and outcomes • Reduction in inequalities (core 20 plus 5) Compassion (Staff Experience) • Increased staff satisfaction and wellbeing Sustainability • High quality clinically and financially sustainable services • Reduction in out of area placements • Integrated pathways of care that improved efficiency and effectiveness by improving flow and reducing duplication, complexity and unwarranted variation	1. Access Wellbeing 2. CYP MH Transformation System programme where we are the lead partner System programme where we are a supporting partner	**Clinical Lead** • Eman Shweikh **Operational Lead** • Morad Margoum **Transformation Lead** • Lauren Leete

Access Wellbeing		Programme SRO:	Rachel Small
Programme Mandate/ Brief	**Improve the Mental Health Wellbeing for the people of Dorset, through a collaborative service delivery approach across Dorset providing timely access to consistent and seamless MH provision.** The focus will be on designing services within the context of a person -centred, community -focused model, where Dorset residents are aware of and can access the most appropriate form of support in a timely manner. This will enable positive self -care and risk-taking in relation to mental health and wellbeing promotion and prevention of ill health.		
Summary Update	• **Boscombe hub go live 9th Sept** • **Further recruitment for Help & Care and The Lantern underway, will support wider development of offer in Poole and west inclu ding Outreach offer.** • **Mapping of wider complex trauma offer complete,** • **Poole go live w/c 9th Sept, recruitment underway for North & Weymouth.** • **All adult caseloads reviewed, and action plan developed. Support transition planning.** • **Digital Front Door - Phase 1 website live on 9th Sept.**		
Programme stage	Develop (Complex Trauma & CMHT reprofiling) & Deliver (Universal)	Programme RAG	

Strategic Outcome	Ambition	Impact hypothesis	Impact realisation timeframe (TBC)
CARE **User experience**	**Impact on safety, quality & experience**	Reduction in adults experiencing an acute mental health condition cared for outside of Dorset	**2-3 years**
		Increased number of people feeling confident, supported and empowered to manage their own condition	**12 – 24 months**
COMMUNITIES **Improved population health**	**Reduce unplanned contacts & bed days**	Reduction in unplanned contacts (Crisis) and MH Bed days	**12 – 24 months**
	Potential to improve equity of service access and outcomes	Increased and timely access for adults and older people to MH & Wellbeing support, psychological therapies and pharmacological offers that maximise benefits	**6 – 18 months**
		Reduce unwarranted variation in prevalence rates and improve QoL indicators	**12 – 24 months**
COLLEAGUES	**Potential to improve staff health & Wellbeing**	Staff recommend the service as a great place to work	**12 – 24 months**
		Established positive and strong partnerships across system organisations	**6 – 18 months**
SUSTAINABILITY	**High quality clinically and financially sustainable services**	Service is operational within the financial envelope	**Ongoing**
	Reduction in per capita cost (system) Improved efficiency and effectiveness	TBD - Improved health utilisation and associated costs	**24 – 36 months**

CYP MH Transformation		Programme SRO:	Elaine Hurll
Programme Mandate/ Brief	Working with partners to create a system-based approach that focuses on the needs of the individual children, young people & families. Reimagining the way we work to provide a holistic, coherent and integrated CYPMH & Families offer when they need it, in order to: Support children and young people to have good emotional mental health and wellbeing regardless of the their neurodiverse. • Reduce the negative effects of emotional and mental health difficulties(inc. Trauma) • Improve the transition into and experiences of adulthood • A service the adopts a trauma informed and neurodivergence inclusive model		
Summary Update			
Programme stage	Define	Programme RAG	TBC

Strategic Outcome	Ambition	Impact hypothesis	Impact realisation timeframe
CARE **User experience**	**Impact on safety, quality & experience**	Increased inclusion in mainstream schools	**TBA**
		Young people and families will be valued as partners in their care and treatment and report a positive experience of care and support	**TBA**
COMMUNITIES **Improved population health**	**Reduce unplanned contacts & bed days**	Reduction in unplanned contacts, including presentation at Emergency Departments	**TBA**
	Potential to improve equity of service access and outcomes	Increased and timely access for young people and families to MH & emotional wellbeing support, that is person/ family centred that maximises benefits	**TBA**
		Improved mental health outcome scores	**TBA**
COLLEAGUES	**Potential to improve staff health & Wellbeing**	Staff recommend the service as a great place to work	**TBA**
SUSTAINABILITY	**Reduction in per capita cost (system)**	£X reduction in system cost implications for system services	**TBA**
	Improved efficiency and effectiveness		**TBA**

Sustainable Services

Executive SROs – Chris Hearn and Alastair Hutchison
Senior STP Lead – Judith Dean

What the portfolio is seeking to achieve	Expected Impact	Contributing Programmes	Portfolio Leadership Triumvirate
• Continued access to more specialist, fragile, clinical services by working across organisational and agency boundaries to reduce inequalities, improve outcomes, improve pathway resilience and/or improve productivity. • Optimised use of estates and workforce • Reduce unwarranted variation in clinical care and outcomes through standardising approaches to improve patient care • Services designed to reduce the negative impact on public health and the environment	Care (User Experience) • Reduction in unwarranted variation in clinical practice • Improved patient experience Communities (Population health) • Improved patient access and outcomes Compassion (Staff Experience) • Improved staff satisfaction and well-being Sustainability • High quality clinically and financially sustainable service provision • Reduction in complexity and duplication of service offers • Reduction in per capita cost • Reduction in environmental impact	**Our Dorset Provider Collaborative** • Clinical Networks • Temporary Workforce (Medical and Nursing • Procurement System programme where we are the lead partner	**Clinical Lead** • Associate CMO for Transformation **Finance Leads** • Sarah Day • Claire Abraham **Transformation Lead** • Lauren Leete

ODPC – Clinical Acute Networks Dorset (CANDo)	Programme SRO: Programme Director:	Nick Johnson Sally Banister

Programme Mandate/ Brief	To improve outcomes, reduce inequalities, increase productivity and service sustainability specifically through collaboration between Dorset County Hospital and University Hospitals Dorset.
Summary Update	CANDo = four priority specialties (OMF, Respiratory, Dermatology, Ophthalmology) where joint working groups are supported in implementing service improvements across the wider Dorset footprint, , five other specialties where a network is being supported to bring clinicians and managers together to develop collaboration as "BAU"

Programme stage	0: Direction	1: Discover	2: Define	3: Develop	4: Deliver	5: "Daily" (to BAU)	Programme RAG
		3. OMF	1. Respiratory, 2. Dermatology		5. Ophthalmology: cataracts		

Strategic Outcome	Ambition	Impact hypothesis	Impact realisation timeframe
CARE User experience (Improve Outcomes)	**Impact on safety, quality & experience**	Aligned waiting times through System Load Oversight Reduced waiting in ophthalmology, and dermatology	March 26 March 25
COMMUNITIES Improved population health	**Reduce unplanned contacts & bed days**	Increased primary care dermatology reducing need to access acute hospitals.	March 25
	Potential to improve equity of service access and outcomes	Dorset wide OMF service with multiple sites Dorset wide orthodontics service with multiple sites	Oct 27 April 25
COLLEAGUES	**Potential to improve staff health & Wellbeing**	Reduced pressure in secondary care dermatology Increased sustainability in orthodontics provision	March 25 Oct 27
SUSTAINABILITY	**Reduction in per capita cost (system)**	Reduced cost and aligned follow up policy and practice in respiratory.	March 25
	Improved efficiency and effectiveness	Increased market share in ophthalmology Increase volume of lower cost primary care dermatology	March 25 March 25

To be further developed as part of the whole ODPC programme

Programme:	Our Dorset Provider Collaborative (ODPC)	Programme SRO:	Nick Johnson & Nicola Plumb (ODPC Board Chair – Siobhan Harrington CEO UHD)
Programme Mandate/ Brief	The ODPC drives strategic, system-level transformation, recognising that greater benefits will be achieved for and with our communities by working together at scale. In 2022 a single strategic provider collaborative was established, which is governed by the ODPC leadership Board. The board comprises of all 3 trusts and the GP Alliance, as well as reps from NHS Dorset. WMC and the VCS. The members of the ODPC have agreed on their purpose, values, culture, behaviours, principles, and enablers to work together. 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's overarching aim is by delivering strategic and system level transformation, and developing sufficient maturity, the collaborative is seeking approvals from the ICB and respective Trust Boards for delegated budgetary authority		
Summary Update	The Board's priorities for 2024/25 are • Portfolio 1. Strategic Transformation. CANDo, Shared Services, and Workforce and Agency. FBC for procurement shared service expected Q3 24/25. (NHS Dorset aspiration is £2.63m savings in 25/26 (less £750k cost) • Portfolio 2. Existing collaboratives. One Dorset Pathology, Community Diagnostics, Stroke, Strategic Estates/NHP • Portfolio 3. Integrated Neighbourhood Teams • Portfolio 4. Infrastructure and Development – including maturity development The Board's priorities are consistent with NHS Dorset's intentions letter from June 2024. The first DCH/DHC/UHD Chairs & NEDs steering group scheduled for 3rd October		
Programme stage	• Deliver the capability	Programme RAG	• Amber

Strategic Outcome	Ambition	Impact hypothesis	Impact realisation timeframe
CARE **User experience**	**Impact on safety, quality & experience**	Temporary staffing: increased pt safety due to better consistency and increased working relationships, better experience, reduced quality issues. Considering collaborative staffing models with the 3 trusts	TBC
		Procurement: Enhanced pt safety through better management of devices and opportunities for learning across organisations.	TBC
COMMUNITIES **Improved population health**	**Reduce unplanned contacts & bed days**	Temporary staffing: Increased consistency and knowledge of trusts supporting improved flow .	TBC
	Potential to improve equity of service access and outcomes	Procurement: supporting access through potential for use of similar devices	
COLLEAGUES **Staff experience**	**Potential to improve staff health & Wellbeing**	Temporary Staffing: better management of staff, better cross org/dept working, increased oversight of work, able to identify problems earlier, more consistency, valued staff Procurement: Increased wellbeing through more effective processes and safer practice	TBC
SUSTAINABILITY	**Reduction in per capita cost (system)**	Temporary staffing & Procurement: significant reductions in spend. . NHS Dorset Intentions letter seeking	TBC
	Improved efficiency and effectiveness	Temporary staffing & Procurement: efficient processes	TBC

To be further developed as part of the whole ODPC programme

Working Together to realise the business benefits of collaboration

Executive SROs – Nick Johnson and Nicola Plumb
Senior STP Lead – Paul Lewis

What the portfolio is seeking to achieve	Expected Impact	Contributing Programme	Portfolio Leadership
A clear and compelling strategy articulating the vision, mission and strategic objectives for the two organisations which is embedded across the 2 organisations A learning culture with a thriving and aligned framework that supports transformation and improvement across the organisations Greater collaboration to help simplify decision - making, increase integration and improve quality and outcomes for the people we serve. Enabling support offers that remove the barriers to working across organisational boundaries Optimised resources and reduced duplication and complexity	• Greater collaboration and streamlining of work between DCH, DHC and wider partners • Optimal design and use of our shared estate that is fit for the future • Digital enabled transformation that releases front line staff time to care • Increased corporate service efficiency and value for money • Shared language culture and ways of working that enhance joined up delivery	**Enabling Programmes** • **Electronic Health Record** • **Joint strategy implementation** • **Joint Improvement framework** • **Support services review** • **New Hospitals Programme**	People and Culture • Catherine Granville and Emma Hallett CIO • Stephen Doherty Governance • Jenny Horrabin Strategy and Transformation Lead • Ciara Darley

Appendix B.

Decisions and next steps for projects / programmes not prioritised at this stage

Portfolio	Programme	Decision and next steps
Place & Neighbourhoods	• Community hospital strategy and redesign	• Paused – 25/26 priority informed by outcome of Frailty and Integrated Neighbourhood team development work
	• Diabetes	• Complete agreed actions for 24/25 but pause further development
	• Leg Ulcers	• Develop 'what does good look like' guidance and make available for INTs but do not progress as separate programme
	• DHC 0-19 Team Redesign	• Await outcome of INT development work
	• Population health management	• Define outcomes and then explore options to link to CVD, Respiratory, Frailty and Diabetes clinical networks to pursue
	• Health Inequalities	• Health Inequalities to be mainstreamed into each Transformation and Improvement project but not run as an independent programme
	• Prevention, early detection and intervention opportunity assessment to inform 25/26 priority areas	• Insufficient capacity to support and opportunities likely to come up through INT prioritisation based on population need
Mental Health	• CYP PoE	• Write up and celebrate success of flagship programme and complete outstanding actions. Stop work on business case development and link to CYPMH system transformation
Sustainable Services	• UEC Transformation	• ICB to lead development of OBC. To include UTC proposal and an expectation as to the same day care needs that should be met at neighbourhood level
	• Stroke and Neuro	• Key operational priority – moved to BAU
	• Hip Blocks	• Paper-based assessment as to whether there is availability within the alternative staff groups to take on this work
	• Procedures of Limited Clinical Value and Ambulatory are Sensitive Conditions – opportunity scoping	• Paper based assessment in Q4 subject to capacity
Working Together	• Federated Model	• Pause further development
	• Digital Transformation	• Await outcome of digital prioritisation work
	• MSSP	• Complete essential work and then pause further development

Report to	Dorset County Hospital Board of Directors, Part 1	
Date of Meeting	09 October 2024	
Report Title	Our Dorset Provider Collaborative	
Prepared By	Ben Print, ODPC, Senior Programme Manager, DCH	
Accountable Executive	Nick Johnson, Deputy CEO DCH, and DCH/DHC Joint Chief Strategy, Transformation and Partnerships Officer	
Previously Considered By	Strategy, Transformation and Partnerships Committee in Common	
Action Required	**Approval**	No
	Assurance	Yes
	Information	No

Alignment to Strategic Objectives	Does this paper contribute to our strategic objectives	
Care	Yes	
Colleagues	Yes	
Communities	Yes	
Sustainability	Yes	
Implications	Describe the implications of this paper for the areas below	
Board Assurance Framework	SR7: Collaboration	
Financial	The purpose of ODPC to drive sustainability and productivity. There are no financial implications as a result of this report	
Statutory & Regulatory	Nil	
Equality, Diversity & Inclusion	Ni	
Co-production & Partnership	ODPC is a collaborative approach, working with system partners. Service design includes co-production.	

Executive Summary

The ODPC drives strategic, system level transformation, recognising that greater benefits will be achieved by and with our communities by working together at scale.

This report provides a progress update in terms of its development and high-level portfolio areas and next steps. Assurance is sought from the Committee in Common.

Recommendation

The Board is requested to receive the report for **assurance**

Our Dorset Provider Collaborative

1. Background

1.1. The ODPC, and its Leadership Board was established in 2022, and its priority programmes and governance structure are included

1.2. The Leadership Board comprises of every Executive across the 3 trusts as either a member or an observer, as well as representatives from the Dorset GP Alliance, LMC and the voluntary sector.

1.3. This report provides a progress update in terms of its development and high-level portfolio areas and next steps and asks the Board to note the report.

2. Priority programmes

2.1. **CANDo.** A summary of the current status of the CANDo priority projects and network support is included as an appendix.

2.2. **Shared Services (Procurement).** A proposal for the development of and the transition to a Dorset shared procurement service target operating model (PTOM) and, in parallel, a transformative non-pay savings programme is being developed in partnership with a specialist third party business consultancy. The full programme is designed to be self-funding by way of a shared savings model covering the fees for the service to realise the 2025/26 saving opportunities. A full business case is being developed in Q3, and is expected to be considered by the ODPC Leadership Board and sovereign trusts at the turn of the year

2.3. **Workforce and agency – collaborative bank.** The focus to date has been on nursing but is now beginning to focus on Medical/Locum spend with an SRO having been nominated.

2.4. A MoU is in place to enable staff movement between organisations particularly for MHSWs.

2.5. Off Framework Agency switch off 01/07/2024 – 90 % completed – extensions agreed until Oct 24 for ED / ICU / Midwifery / Children & MH services

3. Existing collaboratives.

3.1. Revised ToR's have been endorsed at ODPC for existing collaborative programmes; One Dorset Pathology, Community Diagnostics, the Stroke Board and NHP/Strategic Estates. The Board is receiving escalations and have forward planned a deep dive into each of them on a rotating basis.

3.2. At the March 2024 ODPC the ODPC formally approved the recommendation that the Integrated Neighbourhood Teams Programme Broad will be a subgroup of the ODPC, endorsed the ToR for the INT Programme Board, and noted the draft MOU between DPGA and Dorset Health Care.

4. Governance

4.1. The Board continues to meet monthly, and Siobhan Harrington, UHD CEO, is the nominated Chair for 2024/25. As of May 2024, all 3 Trusts Executives who weren't a Board member, have been invited to attend as an observer.

4.2. The first Trust Chairs/NEDs Informal Steering Group is scheduled for 3rd October. This will add further challenge and scrutiny to the ODPC.

4.3. Recruitment for a dedicated ODPC Programme Director is currently taking place.

4.4. The Board received an Intentions letter from the ICB in June 2024. It was reassuring that the IBCs priorities were consistent with the ODPC's (CANDo, Shared services – procurement, Temporary spend – Medical and Nursing, INT, maturity matrix and assurance). The Board was concerned however that that the combined expectations for the ODPC alongside all other requirements on the partners (as reflected in Trust Specific Letters from the ICB) were significant in scale and complexity, and dynamic prioritisation through the year may be required. The Board has responded formally to the ICB.

4.5. Key messages/decisions from each Board are captured and disseminated to Trusts. The key messages from July's Board are attached as an appendix. A risk register is maintained and presented to each Board. The key risks are included as an appendix.

5. ODPC development and maturity

5.1. A ODPC Leadership Board development session in March (which included NHS Dorset Executives) agreed the following ambition:

- By delivering strategic and system level transformation, and developing sufficient maturity, the collaborative is seeking approval from the ICB and respective Trust Boards, for delegated budgetary authority from 1st April 2025.
- To take oversight of key strategic issues such as workforce and finance.
- To build trust and closer working relationships between the providers.
- To improve by at least one rating in all areas of the ODPC maturity matrix by the end of the year based on an agreed ODPC maturity

development plan, e.g. from emerging to developing, or from developing to maturing.

5.2. The 2024/25 priorities that the ODPC is currently focused on primarily fit across three of its key portfolios:

Portfolio 1 Strategic transformation with an aim to deliver across several priority areas:	• CANDo – Clinical Acute Networks • Shared Services • Workforce and Agency
Portfolio 2 Provide a forum for collective provider agreement and decision-making for existing collaborative programmes:	• One Dorset Pathology • Community Diagnostics • Stroke Board • NHP/Strategic Estates
Portfolio 3: Five Year Forward Plan Priorities	• Integrated Neighbourhood Teams
Portfolio 4: ODPC infrastructure and Development	• Maturity Development • Ways of Working • PMO/Benefits Management

5.3. NHSE has produced a maturity matrix self-development tool designed to support all types and sizes of collaboratives to accelerate the benefits they can deliver for their populations. One focus in 2024-25 is evidencing the added value of the ODPC. To that end, Trust Executives and NHS Dorset colleagues self-assessed against the matrix, which evidenced that the collaborative is still largely emerging across the domains, and a further study in Q4 2024/25 will be undertaken to capture the extent it is maturing as we implement plans to support that development.

6. Conclusion

6.1. The above report summarises the continued progress within the collaborative confirms its priorities for 2024/25.

7. Recommendations

7.1. The Board is recommended to receive the report for **assurance**

Name and Title of Author: Ben Print, Senior Programme Manager
Date: 18th September 2024

8. Appendices

Appendix 1. ODPC Overview and Governance
Appendix 2. CANDo overview
Appendix 3. Key messages ODPC Board July 2024
Appendix 4. Risk register

Our Agreement

PROMOTE
Promote early and timely interventions to prevent or minimise deterioration and dependence.

REDUCE
Reduce unwarranted variation and inequality in health outcomes, access to services and experience.

IMPROVE
Improve the resilience, responsiveness and sustainability of services by providing mutual support.

CREATE
Create an environment where people are at the centre of everything we do, and Dorset is the best place to work.

ENSURE
Ensure that specialisation and consolidation occur where this will provide better outcomes and best value for money.

Our Behaviours

1. Build Trust, going beyond self interest for the good of the collaborative.
2. Positive outlook focused on achievements as well as challenges.
3. Encourage innovative thinking and appreciative enquiry.
4. Respect and encourage, differing perspectives, professional advice and guidance.
5. Commit to the Provider Collaborative and dedicate the time.
6. Act with integrity and honesty. Empower others to act.
7. Be accountable to yourself and others for your actions.
8. Provide mutual support to other members.
9. A pro-equity culture will be promoted and developed. Everyone will be treated equally.

Our Values

Working together for the general public and individuals.
The general public and individuals come first in everything we do. We will co-design and co-produce services to ensure they are tailored to the needs of our service users.

Respect, dignity and inclusion.
We value every person – whether patient, their families or carers, or staff - as an individual. We respect their differences, their aspirations and commitments in life, and seek to understand their priorities, needs, abilities and limits. We will be inclusive.

Commitment to quality of care.
We earn the trust placed in us by insisting on quality and striving to get the basics of quality of care – safety, effectiveness and patient experience – right every time.

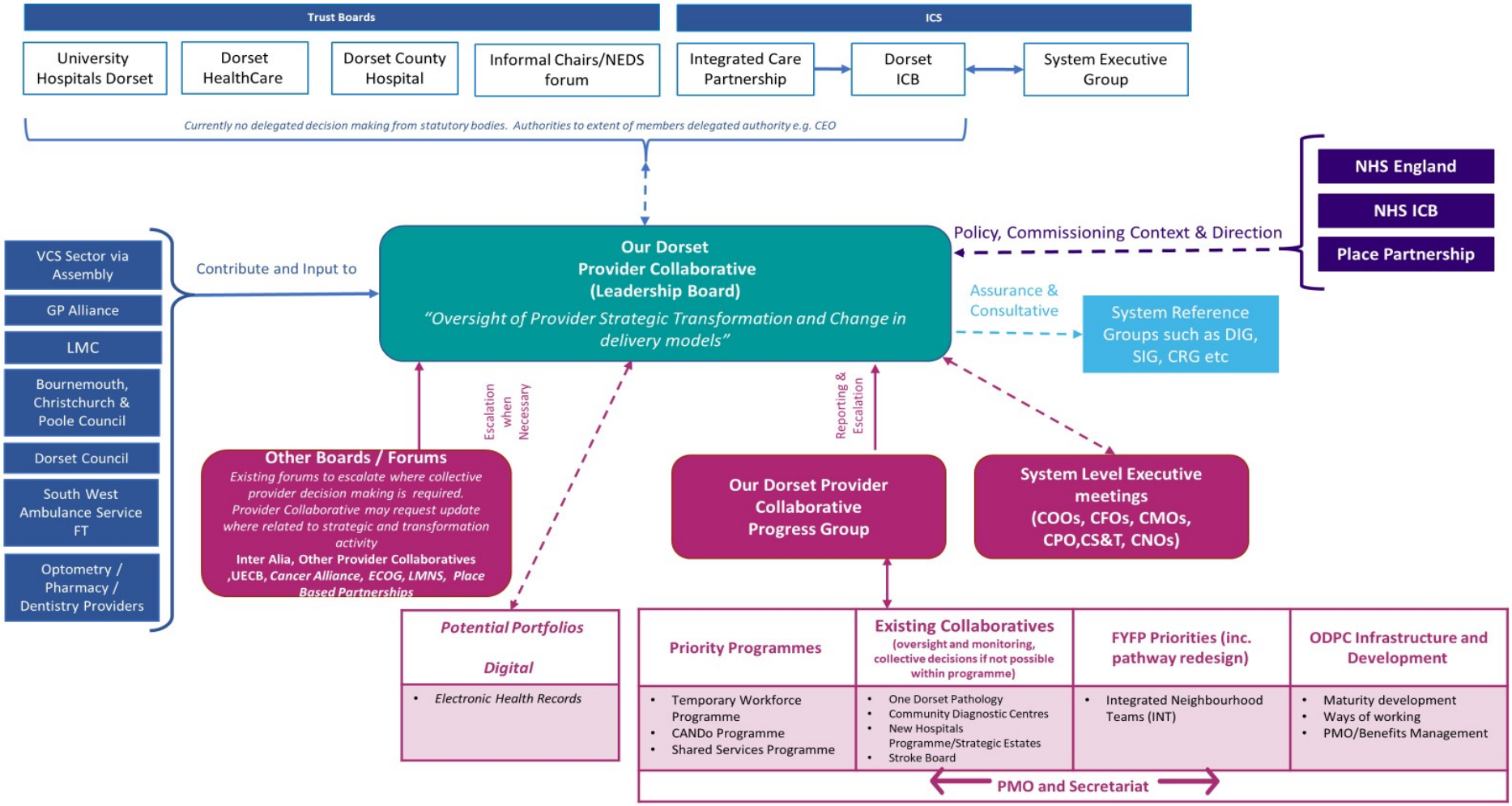
Compassion.
We ensure that compassion is central to the care we provide and respond with humanity and kindness to each person's pain, distress, anxiety or need.

Improving lives.
We strive to improve health and wellbeing and people's experiences of the NHS.

Everyone counts.
We maximise our resources for the benefit of the whole community, and make sure nobody is excluded, discriminated against, or left behind.

Our Principles

1. All stakeholders will work to support the purpose(s) of the Dorset Integrated Care System and the Our Dorset Provider Collaborative. This means that on some occasions, organisational and individual interests will need to be subsidiary. If this results in an organisation being significantly disadvantaged, the implications and impact of this will be identified. The Provider Collaborative Leadership Board will work to recognise and reconcile these difficulties and will provide support to mitigate risks through the transitional period.
2. Trust is the basis of most relationships. All stakeholders will work hard to establish and maintain trust with each other. If trust is compromised, it will be discussed, and work undertaken to seek to repair it.
3. Open, transparent, and constructive dialogue between all the members of the Our Dorset Provider Collaborative will be a given – even if the messages are difficult. When a colleague (or organisation) needs help, others will do their best to provide it. People will not 'play games' with each other.
4. Disagreements (which will inevitably occur) will be handled professionally and in a way that, if necessary, allow people to 'agree to disagree' – without derailing the process.
5. The key stakeholders in the Our Dorset Provider Collaborative are experienced, competent people who are trying to do the right thing, at the right time and in the right way. The systems and processes to measure, monitor and manage performance should be relatively light touch and proportionate to reflect this assumption.
6. It is neither efficient nor effective for everyone to be actively involved in everything. There will therefore be many occasions when people have to act on behalf of others. All parties will at all times act in the best interests of the greater good.



CANDo A Quick Reminder….

Our Dorset Provider Collaborative
Chair: Siobhan Harrington Chief Executive, University Hospitals Dorset

Temporary Workforce

Clinical Acute Networks Dorset (CANDo)

Procurement

Dorset Acute Networked Board
(BAU performance of acute services delivered by one trust for both)
Chair: Prof Alastair Hutchison Chief Medical Officer DCH

CANDo Transformation Programme
Transformation Projects to support our objectives
Chair: Nick Johnson,Chief Strategy, Transformation and Partnerships Officer DCH

Our purpose is to

- Improve outcomes for patients
- Reduce inequalities
- Improve service resilience and sustainability
- Improve value for money productivity and efficiency

Through collaboration between Dorset County Hospital and University Hospitals Dorset (and in partnership with others)

CANDo Network Support

- Orthopaedics
- Urology
- ENT
- Gynaecology
- General Surgery
- Gastroenterology

CANDo priority specialties

- Dermatology
- Respiratory
- Ophthalmology
- OMF

Our Dorset

Network support = helping a lead clinician run a Dorset wide network. Discussion about what is needed for General Surgery and Gynaecology not concluded
Specialty Programme = network support plus projects. Red text indicate areas where outcomes to be achieved are awaited from the ICB.

Baker,Abi
03/10/2024 16:29:16

Proposed CANDo Programme 2024/2025

Category	Area	Proposed Projects
Priority Specialties	Ophthalmology	• Further embed network. • Develop Community Model and offer to commissioners. Implement if service offer is accepted. • Support elective hub development at UHD, regaining market share from the independent sector ensuring gains for patients and s ervices in the west of Dorset.
	Dermatology	• Join the ICB led network. • Review pathways and implement service changes intended to speed throughput, ease secondary care pressures, and make best use of community capacity and expertise, improving waiting times and experience for patients.
	Respiratory	• Join ICB led network & support agreed developments in "Optimising Treatment" element of ICB programme (making appropriate lin ks with secondary prevention). • Promote the spread of a population management approach across the whole Dorset system seeking improvements in productivity an d reduced inequalities.
	OMF	• Support system partners to develop a future pan Dorset OMF service model for implementation when the current contractual arra ngements expire. • The new model must offer improvements in productivity and or value for money and reduced inequalities.
Network support only	Orthopaedics ENT Urology Gastroenterology	• Continue to support quarterly network meetings including shared oversight of GIRFT and performance
	Gynae	• Establish and support quarterly network meetings. including shared oversight of GIRFT and performance. Liaise with ICB in r espect of any ICB led programme
	General Surgery	• Establish and support quarterly network meetings including shared oversight of GIRFT and performance
Enabling Projects	Shared oversight of networked Services	• Develop the Dorset Acute Networked Services Board so that both acute trusts collectively monitor the performance of services which are already – or become- networked.
	Shared waiting List	• Develop and implement a tool for collective review of waiting lists enabling dynamic mutual aid (and pre -emptive action not just post referral inter trust patient transfer).
Exiting specialties	Rheumatology Orthodontics	• In Q1 complete the transfer of rheumatology services to UHD delivering an equitable and sustainable service. Transfer resour ce to other programmes as above. • In Q1 complete the transfer of orthodontics services to UHD delivering an equitable and sustainable service. Transfer resour ce to other programmes as above.

Notes
1. OMF has been added back in-reflecting renewed interest in developing a shared approach. Slow stream- reflecting contractual commitments
2. Specialties will consider all system spend as in scope not just that spent with the NHS

Our Dorset

OUR DORSET PROVIDER COLLABORATIVE JULY 2024 - KEY MESSAGES FROM ODPC LEADERSHIP BOARD		
AREA	**DECISION/ACTION/UPDATE**	**LEAD**
CANDo	The first Dorset Acute Network Services Board was held on 1st July, and chaired by Alastair Hutchinson, Chief Medical Officer DCH. It focussed on a Deep Dive on Neurology Successful transfer of Rheumatology to UHD huge amount of work from clinical and operational staff. The Executive teams at both Trusts want to thank everyone involved in delivering this significant service change. Single manager role created and recruited for a pan Dorset orthodontics service as a key step to a single DCH led service. Working with UHD/DCH ENT consultants on how a joint on-call rota could work	Sally Banister, CANDo Programme Director, DCH
Temporary staffing	Off Framework Agency switch off enacted on 1st July. 90 % completed, with extensions agreed until Oct 24 for ED / ICU / Midwifery / Children & MH services	Cara Southgate, DHC
Procurement	The Board noted the approach to commence a business case which will consider the viability of a single procurement function	Pete Papworth UHD, Chris Hearn DCH/DHC
NHS Dorset Intentions letter	The Board discussed NHS Dorset's priorities and expectations of the collaborative (CANDo, Integrated Neighbourhood Teams, Temporary staffing, Shared services, Maturity matrix and assurance), agreeing a response to the ICB	Nick Johnson, DCH/DHC
Chairs/NEDs Informal Steering Group	The first Chairs/NEDs Informal Steering Group is scheduled for 1st August. Trusts Chairs with further NED representatives, and the GP Alliance will provide challenge and scrutiny to the Board	Nick Johnson, DCH/DHC
ODPC Programme Director	The Board noted recruitment for a Programme Director was planned to commence	Nick Johnson, DCH/DHC
ODPC LEADERSHIP BOARD		
The ODPC Leadership Board comprises of Executives from DCH, DHC,UHD, and the Dorset GP Alliance as well as representatives primary care, Wessex Local Medical Committee and the voluntary and community sector. Siobhan Harrington, UHD CEO is the Board's Chair for 2024/25.		

Our Dorset

RISK

Risk / Issue description (Top 3)	Consequence	Likelihood	Risk Score	Current mitigation	Decisions Required
1) Lack of resource committed to the ODPC creating a risk that the ODPC will not have the appropriate infrastructure in place to enable delivery and provide assurance of priorities (once determined) impacting the ODPCs ability to achieve its strategic goals.	Major	Almost certain (without mitigation)	20 – initial 16 – current 89 target score	• Developed Options and associated benefits and risks to meet resource requirements • Providers to identify resource based on options • Additional resource identified through UHD – once in position	Initial paper brought to Board. Further options/approach to be developed, for subsequent Board decisions
2) Lack of commitment of providers to the ODPC in terms of time and attention poses a significant risk to the successful development of the ODPC in the systems architecture and will impact the ultimate effectiveness and ability to achieve its strategic aims.	Serious	Almost certain (without mitigation)	16 – initial 16 – current 89 target score	• Crucial to ensure that system providers prioritise the ODPC and are fully committed to ensure the success of the ODPC • Identify Lead Executive Link from each provider	As above, Initial paper brought to Board. Further options/approach to be developed, for subsequent Board decisions
3) Insufficient communication flow from the provider collaborative to leadership teams may undermine team commitment to prioritise priority programmes within the collaborative.	Serious	Almost certain (without mitigation)	16 – initial 16 – current 8 target score	• Establish Clear Communication Channels: Implement formal channels and protocols for sharing relevant updates, progress reports, and any changes in priority programs to ensure seamless communication between the provider collaborative and leadership teams.	WiP for basic presence on NHS Dorset website Medium term priority to develop tri-trust Sharepoint site Key messages agreed at each Board meeting

INTEGRITY | RESPECT | TEAMWORK | EXCELLENCE

NHS
Dorset County Hospital
NHS Foundation Trust

Escalation Report

Committee: Quality Committee

Date of Meeting: 17th September 2024

Presented by: Claire Lehman

Significant risks / issues for escalation to Board for action	• The importance of and risks relating to digital in relation to a number of workstreams, including clinical coding, Friends and Family Test (FFT), and safeguarding • Continuing issues with renal transport; discussions around whether this needed to be escalated further. • Readmission report and dashboard, in particular the strategic element relating to demographic changes and the implications for the Trust and the system. • Learning from Deaths Q1 Report recommended to Board for approval • Maternity report

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:
	  ○ That the Trust was in between FFT providers at present and was exploring the feasibility of an in-house provider.
	  ○ Discussion around renal transport, noting this had been an issue for nearly a year
	• Board Assurance Framework, with positive feedback for the revised design.
	• Quality Risk Report
	• Maternity Reports including:
	  ○ Safety Report
	  ○ Trust Claims Scorecard (Obstetric and Neonatal)
	  ○ Saving Babies Lives (v3) Implementation Report
	• Trust Response to NHS England Letter – Patient Safety and Quality in highly pressurised services
	• Health Inequalities: Progress and Priorities Update
	• Readmission Report and Dashboard
	• 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 and Learning Disabilities Steering Group
	  ○ Safeguarding Committee
	  ○ Patient Experience and Public Engagement Committee
	  ○ Clinical Effectiveness Committee
	  ○ Infection Prevention and Control Committee
	  ○ Research Steering Group
	  ○ Patient Safety Committee
	• August 2024 Final Version Maternity Report (circulated in lieu of August meeting)
	• ICB Quality Committee Escalation Report

Decisions made by the Committee	• Approval of the Quality Assurance Group Terms of Reference.

Implications for the Corporate Risk Register or the Board Assurance Framework (BAF)	• Review of the Board Assurance Framework and Quality Risk Report
Items / issues for referral to other Committees	• People and Culture Committee to seek assurance that an action plan is in place to improve safeguarding training compliance.

Report Front Sheet

1. Report Details			
Meeting Title:	Board Meeting		
Date of Meeting:	9th October 2024		
Document Title:	**Maternity Quality and Safety Report August**		
Responsible Director:	Dawn Dawson, CNO	Date of Executive Approval	02.10.2024
Author:	Jo Hartley, Director of Midwifery & Neonatal Services		
Confidentiality:	No		
Publishable under FOI?	Yes		
Predetermined Report Format?	Yes		

2. Prior Discussion		
Job Title or Meeting Title	**Date**	**Recommendations/Comments**
Quality Committee	17/09/2024	approved

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

3. Executive Summary

This report sets out to the Trust Board the quality and safety activity covering the month of July 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
- Post Partum Haemorrhage rate over 1500mls slightly below target – normal variation
- 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 babyloss incidents. One baby was a late loss, one baby was an intrapartum stillbirth at the tertiary unit and one baby was a late miscarriage
- Risk register updated.
- 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.
- Good progress with triage and Birmingham Symptom Specific Obstetric Triage System in DAU (Day Assessment Unit).
- Two models of resuscitaires identified and to be trialled prior to purchase
- Two complaints received in July. Details provided of actions identified from recent complaints

	• Workforce data. Poor mental health is the primary reason for Long Term Sickness. 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
4. Action recommended	The committee is recommended to receive the report for **assurance.**

5. Governance and Compliance Obligations				
Legal / Regulatory Link		**Yes**		Providing assurance around a number of local and national metrics and KPIs
Impact on CQC Standards		**Yes**		Integral to CQC standards
Risk Link		**Yes**		Links to Board assurance Framework
Impact on Social Value		**Yes**		
Trust Strategy Link		The quality of our services in providing safe, effective, compassionate, and responsive care links directly with strategic objectives		
Strategic Objectives	People	Credibility of Trust		
	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**	

NHS
Dorset County Hospital
NHS Foundation Trust

Maternity & Neonatal Quality and Safety report

September 2024

Submitted by Jo Hartley, Director of Midwifery & Neonatal Services

Executive sponsor: Dawn Dawson CNO

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Executive Summary

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

- SPC charts reproduced in report. CO at booking, 36 weeks and smoking at time of delivery showing standard variation exceeding or very close to the target
- Three incidents of 3rd & 4th degree tear over August and September. SPC chart for national data provided demonstrating an increase in 3rd and 4th degree tears
- Babies admitted to the neonatal unit >37 weeks gestation 9.2%. This is above the target of 5%. All cases reviewed by the ATAIN (Avoiding Term Admissions into the Neonatal service) multi-professional team. Quarter 1 ATAIN report included in this paper. Primary reason for admission is TTN (transient tachypnea of the newborn). Three possible avoidable admissions identified. Quarterly percentage is <5%.
- Post partum haemorrhage (PPH) rate over 1500mls slightly above target – standard variation
- Reduction in percentage of babies receiving breast milk as their first feed. This may reflect the postnatal capacity to staff > 1 midwife and 1 MSW for the ward.
- Three additional SPC charts – caesarean rates, emergency and planned and women on a continuity of car pathway at 28 weeks. No target identified for caesareans or continuity pathway. The priority of continuity of care is for women from an ethnic minority and/or living in areas of deprivation
- One RCA remains – the Maternity and Newborn Safety Investigations (MNSI) case. Learning from incident Panel (LIP) has now convened. Action plan to be updated and shared with parents
- Safety Walk About on the maternity unit with DoN, NED Safety Champion, LMNS Deputy Director of Maternity
- Three in-utero transfers – two to UHD and one to a level three NICU due to gestation
- Perinatal Mortality Review Tool process will review all relevant cases of babyloss.
- Risk register updated.

    1. The neonatal nursing staffing remains high risk due to the requirement of a supernumerary coordinator 24/7. NHS Resolutions have confirmed this is expected for all neonatal services
    2. Awaiting response from charitable funding requested for three resuscitaires
    3. Funding for 10th consultant agreed through LMNS – approximately 9 PAs
    4. The replacement call bell system completed in SCBU and starting in Maternity
    5. Cairn medical (providers of Entonox testing system) cannot locate the returned testing cannisters from April. New cannisters provided and testing to recommence

- One complaint received in August. Trust scorecard triangulating claims and complaints included
- One transfer from DCH SCBU to a level 3 NICU – no care concerns identified
- Workforce data not provided this month
- Training compliance not completed for this month – will be included in next report. The multi-professional simulation across ED, Maternity, Theatres and SCBU was very successful on Aug 30th
- ATAIN report as noted above
- Minutes from Quadrumvirate meeting. Initial themes from SCORE Survey discussed
    - Taking breaks
    - Improving feedback processes
    - Burnout
    - Improving handover on SCBU (staff report feeling 'judged')
    - Supernumerary coordinator in SCBU
    - More midwives on a shift
    - Options for sabbatical for consultants
    - Concerns about management of the midwives off-duty in relation to 6/52 in advance and oncalls

Activity

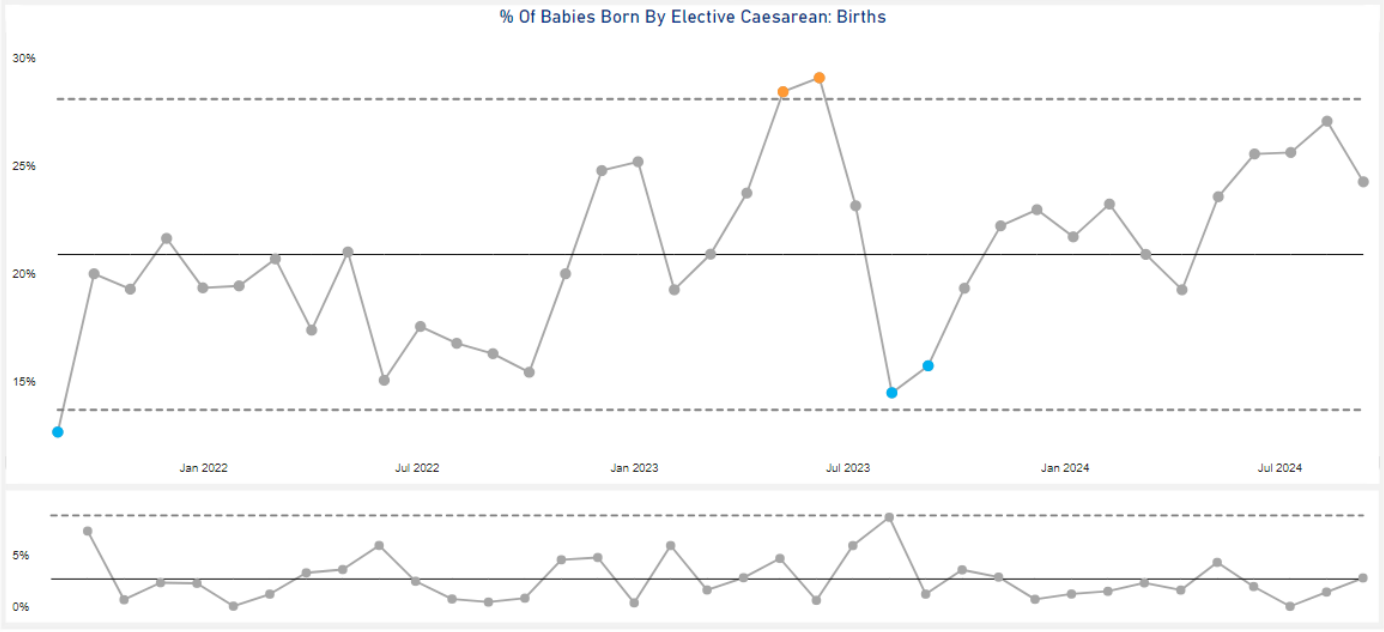
Exception report for SPC charts (NTI – no target identified)

Metric	Target	Current position and mitigation/actions
% babies born by elective caesarean	NTI	24.3%
% babies born by emergency caesarean	NTI	24.3%
% on a continuity of care pathway by 28 weeks	NTI	19.1%
% smoking at time of delivery	6%	3.9%
% CO recorded at booking	95%	95.2%
% CO record at 36 weeks	95%	87.5%
Rates per 1000 of stillbirth	4	1
Rates per 1000 of neonatal deaths	2	Nil
% babies >37 weeks admitted to SCBU	5%	9.8%
Rates per 1000 of PPH >1500mls (previous three months)	30	34.4
Rates per 1000 of 3rd/4th degree tears	25	17.2
% 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	69.2%

MetricName

% Of Babies Born By Elective Caesarean

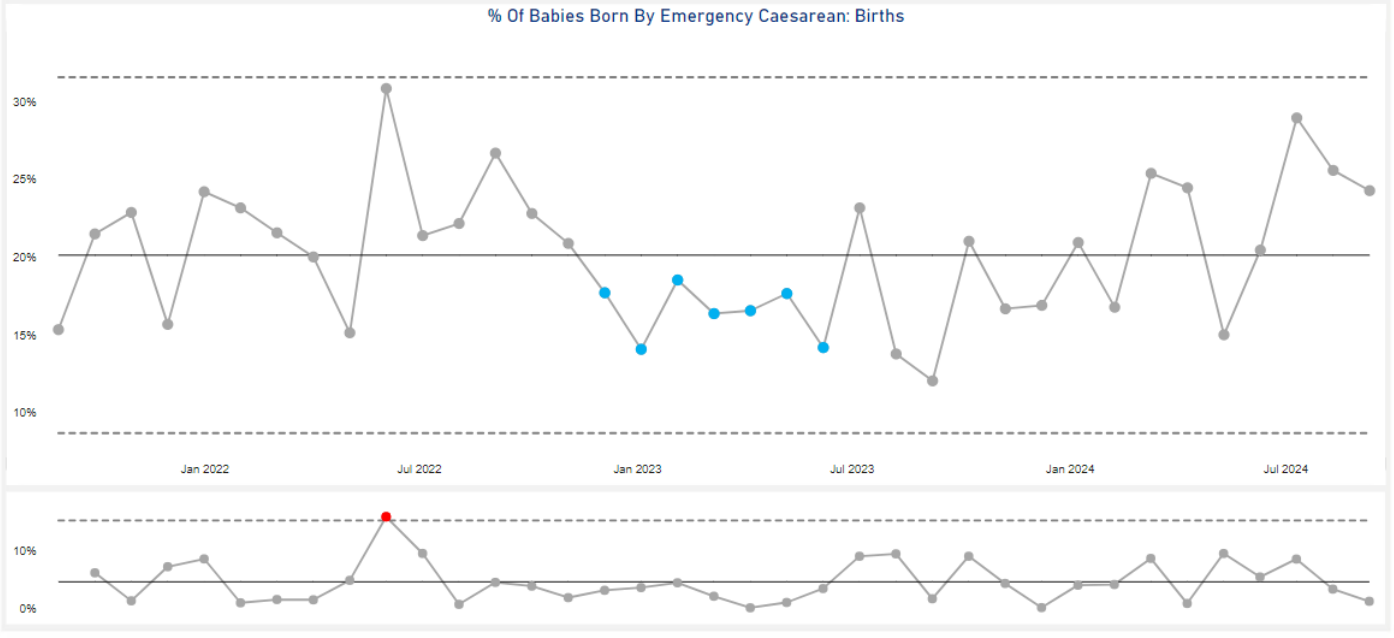
31/08/24 Latest Date	**13.7%** -3σ	**23** Metric ID	Variation	Assurance
24.3% Value	**20.89%** Mean	**Month** Horizontal Axis		
Target	**28.09%** +3σ	**% Meeting Standard** Vertical Axis		

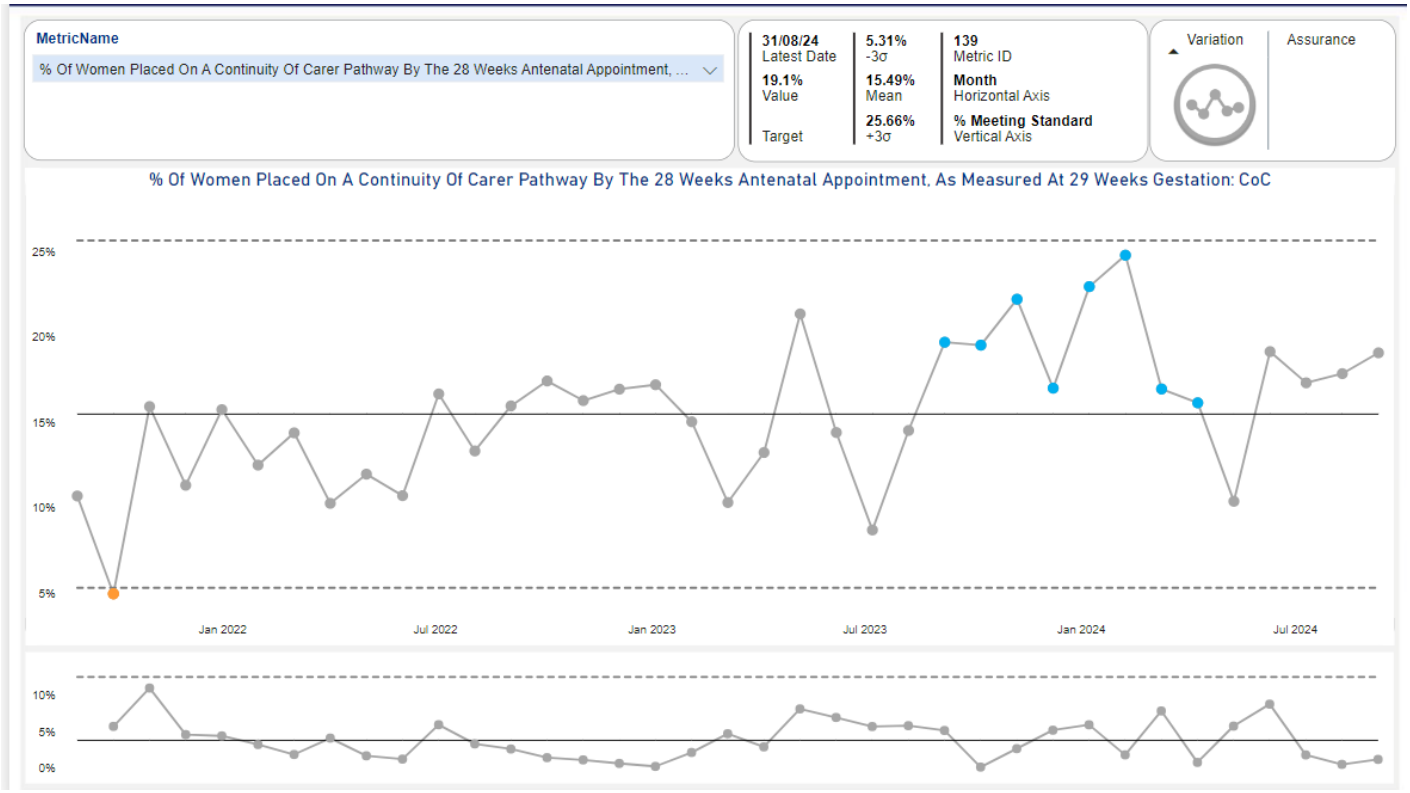


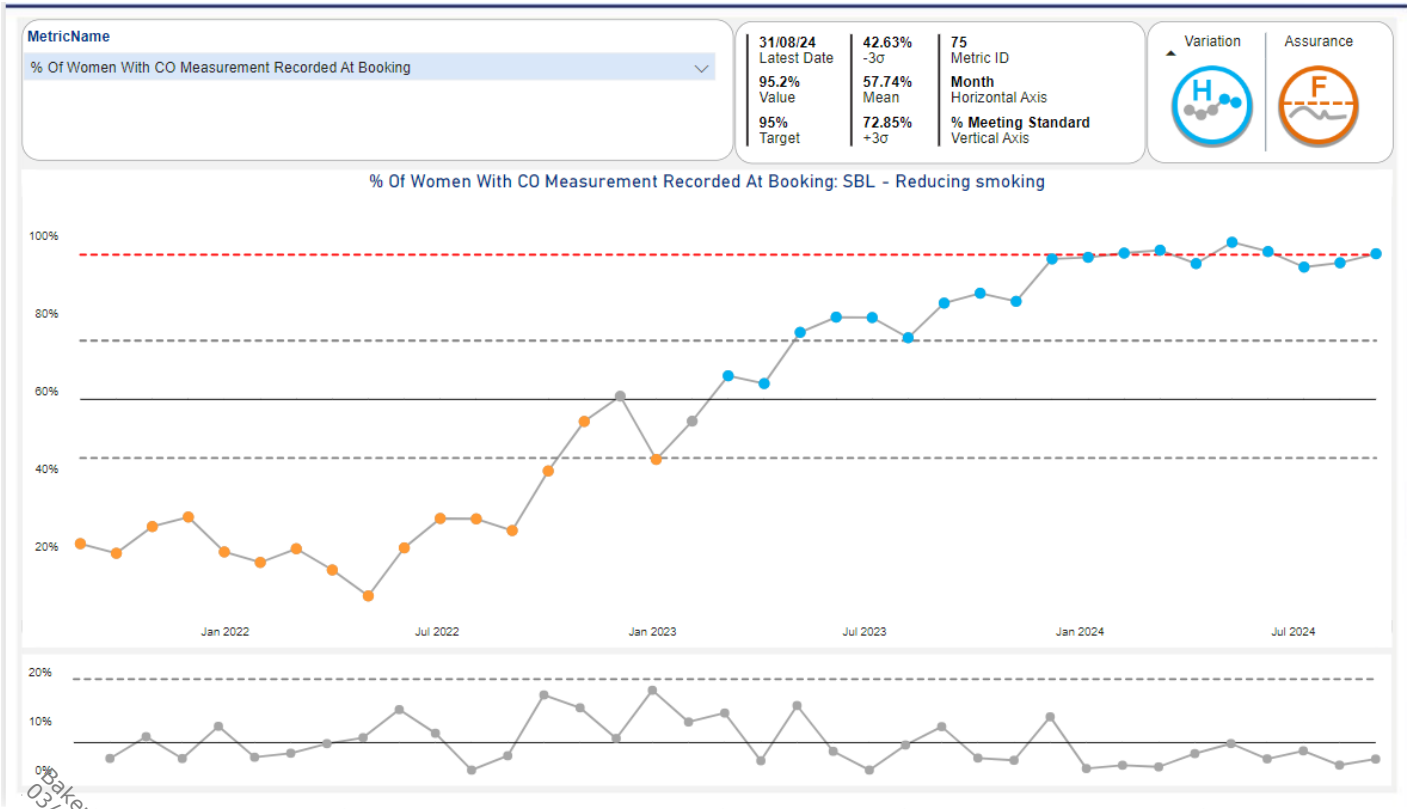
MetricName

% Of Babies Born By Emergency Caesarean

31/08/24 Latest Date	**8.69%** -3σ	**24** Metric ID	Variation	Assurance
24.3% Value	**20.12%** Mean	**Month** Horizontal Axis		
Target	**31.55%** +3σ	**% Meeting Standard** Vertical Axis		





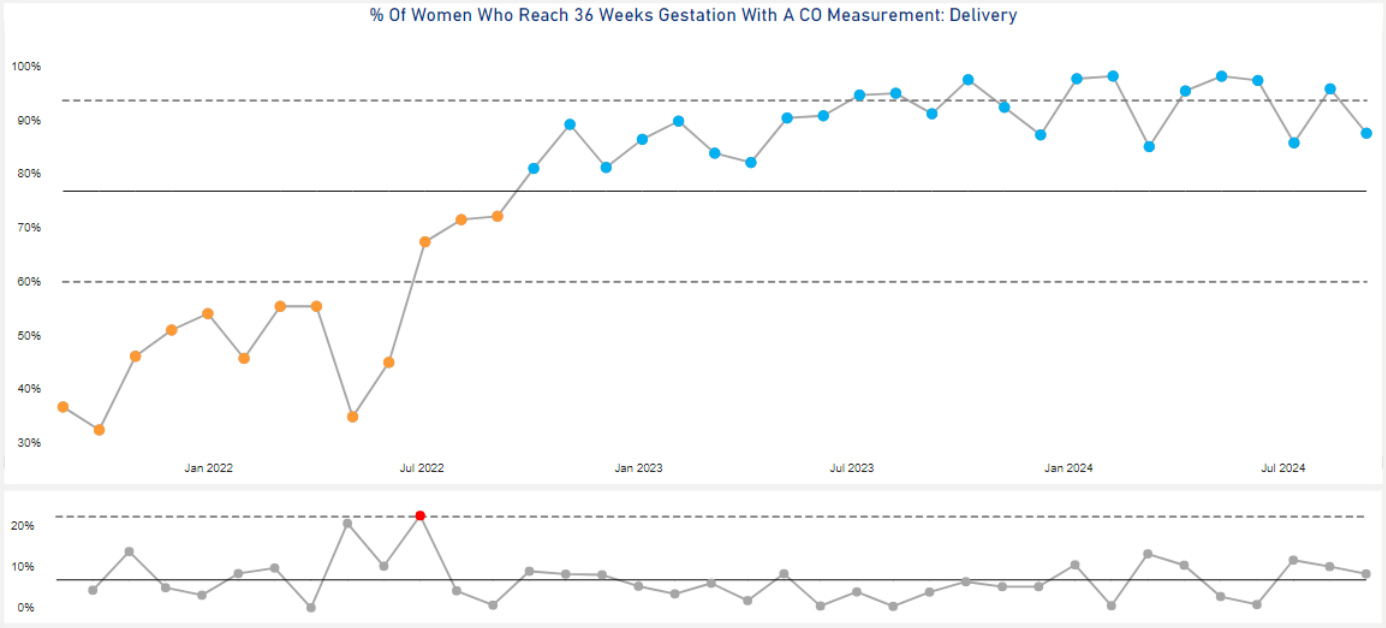


MetricName

% Of Women Who Reach 36 Weeks Gestation With A CO Measurement

31/08/24 Latest Date	**59.88%** -3σ	**169** Metric ID
87.5% Value	**76.72%** Mean	**Month** Horizontal Axis
Target	**93.57%** +3σ	**% Meeting Standard** Vertical Axis

Variation | Assurance

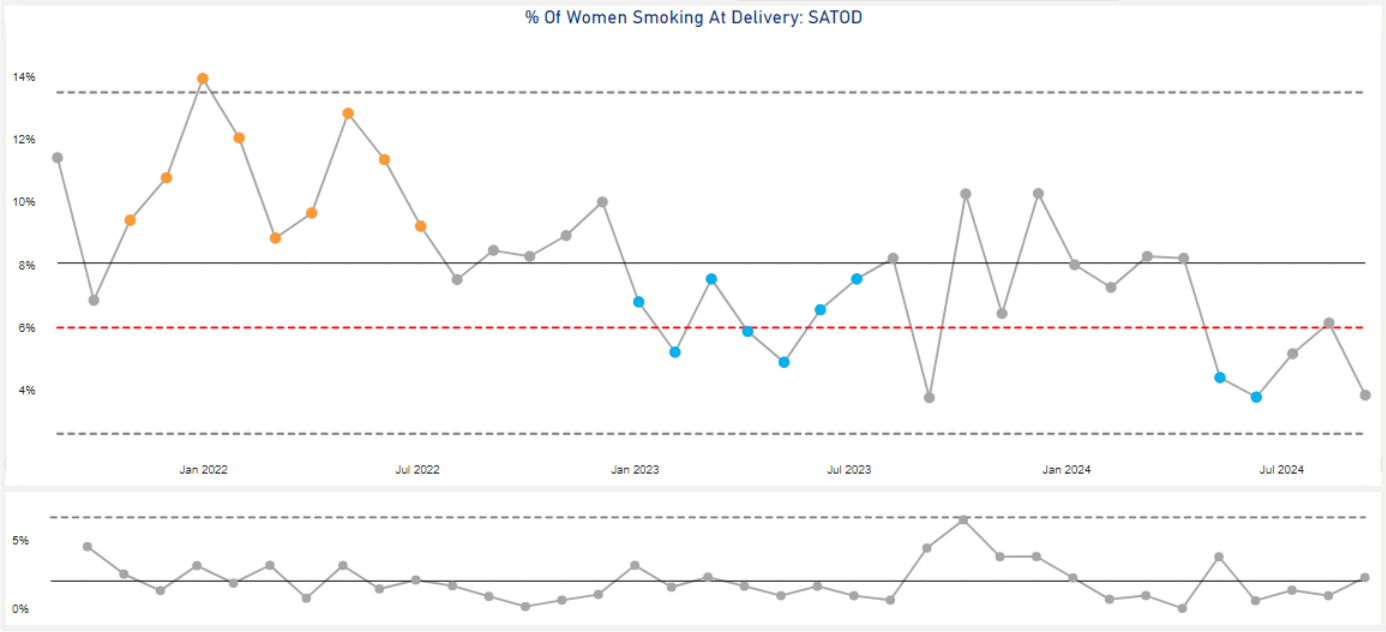


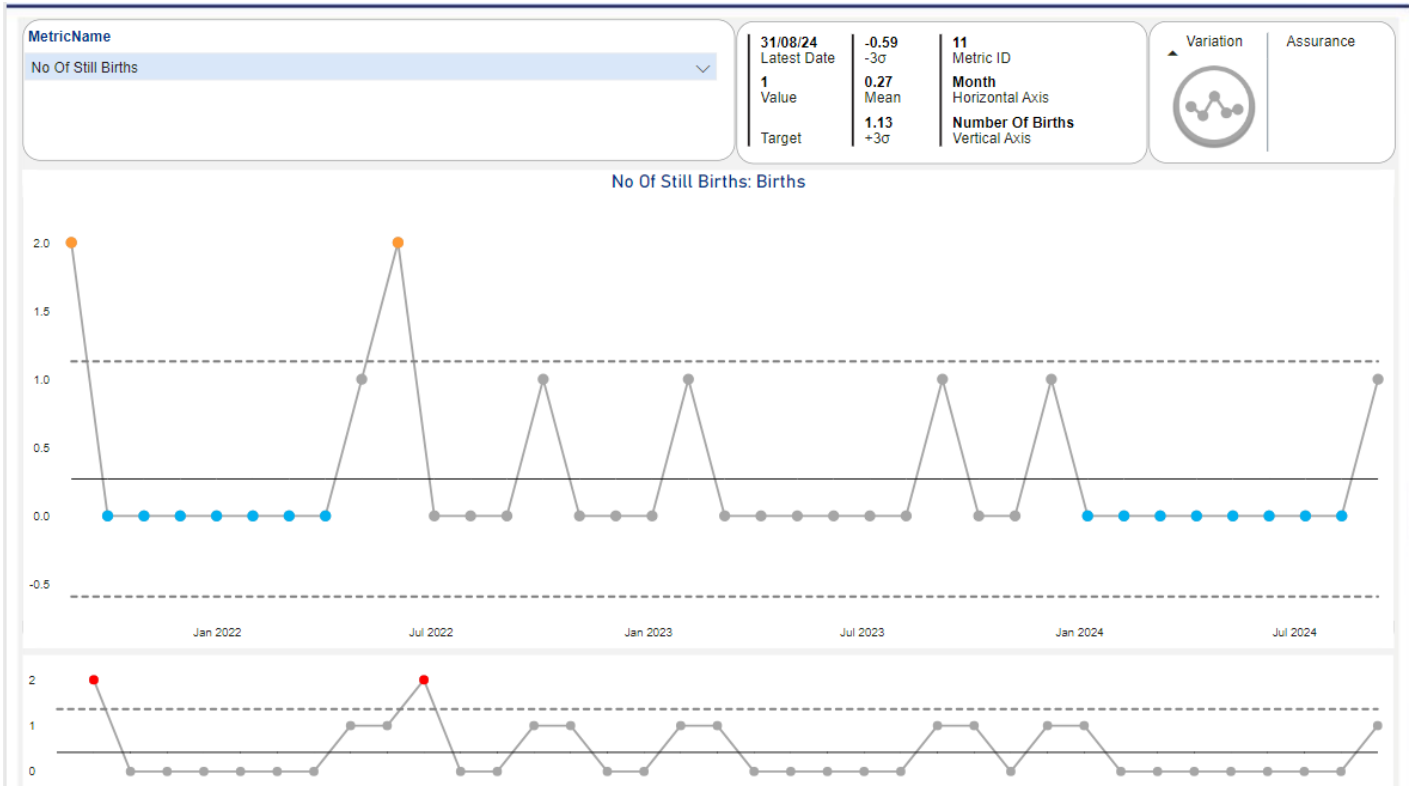
MetricName

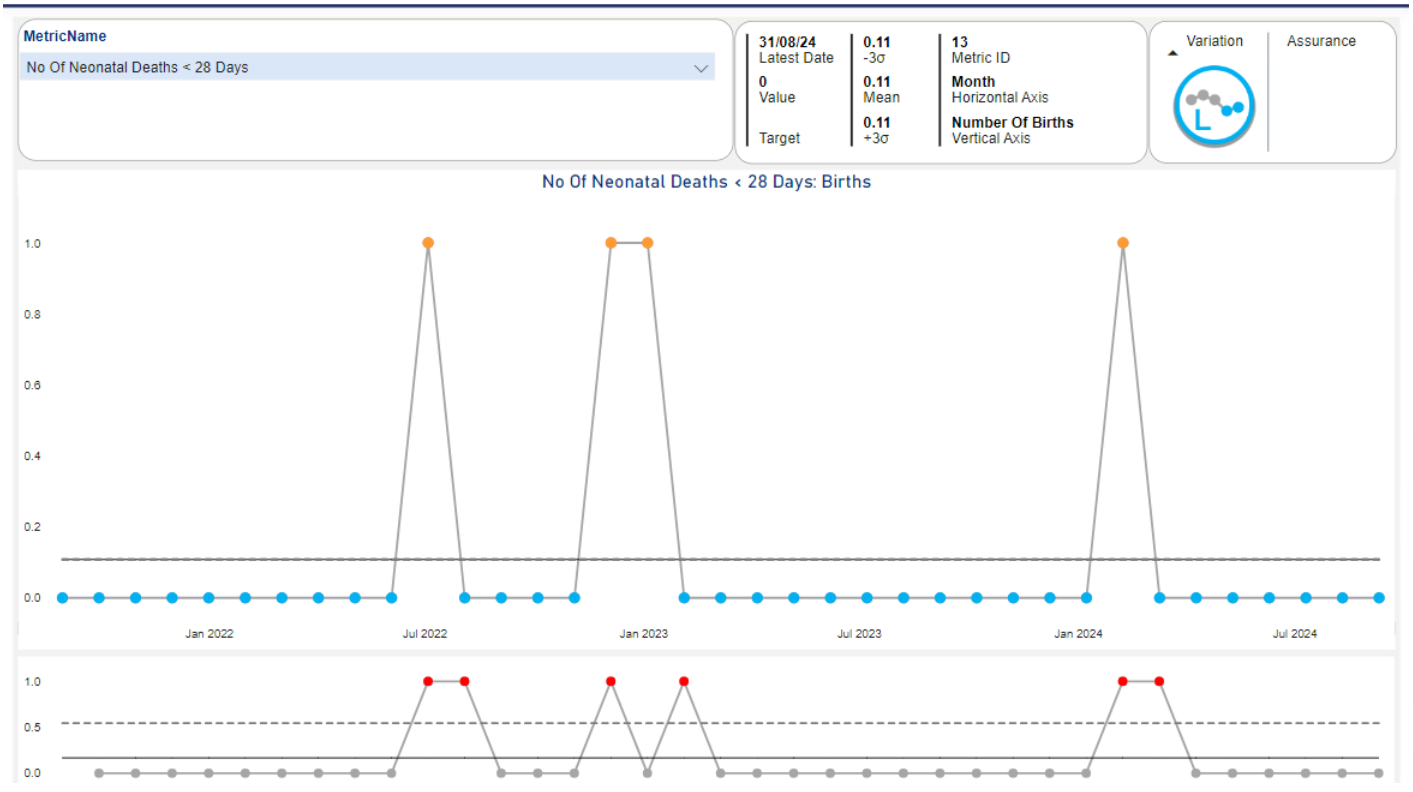
% Of Women Smoking At Delivery

31/08/24 Latest Date	**2.62%** -3σ	**56** Metric ID
3.9% Value	**8.06%** Mean	**Month** Horizontal Axis
6% Target	**13.49%** +3σ	**% Meeting Standard** Vertical Axis

Variation | Assurance





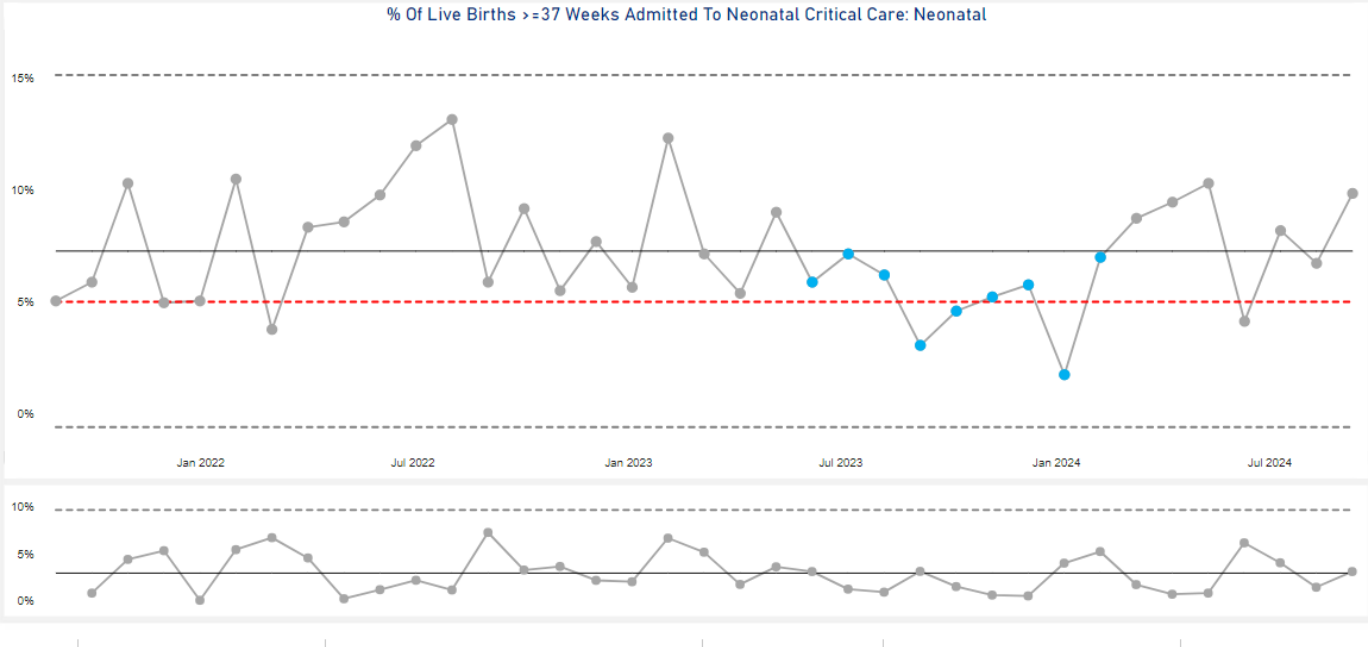


MetricName

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

31/08/24 Latest Date	**-0.59%** -3σ	**101** Metric ID
9.8% Value	**7.27%** Mean	**Month** Horizontal Axis
5% Target	**15.12%** +3σ	**% Meeting Standard** Vertical Axis

Variation Assurance

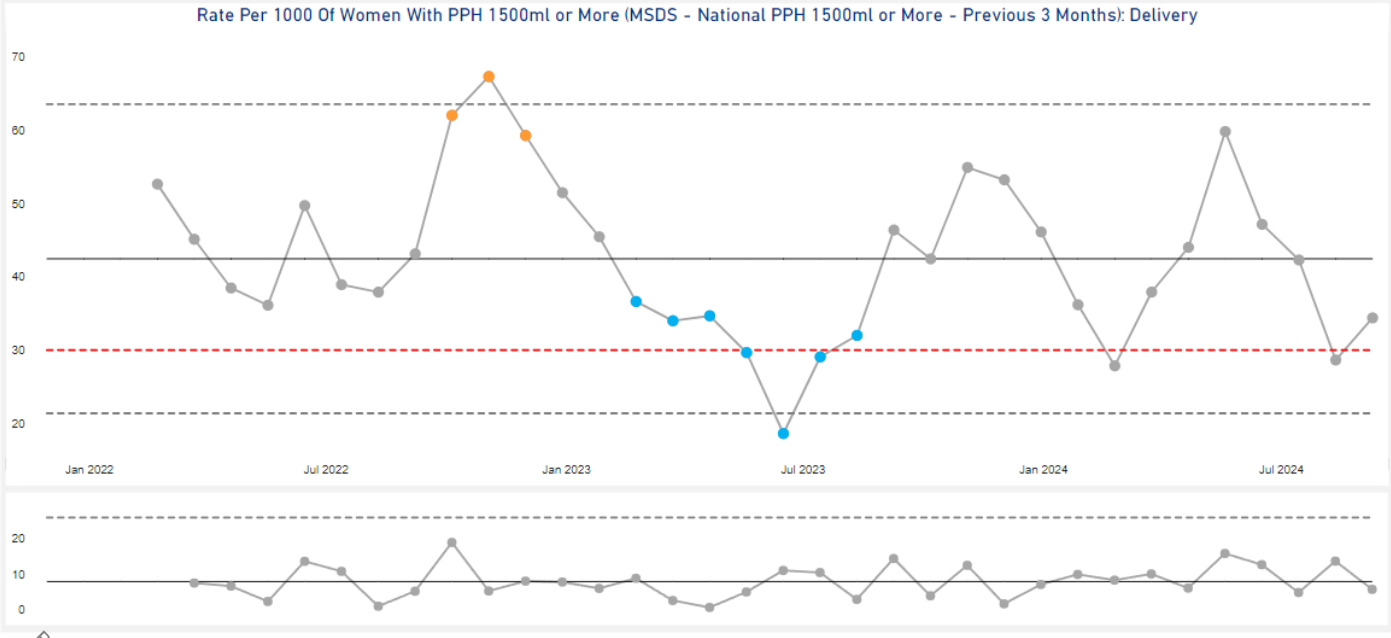


MetricName

Rate Per 1000 Of Women With PPH 1500ml or More (MSDS - National PPH 1500ml or More - Prev...

31/08/24 Latest Date	**21.38** -3σ	**178** Metric ID
34.4 Value	**42.45** Mean	**Month** Horizontal Axis
30 Target	**63.53** +3σ	**Rate Per 1000** Vertical Axis

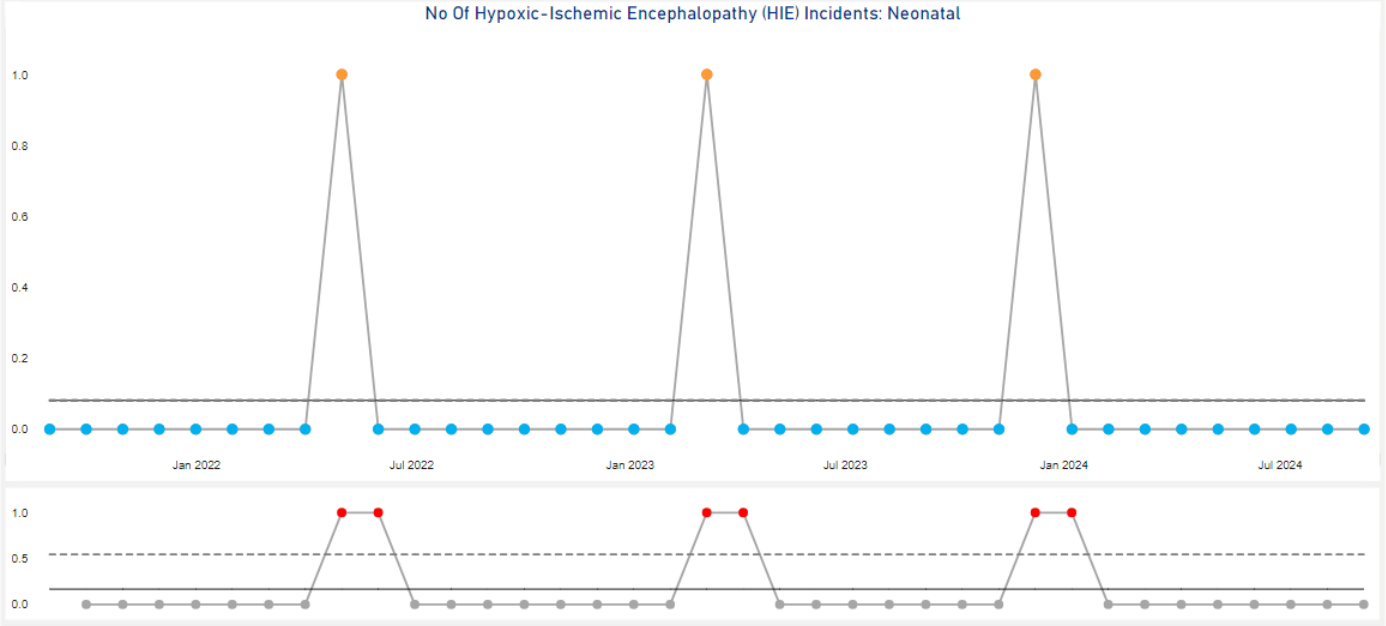
Variation Assurance



MetricName

No Of Hypoxic-Ischemic Encephalopathy (HIE) Incidents

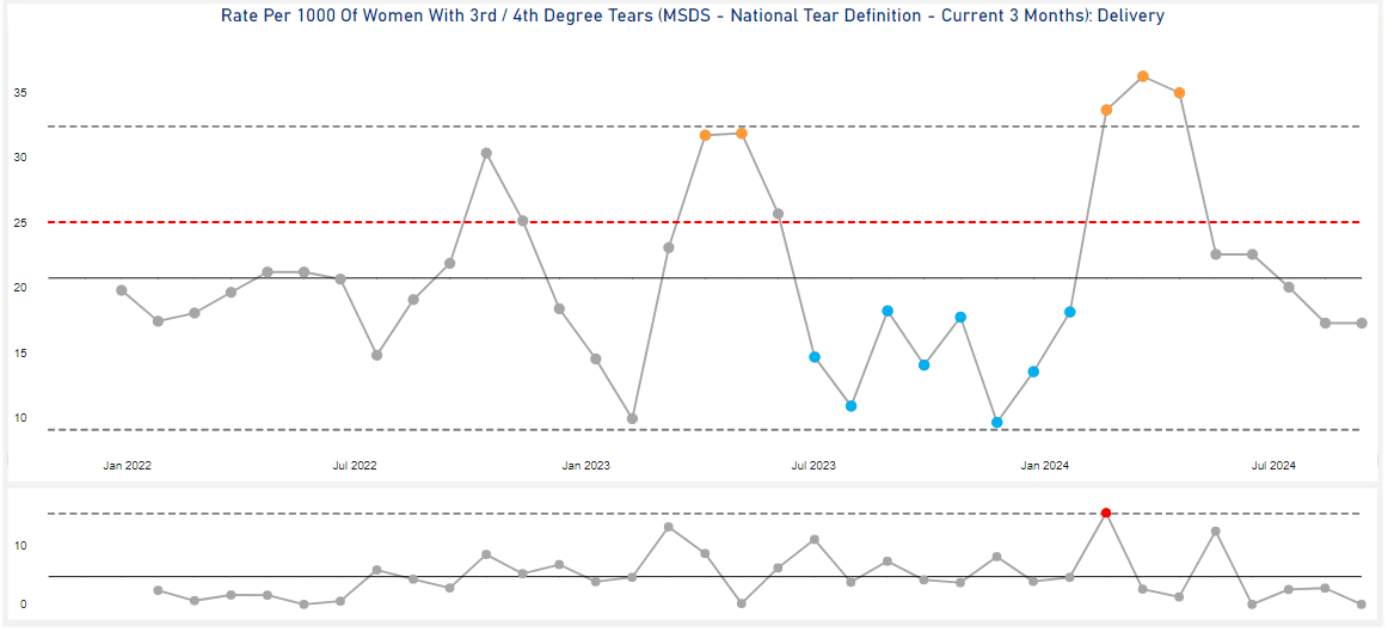
31/08/24 Latest Date	0.08 -3σ	57 Metric ID	Variation	Assurance
0 Value	0.08 Mean	Month Horizontal Axis		
Target	0.08 +3σ	Number Of Births Vertical Axis		



MetricName

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

31/08/24 Latest Date	9.05 -3σ	182 Metric ID	Variation	Assurance
17.2 Value	20.7 Mean	Month Horizontal Axis		
25 Target	32.36 +3σ	Rate Per 1000 Vertical Axis		

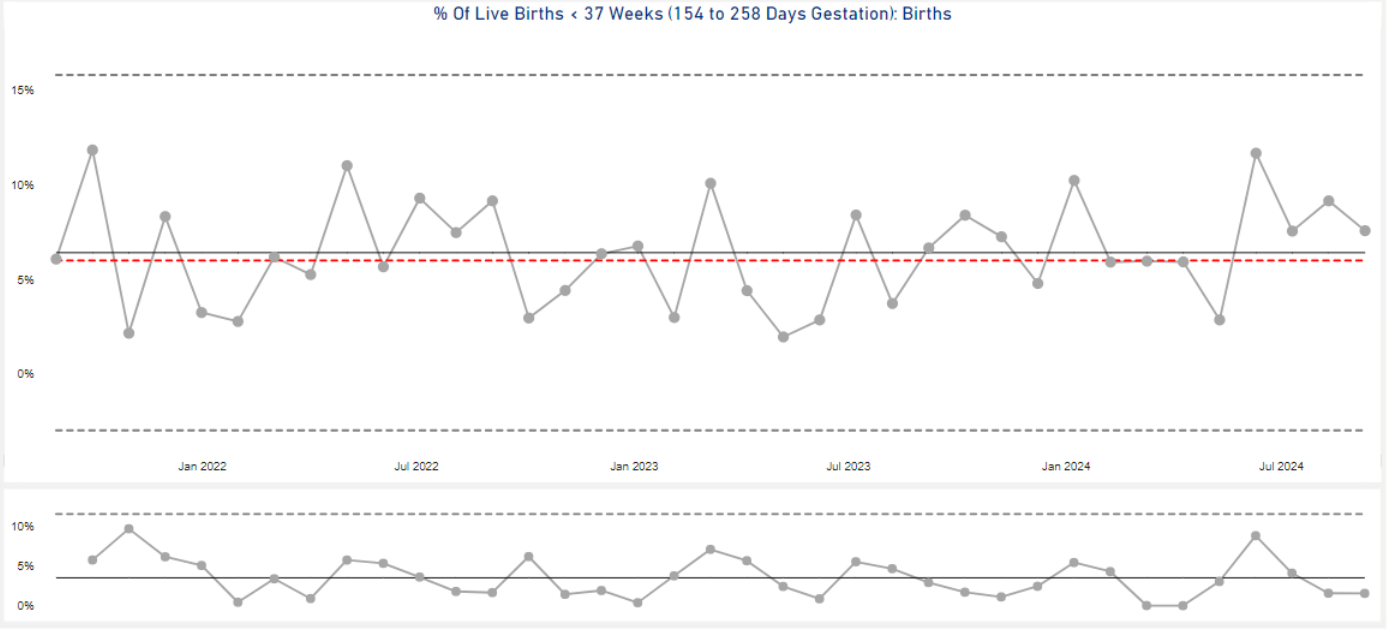


MetricName

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

31/08/24 Latest Date	**-2.98%** -3σ	**106** Metric ID
7.6% Value	**6.42%** Mean	**Month** Horizontal Axis
6% Target	**15.82%** +3σ	**% Meeting Standard** Vertical Axis

Variation | Assurance

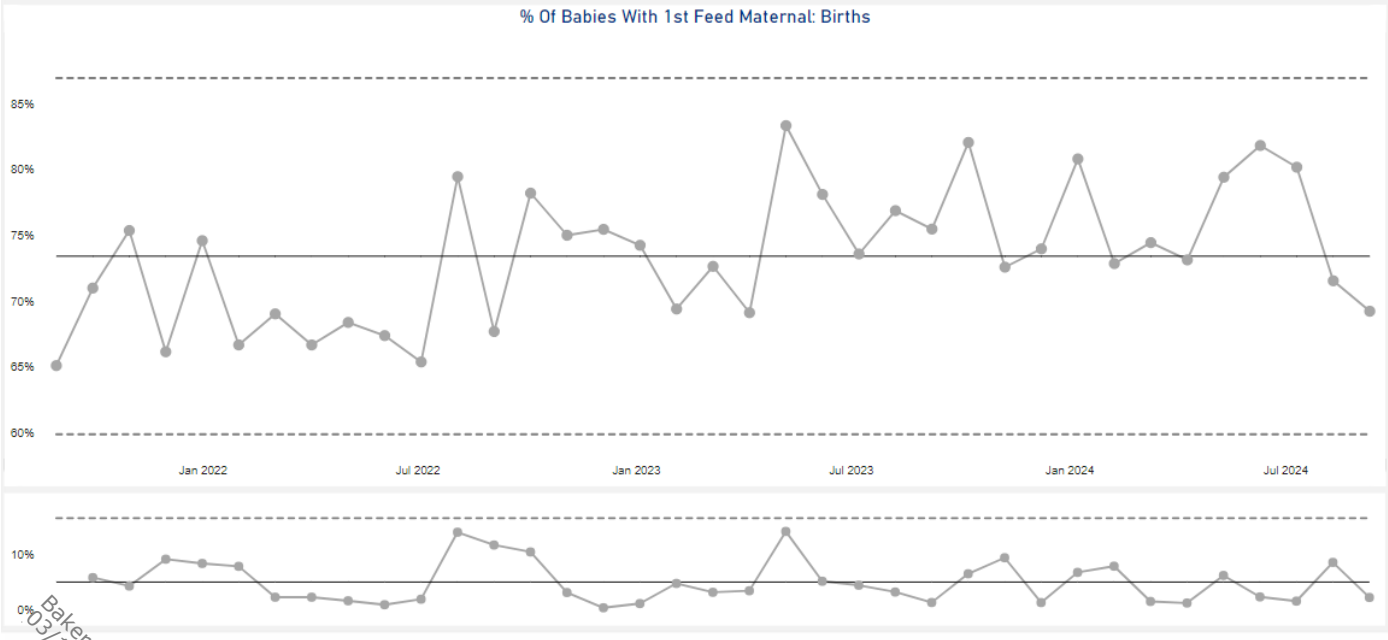


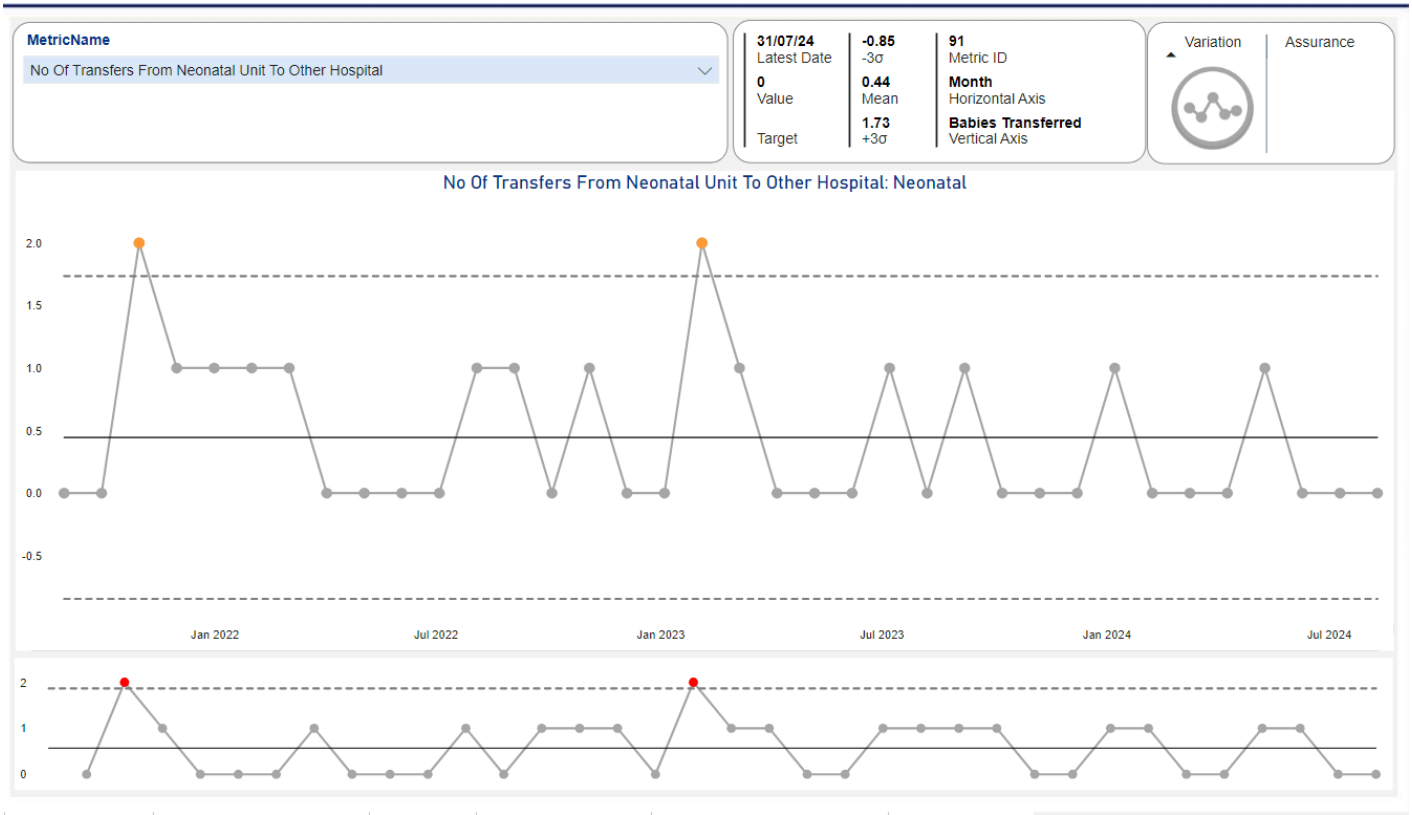
MetricName

% Of Babies With 1st Feed Maternal

31/08/24 Latest Date	**59.88%** -3σ	**34** Metric ID
69.2% Value	**73.41%** Mean	**Month** Horizontal Axis
Target	**86.94%** +3σ	**% Meeting Standard** Vertical Axis

Variation | Assurance





Total Number of Incidents submitted for July 2024

maternity & neonatal
89

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

Red flag	Descriptor	Incidents for August
RF1	Escalation to divert of maternity services & poor staffing numbers, including medical staffing and SCBU	11
RF2	Missed medication	5
RF3	Delay in providing or reviewing an epidural in labour	0
RF5	Full examination not carried out when presenting in labour	0
RF6	Delay of ≥2 hours between admission for induction of labour & starting process	multiple incidents with 6 datix
RF7	Delay in continuing the process of induction of labour	
RF8	Unable to provide 1 to 1 care in labour	0
RF9	Unable to facilitate homebirth	0
RF10	Delay of time critical activity	0

In-utero transfers – UHD is default level 2 NICU for DCH pregnancy <32 weeks	
UHD	2
Portsmouth	1 Appropriate transfer 24+4/40. Level 3 NICU required

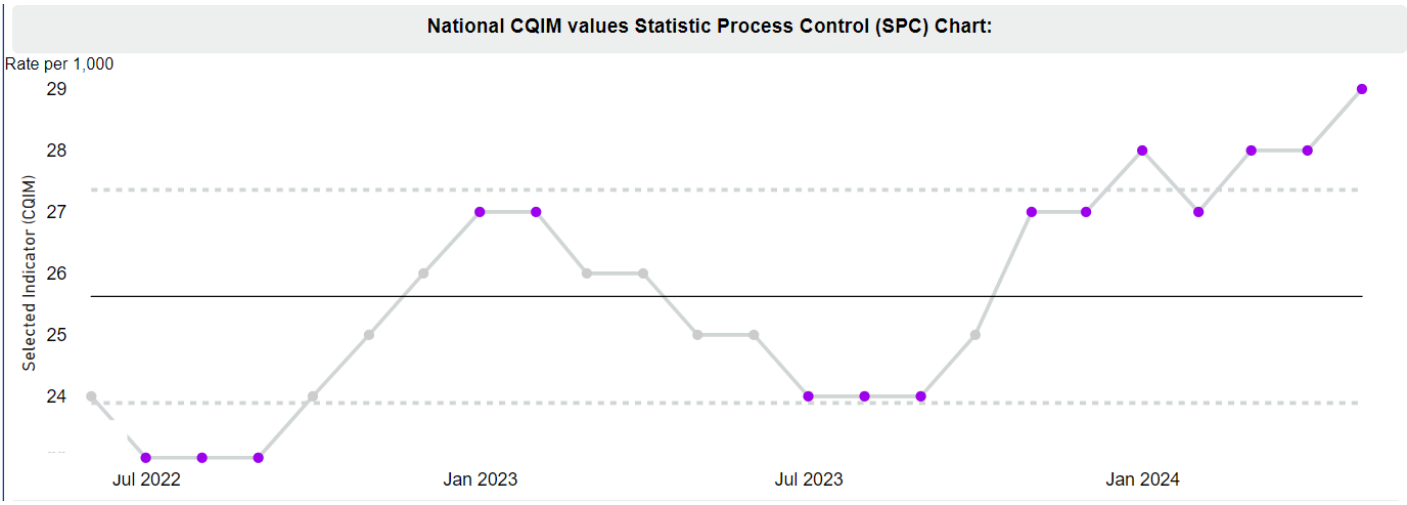
Incidents graded as moderate harm or above for August

nil

3rd & 4th degree tears July and August

Parity	Ethnicity	BMI	Age	Grade of tear	Mode of birth	Length of 2nd stage	Birthweight	hands	OASI	Position of woman	Blood loss	Referral made
0	White English	23	32	3a	Ventouse	69mins	2436g <2nd centile	on	yes	lithotomy	1102	Physio gynae
0	South East Asian	36	34	3b	vaginal	36mins	2710g 57th centile	off	no	Semi-recumbent	2321	Physio gynae
0	White English	17	24	4th	forceps		3630g 93rd centile	on	yes	lithotomy	330	Colorectal f/up by consultant

Please note the national SPC chart demonstrating a national issue with rising 3rd and 4th degree tear rates.



Since Nov 2023 (the first purple dot on the incline) which is a rolling amalgamation of 3 months data (so Sept-Nov) there has been a statistically significant national increase on an upwards trajectory. The counter to this (or intervention) is the OASI care bundle as per the NHS 3 year delivery plan as an example of QI and best practice.

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

DCH88563 – 27/11/23
Update LIP 08/08. Actions agreed. Action plan to be updated and share with family. Tracked through LMNS

Safety Walkabout July 2024

Jo Howarth, DoN. Eiri Jones, NED. Hannah Leonard deputy Director of Maternity, LMNS
Excellent standards of cleanliness

Operationally very busy, active risk management and staffing escalations in place
Fragility of finger probes noted. DoN to discuss with Medical Electronics
Colostrum collection safety alert discussed. Safety actions noted.
Replacement model resuscitaire on the ward for trial – positively received by staff
Positive comments from service users – acknowledging the workload and how busy staff were

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. 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 coordinator (as per National Service specification). **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. To maintain safety of staff, infants and carers we require a minimum of 18.21WTE (3 x 6.07), as per the Neonatal Nursing workforce Calculator. Our establishment only accommodates a total of 15.18wte. **Update** Current position and action plan presented at LMNS Transformation Meeting. Robust discussion including the challenges of being a small neonatal service. Non-clinical facing staff during the daytime need to be formally acknowledged on the roster as contributing to the supernumerary status of the coordinator. Business case will be submitted to increase trained staff.	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 Ipads **Update** Planned digitalisation of SCBU delayed due to lack of funding. 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 7year 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. Standard contract until 28/02/2025. Risk highlighted in the 2024/25 Capital Programme for prioritisation as needing replacement as soon as possible **Update** A recent incident when all three ventilators out of use – had there been an admission of premature twins (for example), the lack of access to ventilators could have negatively impacted on the babies' outcome. Recently the neonatal service has been very busy with several unexpected admissions. Scoping of cost to replace ventilators underway	26/02/2024, Debora Pascoal-Horta, neonatal matron, quarterly review	Moderate 9	care group
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 model. Possibility of procurement with neighbouring trust. Initially sat with the Capital Replacement Programme but likely need to seek charitable funding. There have been no cases of a resuscitaire not being available for every labouring woman **Update** Model agreed (lower cost version but full specification). Charitable request submitted and awaiting outcome	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 full time 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. **Update** No change to current situation	28/05/2024 managed by Becky Fry, Public Health Lead Midwife, 6 month review	Moderate 8	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** Intrapartum matron to lead on this workstream. Will require an uplift in anaesthetic and obstetric consultant attendance	29/06/2023 managed by Jo Hartley DoM, quarterly review	moderate 9	division
1742 & 1759	additional obstetric consultant capacity required to meet national KPIs	currently providing obstetric and gynae services on a 1:7 rota with 8 consultants. Unable to provide nationally mandated level of care to some high-risk groups of women. Also unable to provide a consultant evening (8pm) face to face handover. New consultant has made a very successful start with the service. F2F handover and ward round acknowledged as a priority but will require job plan review as changes in on call provision from some consultants impacts these arrangements. Likely funding for tenth consultant – awaiting confirmation **Update** Funding for 10th consultant confirmed (9 PAs so less than fulltime). Recruitment to follow	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. Monthly audit completed today and positive results demonstrating good compliance around KPIs relating to triage - approaching 90%. There is evidence that reduced compliance relates directly to reduced staff in ANDAU **Update** No further update. Next audit of compliance with triage times pending	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** Replacement completed in SCBU. To commence in maternity unit.	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 testing cannisters were returned to Cairns 06/04 but thus far Cairns are unable to locate them (initially the company declared no knowledge of the return). Escalated appropriately to Cairns and to Estates to either locate the canisters or retest. **Update** Cairns confirm they cannot locate the testing cannisters so testing to recommence urgently. Awaiting delivery of cannisters from Cairns	24/12/2019 Managed by Nichola Coliandris, Matron, quarterly review	Moderate - 12	Corporate
876	Maternity Staffing	Currently over-recruited into band 5 NQM to allow for attrition in the coming year. Awaiting new starters **Update** Heathroster being reviewed in line with funding streams to ensure all posts are represented in the business case. BR Plus audit if safe staffing commenced. Vacant shifts continue relating to LTS, STS, maternity leave. Staff reallocated from community and specialist roles to ensure safety on labour ward but evidence of staff burnout and stress levels increasing.	21/09/2021 Managed by Jo Hartley, Director of Midwifery, Monthly reviews	Moderate - 12	corporate

Complaints for maternity and SCBU

Total informal and formal

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

Maternity Score Card

Trust Claims Scorecard (obstetric) 2013 - 2023

Top 5 injuries by volume:	Top 5 injuries by value:
• Psychological damage (6) • Unnecessary pain (3) • Bowel damage/dysfunction (2) • Brain damage (2) • Hypoglycaemia (1)	• Brain damage (2) • Chromosomal abnormality (1) • Bowel damage/dysfunction (2) • Psychiatric/psychological damage (6) • Hypoxia (1)
Top causes by volume:	**Top 5 causes by value:**
• Fail to warn – informed consent (3) • Not specified (2) • Assault, Etc by hospital staff (2) • Perineal Tear 1st, 2nd, 3rd Deg (2) • Fail to recog. complication of (2) • Foreign body left in situ (1)	• Fail to warn – informed consent (3) • Fail AN screening (1) • Perineal tear 1st, 2nd, 3rd Deg (2) • Assault, Etc by Hospital staff (2) • Fail / Delay treatment (1)

Complaints (6 new, 1 reopened) Q1 April -June 2024

- It is essential that parents with a baby in the Neonatal Unit are treated with compassion and kindness
- Review the way in which midwives and obstetric doctors communicate information around extreme prematurity with parents
- The need for improved communication across departments, to help avoid delays
- Complaint reopened to address a patients more specific requests surrounding examinations

Incidents Q1

3rd degree tears (4) 4th degree tears (0) (1.6% of vaginal births).
Antepartum in-utero transfer out (6)
Admissions to scbu (all) (24)
Re-admission of baby to maternity (12)
Re-admission of mother to maternity (5)

MIS Year 6 requirements: Trust's claims scorecard is reviewed alongside incident and complaint data and discussed by the maternity, neonatal and Trust Board level Safety Champions at a Trust level (Board or directorate) meeting. Scorecard data is used to agree targeted interventions aimed at improving patient safety and reflected in the Trusts Patient Safety Incident Response Plan (PSIRP).

NHS Dorset County Hospital NHS Foundation Trust

Themes Q1

- Sensitivity surrounding premature birth
- Communication with women and families
- Support for women needing transfer to tertiary unit due to prematurity
- Readmission of mothers and babies to maternity & SCBU

Learning Q1

- The use of language and timing of discussions surrounding extreme prematurity can have a lasting effect on families
- Importance of responding to concerns raised by families promptly
- Ensuring staff are sensitive to families that need readmission due to either maternity or SCBU
- There must be consultant to consultant referral when transferring out to tertiary unit

Action Plan Q1

Not started | In progress | Completed

Review the appropriateness of re -admissions to maternity for mother and baby. To look at pathways, wait times and workload	EP, GW Oct 2024	
To review transfer out to tertiary units. Review tool commenced.	NC/Safety team Nov 2024	
To explore ways of shared learning for sensitive discussions surrounding extreme premature birth and pregnancy loss	EP Bereavement team Dec 2024	
3rd/4th degree tears thematic review monthly	MOH Group	
Attain review of term admission to scbu. QI	Attain group	

Workforce data

Not available

Neonatal transfer out data for August – one

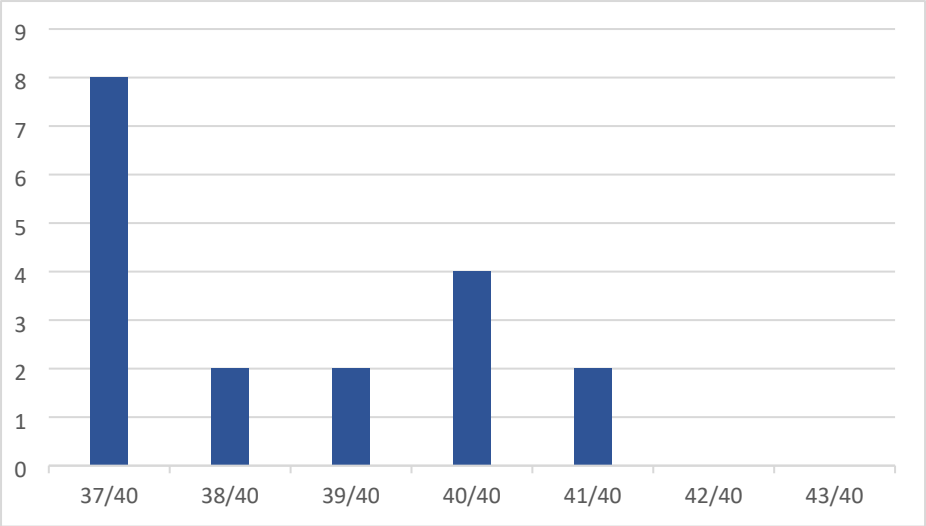
Low oxygen saturations identified by midwife and appropriate, prompt transfer organised. On arrival, baby required intubation for congenital pneumonia so transferred to Southampton NICU. Discharged fit and well

ATAIN report quarter one

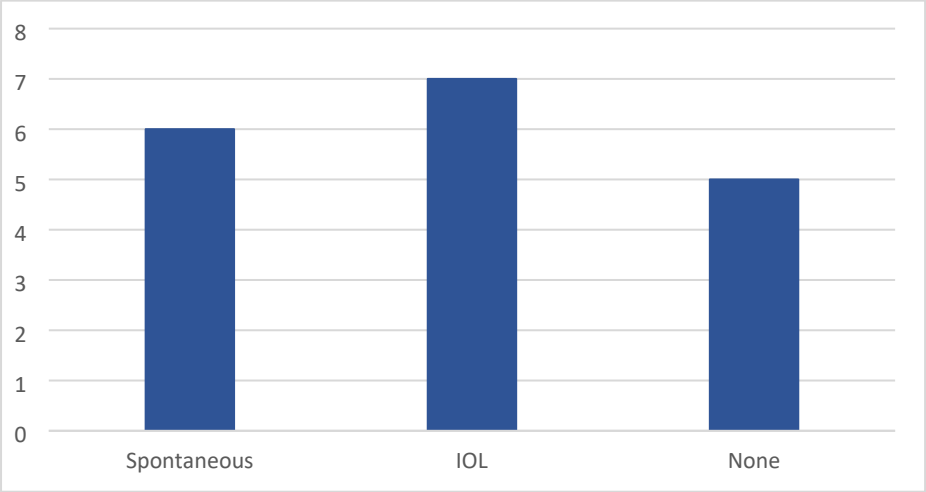
ATAIN reviews (infants equal or >37 weeks gestation) quarter I

	April 2024	May 2024	June 2024	Total
Total of live births	**140**	**137**	**119**	**396**
Total number of admissions in month/percentage	**10 7.1%**	**3 2.2%**	**5 4.2%**	**18 4.5%**

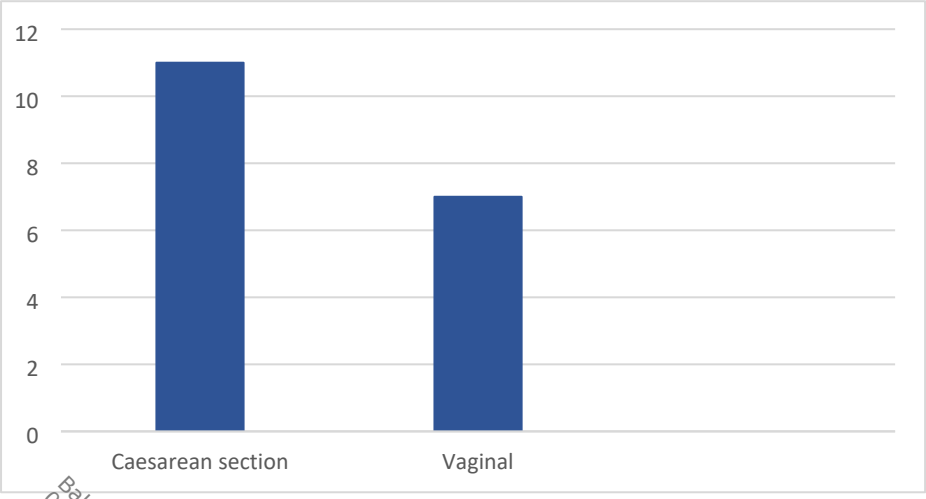
Gestation at Birth



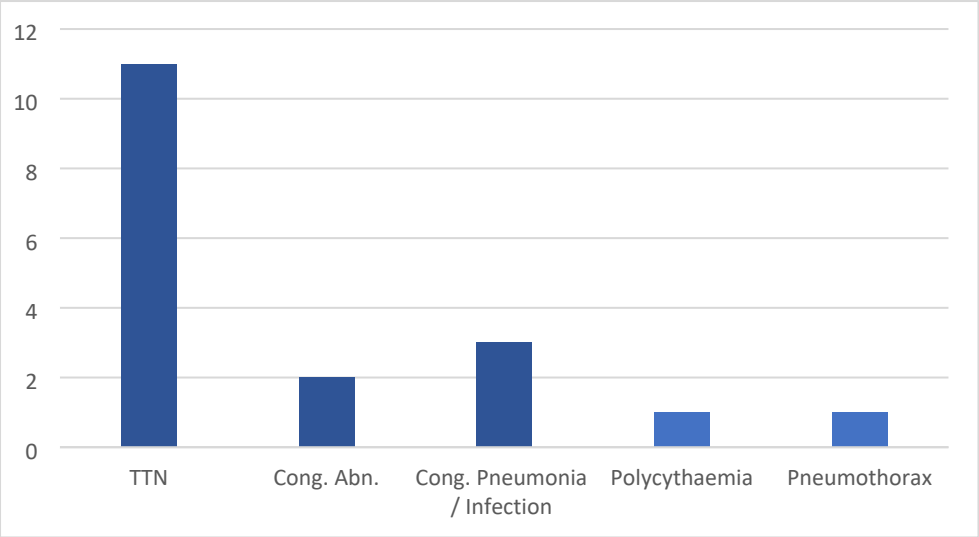
Onset of Labour



Type of delivery



Reason for Admission



Findings from the reviews

For this first quarter of the year, we had a total of eighteen term admissions.

Possible avoidable admissions

- One infant was identified as an avoidable term admission, due to poor feeding
- A second infant was identified as a potential avoidable admission due to respiratory distress possibly worsened due to lack of functioning positive end expiratory pressure (PEEP) circuit on the resuscitaire, but this is not possible to ascertain.
- A third infant was identified as a potential avoidable admission, as there wasn't clear documentation about indication for induction of labour (IOL). This case generated discussion around how difficult the balance can be, when considering maternal mental health versus the need to not deliver infants too soon. This infant was born at thirty-seven weeks following IOL, and there wasn't clear documentation antenatally detailing if all the risks caused to the infant were explained to the mother when performing IOL at that gestation.

Of note, nine infants that were admitted with transient tachypnea of the newborn (TTN) were delivered via caesarean section (either elective or emergency). This was the most common cause of admission.

One infant was diagnosed with sepsis with positive blood culture for GBS.

Examples of good practice

- Prompt and timely SBARs.
- All efforts made to keep infants with their mothers, by providing PEEP for at least 30 minutes.
- Clear, precise, and timely documentation.
- Excellent clinical practice providing Neonatal Life Support at birth, skin-to-skin & feeding within 30mins of life.
- Evidence of excellent multidisciplinary collaboration

Action Plan	Timeframe	Owner
Provide a refresher session to the Neonatal MDT Team about contemporaneous documentation, and Badger App, during the SCBU update days.	Extended until March 2025.	DPH

Maternity Quadrumvirate Meeting

Minutes of the Meeting of 8th August 2024
In person and online

Present: Jo Hartley, Director of Midwifery
Clare Hollingsworth, Consultant Paediatrician
Beena Dandawate, Consultant Obstetrician
Jo Howarth – Director of Nursing

Apologies: James Male
Eiri Jones

Matters arising

- **Emotional wellbeing check-in** – Quad members present described feeling overwhelmed with competing priorities

- **Service exceptions –** discussion centred on
  - The importance of agreeing the specialist roles in obstetrics and paediatrics and finalising job planning. The divisional director is overseeing job descriptions for these roles and clarity about tenure. The new obstetric consultant is taking on the governance lead, PMRT lead and college tutor role.
  - The replacement of the call bell system is now underway – starting in SCBU.
  - Discussion around the escalation process for neonatal staffing and the future involvement of the paediatric ward. The neonatal staffing remains a key risk for MIS and all options will be considered
  - The workstream focusing on an elective pathway for caesareans is being led by the Intrapartum Matron – requirements will be theatre space, increased anaesthetic staff and increased obstetric staff

- **Staffing and recruitment**
  - Funding has been confirmed from the ICB for a tenth consultant obstetrician – almost 10 PAs.
  - The Head of Midwifery is unable to take up her responsibilities until the recruitment process is completed for the vacated Safety Lead post. This is impeding progress in establishing the new Governance and Management structure on the maternity service and impacting essential workstreams

- **Consideration of culture including SCORE survey**
  Key themes identified are
  - Taking breaks
  - Improving feedback processes
  - Burnout
  - Improving handover on SCBU (staff report feeling 'judged')
  - Supernumerary coordinator in SCBU
  - More midwives on a shift
  - Options for sabbatical for consultants
  - Concerns about management of the midwives off-duty in relation to 6/52 in advance and oncalls

- **Training Needs Analysis**
  - Discussion about headroom increase to allow for the significant increase in mandatory training for midwives.
  - New plan agreed to address issues around anaesthetists attending PROMPT

- **User feedback**
  - Discussion of a complaint relating to intimate examinations. Importance of clinicians reading the signs even if the woman doesn't obviously withdraw consent. To be discussed with the individual clinician by the CD and at RHCG and consultant meeting

Learning from Deaths Report Q1 2024/25

1. Report Details			
Meeting Title:	Board of Directors, Part 1		
Date of Meeting:	09 October 2024		
Document Title:	Learning from Deaths Q1 2024/25		
Responsible Director:	Prof Alastair Hutchison	Date of Executive Approval	
Author:	Dr Julie Doherty / Prof Alastair Hutchison		
Confidentiality:	No		
Publishable under FOI?	Yes		
Predetermined Report Format?	No. However formatted in line with SW Regional guidance. Breadth of data presented is recognised as an exemplar within SW Region.		

2. Prior Discussion		
Job Title or Meeting Title	**Date**	**Recommendations/Comments**
Hospital Mortality Group	11 Sept 2024	
Quality Committee	17 Oct 2024	Escalated to Board

3. Purpose of the Paper	To inform the Quality Committee of the learning occurring from deaths being reported, investigated and appropriate findings disseminated throughout the Trust. To also outline additional measures put in place to assure the Trust that unnecessary deaths are not occurring at DCH despite a previously elevated SHMI. Presentation of the Learning from Deaths report at Quality Committee and Trust Board is a mandatory obligation for all Trusts.							
	Note (✓)		*Discuss (✓)*		*Recommend*		*Approve (✓)*	
4. Key Issues	The latest published SHMI data (5 months in arrears) for DCH was 1.0995 This is within the expected range. SHMI data is showing a decreasing trend at DCHFT. We do have concerns that our SHMI may become adversely affected by the lack of resources within the clinical coding dept. Uncoded activity affects our expected mortality.							
5. Action recommended	The Board is recommended to: 1. **DISCUSS and NOTE** the findings of the report 2. **DISCUSS** the additional scrutiny occurring 3. **APPROVE** the publication of the report							

6. Governance and Compliance Obligations			
Legal / Regulatory Link	**Yes**		Learning from the care provided to patients who die is a key part of clinical governance and quality improvement work (CQC 2016). Publication on a quarterly basis is a regulatory requirement.
Impact on CQC Standards	**Yes**		An elevated SHMI will raise concerns with NHS E&I and the CQC. The reduction in SHMI is acknowledged, and the overall trend in DCH's SHMI is favourable.
Risk Link	**Yes**		• Reputational risk due to higher than expected SHMI • Poor data quality can result in poor engagement from clinicians, impairing the Trust's ability to undertake quality improvement • Clinical coding data quality is essential to the Trust's ability to assess quality of care. The Dept remains short-staffed and mitigation measures are in place including coding from EDS/ DPR. There is a risk around agency coders and compliance with NHS Framework. • Clinical safety issues may be under-reported or unnoticed if data quality is poor Other mortality data sources (primarily from national audits) are regularly checked for any evidence of unexpected deaths.

Impact on Social Value			**No**	If yes, please summarise how your report contributes to the Trust's Social Value Pledge
Trust Strategy Link		**How does this report link to the Trust's Strategic Objectives?**		
Strategic Objectives	People	N/A		
	Place	Health inequalities related to 'Place' are well known to impact life expectancy and will be referenced in future reports.		
	Partnership	N/A		
Dorset Integrated Care System (ICS) goals		**Which Dorset ICS goal does this report link to / support?** Understanding and reducing health inequalities		
Improving population health and healthcare			**No**	
Tackling unequal outcomes and access		**Yes**		Health inequalities related to 'Place' are well known to impact life expectancy and will be referenced in future reports.
Enhancing productivity and value for money			**No**	
Helping the NHS to support broader social and economic development			**No**	
Assessments		**Have these assessments been completed?** *If yes, please include the assessment in the appendix to the report.. If no, please state the reason in the comment box below. (Please delete as appropriate)*		
Equality Impact Assessment (EIA)			**No**	Not applicable
Quality Impact Assessment (QIA)			**No**	Not applicable

CONTENTS

1.0 DIVISIONAL LEARNING FROM DEATHS REPORTS

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

1.1 Family Services and Surgical Division Report - Quarter 1 2024/25 Report

Structured Judgement Review Results:

The Family Services & Surgery Division had 57 deaths in quarter 1, of which 56 that require SJR's to be completed. Within quarter 1 62 SJR's have been completed from this quarter and previous months.

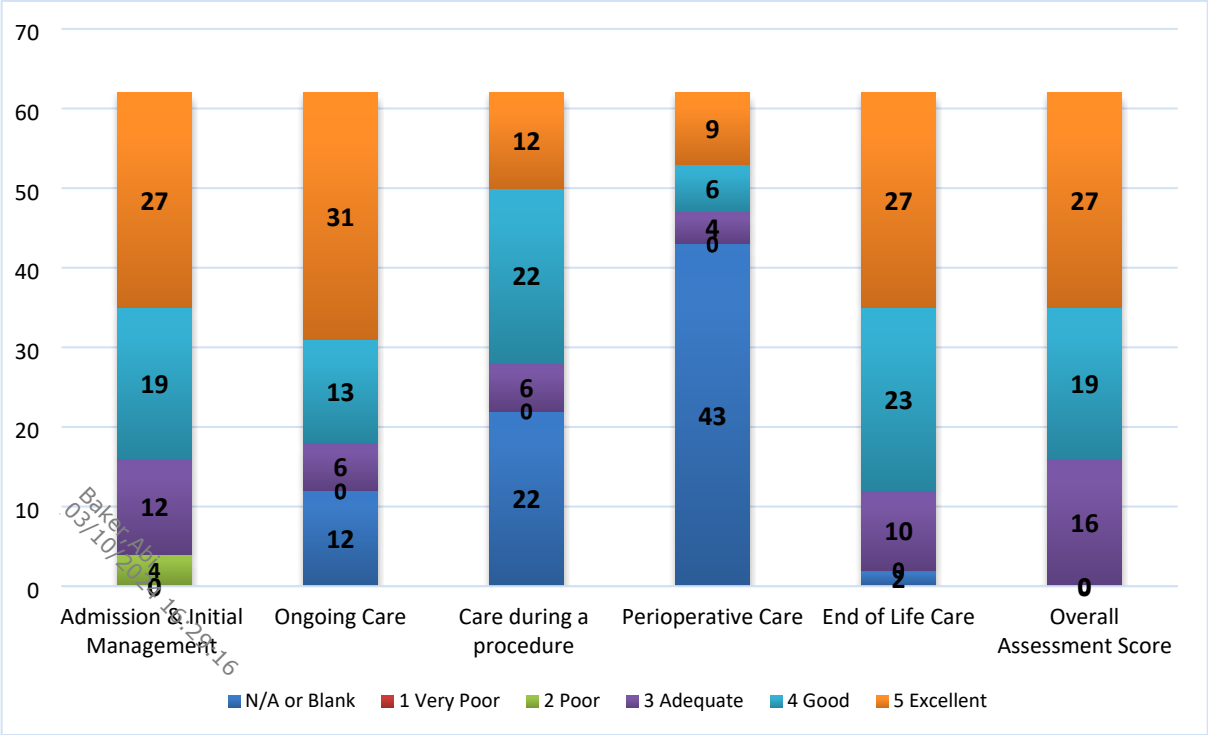
Outstanding SJR's:

The Division have completed a number of SJR's from previous quarters. The backlog of outstanding SJR's (over 2 months) for the Division as at 01/08/2024 is 18:

January	February	March	April	May
3	1	1	3	10

Feedback from SJR's Completed in Quarter 1:

Phase Score	Admission & Initial Management	Ongoing Care	Care during a procedure	Perioperative Care	End of Life Care	Overall Assessment Score
N/A or Blank	0	12	22	43	2	0
1 Very Poor	0	0	0	0	0	0
2 Poor	4	0	0	0	0	0
3 Adequate	12	6	6	4	10	16
4 Good	19	13	22	6	23	19
5 Excellent	27	31	12	9	27	27



Overall Quality of Patient Record:

Blank	Score 1 Very poor	Score 2 Poor	Score 3 Adequate	Score 4 Good	Score 5 Excellent
0	0	1	7	26	28

- Initial phase and ED documentation Comprehensive. ITU plan well-documented and excellent documentation of ongoing developments.
- Medical registrar documentation was excellent.
- Urology SHO records well documented and clear. Medical team records incomplete and poorly documented. ENT adequate.
- The patient record documentation is lacking in initial phase and especially vitals are not documented in detail, the surgical plan was not inclusive of clear DNAR and TEP plan. Renal registrar and ITU reviews were detailed and comprehensive.
- Loose notes, wrong order.
- Initially very good. Lacking findings of relevant and essential investigations.

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

Avoidability of Death Judgement Score:

Score 1 Definitely avoidable	Score 2 Strong evidence of avoidability	Score 3 Probably avoidable (more than 50:50)	Score 4 Possibly avoidable but not very likely (less than 50:50)	Score 5 Slight evidence of avoidability	Score 6 Definitely not avoidable
0	0	0	0	8	54

Action Required:

Following completion of the 62 SJR's, 11 were highlighted as requiring actions.

Further learning via:

- 3 were for formal documented feedback to Department or clinical team – this is completed at the time of the SJR completion.
- 2 were for newsletter inclusion and for formal documented feedback to Department or clinical team.

Other actions:

- 3 for review and discussion at Specialty M&M/Clinical Governance meetings.
- 1 was referred to HMG for discussion.
- 1 requested second SJR from specific specialty.
- 1 was referred for 2nd opinion on diabetic management from physician.

SJRs are now routinely being completed by both Medical and Nursing staff to provide an MDT approach and ensure all aspects of a case are reviewed.

Emerging Themes:

1. Documentation procedures improving
2. DNACPR – lack of continuity decision – in hospital on discharge as well as community into ED.
3. Inappropriate and prolonged resuscitation seems to be increasing

1.2 Division of Urgent & Integrated Care – Quarter 4 Report 2023/24

In quarter 1 there were 145 deaths, 32 SJR's were requested from these deaths, and 25 SJR's were completed during this period (completed SJR's not necessarily from this quarter).

	Q1			Q2			Q3			Q4			Q1		
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan-24	Feb	Mar	Apr	May	Jun
Deaths	61	60	57	65	58	60	49	41	63	65	59	69	48	52	45
Deaths requiring SJR'S from Month	10	10	14	15	14	18	11	14	13	15	16	12	9	8	15
*Completed SJR'S	5	12	16	2	14	17	20	12	3	7	11	2	6	10	9

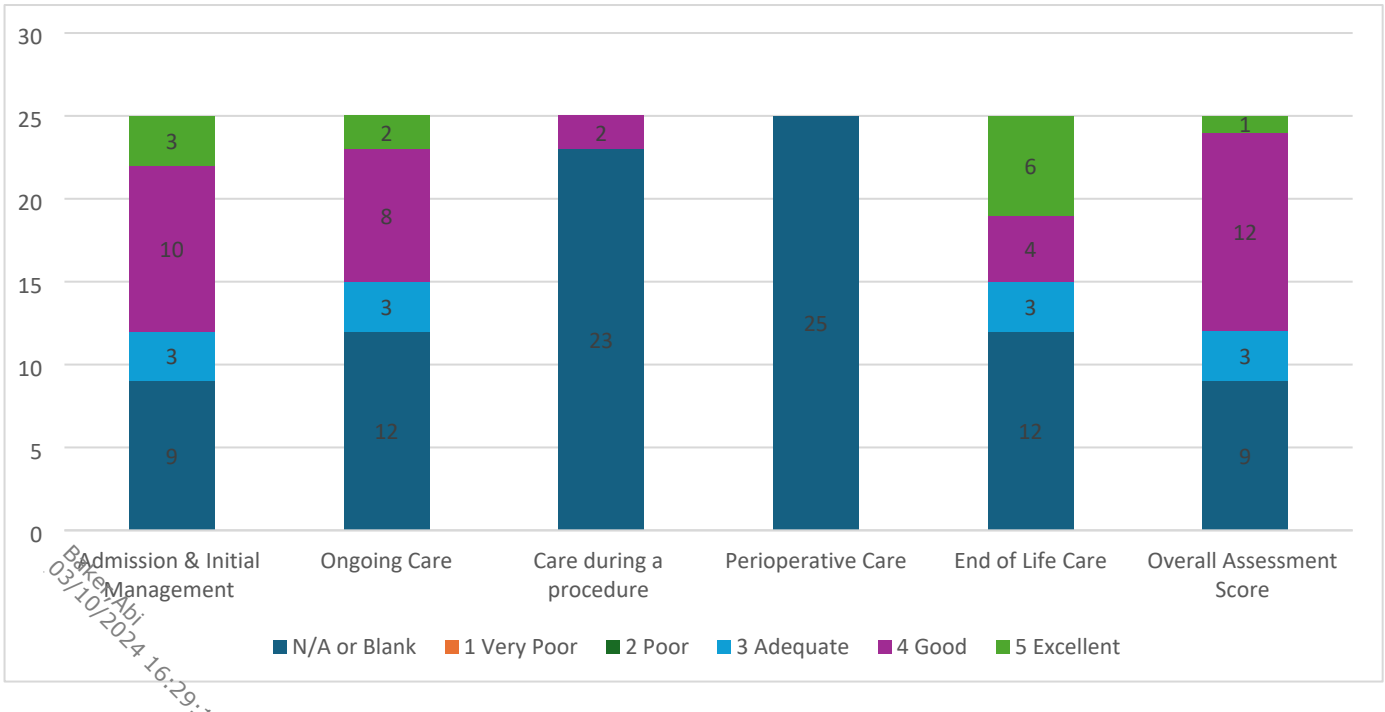
* Completed SJR'S not necessarily from that month's deaths

Outstanding SJRs for the Division as at 01/08/2024 is 82 including outstanding nosocomial reviews:

Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
1	1	1	0	3	5	0	2	7	2

Phase score from 25 completed SJR's in quarter 1:

Phase Score	Admission & Initial Management	Ongoing Care	Care during a procedure	Perioperative Care	End of Life Care	Overall Assessment Score
N/A or Blank	9	12	23	25	12	9
1 Very Poor	0	0	0	0	0	0
2 Poor	0	0	0	0	0	0
3 Adequate	3	3	0	0	3	3
4 Good	10	8	2	0	4	12
5 Excellent	3	2	0	0	6	1



Overall Quality of Patient Record:

Blank	Score 1 Very poor	Score 2 Poor	Score 3 Adequate	Score 4 Good	Score 5 Excellent
9	0	0	5	8	3

- Notes difficult to locate and would prefer for them to be on DPR
- Filing issues made notes difficult to follow. 2 date errors spotted but otherwise comprehensive.
- Good thorough documentation but incorrectly filed so difficult to follow. Illegible handwriting throughout which made it difficult to decipher
- Notes uploaded to DPR backwards
- Initial clerking record poor, occasions where time not always documented when review took place or entry in to the notes

Avoidability of Death Judgement Score:

Score 1 Definitely avoidable	Score 2 Strong evidence of avoidability	Score 3 Probably avoidable (more than 50:50)	Score 4 Possibly avoidable but not very likely (less than 50:50)	Score 5 Slight evidence of avoidability	Score 6 Definitely not avoidable
0	0	0	0	2	14

Action Required:

Following completion of the 25 SJR's, 3 required further actions:

- 1 was highlighted as requiring review by the responsible team where sepsis was implicated in cause of death but sepsis pathway had not been instigated as the haemodynamic changes were attributed to beta-blocker therapy.
- 1 referred to Hospital Mortality Group (HMG) - as would be good to share with federated partners and review care.
- 1 referred to the general surgical team as reviewer contests Covid as being the cause of death.

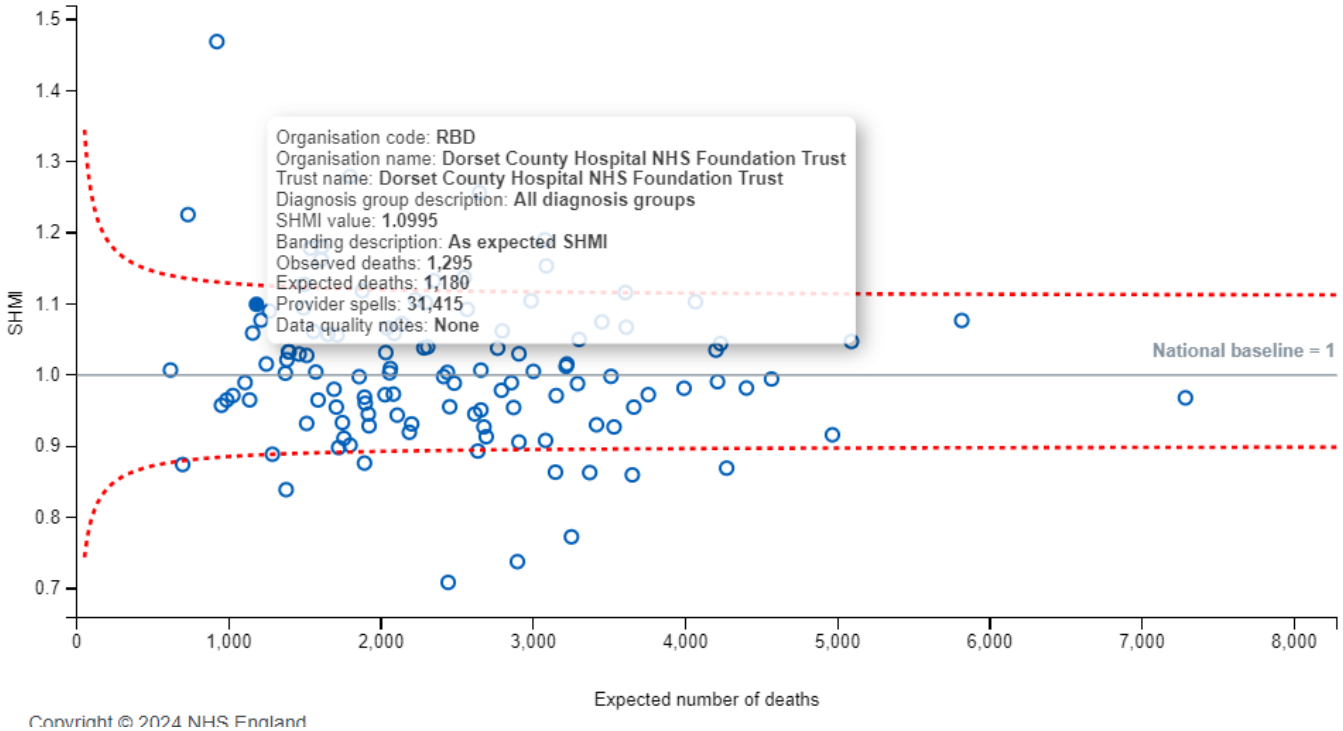
For further LfD and QIP see section 4.

2.0 NATIONAL MORTALITY METRICS AND CODING ISSUES

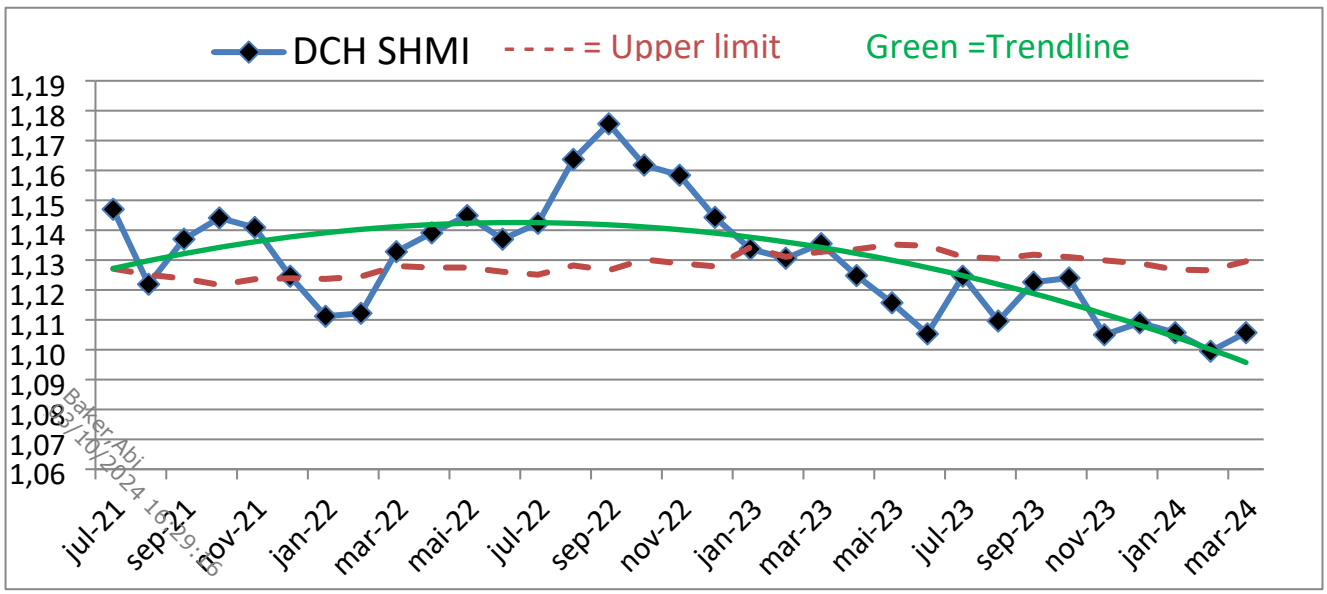
2.1 Summary Hospital-level Mortality Indicator (SHMI)

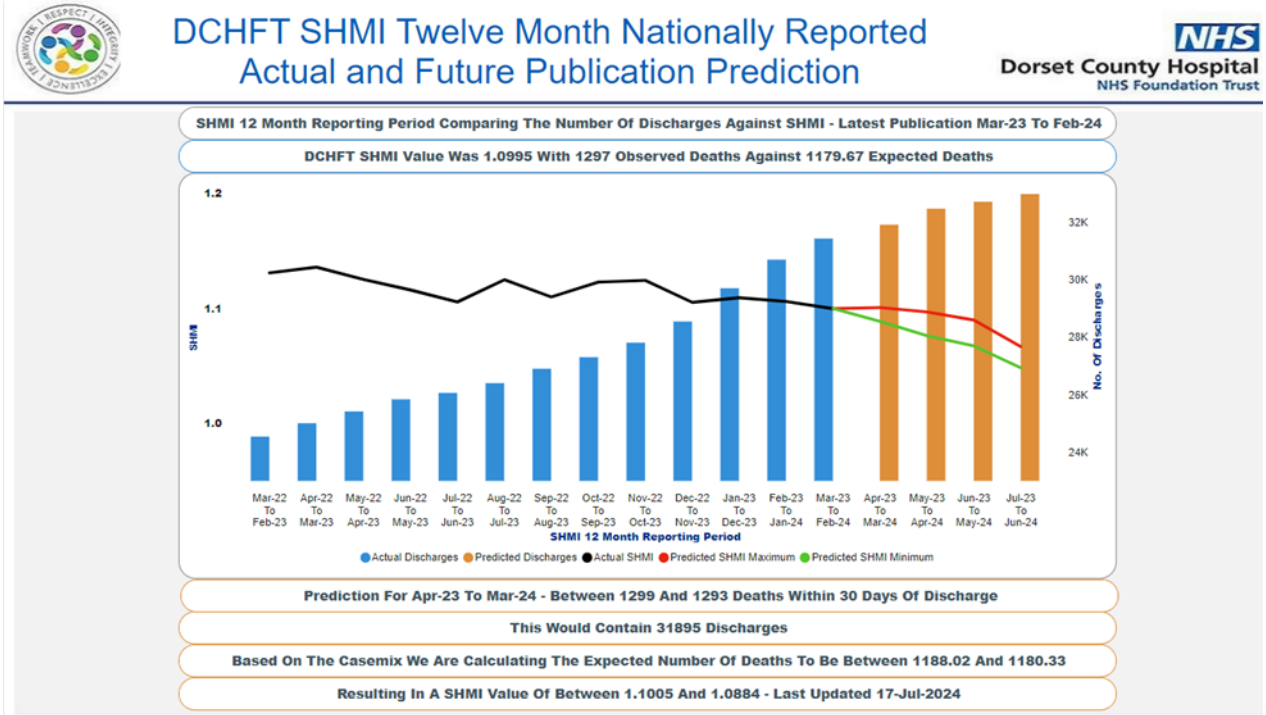
SHMI is published by NHS Digital for a 12-month rolling period, and 5 months in arrears. It takes into account all diagnostic groups, in-hospital deaths, and deaths occurring within 30 days of discharge. It is calculated by comparing the number of observed (actual) deaths in a rolling 12-month period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

The latest SHMI publication from NHS England is for the period March 2023 – Feb 2024. **The Trust's figure is 1.09 which is within the expected range** using NHS England's control limits.



We are aware that our data is influenced by staffing levels in the Coding Department (though mitigations in place), and a possible under-reporting of 'sepsis' in the medical record.
Septicaemia is a recurring alert and further exploration of this is being undertaken (with support from the Deteriorating Patient Group).



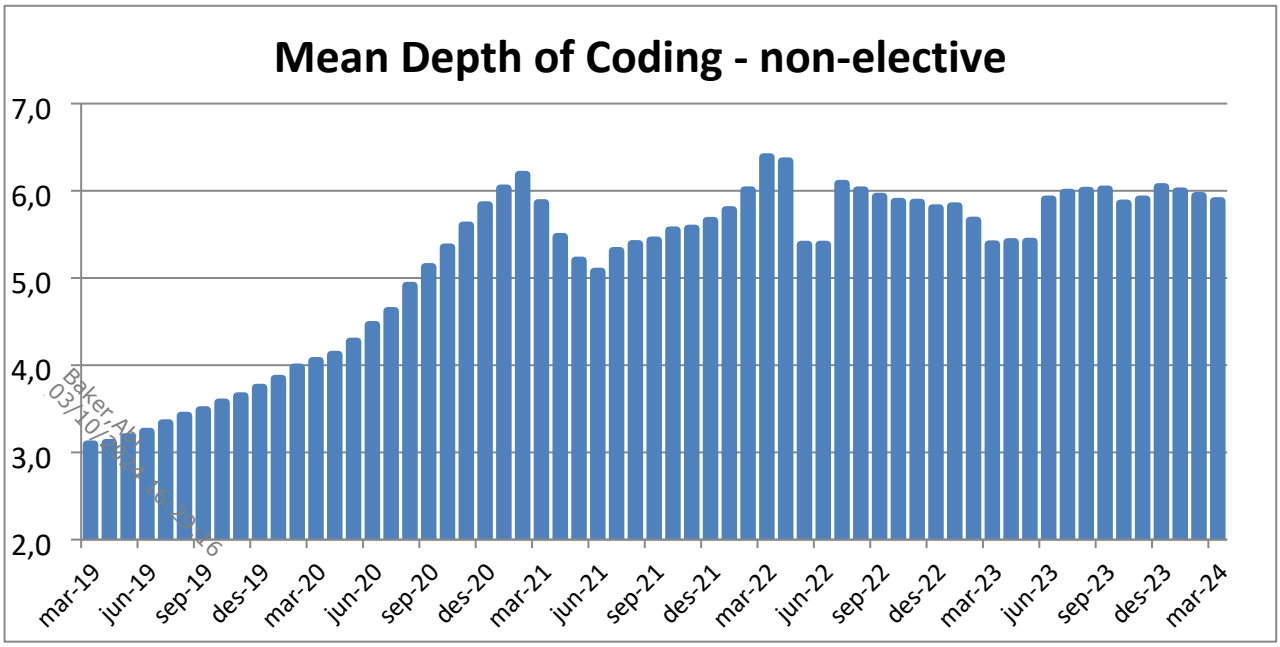


2.2 Depth of coding: NHS Digital states "*As well as information on the main condition the patient is in hospital for (the primary diagnosis), the SHMI data contain up to 19 secondary diagnosis codes for other conditions the patient is suffering from. This information is used to calculate the expected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

DCH's depth of coding had been improving steadily up to March 2022 (see graph below), and subsequent months show it has stabilised at around 6.0 – in line with the national average for non-elective admissions. Dorset Healthcare have been able to provide an additional 20 hours/week of coding time which helps significantly. DCHFT mean depth of coding for elective admissions is slightly below the England Average at 5.3 (compared to 6.0).

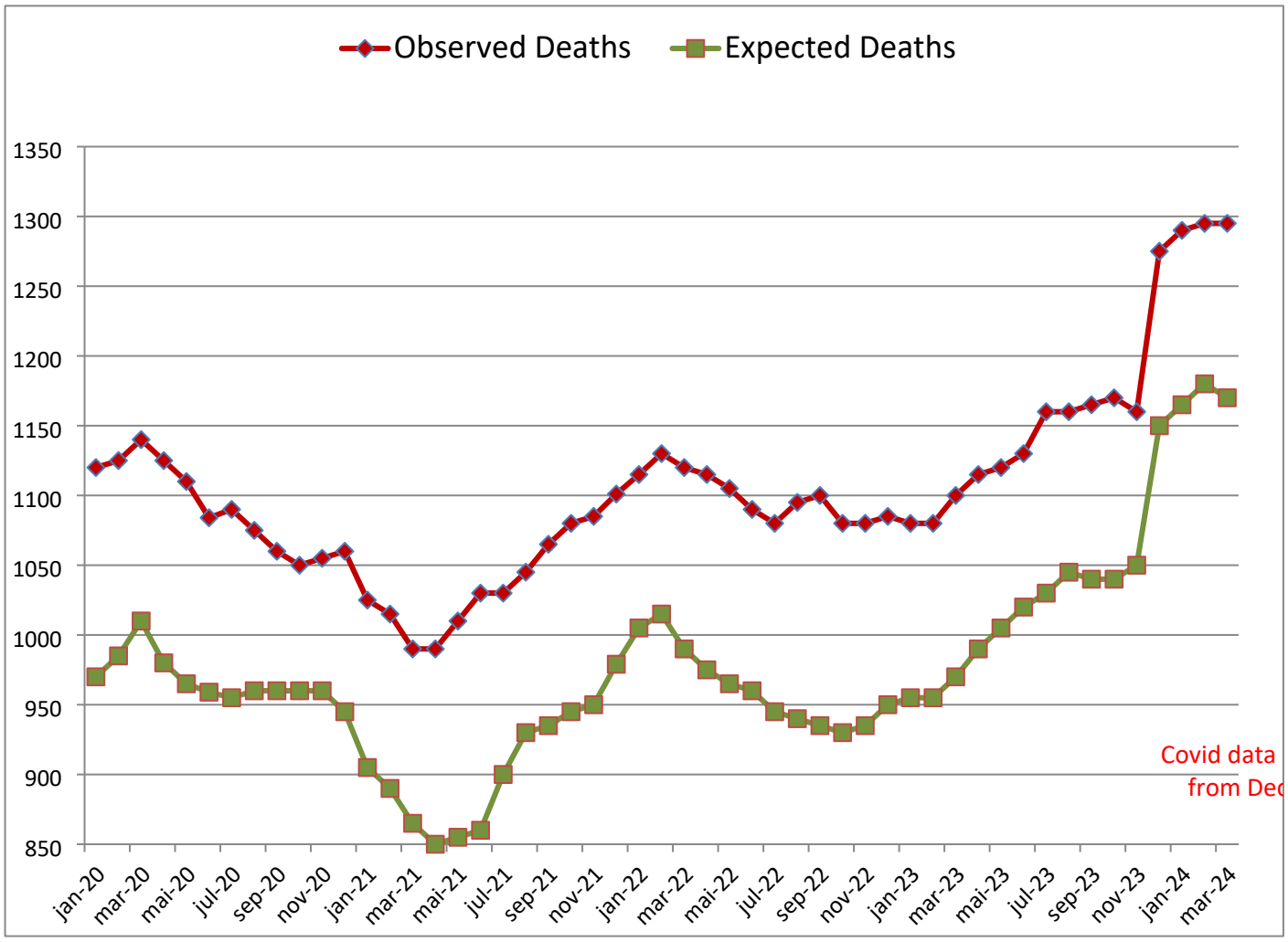
DCH % of provider spells with a primary diagnosis which is a symptom or sign is 15.2 (England average 13.3).

Deep dive into end of 2023 figures conducted to check if the limited measures introduced for coding in some specialities (i.e. coding from EDS, DPR and ICE only) had affected our mortality statistics – to date, they have not. This is re-assuring in light of our unsuccessful recruitment attempts for the coding team. Currently there are three vacancies in the team.



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

The chart below shows observed (actual) and expected (calculated by NHS Digital) deaths over the past 4 years (rolling years from January 2020 to December 2023), the numbers of which are directly influenced by the number of in-patients, particularly during and immediately after the covid-19 pandemic. Whilst both observed and expected deaths tended to decrease over the 7 months to October 22 (as the total number of in-patients has tended to decrease), the expected deaths have recently increased back to their average of around 1,000 per 12 months. The latest figures include all covid-related data, hence the increase of around 100 in the 12 months to December 2023. This quarters observed deaths are 1295 with expected deaths at 1180.



3.0 OTHER NATIONAL AUDITS/INDICATORS OF CARE

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

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

HAT (hospital Acquired Thrombosis) readmission audit results:

A Whole year review from Apr 2023 to March 2024 is in progress, with a full comparative report for years 2022, 2023 and 2024 to provide an indepth understanding expected in the next few months.

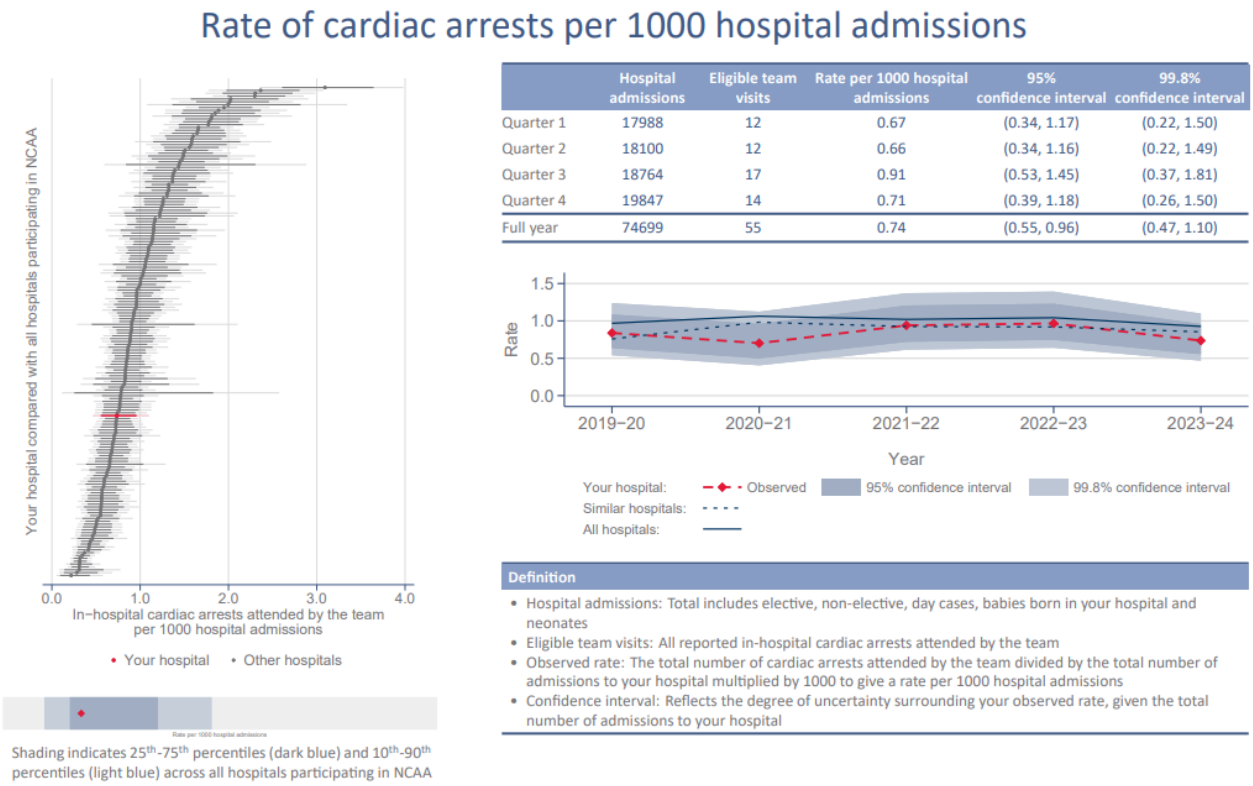
Currently only HAT readmissions are captured. There is ongoing work with BI team to capture all HATs during their index admissions.

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

3.1 NCAA Cardiac Arrest data

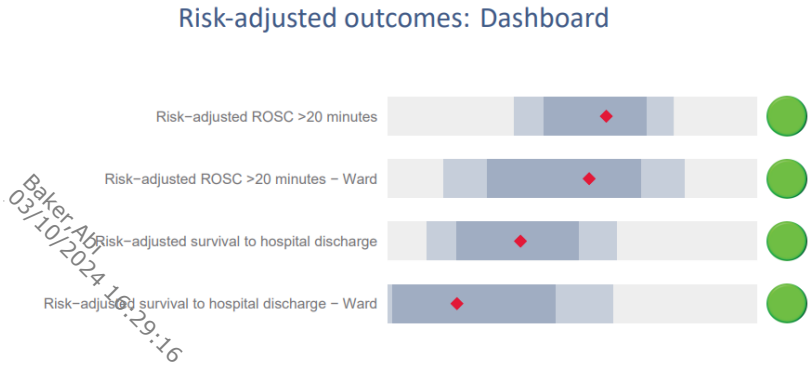
The national Cardiac Arrest audit for DCH including data from 1 April 2023 to 31 March 2024 was published on 23/07/24. Frequent cardiac arrest calls suggest unanticipated deteriorations in a patient's condition, whereas fewer calls suggest higher standards of ward care, although this is unproven.

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



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

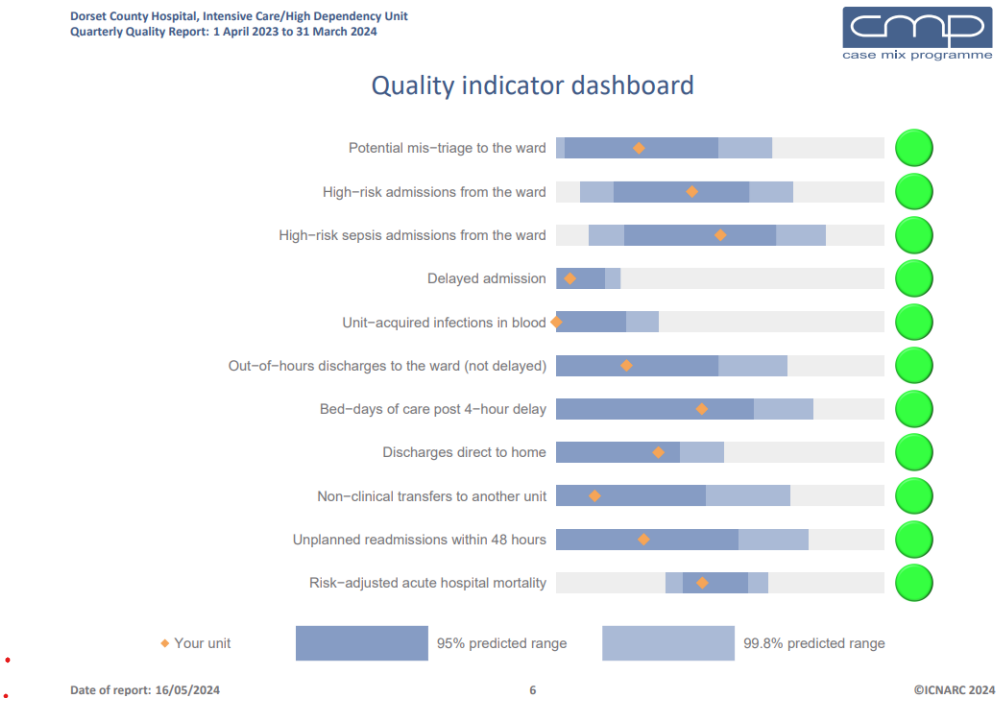
a) Time to 'Return of Spontaneous Circulation' (a measure of resuscitation effectiveness) and
b) Survival to Discharge.
These and all other measures in the report get a 'green' indicator.



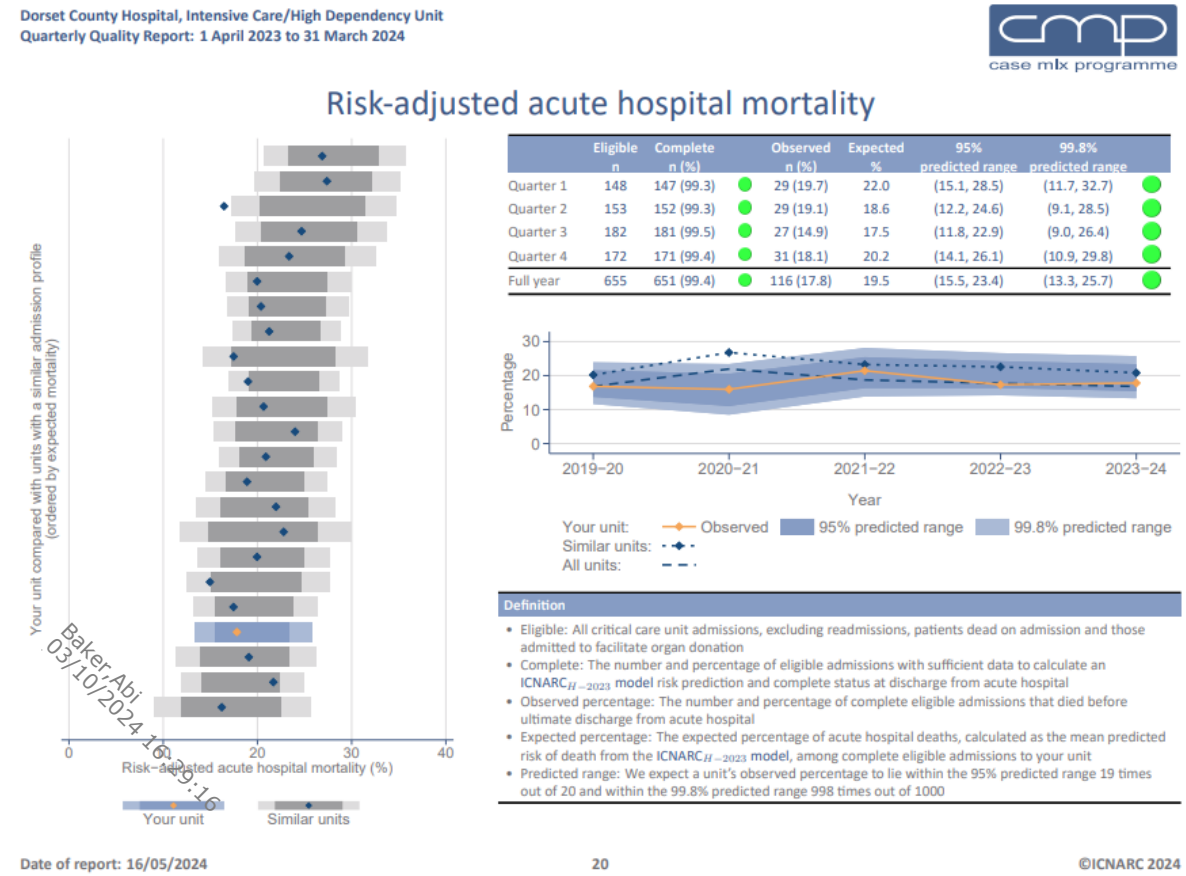
3.2 National Adult Community Acquired Pneumonia Audit latest data – last published Nov 2019 and not undertaken for either 2019/20 or 2020/21. Data collection restarted in Spring 2022 but it is unclear whether this has completed.

3.3 ICNARC Intensive Care survival data for financial year 1 April 23- 31 March 24; n = 679 patients.

All indicators remain in the GREEN area.



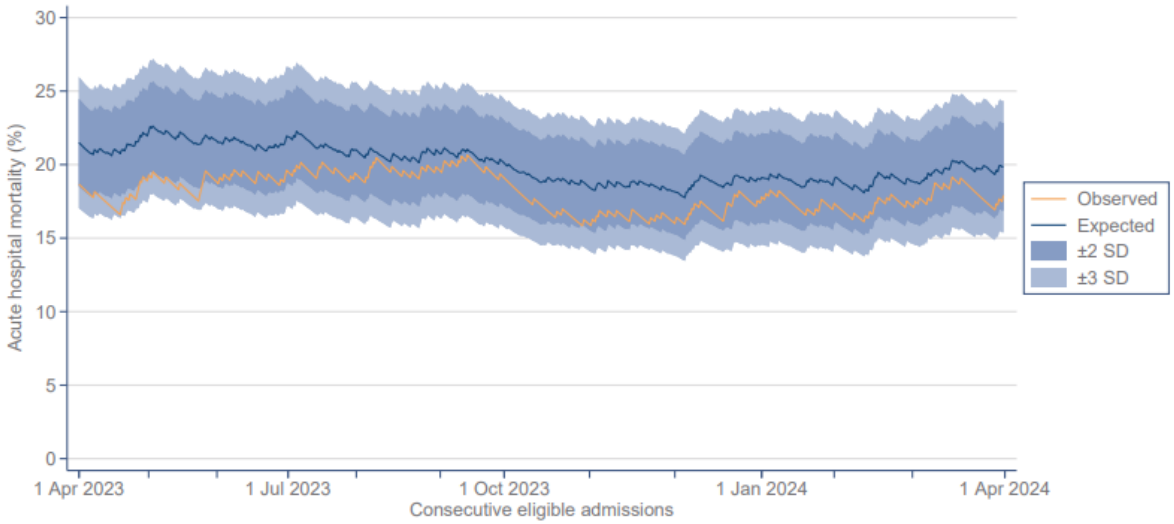
The charts below show the "risk-adjusted acute hospital mortality" following admission to the DCH Critical Care Unit. They compare observed and expected death rates in a similar fashion to SHMI.



These results are well within the expected range.

case mix programme

Risk-adjusted acute hospital mortality (EWMA plot)

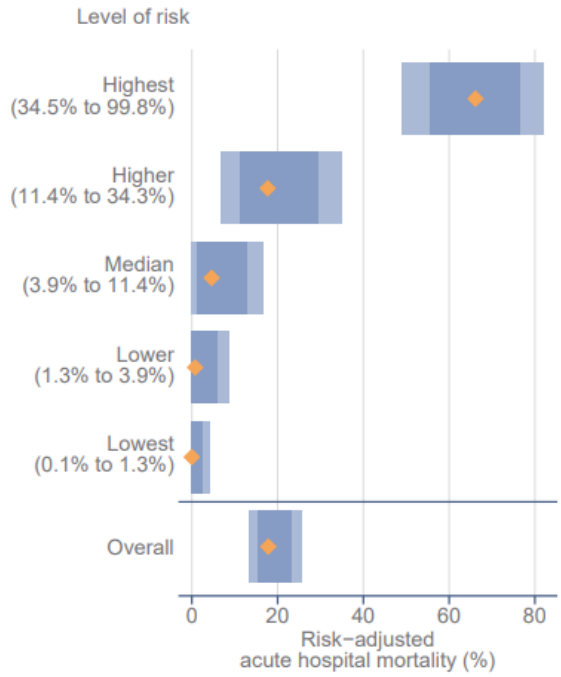


Explanation

- The Exponentially Weighted Moving Average (EWMA) plot shows the trends in observed and expected acute hospital mortality in your unit for the time period of the report
- Expected acute hospital mortality is calculated from the ICNARC$_{H-2023}$ model
- The plots are updated after each consecutive eligible admission and points are 'exponentially weighted' – giving a larger weighting to the most recent admissions to smooth the appearance of the lines
- The blue shaded areas of the plot represent 2 and 3 standard deviations (SD) above and below the expected line
- If the observed line is above the blue shaded areas, this means the observed acute hospital mortality is significantly higher than expected
- If the observed line is below the blue shaded areas, this means the observed acute hospital mortality is significantly lower than expected

case mix programme

Risk-adjusted acute hospital mortality (by predicted risk)

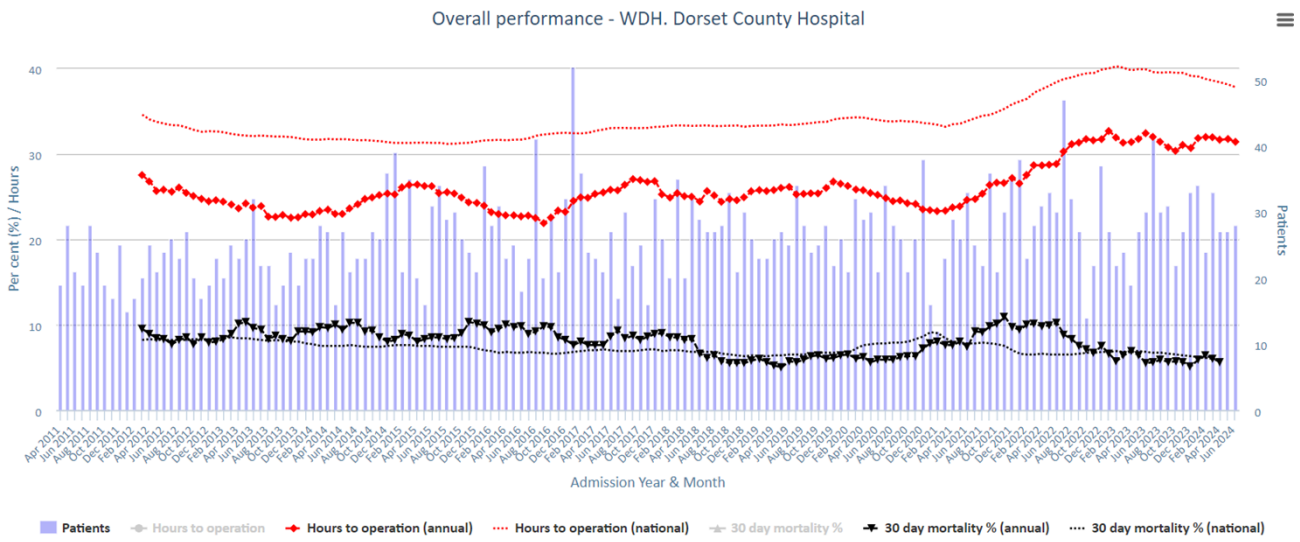


Level of risk	N	Observed n (%)	Expected %	95% predicted range	99.8% predicted range	
Highest	130	86 (66.2)	66.6	(55.4, 76.5)	(49.1, 82.1)	
Higher	130	23 (17.7)	20.6	(11.3, 29.4)	(6.9, 35.1)	
Median	130	6 (4.6)	7.1	(1.2, 12.7)	(0.0, 16.8)	
Lower	130	1 (0.8)	2.5	(0.0, 5.9)	(0.0, 8.7)	
Lowest	131	0 (0.0)	0.7	(0.0, 2.5)	(0.0, 4.4)	
Overall	651	116 (17.8)	19.5	(15.5, 23.4)	(13.3, 25.7)	

Explanation

- Risk-adjusted acute hospital mortality (by predicted risk) is designed to help identify patient subgroups in which acute hospital mortality is higher (or lower) than expected
- Admissions are divided into 5 equal-sized groups (or 3 if fewer than 250 complete eligible admissions are available), according to their predicted risk of acute hospital mortality
- N is the number of complete eligible admissions (see Risk-adjusted acute hospital mortality)
- Predicted acute hospital mortality is calculated from the ICNARC$_{H-2023}$ model
- If observed acute hospital mortality is higher than predicted overall, then this analysis may help to identify patient subgroups driving that elevation; if acute hospital mortality is within the predicted range overall, then this analysis may still identify subgroups in which mortality is higher or lower than expected

3.4 National Hip Fracture database for Q1



Baker, Abi
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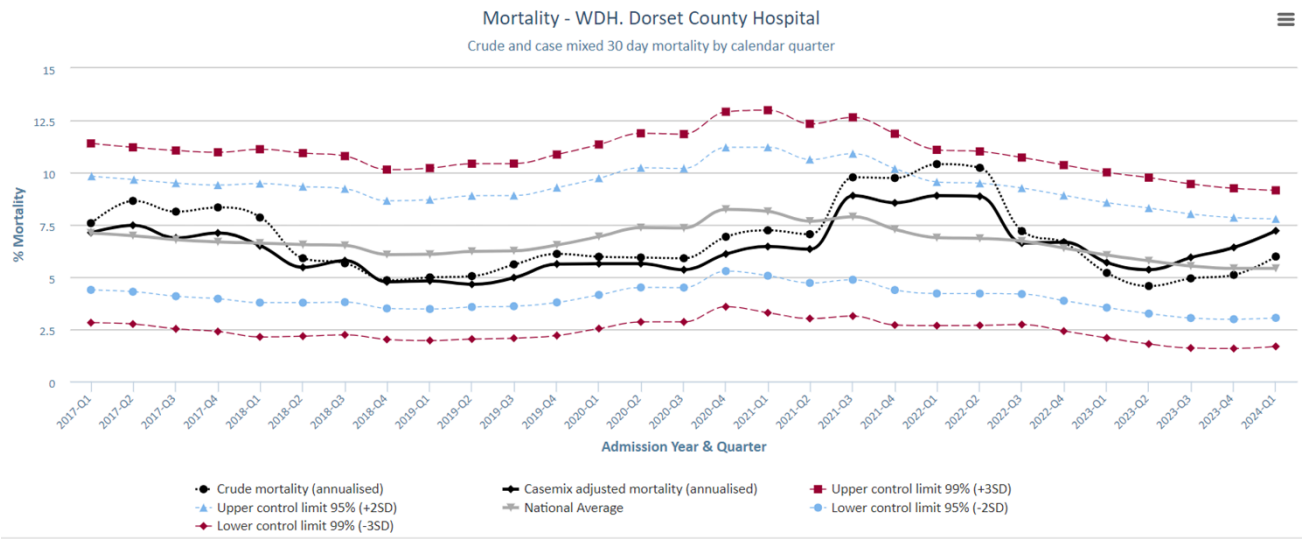
'Hours to operation' remains significantly better than the national average with 30 day mortality in line with the national average.



3.5 National Emergency Laparotomy Audit

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

Lingering issues exist within website and some incomplete data mean that there is no new information of relevance to mortality for Q1.

3.6 Getting it Right First Time; reviews in Qtr 1

Since the last LfD report, GIRFT have conducted the following reviews:

Diabetes 01/05/24

Head and Neck Cancer 21/05/24

Action plans for GIRFT reviews are presented to the Clinical Effectiveness Committee

3.7 Trauma Audit and Research Network

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

3.8 Readmission to hospital within 30 days

A readmission to hospital within 30 days suggests either inadequate initial treatment or a poorly planned discharge process.

Following concerns regarding data accuracy, validation work is complete with the creation of a new dashboard to monitor both re-admission but more importantly quality aspects around re-admission with potential QI opportunity.

No new data for Q1.

3.9 National Child Mortality Database

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

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

NCMD publications of note for 2024 Q1:

a) https://www.ncmd.info/publications/child-death-learning-disability-autism/ Data April 2019 – March 2022 published July 2024
Recommendations with implications for DCH and partners -

i) Ensure reasonable adjustments are discussed with and provided for all children with a learning disability, autistic children, and where necessary their families and carers, and that the details of these needs are appropriately captured in the "reasonable adjustments digital flag" in their clinical record. Action: all healthcare professionals

ii) Ensure "Was not brought" policies recognise and meet the needs of the complex lives of children with a learning disability, autistic children and their families, and that they support effective attendance at appointments with suitable safeguarding and escalation in place where needed. Action: Integrated Care Boards

iii) Ensure increased focus to ensure that children and young people are not waiting inappropriately long times for autism assessment, in line with NICE and NHS national framework and operational guidance for autism assessment services. Action: Department of Health & Social Care

iv) Ensure that autistic children, and those waiting for an autism assessment, have timely access to appropriate support with mental health services, including talking therapies. Services provided should recognise the importance of post diagnostic support to these groups. Action: Commissioners of mental health services

b) Child drowning deaths in England (ncmd.info) Data April 2022 – March 2023 published 22 July 2024

There were 16 (39.0%) deaths due to drowning of children aged under 5 years, 17 (41.5%) aged 5-14 years and 8 (19.5%) aged 15-17 years. When adjusting for the population of children within these age groups, drowning rates are higher for children under 5 (5.22 per 1 million children) as well as those aged between 15 and 17 years (4.03 per 1 million children).
The highest proportion of child drowning deaths occurred in inland open water, such as lakes and rivers (48.8%, n=20). There were 10 (24.4%) deaths that occurred in the bath at home, and 6 (14.6%) child drowning deaths in 'other residential' water, including 3 in residential hot tubs. Coastal deaths were included in the 5 other (12.2%) deaths.
In 90.0% (n=36/40) of drowning deaths the child was not being supervised by an adult at the time of their death. This included all deaths where the drowning occurred in the bath (n=10), as well as those in 'other residential' water (n=6), such as hot tubs.

Local learning from child deaths (CDOP) mirrors national learning & the annual report was summarised at HMG (17/07/24) by the designated doctor for child deaths for Dorset:

1. A need for improved process for the transfer of tertiary neurology care when a family move to a new area.
2. A need for improved funding for paediatric palliative care to ensure adequate consultant cover and nursing capacity to deliver end of life care in the community.
3. Review of CHC funding and Personal health budgets needed to ensure families have the financial support they need at times of crisis and are not overwhelmed by the bureaucratic complexity of the systems.
4. The notification pathway following a child death has been reviewed and updated to ensure it is comprehensive and efficient.
5. Patients with open access should be offered a physical assessment if the parents are concerned about them. Open access policy is being reviewed to ensure advice is discussed with someone of sufficient seniority
6. Telephone discussions with families must be documented. Open access policy is being reviewed to ensure standard documentation is in place and used by all staff.
7. Privacy and dignity during critical care is important. A privacy screen should be used where necessary and staff who have no role in the resuscitation should not be in the vicinity.

8. Process for seeking feedback from bereaved families needs to be reviewed (raised with Patient Experience Team).

3.10 MBRRACE data:

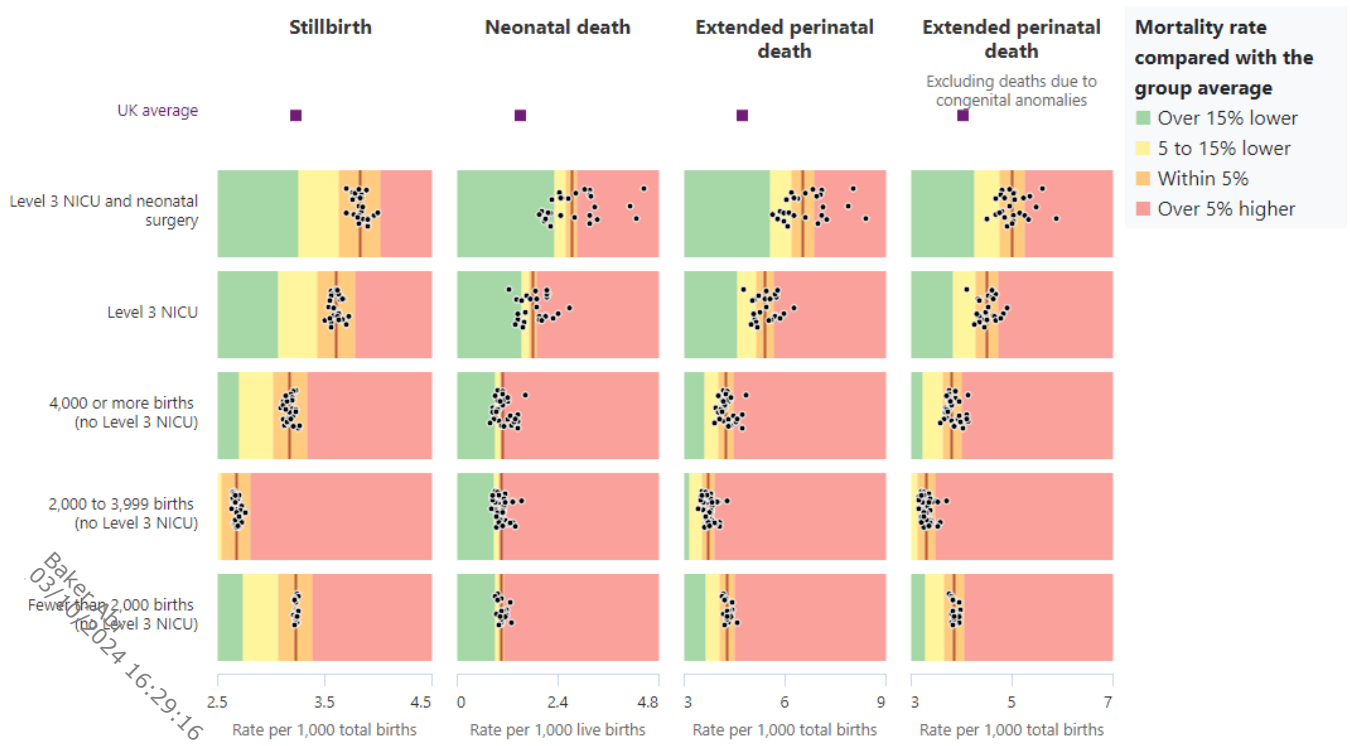
MBRRACE Perinatal Mortality Surveillance UK perinatal deaths of babies born in 2022 (state of the nation report): Published July 2024
https://timms.le.ac.uk/mbrrace-uk-perinatal-mortality/surveillance/
This is the tenth MBRRACE-UK Perinatal Mortality Surveillance Report. The report is divided into five sections: perinatal mortality rates in the UK; mortality rates for Trusts and Health Boards; mortality rates by gestational age; mortality rates by ethnicity and socio-economic deprivation; and a description of the causes of perinatal death.

Key messages-

- **Extended perinatal mortality rates** decreased across the UK in 2022 (UK extended perinatal mortality rate: **5.04 per 1,000** total births) after a rise in 2021, although rates remain higher than both 2019 and 2020. For the purposes of MBRRACE-UK reporting, extended perinatal death refers to all stillbirths and neonatal deaths.
- Compared with rates in 2021, **stillbirth rates per 1,000 total births** in 2022 were lower across all the devolved nations except Scotland, where there was a small increase: **3.35 (UK)**; 3.33 (England); 3.31 (Scotland); 3.63 (Wales); and 3.49 (Northern Ireland).
- There were increases in the **neonatal mortality rate per 1,000 live births** in England and Wales compared with 2021: **1.69 (UK)**; 1.67 (England); 1.59 (Scotland); 1.91 (Wales); and 2.29 (Northern Ireland).
- Stabilised & adjusted neonatal mortality rates continued to show wide variation, with just 21.5% of Trusts and Health Boards falling within 5% of their comparator group average.

To account for the wide variation in case-mix, Trusts and Health Boards were classified hierarchically into five mutually exclusive comparator groups, based on their level of service provision. In order to compare Trusts and Health Boards more fairly, stabilised & adjusted mortality rates were calculated and colour-coded according to the variation from their respective comparator group average. Where there is only a small number of births in an organisation it is difficult in any one year to be sure that any extreme value seen for the crude mortality rate is real and not just a chance finding. A stabilised rate allows for the effects of chance variation due to small numbers.

Figure 2: Stabilised & adjusted stillbirth, neonatal and extended perinatal mortality rates for Trusts and Health Boards by comparator group: United Kingdom and Crown Dependencies, for births in 2022



Data sources: MBRRACE-UK, PDS, ONS, NRS, PHS, NIMATS, States of Jersey.

Dorset County Hospital NHS Foundation Trust

Year	Births	Crude stillbirth rate	Stabilised & adjusted stillbirth rate	Stabilised & adjusted stillbirth rate (95% CI)	Crude neonatal mortality rate	Stabilised & adjusted neonatal mortality rate	Stabilised & adjusted neonatal mortality rate (95% CI)	Crude extended perinatal mortality rate	Stabilised & adjusted extended perinatal mortality rate
2018	1,699	-	2.32	(1.50 to 3.22)	-	0.52	(0.18 to 1.10)	2.35	2.84
2019	1,624	-	3.13	(2.18 to 4.05)	-	0.99	(0.50 to 2.04)	3.08	4.12
2020	1,481	2.70	2.59	(1.75 to 3.87)	2.03	0.99	(0.53 to 1.90)	4.73	3.58
2021	1,573	-	2.73	(1.77 to 4.04)	-	0.50	(0.17 to 0.97)	3.18	3.22
2022	1,497	2.67	3.23	(2.40 to 3.79)	2.01	1.19	(0.60 to 2.38)	4.68	4.43

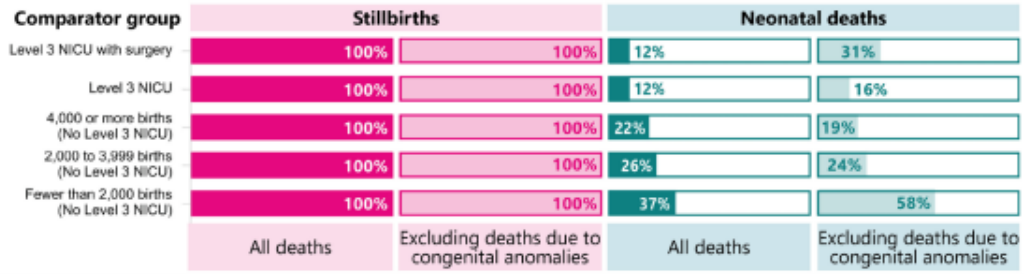
VIBRACE data
SW figures from the Perinatal Mortality data viewer

Mortality rate compared with the group average
Over 15% lower · 5 to 15% lower · Within 5% · Over 5% higher
Suppressed

Organisation	Stabilised and adjusted figures 2022 information: Neonatal deaths (per 1000 live births)	Stabilised and adjusted figures 2022 information: Stillbirth (per 1000 live births)	Stabilised and adjusted figures 2022 information: Extended perinatal (per 1000 live births)	Crude mortality figures 2022 information: Neonatal deaths (per 1000 live births)	Crude mortality figures 2022 information: Stillbirth (per 1000 live births)	Crude mortality figures 2022 information: Extended perinatal (per 1000 live births)	Total Number of births	Type of unit
University Hospitals Bristol & Weston	4.12	3.82	7.89	4.35	3.47	7.80	4616	Level 3 NICU and Neonatal surgery
North Bristol	2.03	3.51	5.54	2.05	1.49	3.54	5371	Level 3 NICU
University Hospitals Plymouth	1.75	3.68	5.41	1.70	4.79	6.48	3551	Level 3 NICU
Royal Devon University Hospitals	1.27	3.21	4.48	1.46	3.54	4.99	4808	4000 or more births
Gloucestershire Hospitals	1.22	3.12	4.33	1.26	1.98	3.24	5556	4000 or more births
Royal United Hospitals Bath	1.10	3.12	4.21	0.94	1.41	2.34	4268	4000 or more births
Somerset FT	1.03	3.15	4.18	0.71	2.14	2.85	4207	4000 or more births
University Hospitals Dorset	0.86	3.09	3.94			1.25	4012	4000 or more births
Great Western	1.30	2.67	3.97	1.87	2.13	4.00	3751	2000-3999 births
Royal Cornwall	1.09	2.71	3.80	1.08	3.22	4.29	3731	2000-3999 births
Salisbury FT	0.91	2.66	3.58			1.38	2175	2000-3999 births
Dorset County	1.19	3.23	4.43	2.01	2.67	4.68	1497	Under 2000 births
Torbay & South Devon	0.91	3.26	4.15			4.21	1902	Under 2000 births

2. There was wide variation in neonatal mortality rates

Percentage of organisations with mortality rates within 5% of the group average



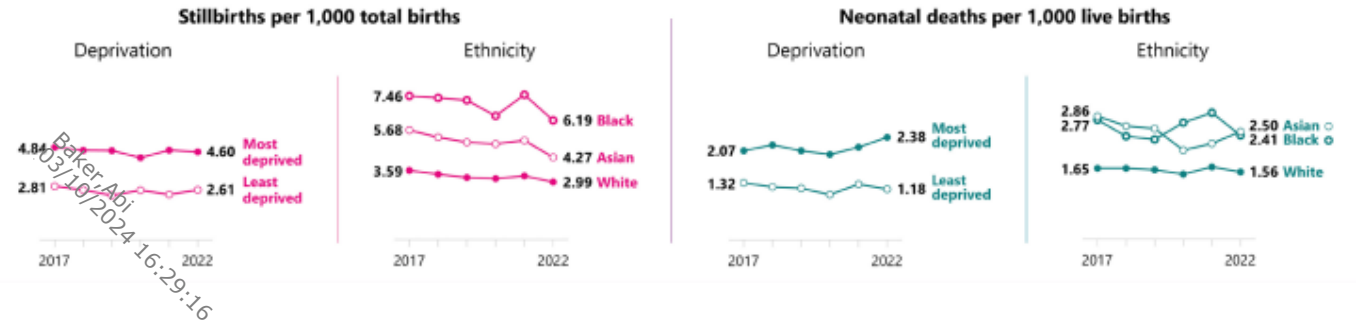
What is a stillbirth or neonatal death?

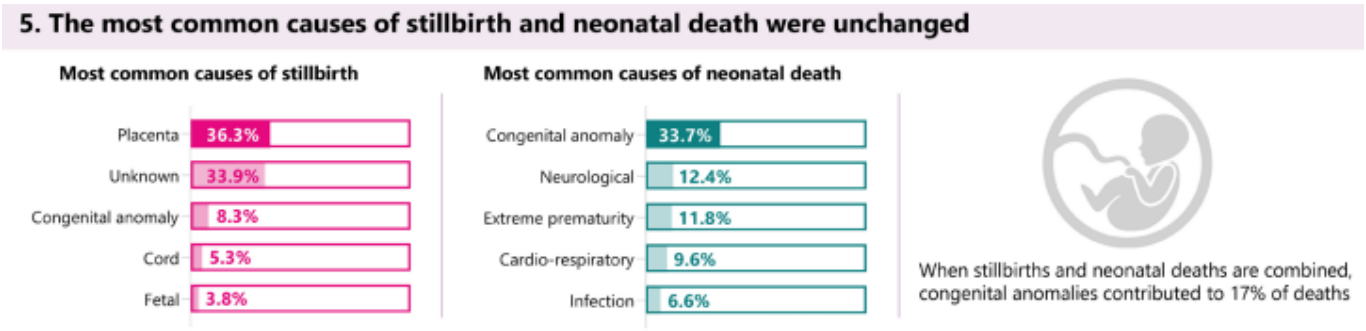
A **stillbirth** is the death of a baby before or during birth once a pregnancy has reached 24 completed weeks.

A **neonatal death** is a baby born at any gestation who lives, even briefly, but dies within 28 days of birth.

All rates in this report are for babies born from 24 completed weeks and include deaths due to congenital anomalies, unless otherwise stated.

4. Despite recent improvements, inequalities in mortality rates by deprivation and ethnicity remain





The maternity and neonatal teams at DCH use the BAPM Perinatal Optimisation Pathway to support improving outcomes for preterm babies. Compliance with PERIPrem is monitored at Perinatal M&M meetings when presenting cases.
https://www.bapm.org/pages/perinatal-optimisation-pathway
https://www.healthinnowest.net/our-work/transforming-services-and-systems/periprem/

3.11 National Perinatal Mortality Review tool

Data included in the Maternity safety report to Quality Committee in line with Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme (MIS) standards.

2 incidents relating to care provided by DCH were reported to MBRRACE-UK via the PMRT in Quarter 1. The hospital within which the baby dies is responsible for reporting cases therefore 1 case was reported by DCH and 1 case was the responsibility of another Trust where the baby died. This mother was booked and cared for by DCH in the antenatal period and transferred in the antenatal period to a tertiary centre due to the gestation of the pregnancy. DCH are involved with the PMRT process and review for this baby, but the tertiary centre leads the reviews.

Neither case met the threshold for referral to Maternity and Newborn Safety Investigations (MNSI) and no concerns have been raised with the notification and surveillance submissions and the current reporting process is to continue.

4.0 QUALITY IMPROVEMENT ARISING FROM SJRs & HMG

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

1. TEP policy update arising from the task group:

   The main changes proposed for discussion are:

   - That all patients have a TEP completed on admission along with a resuscitation decision. There are circumstances when this can be deferred for up to 48 hours.
   - A decision for full escalation and attempt at resuscitation can be documented on the new TEP form – removing the uncertainty as to whether decisions around resus or 'allow a natural death' have been made or considered.

2. Frailty:

   - Use of the term frailty of old age on medical death certificates and whether this has or will lead to a reduction in other medical diagnoses and thus impact on expected deaths

3. Review of incidents of elderly patients with a long stay in ED and prescribing of anticipatory meds

5.0 MORBIDITY and MORTALITY MEETINGS

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

Examples of Learning and Actions from M&M Meetings:

Paediatrics
Learning & actions:

- CCLG have guidelines around referral timeliness/requirements
- Idiosyncratic side effects of chemotherapy agents must be known and considered during assessment.
- Pathways for CYP on active treatment for malignancy discussed
- Excellent recognition of progressive neurology with appropriate escalation and timely intubation
- Professional curiosity vs rationalising investigations
- Communication challenges with non-English speaking families, especially in emergency situations.
- Advice from tertiary centre vs clinical assessment of child in front of you.
- Delays in imaging reporting impacting clinical decision making and treatment initiation.
- Challenges of managing extreme parental anxiety whilst advocating for CYP.
- Ceilings of care and professional unease with decisions.

Anaesthetics

1. Theatre Coordinator to remain contactable at all times to facilitate urgent arrangements or patients requiring immediate intervention in this case a patient needing to go to theatre for a PPH.
2. TIVA pump failure: remain diligent and replace pumps asap.
3. Do not use relatives as translators as per the guidance as can lead to distress and misinformation being communicated.
4. Antibiotic prescribed for incorrect patient. No harm as not given but reflected on how easy it is to pick incorrect patient on EPMA. Highlighted need to double check patient on EPMA when prescribing. Are there any systems that could be put in place on EPMA to make this error less likely to recur?
5. No latex free sterile gloves available in correct size for sterile procedure in latex allergic patient. Stores staff were on leave – need to allow for cover so stock not missing.
6. Incorrect strength of ketamine signed for in CD book. Ensure not just correct drug but also correct strength signed for.
7. No ODP available for maternity brief for elective section due to cardiac arrest on the wards. Complex section was then delayed which was tricky as no anaesthetic consultant in maternity in the afternoon. Highlights the need for dedicated maternity ODP and not bleep holder – trial of this in the daytime has shown it is useful.
8. Penicillin allergy recorded as penicillamine. Recurring error on EPMA. Reminded to ensure correct allergy noted and whether drug group or drug itself. Would be good if EPMA could have something in place to reduce this risk.

General and Colorectal Surgery

1. Communication challenges with non-English speaking families, especially in emergency situations. Advice from tertiary centre vs clinical assessment of child in front of you. Delays in imaging reporting impacting clinical decision making and treatment initiation. Challenges of managing extreme parental anxiety whilst advocating for CYP. Ceilings of care and professional unease with decisions.

- Good management of the complication (second CEPOD theatre opened).
- Unusual complication. Cause of megacolon not clear ? Ischaemic. Perforation managed successfully.

Elderly Care & Stroke

- Learning: The importance of updating patients' families on their medical condition, particularly if they are unable to come to the hospital (Covid).

6.0 LEARNING FROM CORONER'S INQUESTS Q1

During the period 01.04.2024 to 26.06.2024, 18 inquests were opened. A total of 16 Inquests Hearing were held, some of which will have related to the previous financial year.

For these 16 cases, 30 statements were obtained from clinicians involved in the patient's care.
7 clinicians were called to give live evidence, which gives a percentage of 23% of clinicians who provide a statement being called to give evidence for this period.

No Inquests have progressed to a claim in this period as yet, although we have 1 case that we are expecting to progress via the litigation route. This is the case we received the Regulation 28 (Prevention of Future Deaths) in relation to out of hour access to interventional radiology. This has now been redirected to NHS England.

No legal representation was required to support the Inquest process through this period and 1 Pre-Inquest Review was conducted

As of July 2024, HMG will be receiving quarterly reports to triangulate data from inquests and SJRs.

Learning Identified:

- To improve documentation of clinical discussions between provider units
- Review of discussions with families around DNAR decisions
- Lower threshold for scanning neck in older patients with Head injury (NICE)
- Remember possibility of high cervical injury in headache presentations (occipital / craniocervical pain)
- Repeat attenders should be reviewed by a senior clinician

7.0 LEARNING FROM CLAIMS Q1

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

Claims pattern Quarter 1 FY 24/25.

New potential claims	15
Disclosed patient records	18

Formal claims	11
Settled claims	2
Closed - no damages	1

8.0 SUMMARY

The latest SHMI publication from NHS England is for the period 1 April 2023 – 31 March 2024. The Trust's figure is 1.1057, which is within the expected range using NHS England's control limits.

The DCH internal prediction has been that SHMI will continue to fall gradually over the following three months to around 1.0700 - however this depends on the resources within the coding department. We are aware that our data may become adversely influenced by resource challenges within the Coding Department and a possible under-reporting of 'sepsis' in the written medical record. The clinical coding risk is rated as high on the risk register. The team have implemented strategies for risk mitigation.

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

Report Front Sheet

1. Report Details			
Meeting Title:	Board of Directors, Part 1		
Date of Meeting:	09 October 2024		
Document Title:	National Inpatient Results and Action Plan		
Responsible Director:	Dawn Dawson Chief Nursing Officer	Date of Executive Approval	02/10/2024
Author:	Hannah Robinson (Volunteer and Patient Experience Team)		
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	Noted

3. Purpose of the Paper	The report provides an overview of the National Inpatient Survey results 2023. (These were released to the Trust from Picker prior to public publication in August 2024).							
	Note	✓	*Discuss*		*Recommend*		*Approve*	
4. Key Issues	Report highlights bottom and top areas scored with benchmarking against other Trusts. Improvement maps included in the report indicate areas which should be considered for 'priority' and 'managed closely' and these have been categorised into three key focus areas – Care, Discharge and Admission to form an action plan. Action plan is included in this report considering ongoing service improvements in months since the survey was conducted and recognises programmes of work already underway. Further development of the action plan and progress will be picked up through quarterly PEPEC.							
5. Action recommended	The Board is recommended to: 1. **NOTE** the NIS Report and Action Plan.							

6. Governance and Compliance Obligations			
Legal / Regulatory Link	**Yes**	**No**	*Note public publication is currently embargoed.*
Impact on CQC Standards	**Yes**	**No**	*National Surveys are part of CQC national compliance.*
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**	*Action plans linked to t this report will provide improvements linked to this goal*
Tackling unequal outcomes and access		**Yes**	**No**	*As above*
Enhancing productivity and value for money		**Yes**	**No**	*Patient experience improvements will result in a reduction of complaints ultimately saving time / money spent investigating them.*
Helping the NHS to support broader social and economic development		**Yes**	**No**	*Patient experience improvements support learning and feeds into wider system sharing and change.*
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**	

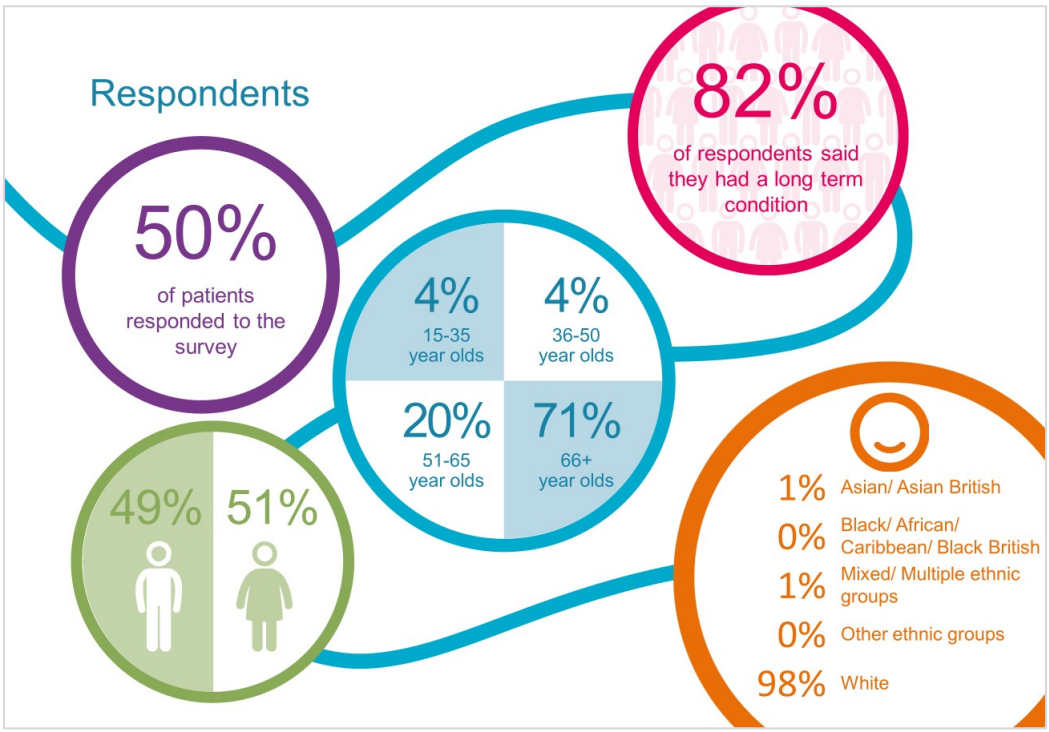
Report Title	**National Inpatient Survey 2023 Report and Action Plan**
Meeting	**Board of Directors, Part 1**
Author	**Hannah Robinson – Volunteer and Patient Experience Lead**

1.0 Introduction

This document summarises the findings from the NHS Inpatient Survey 2023, carried out by Picker, on behalf of Dorset County Hospital NHS Foundation Trust.

Picker was commissioned by 64 Inpatient organisations to run their Survey. A total of 1250 patients from our Trust were invited to complete the questionnaire. 1172 patients were eligible for the survey, of which 590 returned a completed questionnaire, giving a response rate of 50% (compared to the Picker average response rate of 43%) and our previous 2022 response rate of 46%.

1.1 Respondent Demographic:



2.0 Headlines – Top / Bottom / Most Improved / Most Declined Scores

Top 5 Scores vs Picker Average			Bottom 5 Scores vs Picker Average		
Question	Trust	Picker Avg	Question	Trust	Picker Avg
Q8. Staff explained reasons for changing wards at night	87%	81%	Q50. Asked to give views on quality of care during stay	24%	35%
Q5. Did not have to wait too long to get to a bed on a ward	77%	72%	Q2. Did not mind waiting as long as did for admission	53%	58%
Q33. Enough information given about care and treatment while on a virtual ward	95%	91%	Q42. Before leaving hospital knew what would happen next with care	80%	84%
Q34. Information given about the risks and benefits of continuing treatment on a virtual ward	83%	80%	Q41. Given information about medicine at discharge	82%	86%
Q13. Hospital food was very or fairly good	72%	68%	Q36. Staff involved family or carers in discussions about leaving the hospital	56%	59%

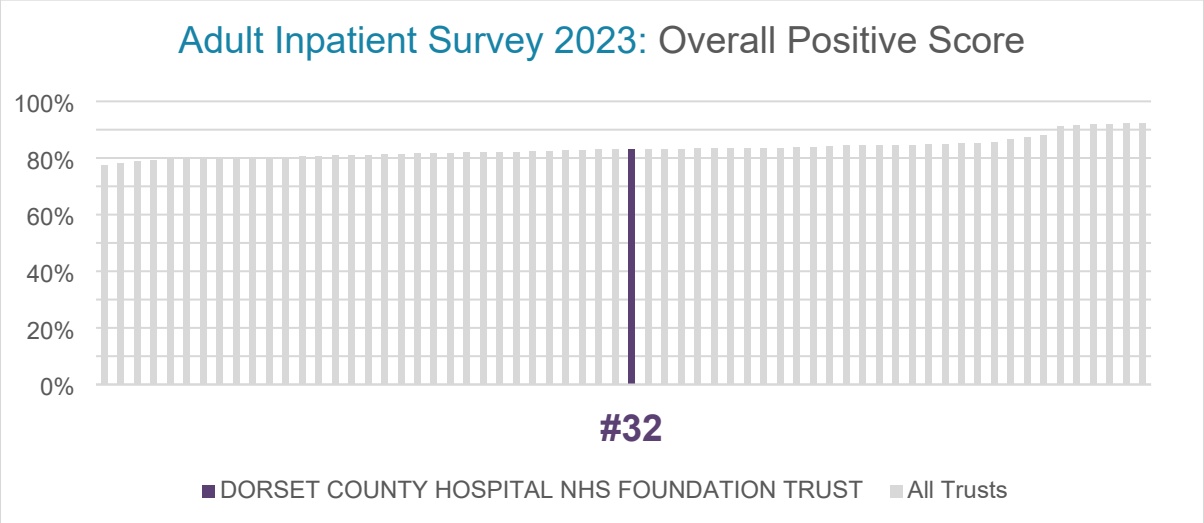
Most Improved Scores			Most Declined Scores		
Question	Trust 2023	Trust 2022	Question	Trust 2023	Trust 2022
Q50. Asked to give views on quality of care during stay	24%	6%	Q41. Given information about medicine at discharge	82%	89%
Q23. Always or sometimes enough nurses on duty	92%	88%	Q2. Did not mind waiting as long as did for admission	53%	58%
Q5. Did not have to wait too long to get to a bed on a ward	77%	75%	Q24. Staff did not contradict each other about care and treatment	63%	69%
Q37. Staff discussed need for additional equipment or home adaptation after discharge	80%	79%	Q44. Staff discussed need for further health or social care services after discharge	76%	81%
Q40. Understood information about what they should or should not do after leaving hospital	98%	97%	Q14. Got enough help from staff to eat meals	84%	89%

2.1 Overall results:

80% - Q49. Rated Overall experience as 7/10 or more
99% - Q48. Treated with respect and dignity overall.
98% - Q18 – Had confidence and trust in the doctors

3.0 League Table and External Benchmarking

The league table shows the overall positive score's ranking in comparison to the overall positive score of every other organisation that ran the Adult Inpatient Survey 2023 with Picker. The overall positive score is the average positive score for all positively scored questions in the survey.



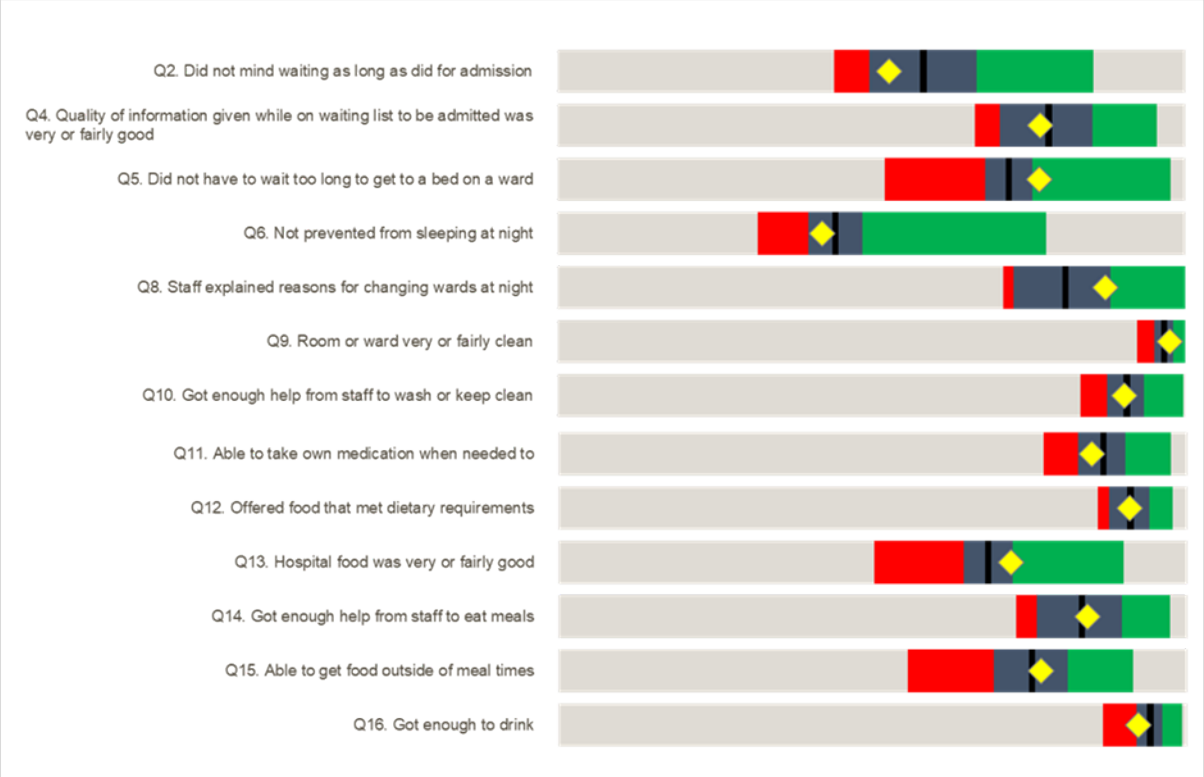
External benchmarking compares experiences in our organisation with those of other organisations who commissioned picker to conduct their survey. This provides an understanding of where our performance sits in relation to the overall trend (i.e. The "picker average").

Each bar shows the range of performance for a specific question, which helps to highlight where improvements are possible, or resources could valuably be concentrated.

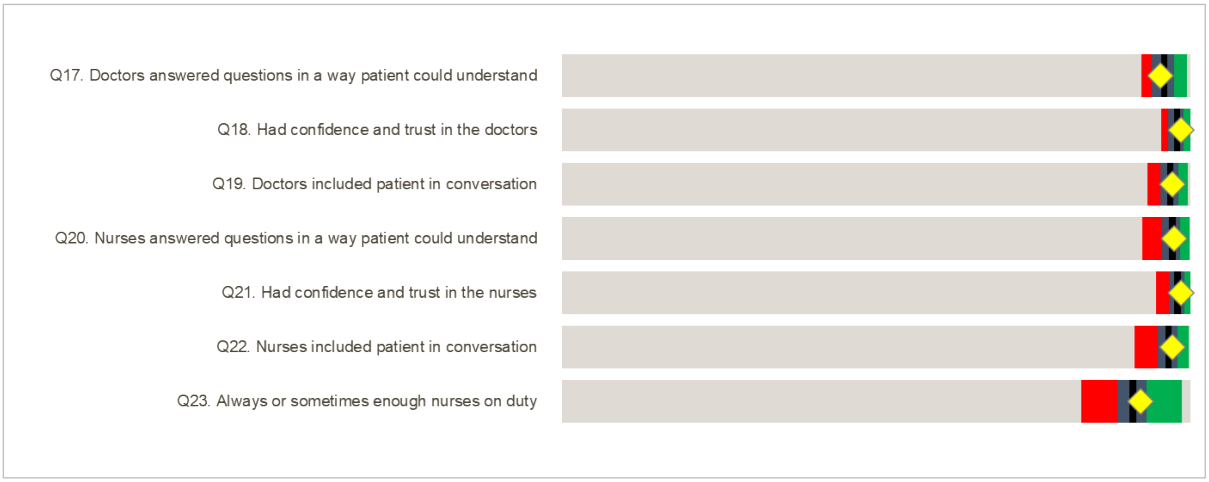
Key to benchmarking charts:

	Significantly negative range
	Range
	Average Score
	Significantly positive range
	DCH

Admission to hospital & the hospital & ward



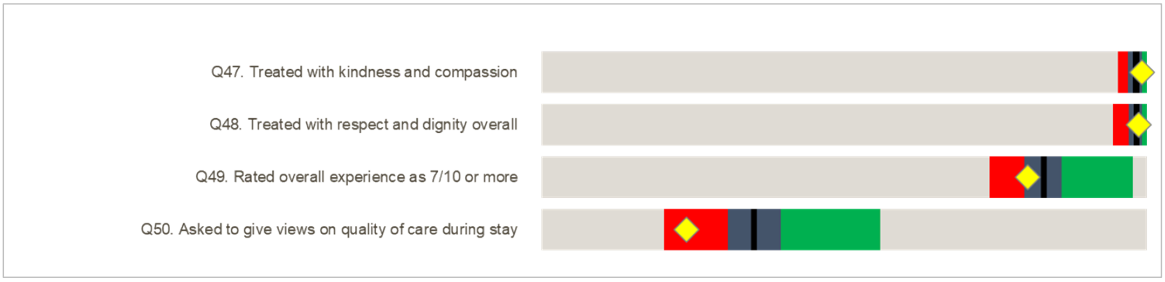
Doctors & Nurses



Your care & treatment

Leaving hospital

Overall



4 Improvement Maps

To support the deployment of resources in the most effective way possible, Picker have created Improvement Maps™. These correlate what matters most to patients with our performance across all scored questions.

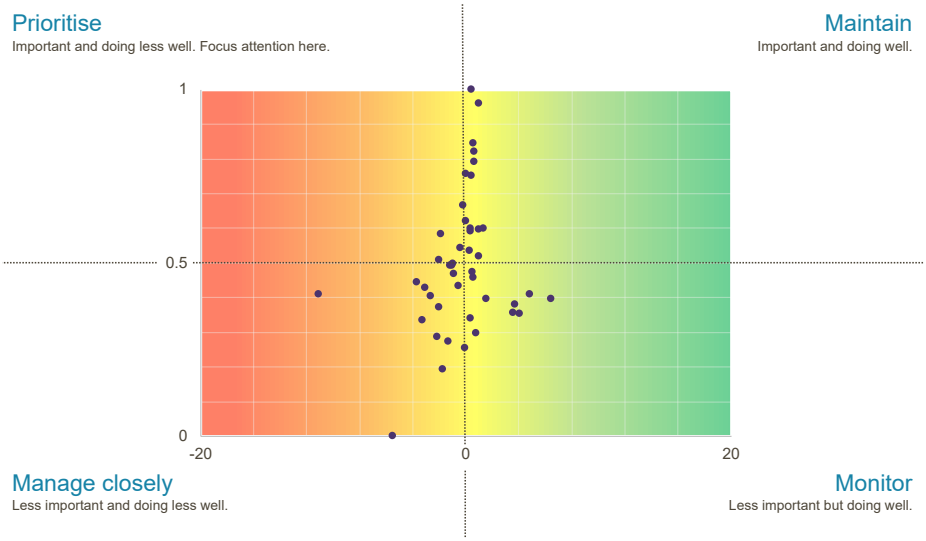
Improvement Maps™ correlate the results of each question with the overall rating question (Q49). Questions are then ranked by the extent that they contribute to patients' overall experience. Results are then compared to DCH performance in comparison to the Picker Average.

The Y (vertical) axis shows the importance of each question to patients' experience; the most important questions appear in the top two quadrants.

The X (horizontal) axis shows our performance in comparison to the Picker Average. Where we have performed better than the Picker Average, questions appear in the right-hand quadrants. Where we have performed worse than the Picker Average, questions are plotted in the left-hand quadrants.

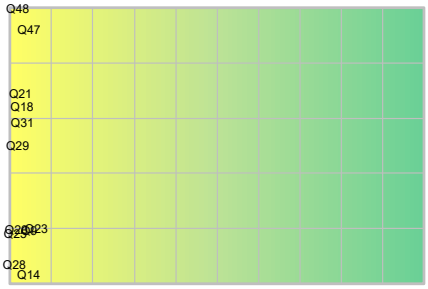
Details of the questions included in each quadrant are on the following pages.

Overall Improvement Map



Maintain

Important and doing well.



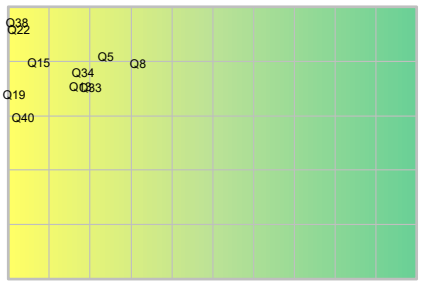
SUMMARY

Number of questions in this quadrant: 12

Q	Question text	PS%
Q48	Treated with respect and dignity overall	99%
Q47	Treated with kindness and compassion	99%
Q21	Had confidence and trust in the nurses	98%
Q18	Had confidence and trust in the doctors	98%
Q31	Existing individual needs taken into account	93%
Q29	Staff helped control pain	98%
Q23	Always or sometimes enough nurses on duty	92%
Q20	Nurses answered questions in a way patient could understand	97%
Q9	Room or ward very or fairly clean	98%
Q25	Was involved in decisions about care and treatment	81%
Q28	Given enough privacy when being examined or treated	99%
Q14	Got enough help from staff to eat meals	84%

Monitor

Less important but doing well.



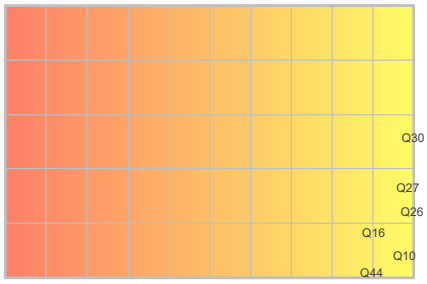
SUMMARY

Number of questions in this quadrant: 10

Q	Question text	PS%
Q38	Given enough notice about when discharge would be	87%
Q22	Nurses included patient in conversation	97%
Q5	Did not have to wait too long to get to a bed on a ward	77%
Q15	Able to get food outside of meal times	77%
Q8	Staff explained reasons for changing wards at night	87%
Q34	Information given about the risks and benefits of continuing treatment on a virtual ward	83%
Q13	Hospital food was very or fairly good	72%
Q33	Enough information given about care and treatment while on a virtual ward	95%
Q19	Doctors included patient in conversation	97%
Q40	Understood information about what they should or should not do after leaving hospital	98%

Prioritise

Focus attention here.



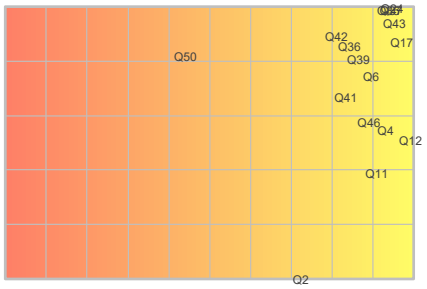
Q	Question text	PS%
Q30	Staff helped when needed attention	98%
Q27	Felt able to discuss worries and fears with staff	91%
Q26	Right amount of information given on condition or treatment	80%
Q16	Got enough to drink	92%
Q10	Got enough help from staff to wash or keep clean	90%
Q44	Staff discussed need for further health or social care services after discharge	76%

SUMMARY

Number of questions in this quadrant: 6

Manage closely

Less important and doing less well.



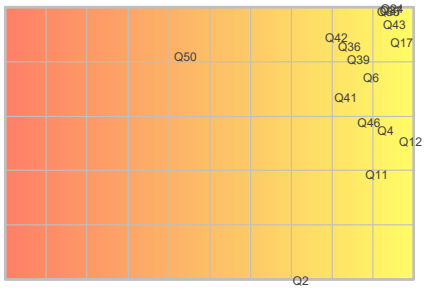
Q	Question text	PS%
Q24	Staff did not contradict each other about care and treatment	63%
Q37	Staff discussed need for additional equipment or home adaptation after discharge	80%
Q35	Felt involved in decisions about discharge from hospital	72%
Q43	Staff told patient who to contact if worried after discharge	74%
Q42	Before leaving hospital knew what would happen next with care	80%
Q17	Doctors answered questions in a way patient could understand	95%
Q36	Staff involved family or carers in discussions about leaving the hospital	56%
Q50	Asked to give views on quality of care during stay	24%

SUMMARY

Number of questions in this quadrant: 16

Manage closely

Less important and doing less well.



Q	Question text	PS%
Q39	Given information about what they should or should not do after leaving hospital	75%
Q6	Not prevented from sleeping at night	42%
Q41	Given information about medicine at discharge	82%
Q46	Got enough support from health or social care professionals after discharge	75%
Q4	Quality of information given while on waiting list to be admitted was very or fairly good	77%
Q12	Offered food that met dietary requirements	91%
Q11	Able to take own medication when needed to	85%
Q2	Did not mind waiting as long as did for admission	53%

SUMMARY

Number of questions in this quadrant: 16

5 National Inpatient Survey 2023 – Improvement Action Plan – V1 20240717

The action plan below has been developed with divisional head of nursing, divisional quality and governance leads and the patient flow transformation manager. This is version one with consolidation of this to be agreed through PEPEC.

It is taken into consideration in development of this plan that inpatient results are based on feedback received in Nov/Dec 23 and that new initiatives and service improvements which may have been picked up through the inpatient survey are already underway.

Focus areas for improvements have been identified through the 'priority' and 'manage closely' improvement maps detailed in section 4 of this report. Actions will be managed through their host programmes with progress measured at PEPEC.

Action Plan meeting: 20240626 Next review: 20240801 – PEPEC Agenda

NIS 2023 Publication Date: August 2024 NHS patient survey programme: outline programme and publication dates - Care Quality Commission (cqc.org.uk)

Measure of Success

We will aim to ensure all the below goals help us to meet at least the Picker average in the 2024 NIS. We will carry out our own survey on the specifics to measure progress and adjust actions as required.

New initiatives and quality improvements which have been put in place since the survey was carried out will be factored into the action plan below. A survey to assess impact to date to be carried out.

Relevance

All of the goals below align to Trust and wider NHS Strategy and objectives and provide opportunity to improve patient experience.

National Inpatient Survey Action Plan	
Focus Area - Care	
Objective	
Improve quality of inpatient care through measures taken to ensure information around how they can get support and raise concerns are well communicated with processes in place to ensure access to basic daily needs.	
What we are already implementing	What we will do
• Lulworth patient rep. Weekly visit, relationship between ward Leader and the volunteer to highlight concerns and good news. • Volunteer team – hydration support • Activities to prevent de-conditioning – painting etc with groups & individuals – working really well on Mary Anning Unit • Ward host role – pilot on Mary Anning and Evershot wards – focus on supporting hydration and nutrition needs. • Information to the kitchen regarding allergies – this is now data fed twice a day from EPMA • Wards working with catering manager to stock more of what they need and less of what they don't using generic ward email addresses	• Roll out of the patient rep role across other wards. • Activity for Patients plan – collaborative approach across teams in line with quality priorities. • Embedding a culture of verbal ward information for patients on admission to a ward.
Focus Area - Discharge	
Objective	
To improve communication with patients around discharge, ensuring the patient, family / carer are involved in conversations around discharge and support post discharge.	
What we are already implementing	What we will do
• Patient Flow transformation group with focus on discharge support and enabling plans in place which will continue roll out through 24/25. This includes development of the patient flow dashboard and intranet page. • EDS working group which may help support knowledge of medication on discharge. • VCS supporting from the Discharge lounge with follow up phone calls post discharge. Feedback from this can highlight where we are doing well and where we can do better	• Plans for Better Care Fund D2A survey to provide further feedback to improve discharge services. • Extensive training packages to be delivered to staff to support confidence in delivering discharge conversations. • Pathway home hub (Frailty SDEC) due to open in autumn 24 providing support to prevent admission and post discharge support. • Capturing of patient stories on their discharge experience to support future service improvements.

• YFW Blood Bikes supporting with medication deliveries for discharged patients allowing them to go home earlier on the day of their discharge. • Implementation of patient discharge leaflet given to patient on admission.	• Roll out of patient rep roll to support signposting to post discharge services and to help raise any concerns patients may have regarding their discharge.
Focus Area - Admission	
Objective	
Improve communication around waiting times and admission alongside work going on to reduce waiting lists.	
What we are already implementing	What we will do
• Admissions – template letter drafted for teams across the trust to use to provide further information to patients around waiting times.	• Roll out of information letter regarding waiting times. • Adoption of national complaint standards which will support and improve the way we communicate with patients raising complaints about waiting times.

RECOMMENDATIONS:

The Board is recommended to:

1. **NOTE** this report.

Report Front Sheet

1. Report Details			
Meeting Title:	Board of Directors, Part 1		
Date of Meeting:	09 October 2024		
Document Title:	Joint Health Inequalities Workstream Update		
Responsible Director:	Dawn Dawson Chief Nursing Officer	Date of Executive Approval	02/10/2024
Author:	Helena Posnett - (Consultant in Public Health (Trust Lead for Health Inequalities, Dorset Healthcare)		
Confidentiality:	No		
Publishable under FOI?	Yes		
Predetermined Report Format?	No		

2. Prior Discussion		
Job Title or Meeting Title	**Date**	**Recommendations/Comments**
Quality Committee	17/09/2024	Noted

3. Purpose of the Paper	This report provides an update on the joint health inequalities workstream between Dorset Healthcare and Dorset County Hospital (the Trusts).						
	Note	✓	*Discuss*		*Recommend*		*Approve*	
4. Key Issues	The report highlights: • progress in key areas of activity since March 2024 (previous update) • steps taken to move towards joint governance; and • the draft joint plan with priorities						
5. Action recommended	The Board is recommended to: 1. **NOTE** the update and 2. **APPROVE** the governance arrangements.						

6. Governance and Compliance Obligations				
Legal / Regulatory Link		**Yes**	**No**	*Health and Social Care Act 2012 and Equality Act 2010*
Impact on CQC Standards		**Yes**	**No**	*Tackling health inequalities is one of CQC's strategic ambitions*
Risk Link		**Yes**	**No**	*If 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**	*Progress with addressing health inequalities impact on people using our services*
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**	*Action plans linked to this report will provide improvements linked to this goal*
Tackling unequal outcomes and access	**Yes**	**No**	*As above*
Enhancing productivity and value for money	**Yes**	**No**	
Helping the NHS to support broader social and economic development	**Yes**	**No**	*Progress with addressing health inequalities impact on people using our services*
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. Introduction

1.1 Dorset Healthcare University Foundation NHS Trust (DHC) and Dorset County Hospital NHS Foundation Trust (DCH) are committed to tackling Health Inequalities (HI): "avoidable, unfair and systematic differences in health between different groups of people.[1]" Since November 2023, as part of the 'Working Together' Programme, the Trusts have been exploring how best to collaborate on this important agenda. To note, DHC employs a Consultant in Public Health, who acts as Trust Lead for HI (the DHC Trust Lead).

1.2 The purpose of this paper is to provide an update on the joint Trust approach to HI within the context of wider System working. It describes:

- progress in key areas of activity since March 2024 (previous update)
- steps taken to move towards joint governance; and
- the draft joint plan with priorities

2. Progress since March 2024

2.1 Work has continued across the Trusts in **key areas such as prevention**, including the following:

- During the Spring COVID-19 Campaign, 513 vaccinations were delivered across 23 walk-in clinics at venues identified with community partners in areas of low uptake. An evaluation is informing the approach moving forwards.
- Work continues to progress DHC's revised Smokefree Policy. A second treating tobacco dependence advisor has started on our mental health inpatient wards. 115 service users have been supported since end of April[2], and training has been delivered to wider staff. DCH's Reducing Tobacco Dependency Team continues focused delivery; there has been improvement in the recording and compliance with CO monitoring at booking/smoking status at time of delivery - for women and birthing people served by our maternity services.
- Collaborative working with people with lived experience and voluntary and community sector partners is ongoing in relation to the Patient Care Race Equality Framework (DHC only). A presentation will be co-delivered to Senior Leadership Group in August to enable governance to be clarified and a working group set up to co-develop plans.
- NHS England has approved plans for a practitioner to enable uptake of screening programmes among persons with learning disability; recruitment is underway.
- An Accessible Information Standards policy has been developed at DCH and shared with DHC. Work continues to consult and ensure that information is provided in ways that meet the needs of our population, including easy read, translation and braille.

2.2 Discussions continue at System and Trust Level to **affect change and pivot operations to a 'population health' approach to reduce HI**

- The DHC Trust Lead has been supporting the development of the Joint Strategy and Improvement Framework – ensuring population health and tackling HI is a golden thread.

[1] What are health inequalities? | The King's Fund (kingsfund.org.uk)
[2] At 5th August

- Both Trusts have progressed conversations to strengthen the approach to Quality, Equity and Equality Impact Assessment, and a draft policy is in development. Building on learning from 2023/24, the Trusts are support System-led conversations to identify priorities for Equality Delivery System 2022[3] 24/25.
- At a service level, several related quality improvement projects are underway. These include testing a support offer for patients with learning disability who do not attend/were not brought to outpatient appointments and a community-based assessment day, offering spinal triage and treat alongside wider health and wellbeing services for those on the waiting list in our most deprived areas.
- Data and intelligence remain a priority. At DCH, analysis highlighting variation in access-experience-outcomes for priority populations and key clinical areas was presented to Quality Committee; this led to a recommendation to complete mapping of related activity, which is underway. In collaboration with Trusts, NHS Dorset's Annual Health Inequalities Report was published in support of NHS England's statement on information on HI[4]; this includes 24 indicators, which can inform the development of future Trust Board reporting. Improvement action to tackle unwarranted variation will be overseen by a System HI workstream.
- Further funding has been awarded by NIHR Clinical research Network Wessex and NHS England to continue the work to learn from those with experience of homelessness and being vulnerably housed, what it means to have a voice in research. Presented at Dorset Innovation Hub summit and now named "I am More Than….", the next phase of the project is to develop and deliver practical tools for researchers including those undertaking insights and engagement activities, and build voluntary and community sector capacity to support. Please see: Research engagement with people who have experienced homelessness | Bournemouth University
- The expectation remains for a System workstream to be stood up to guide our approach to workforce development. Two doctors in training have joined on public health placement.

2.3 As part of **developing the Trusts' contribution to the local community**, the DCH lead for social value has supported the development of the Joint Strategy, positioning social value as a golden thread. Conversations have started to implement a shared social value programme and governance across the Trusts, to ensure visibility of plans including in relation to a sustainability impact assessment.

3. Governance – developing plans with Dorset County Hospital

3.1 A Joint Health Inequalities Steering Group will be established to provide strategic leadership and oversight across both Trusts and meet quarterly. A risk register will be created to ensure mapping and mitigations are in place for delivery of the work programme. A draft Terms of Reference is available on request.

3.2 With Trust and System plans and outcome measures emerging (aligned to the NHS Dorset Joint Forward Plan), an annual plan will ensure momentum is maintained and

[3] The Equality Delivery System (EDS) is a system that helps NHS organisations improve the services they provide for their local communities and provide better working environments, free of discrimination, for those who work in the NHS, while meeting the requirements of the Equality Act 2010. The EDS was developed by the NHS, for the NHS, taking inspiration from existing work and good practice. NHS England » Equality Delivery System 2022

[4] NHS England » NHS England's statement on information on health inequalities (duty under section 13SA of the National Health Service Act 2006)

inform future ambitions. A draft plan is available on request and includes activities in relation to: governance, self-assessment (against NHS Providers Tool[5]), mapping related activities underway and agreeing reporting arrangements, EDS2 Domain 1 and Equality Impact Assessments.

3.3 Assurance will be to the Strategy, Transformation and Partnerships Committee, and onwards to Trust Boards. Discussions are underway about the interdependencies and opportunities of the Provider Collaborative.

3.4 Both Trusts engage with the Dorset System HI governance structure to provide updates, share learning and enable alignment. A future communications and engagement plan will be required. In the meantime, awareness raising continues through the organisations.

Contact for further information
Dr Helena Posnett, Consultant in Public Health (DHC Trust Lead for Health Inequalities)

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[5] Reducing health inequalities: A guide for NHS trust board members (nhsproviders.org)

Finance and Performance Committee in Common Assurance Report for the meeting held on Monday 23 September 2024

Chair:	Executive Lead:	Date of Next Meeting:
Dave Underwood	Chris Hearn Anita Thomas	Monday 25 November 2024
Quoracy met?	Yes	
Purpose of the report	To assure the Board on the main items discussed by the Finance and Performance Committee in Common and, if necessary, escalate any matter(s) of concern or urgent business which the Finance and Performance Committee in Common is unable to conclude.	
Recommendation	To receive the report for **assurance**	

Significant matters for assurance or escalation, including any implications for the Corporate Risk Register or Board Assurance Framework	• Receipt of the revised Board Assurance Framework and committee assigned risks, noting that there was a single set of strategic risks for both Trusts but a separate Board Assurance Framework for each Trust, due to the difference in assurances around those risks. A dynamic document that would be further developed and linked to the Corporate Risk Register for each Trust. • New risk relating SR5 regarding to fire compliance. Actions underway to mitigate the risks, but the controls should be noted as red at present. • Seasonal Surge (winter) plan – recommended to Board for approval • Premises assurance model recommended to Board for approval • Annual EPRR Statement

Key issues / matters discussed at the meeting	The committee received, discussed and noted the following reports:
	• Committee in Common Transition Report
	• Corporate Risk Register highlighting a new risk relating to fire compliance, as reported to September's Risk and Audit Committee.
	• Non-Clinical Risk report.
	• Performance Report
	• Clinical Coding Workforce Strategy. Option four endorsed by the committee.
	• Patient Pathway Improvement Programme Report noting the extent of work undertake in this programme.
	• Finance Report noting
	  ○ The balance between vacancies, cost savings and quality impacts.
	  ○ Update on the broader system financial position at half-two and the Trust's position within that. Introduction of a recovery director at system level to improve the financial position, and weekly executive-led financial recovery meetings.
	• Cost Improvement Programme (CIP) Deep Dive (DCH) noting a 5% CIP requirement with a focus on setting up programmes for long term cost improvements. Growing engagement across the Trust and

	recognition that CIP is everyone's responsibility. The committee requested that October's Informal Meeting would focus on the Cost Improvement Plan for both Trusts. • Medium Term Financial Plan Update noting that guidance from the Dorset ICB was still in development and there was little to update at this time.

Decisions made at the meeting	• Seasonal Surge (winter) plan recommended to Board for approval
	• Premises assurance model recommended to Board for approval
	• Recommendation to Board to approve the following contracts:
	  ○ Radiology Reporting Routine Hexarad
	  ○ East Dorset Renal Satellite Unit – Staff

Issues / actions referred to other committees / groups	• Nil

Quoracy and attendance				
	23/09/2024	**25/11/2024**	**27/01/2025**	**24/03/2025**
Quorate?	Y			
Dave Underwood	Y			
Chris Hearn	Y			
Alastair Hutchison	Apols			
Nick Johnson	Y			
Stephen Tilton	Y			
Anita Thomas	Y			
Frances West	Y			

Report to	Dorset County Hospital Board of Directors, Part 1	
Date of Meeting	09 October 2024	
Report Title	DCH Finance Report	
Prepared By	Claire Abraham, Deputy Chief Finance Officer (DCH)	
Accountable Executive	Chris Hearn, Chief Finance Officer	
Previously Considered By	Finance and Performance Committee in Common	
Action Required	**Approval**	-
	Assurance	Y
	Information	-

Alignment to Strategic Objectives	Does this paper contribute to our strategic objectives	
Care	Yes	
Colleagues	Yes	
Communities	Yes	
Sustainability	Yes	
Implications	Describe the implications of this paper for the areas below	
Board Assurance Framework	SR6 – Finance	
Financial	Value for money and financial sustainability	
Statutory & Regulatory	Monitoring, active intervention to deliver operational plan	
Equality, Diversity & Inclusion	n/a	
Co-production & Partnership	System financial plan delivery	

Executive Summary

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.

Key Messages

Month five delivered a deficit of £0.490 million after technical adjustments, being £0.04 million against a plan of £0.450m deficit. The year to date position is £0.5 million away from plan standing at an actual deficit of £6.9 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 19, and circa 52 no criteria to reside (NCTR) patients being supported which were captured at the end of August (not average).

Agency expenditure has continued at lower than budgeted levels with total month spend of £0.6 million. This reflects the ongoing delivery work of the High Cost Agency Reduction Programme supported by all functions.

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 £14.4 million and is circa 5% of expenditure budgets in line with peers and national planning expectations.
The target has been identified in full with year to date delivery at 18% of the target being £2.6 million. High risk schemes equate to 36% (£5.2m) of the target, medium risk at 37% (£5.3m) and remaining low risk schemes at 9% (£1.3m)

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 five is behind plan at £0.4 million due to timing of equipment purchases. Year to date spend is £7.8 million and behind plan by £1.4 million largely due to NHP enabling works offset by internal schemes being ahead of plan by £0.7m both linked to timing.

The cash position to August amounts to £8.8 million and is ahead of plan due to non-recurrent 2023/24 income from Dorset ICB received earlier than expected, £1.5m of national revenue support paid in April to facilitate repayment of working capital and recent VAT rebate from HMRC.
Cash remains a high risk area for the Trust with modelling indicating further cash support will be required in quarter three.

Key Actions

- 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, noting significant challenges associated.
- Target areas include Non clinical bank pay; Facilities incl non pay & provisions; external security; medical additional sessions and medical agency usage; theatre utilisation, NCTR and escalation beds.
- Efficiency support meetings led by CFO ongoing with all areas, overseen by Value Delivery Board
- Working group in place to recover WTE to March 2023 levels overseen by Exec led SRO
- Ongoing daily cash monitoring – cash shortfall risk in Q3 being validated ahead of national provider revenue request deadline mid September with ongoing efficiency delivery essential in line with planned levels and grip and control paramount
- Agency monitoring continues with medical focus escalated to CMO
- Capital programme monitoring noting over subscription and current internal programme overspend.

The forward view of contracts as at August 2024 has been included in Appendix 1 and shows a summary of upcoming contracts for renewal, with budgeted pressures being finalised. This is an active view and is updated as additions arise, when renewals approach and tenders are undertaken.

Recommendation

The Board is recommended to:

1) Receive the report for **assurance**, noting the month five financial position for the financial year 2024/25 and Appendix 1 - Forward View of Contracts

INTEGRITY | RESPECT | TEAMWORK | EXCELLENCE

NHS
Dorset County Hospital
NHS Foundation Trust

Financial Position Update 2024/25

August 2024 - Month 5

Chris Hearn
Chief Financial Officer

Financial Position Update - August 2024

Executive Summary

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

In August 2024, Dorset County Hospital NHS Foundation Trust (DCHFT) has delivered a month 5 deficit of £0.490 million after technical adjustments, an adverse performance of £0.044 million against the revised plan of £0.447 million deficit.

This overspend in month has been driven by, 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, including continued specific pressure around Mental Health patients, although this has reduced from last month. Escalated beds at the end of the month were 15 with circa 51 no criteria to reside (NCTR) patients being supported. Agency expenditure has maintained a reduction against 2023/24 totals due to the impact of the agency rate reduction and increase in substantive recruitment, but not at the same level as quarter 1 due to additional support needed to cover mental health support. In addtion, ongoing medical rota gaps across ED, General Medicine and Urology are being covered at higher rates than budgeted.

The Trust wide efficiency target for the year stands at £14.4 million and is circa 5% of expenditure budgets in line with peers and national planning expectations. The programme is fully identified however contains 36% of high risk schemes. Delivery to date stands at £2.6m this is c£0.7m behind phased plan of delivery to month 5. Contributing cost avoidance and cost reduction is now being included (£1.8 million YTD). Efficiency delivery remains a significant high risk for the Trust with laser focus required from all responsible officers to deliver schemes as planned.

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 5 YTD spend totalling £7.9 million, a net £1.4 million behind rephased plan due to underspends on externally funded projects. Externally funded projects are £1.7 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 £0.7 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 31 August was £8.8 million above plan due to timing of VAT recovery on 2023/24 spend received from HMRC. 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. Modelling indicates a risk of cash shortfall in the second half of the year.

Financial Position Update - August 2024

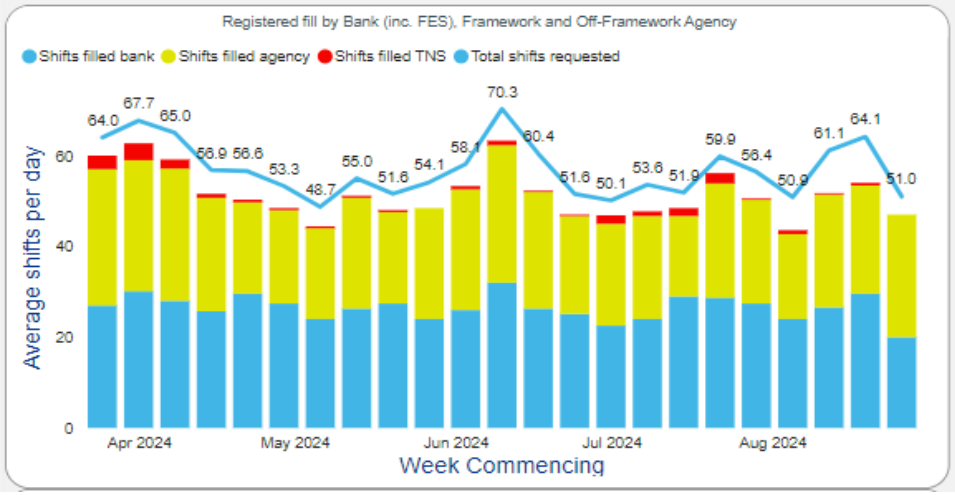
Key Risks

Red Risks:

The Trust has an efficiency delivery requirement of £14.4 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 including workforce review and productivity stretch totalling £7.5m. Without continued development of these 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 has improved since last year due to a combination of factors including system agency rate reduction and vacancy level decreases. NHSE is expecting all off framework agency spends to cease completely this quarter, if acheived the Trust aims to see a further FYE reduction of £1 million on spend. This has been achieved largely throughout quarter 1, however month 4 saw additional operational pressures where high cost Mental Health agency nursing was required. This has continued into M5, albeit it at a reduced level. The opening of Portisham Ward to support the extreme pressures seen in ED has also seen an impact on the useage of agency in M5. 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

Financial Position Update - August 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 later in 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 are likely throughout the year when required, which is forecast to be necessary in quarter 3. 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 to request support 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 (£7.4 million). 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 and there are 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, identify and manage this risk.

Financial Position Update - August 2024

Key Risks

Amber Risk:

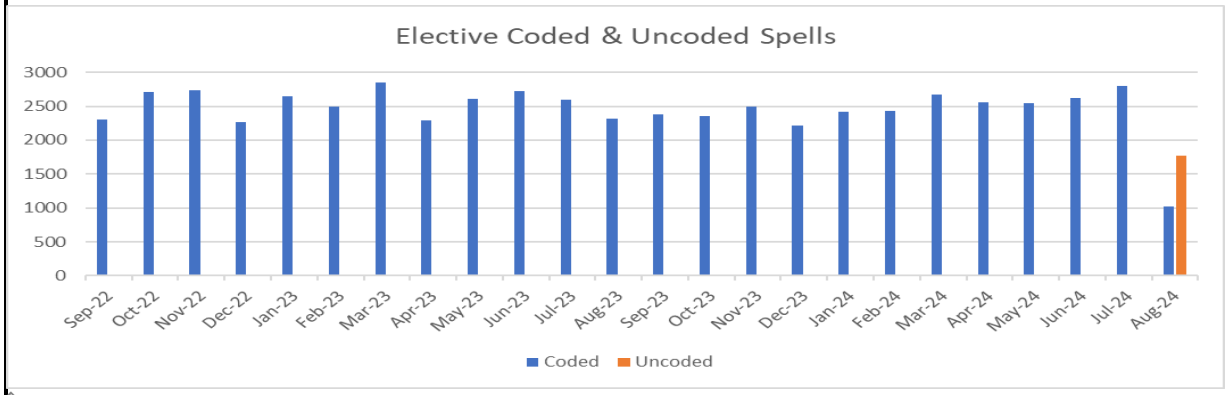
From 2023/24 NHS England introduced the Aligned Payment and Incentive (API) approach to all NHS standard contracts. This approach splits the payment mechanism for the majority of NHS contracts into two envelopes, Fixed and Variable.

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 August 2024 the Trust has 4,370 uncoded spells,1,788 are for Elective activity and 2,582 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 - August 2024

Recovery Plans

Targeted Service Areas and Development Plans
- Recovery plans for overspending areas are identified, with focus on strong cost controls and identification and removal of avoidable costs. Possible mitigations to be considered with additional governance support to evidence efficient working processes.
- Regular messaging about Financial position and required efficiency focus is being provided at Divisional Managers weekly meeting, Value Delivery Board and Senior Leadership Group.
- Analysis of non-clinical bank pay is taking place with plans to reduce spend in this area.
- Other key focus area's include; facilities including non pay & provisions, external security, medical additional sessions, medical agency usage, along with theatre utilisation, NCTR and escalation beds.

Income recovery
- Maximise private patient income and ESRF income within insourcing budget.
- Review activity coding for completeness.

Workforce measures
- Strong recruitment controls in place, formal Exec approval needed from weekly Recruitment Control Panel.
- Working group in place to recover WTE to March 2023 levels overseen by Exec led SRO.
- Agency monitoring continues with medical focus escalated to CMO.

Investment Reviews
- Review prior investments to gain understanding and assurance that expected benefits will be delivered, reconsider continuation if necessary.
- Review investments in progress, ensure in-year benefits or recognised high risk drivers.

CIP and efficiencies
- CFO CIP support meetings ongoing with all areas, overseen by Value Delivery Board.
- Meetings with all SROs booked with focus on identified into delivery.
- Active system recovery meetings in train with unpalatables under review

Cash
- Ongoing daily cash monitoring and weekly cashflow review.
- Timely invoicing and early and effective debt collection.

Financial Position Update - ~August 2024
Income & Expenditure

Income and Expenditure

The overall revenue position is a £0.490 million in month actual deficit, £0.044 million adverse to plan after technical adjustments. The YTD position is £0.5 million away from plan. Costs supporting Industrial Action and one off redundancy costs have contributed to this overspend, along with continued inflationary pressures, offset by improved agency expenditure and savings against COVID costs .

The Operating Income from patient care activities in month variance is due to; out of contract income, estimated month 1 - 5 Elective Services Recovery Fund (ESRF) income and high cost drugs income offset with expenditure.

Pay costs are over plan due to supporting industrial action in quarter 1, 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. August has seen a continued improved trend in agency costs against 2023/24 levels, however an increase to the last quarter of last year due to high risk Mental Health patients treated in July and again in August (although a lower level in month).

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	21,216	22,979	1,762	106,082	113,780	7,698
Private Patients	87	92	5	433	500	66
Other clinical revenue	37	80	43	185	192	7
Other non-clinical revenue	2,074	3,264	1,190	10,082	11,521	1,439
Operating Income	**23,414**	**26,414**	**3,000**	**116,782**	**125,992**	**9,210**
Total Income	**23,414**	**26,414**	**3,000**	**116,782**	**125,992**	**9,210**
Raw materials and consumables used	(3,401)	(4,568)	(1,167)	(18,932)	(22,951)	(4,020)
Employee benefit expenses:						
Substantive	(13,297)	(15,466)	(2,170)	(68,309)	(74,691)	(6,383)
Bank	(857)	(967)	(110)	(4,523)	(5,246)	(723)
Agency	(830)	(649)	181	(4,035)	(3,112)	923
Other operating expenses (excl. depreciation)	(3,993)	(3,810)	182	(19,909)	(19,846)	63
Operating Expenses	**(22,376)**	**(25,460)**	**(3,084)**	**(115,707)**	**(125,846)**	**(10,139)**
Profit/(loss) from Operations (EBITDA)	**1,038**	**954**	**(84)**	**1,075**	**146**	**(929)**
Other Non-Operating income (asset disposals)	0	0	0	0	(1)	(1)
Total Depreciation and Amortisation	(1,035)	(1,035)	0	(5,176)	(5,175)	1
PDC Dividend expense	(408)	(408)	(0)	(2,041)	(2,041)	(0)
Total finance income	22	58	36	113	354	242
Total interest expense	(64)	(73)	(9)	(322)	(308)	14
Total other finance costs	(0)	(0)	(0)	(£0)	(£1)	(1)
SURPLUS/ (DEFICIT)	**(448)**	**(505)**	**(57)**	**(6,352)**	**(7,026)**	**(674)**
Technical Items Adjusted for:						
Donations Non-Cash Assets	(40)	(21)	19	(200)	(21)	179
Depreciation Donated Assets	40	36	(4)	200	179	(21)
SURPLUS/ (DEFICIT)	**(448)**	**(490)**	**(43)**	**(6,352)**	**(6,868)**	**(517)**

Financial Position Update - August 2024
Industrial Action

2024/25 Industrial Action

Costs incurred in June and the initial part of July supporting Industrial Action amount to £0.196m with a further £0.255m estimate of lost activity income. Of which, for July reporting purposes, £0.062m of net staff cost and an estimated £0.102m of lost activity income were incurred.

For DCHFT, June & July 2024 the combined net cost & lost elective recovery activity is estimated at £0.4m.

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, however recent national advice indicates this is expected to be funded.

2024/25 Industrial Action Staff Group	Junior Doctors £'000	Junior Doctors £'000	Total £'000
Strike Date	***27-30 Jun***	***1-2 July***	
Immediate backfill costs to cover services	*£118*	*£78*	**£196**
Offset by Salary Savings	*-£25*	*-£17*	**-£42**
Net Cost	***£92***	***£62***	**£154**
Number of Industrial Action Days	*3*	*2*	5
Estimate of Lost ERF Activity	*£153*	*£102*	**£255**
Net Cost & ERF Income Loss	**£245**	**£164**	**£409**
Estimated Cost Per Day £'000	£82	£82	£82

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 - August 2024

Trust Wide Performance: Agency

Pay Analysis - Agency

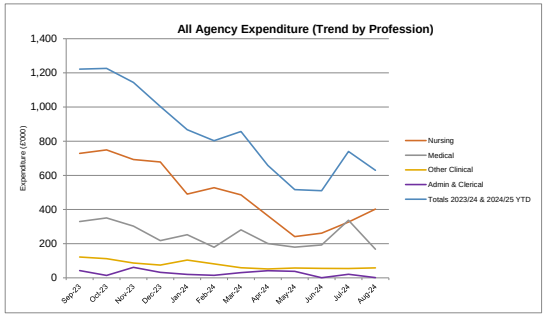
Agency costs equated to £0.6 million of actual expenditure in month against a plan of £0.8 million, showing a £0.1 million increase on last month and back in line with prior quarter spend., however still slightly higher due to continued Mental Health interventions and sickness cover.

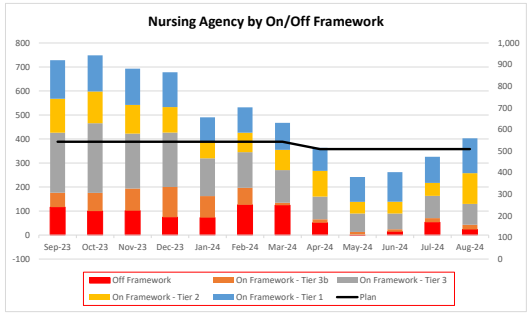
Agency expenditure remains over the 3.2% of total pay NHSE target set for 2024/25, to 3.8% of pay budgets - improved from 4.4% last month.

Although there is continued improvement in agency expenditure, 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 with a break glass procedure adopted to maintain essential safety only.

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.





Agency Spend by Profession (£'000)	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24
Nursing	728	749	693	678	490	528	486	364	241	262	327	403
Medical	329	351	303	218	253	179	281	201	180	193	338	167
Other Clinical	122	112	86	75	104	82	59	52	58	55	54	58
Admin & Clerical	42	14	62	32	20	15	31	42	38	1	21	1
Totals 2023/24 & 2024/25 YTD	**1,222**	**1,226**	**1,144**	**1,003**	**867**	**803**	**857**	**658**	**517**	**510**	**740**	**629**

YTD Actual	YTD Plan	Variance
1,596	2,920	1,324
1,078	1,194	116
277	515	238
102	172	70
3,054	**4,801**	**1,746**

Nursing Agency Category	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24
Off Framework	116	100	102	74	73	126	125	51	-1	14	54	23
On Framework - Tier 3b	60	76	92	126	90	71	10	15	13	10	17	20
On Framework - Tier 3	250	290	229	227	157	148	136	94	77	66	93	87
On Framework - Tier 2	141	133	120	106	69	81	84	107	48	49	54	128
On Framework - Tier 1	161	150	151	145	102	105	113	96	104	123	109	145
Plan	543	543	543	543	543	543	543	509	509	509	509	509
Orders awaiting allocation	0	0	0	0	0	0	0	0	0	0	0	0
Totals 2023/24 & 2024/25 YTD	**728**	**749**	**693**	**678**	**490**	**532**	**467**	**364**	**241**	**262**	**327**	**403**

Pay Metrics	In Month Actual	YTD Actual
Agency expenditure as % of total pay	3.8%	3.7%
Off framework expenditure as % of total agency	8.5%	5.0%

Areas Using Nursing Agency Including Off Frameworkk YD (£'000)

Area	On Framework	Off Framework	of which: RNMH	Total Nursing Agency	%
Emergency Dept Main Dept	306	16	1	322	20%
Moreton Ward - Respiratory	160	1		161	10%
Day Surgery Unit	140	1		140	9%
Abbotsbury Ward	109	17	13	126	8%
Purbeck Wd	110	1		109	7%
Lulworth Ward	95	1		94	6%
Fortuneswell Ward	84	0		83	5%
Kingfisher Ward	56	27	3	83	5%
Stroke Unit	71	10		82	5%
CRCU	73	5		78	5%
Ilchester Integrated Assessmen	60	1		61	4%
DCH Dialysis	56	-		56	3%
The Mary Anning Unit	48	1		49	3%
Ridgeway Wd	40	0		40	2%
Theatre Suites	29	-		29	2%
Prince Of Wales	27	1		28	2%
Evershot Ward	27	1		25	2%
SCBU	1	18		19	1%
Cardiology Care Ward	13	0		12	1%
Surge Area	5	-		5	0%
SDEC	3	1		3	0%
B'Mth Dialysis	2	-		2	0%
Discharge Team	1	-		1	0%
Main Outpatients	1	-		1	0%
Total Nursing Agency YTD	**1,516**	**94**	**17**	**1,609**	

Financial Position Update - August 2024
COVID Expenditure

Covid Narrative
Covid spend increased in August to £0.4 million from £0.3 million in July. 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	Jul-24	Aug-24	YTD
Plan:		**£2,287**	**£211**	**£211**	**£209**	**£208**	**£205**	**£839**
Expenditure:								
Pay	Substantive	£282	£1	£1	£14	£34	£9	£50
	Bank	£108	£0	£3	£7	£0	£0	£10
	Agency	£1	£0	£0	£0	£0	£0	£0
Total Pay		**£391**	**£1**	**£4**	**£21**	**£34**	**£9**	**£60**
Non-pay	Clinical Supplies and Services	£223	£32	£4	£22	£26	£52	£84
	General Supplies and Services	£0	£0	£0	£8	£5	£6	£13
	Establishment Expenditure	£6	£0	£0	£0	£0	£0	£0
	Other Non-Pay (security)	£472	£22	£21	£21	£23	£47	£87
	Premises and Fixed Plant	£162	£12	£12	£12	£3	-£12	£39
Total Non-pay		**£863**	**£65**	**£38**	**£62**	**£57**	**£93**	**£222**
Total Expenditure		**£1,254**	**£66**	**£41**	**£83**	**£91**	**£102**	**£384**
Total Surplus/(Deficit)		**£1,033**	**£145**	**£170**	**£126**	**£117**	**£103**	**£660**

Financial Position Update - August 2024
Sustainability & Efficiency

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 c£0.9m has been achieved, £0.4m coming from agency cost reduction and the remainder largely from Covid lower levels than planned (£0.330 savings) and pay slippage. YTD delivery stands at c£4.4m (including £1.4m of agency cost reduction - compared to 2023/24 levels). There is expected to be a catch up for Division B in Month 6 to increase this figure.

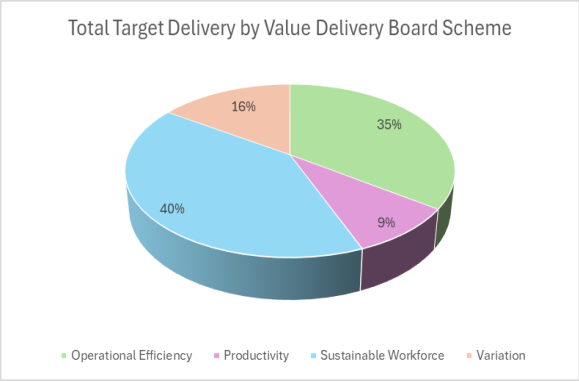
£4.6 million has been planned as fully identified schemes and in progress.
£2 million of schemes are identified, but not yet started.
£5.2 million of stretch schemes have been identified linked to workforce reviews, non recurrent delivery opportunities and sickness review and private patient income.

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.

Efficiency by Division	Plan	Identified High Risk	Identified Medium Risk	Identified Low Risk	Total Identified	Cash Releasing YTD	%
Family & Surgical Services	1,452		715	737	1,452	466	32%
Urgent & Integrated Care	1,403		581	822	1,403	762	54%
High Cost Agency & Off Framework Reduction	1,000			1,000	1,000	997	100%
Finance, Estates & Facilities	1,581		926	655	1,581	-	-
COVID Savings	428			428	428	330	1
Digital	329		232	97	329	-	-
Sickness Review	318	318			318	-	-
Corporate	123			123	123	-	-
Private Patient Income	47	47			47	-	-
Human Resources	38			38	38	7	0
Nursing	9		9		9	2	22%
WTE Reduction	3,918	3,918			3,918	-	-
Productivity - CANDo etc	2,722	922	1,800		2,722	-	-
Productivity Stretch Insourcing	1,000		1,000		1,000	-	-
Grand Total	**14,369**	**5,205**	**5,264**	**3,899**	**14,368**	**2,564**	**18%**
Total as at August 2024	**14,369**	**5,205**	**5,264**	**3,899**	**14,368**	**2,564**	

Scheme Status	Sustainable Workforce £'000	Productivity £'000	Variation £'000	Operational Efficiency £'000	Total £'000
Delivered	1,026		124	1,414	**2,564**
Identified - in progress	545	256	960	2,833	**4,594**
Identified - not started	7	99	1084	815	**2,005**
Identified Stretch Targets (High Risk):					
Workforce WTE Review	3,922				**3,922**
Stretch - NR & Sickness Reviews	318				**318**
Productivity		966			**966**
Total CIP 5%	**5,818**	**1,321**	**2,168**	**5,062**	**14,369**



Cost Avoidance Schemes	Cost Avoidance YTD
Family & Surgical Services	**681**
Income - Non-Patient Care	-
Pay - Agency - reduce the reliance on agency	681
Pay - Establishment reviews	-
Urgent & Integrated Care	**1,173**
Income - Non-Patient Care	17
Non-Pay - Procurement (excl drugs)	47
Pay - Agency - reduce the reliance on agency	1,109
Pay - Establishment reviews	-
Grand Total	**1,854**
Total as at August 2024	**1,854**

Efficiency Plan	£'000	%
Recurrent		
Pay	5,205	
Non Pay	1,972	
Income	230	
Total Recurrent	**7,406**	**52%**
Non Recurrent		
Pay	2,338	
Non Pay	4,306	
Income	319	
Total Recurrent	**6,962**	**48%**
Grand Total	**14,369**	

Financial Position Update - August 2024

Cash

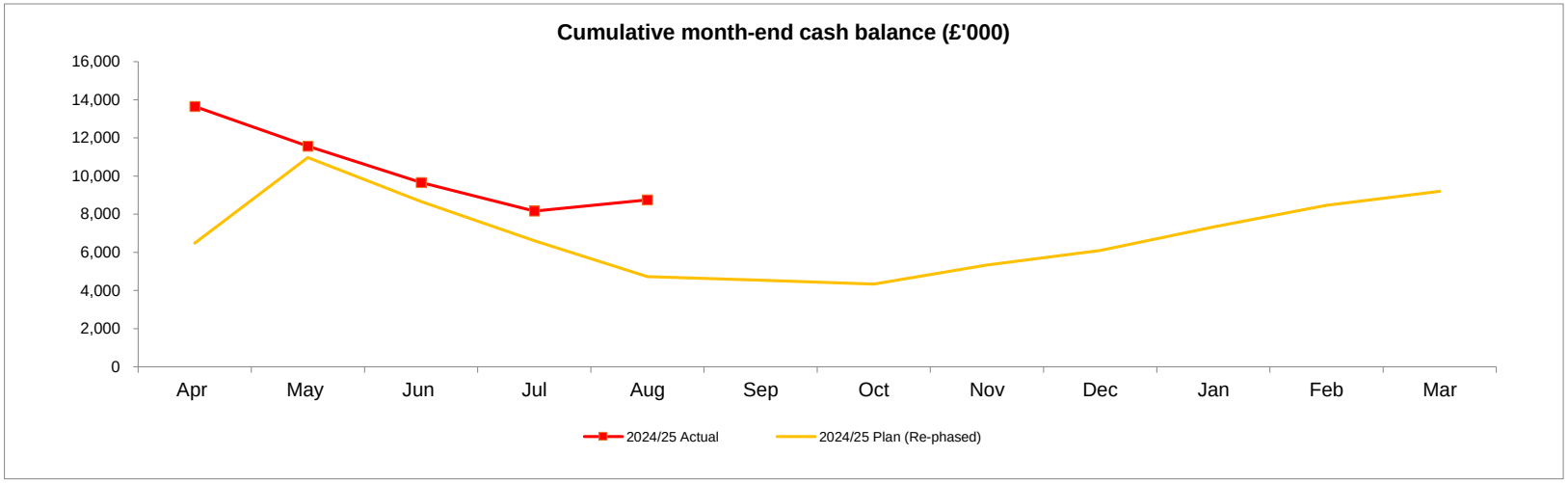
Cash Balance incl Forecast

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 £8.7 million at end of August, which is ahead of forecasted position of £4.7 million. During August, the Trust benefitted from receiving CDC income of £0.6 million ahead of schedule from Dorset ICB. The Trust also received capital PDC income totaling £2.4million toward NHP capital expenditure. Payments were lower in August due to timings, this is expected to catch up in Setember.

The Trust received the first instalment of revenue support funding in April totalling £1.5m which supports the repayment of working capital, while revenue support funding has not been required since April is anticpated that further support will be needed in quarter 3 if efficiency targets are not achieved in line with plan.

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 deliver all efficiency schemes, in conjunction with ongoing system conversations regarding 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						4,543	4,337	5,334	6,099	7,337	8,466	9,201
2024/25 Actual	13,650	11,566	9,660	8,164	8,752							

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Financial Position Update - August 2024

Capital

Capital Programme Narrative

Capital expenditure year to date to the end of August was £7.8 million and behind plan by £1.4 million.

Internally Funded schemes are overall ahead of plan at the end of August by £0.7 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 £1.7m 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	250	0	250	350	0	350	1,932	1,932	1,932	0
East Wing Theatre	0	234	(234)	450	489	(39)	1,527	1,527	0	(1,527)
Estates Schemes	**23**	399	(376)	**1,053**	2,311	(1,258)	1,786	1,802	1,650	(152)
Digital Services										
Digital Schemes	**168**	127	41	**882**	746	136	1,642	1,650	2,291	641
Equipment										
East Wing Theatre Equipping	0	0	0	0	0	0	192	295	295	0
Other Equipment	56	80	(24)	366	281	85	234	235	1,272	1,037
Sub-Total Internally Funded Expenditure	**497**	**839**	**(342)**	**3,101**	**3,828**	**(727)**	**7,313**	**7,441**	**7,440**	**(1)**
Donated										
Other Donations		21	(21)		21	(21)	21	21	0	(21)
Chemotherapy Unit Refurbishment	0	0	0	40		40	459	459	480	21
Sub-Total Planned Donated Expenditure	**0**	**21**	**(21)**	**40**	**21**	**19**	**480**	**480**	**480**	**0**
IFRS 16 Lease Additions										
Warehouse	0	0	0	0	546	(546)	546	546	480	(66)
MSCP Lease remeasurement	0	0	0	1,000	392	608	392	934	1,000	66
CEF Lease remeasurement	600	215	385	600	215	385	215	600	600	0
One Dorset Pathology	0		0	0		0		250	250	0
Accommodation & Vehicle Lease Additions	0	54	(54)	41	139	(98)	139	150	150	0
Sub-Total Planned IFRS 16 Expenditure	**600**	**269**	**331**	**1,641**	**1,292**	**349**	**1,292**	**2,480**	**2,480**	**0**
Total Internal & Leased Capital Expenditure	**1,097**	**1,129**	**(32)**	**4,782**	**5,141**	**(359)**	**9,085**	**10,401**	**10,400**	**(1)**
Additional funded schemes										
NHP Development	85	282	(197)	588	785	(197)	1,511	1,511	758	(753)
NHP Works	0		0	0		0		12,996	12,819	(177)
NHP Enabling	750	81	669	3,755	1,798	1,957	1,827	4,660	4,660	0
Digital EHR Funding	31	40	(9)	184	186	(2)	514	1,093	1,093	0
CDC Funding	0	1	(1)	16	15	1	16	16	16	0
Mental Health UEC Funding			0			0			257	257
Inventory Management System (pending)		30	(30)		30	(30)	30	30	0	(30)
Total Externally Funded Capital Expenditure	**866**	**434**	**432**	**4,543**	**2,814**	**1,729**	**3,898**	**20,306**	**19,603**	**(703)**
Total Capital Expenditure	**1,963**	**1,563**	**400**	**9,325**	**7,955**	**1,370**	**12,983**	**30,707**	**30,003**	**(704)**
Expenditure as a % of Plan			80%			85%				102%

Report to	Dorset County Hospital Board of Directors, Part 1	
Date of Meeting	09 October 2024	
Report Title	Operational Resilience and Capacity Plan (Winter) 2024/25	
Prepared By	Lesley Roberts, Head of Operations	
Accountable Executive	Anita Thomas, Chief Operating Officer	
Previously Considered By	Anita Thomas, Chief Operating Officer SLG 18th September 2024 Finance and Performance Committee in Common	
Action Required	**Approval**	X
	Assurance	-
	Information	-

Alignment to Strategic Objectives	Does this paper contribute to our strategic objectives	
Care	Yes	
Colleagues	Yes	
Communities	Yes	
Sustainability	Yes	
Implications	Describe the implications of this paper for the areas below	
Board Assurance Framework	Referenced specifically under SR4 Capacity, Demand	
Financial	Intension to indicate good use of resources through a surge period in line with financial planning	
Statutory & Regulatory	Support meeting agreed unplanned and planned service standards throughout the surge period	
Equality, Diversity & Inclusion	Impact on ED&I considered	
Co-production & Partnership	Admission Avoidance and effective Discharge processes require working in partnership with other health and social care partners and closely aligned to VCSE support offers.	

Executive Summary

System context:
In 24/24 Q1 and Q2 the system has been in receipt of the Better Care Fund (BCF) Support offer as part of the National Discharge Taskforce. This offer focusses on the Discharge to Assess (D2A) aspect of system working and includes a specific offer to implement and improve Transfer of Care Hubs. The BCF team were due to feedback on their outputs in September 2024 but this has been superseded by the ICS and Local Authorities bringing in a Strategic Partner (Newton) to complete a diagnostic of the whole System Urgent and Emergency Care provision to include D2A through causes for emergency presentations, discharges and community offers including social care. Patient stories alongside staff and data/intelligence workstreams are present in both schemes. Efforts have been made to reduce duplication and blend the BCF support with the Newton offer wherever possible. Newton are due to present their findings and proposals for system reform to the Senior Executive Group for Dorset ICB at the end of September.

Early drafts of the outputs and conclusions indicate a proposal with 3 'Horizons' within their change plan. Horizon 1 would focus on optimising existing services throughout Winter 24/25 while building on successes to inform Horizon 2 in 2025/26.

As a consequence of the above System interventions the Dorset System Winter plan is still in development and subject to further iterations depending on the adoption of all or part of the Newton plan. This document therefore concentrates on where DCH in partnership with others can continue its journey of improvement and remains open to further influence of system plans where appropriate and

aligned to our ambitions this winter. When System documents are finalised they will be brought through the Committee in common in order to inform and provide further assurance on our winter plans. For the reasons stated therefore Appendix 6 ICS Winter Plan is not available and the Plan remains in draft form, although the DCH specific elements are unlikely to be amended following submission to the Committee.

Specific to the attached document:

This DCH based surge plan has developed in a similar timeframe to the two interventions detailed above and is informed by them and the Working Together Program between DCH and Dorset Healthcare. In addition there is an internal Patient Flow Transformation Program focussing on the key areas of prevention, first 24 hours, Inpatient processes and Discharge which includes partnership working but with a lens on what DCH can influence, improve and implement for internal process and patient experience improvement.

Winter typically results in an increase in demand both from seasonally affected conditions and increased risk relating to infection prevention and control outbreaks, and the potential risk of respiratory disorders. Emphasis for this winter is in ensuring increased winter activity and associated levels of acuity can be managed alongside the risk of increased admissions particularly Flu, Covid and RSV. Fundamental to this is our ability to maintain essential emergency care services and ensure our patients and staff remain safe.

The increased emergency pressures across the Dorset ICS through the summer period have led to a year-round approach to resilience for urgent and emergency care, with implications on elective services, workforce, wellbeing and financial sustainability. Process changes already made through summer relating to the management of flow and bed capacity will continue through the winter period.

Our actions this winter are focused on planning and implementing strategies which are achieved by delivering our services differently and in collaboration with our partners across Dorset.

Key actions (see pages 6-8 for detail):

- Increase Acute Hospital at Home pathways and introduce new specialties reaching 45 beds by September 2024.
- Improve SDEC capacity including direct referrals for 111 and SWAST.
- Increase front door capacity for non-admitted patients by trialling a UTC in ED adjacent estate. (required for the NHP build from Q4, 2024)
- Elective plans to focus on cancer and urgent cases during times of pressure and patients that will be over 65 weeks by the end of the reporting month.
- Maximise use of the Voluntary, Community and Social Enterprise (VCSE) sector to release pressure on the Emergency Department (ED), inpatient wards and patient transport.
- High intensity User program with the Red Cross to increase ED avoidance opportunities.
- Continue to contribute to the redesign of the Home First Programme and subsequent remodelling of community services and social care provision to enable patients to return home quickly with increased community support.
- Implement frailty same day emergency care (SDEC) removing frailty patients from the front door in line with seeing patients in the right place.
- Increase ‘Emzone’ trial on ringfencing flow beds and reduce length of stay (LoS) for short stay patients for medicine and surgery.
- Continue to work with system partners on system redesign to improve admission avoidance and alternative pathways providing primary care and community alternatives to ED where appropriate.

- Improve access to mental health services from ED reducing the time in department for mental health presentations promoting right care, right place.

The Plan contains specific service delivery details which relate to winter including ED response to surges, IPC support, escalation process for management and effective bed management processes.

The Plan will act as a resource for staff throughout the period to refer to for guidance and support. It forms part of our Emergency Planning documentation including Business Continuity Plans and can be found within the EPRR section of the staff intranet. The winter plan for 2024/25 has been informed by feedback received from key clinical and non-clinical staff from within the hospital, a series of system wide meetings and incident management exercises.

The details of the Plan will be cascaded to staff via formal meetings such as Senior Leadership Group and Clinical Leads Forum and through Divisional Governance meetings. It will be supported by a Communications Strategy to include Staff Bulletins, Staff App and promotion via the Staff Intranet front screen.

Recommendation

The Board is asked to:

- Approve the Operational Resilience and Capacity Plan (Winter) 2024/25

Dorset County Hospital
NHS Foundation Trust

Dorset County Hospital NHS Foundation Trust

OPERATIONAL RESILIENCE AND CAPACITY PLAN (WINTER) 2024/25

SEPTEMBER 2024

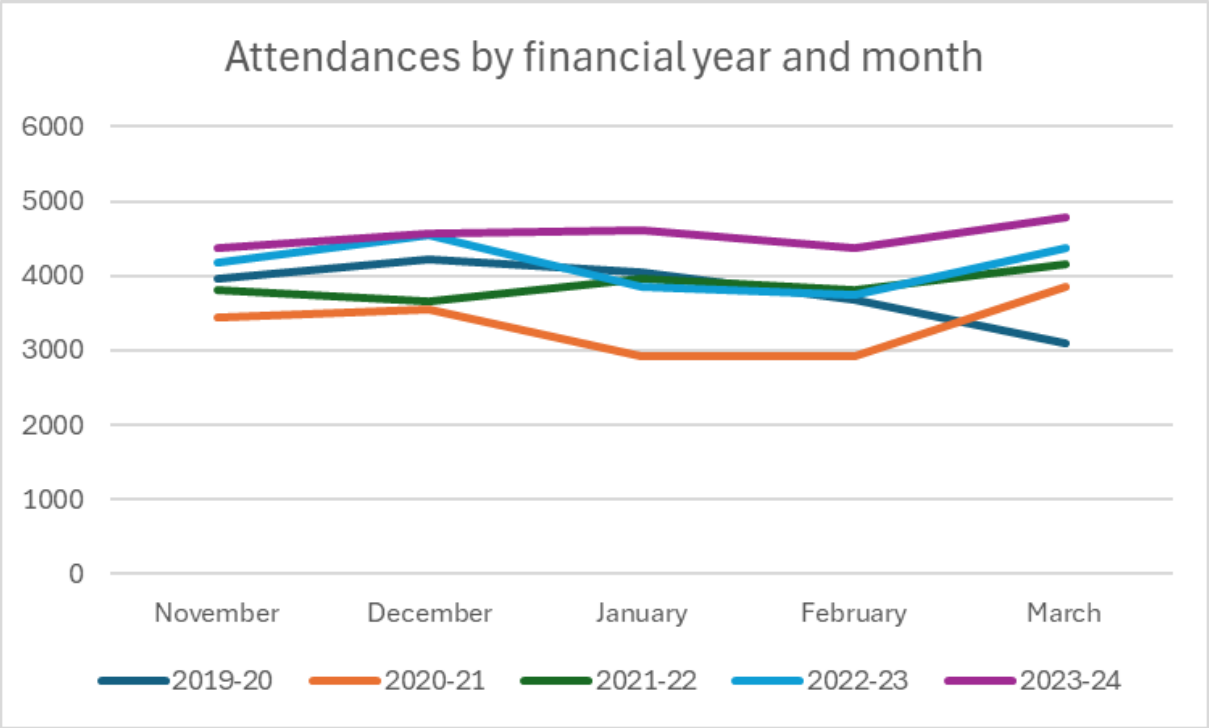
DORSET COUNTY HOSPITAL NHS FOUNDATION TRUST

OPERATIONAL PRESSURE ESCALATION FRAMEWORK 2024/25

TABLE OF CONTENTS

1.0 EXECUTIVE SUMMARY

1.1 Winter typically results in an increase in demand both from seasonally affected conditions and increased risk relating to infection prevention and control outbreaks, and the potential risk of influenza.



1.2 Emphasis for this winter is in ensuring increased winter activity and associated levels of acuity can be managed alongside the risk of increased admissions particularly COVID19, Flu and RSV. Fundamental to this is our ability to maintain essential emergency care services and ensure our patients and staff remain safe, whilst maintaining elective care.

1.3 The increased emergency pressures across the Dorset ICS through the summer period have led to a year-round approach to resilience for urgent and emergency care, with implications on elective services, workforce, wellbeing and financial sustainability. Process changes already made through summer relating to the management of flow and bed capacity will continue through the winter period.

1.4 Our actions this winter are focused on planning and implementing strategies which may only be achieved by delivering our services differently and in collaboration with our partners across Dorset.

1.5 **Key actions:**

- Increase Acute Hospital at Home pathways and introduce new specialties reaching 45 beds by September 2024.
- Improve SDEC capacity including direct referrals for 111 and SWAST.
- Increase front door capacity for non-admitted patients by trialling a UTC in medical outpatients. (required for the NHP build from Q4, 2024)
- Elective plans to focus on cancer and urgent cases during times of pressure and patients that will be over 65 weeks by the end of the reporting month.

- Maximise use of the Voluntary, Community and Social Enterprise (VCSE) sector to release pressure on the Emergency Department (ED), inpatient wards and patient transport.
- High intensity User program with the Red Cross to increase ED avoidance opportunities.
- Continue to contribute to the redesign of the Home First Programme and subsequent remodelling of community services and social care provision to enable patients to return home quickly with increased community support.
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- Continue to work with system partners on system redesign to improve admission avoidance and alternative pathways providing primary care and community alternatives to ED where appropriate.
- Improve access to mental health services from ED reducing the time in department for mental health presentations promoting right care, right place.

1.5 The winter plan for 2024/25 has been informed by feedback received from key clinical and non-clinical staff from within the hospital, a series of system wide meetings and incident management exercises.

1.6 The ICS has prioritised the following actions in preparation for winter 2024/25.

To be updated when ICS plan sent out

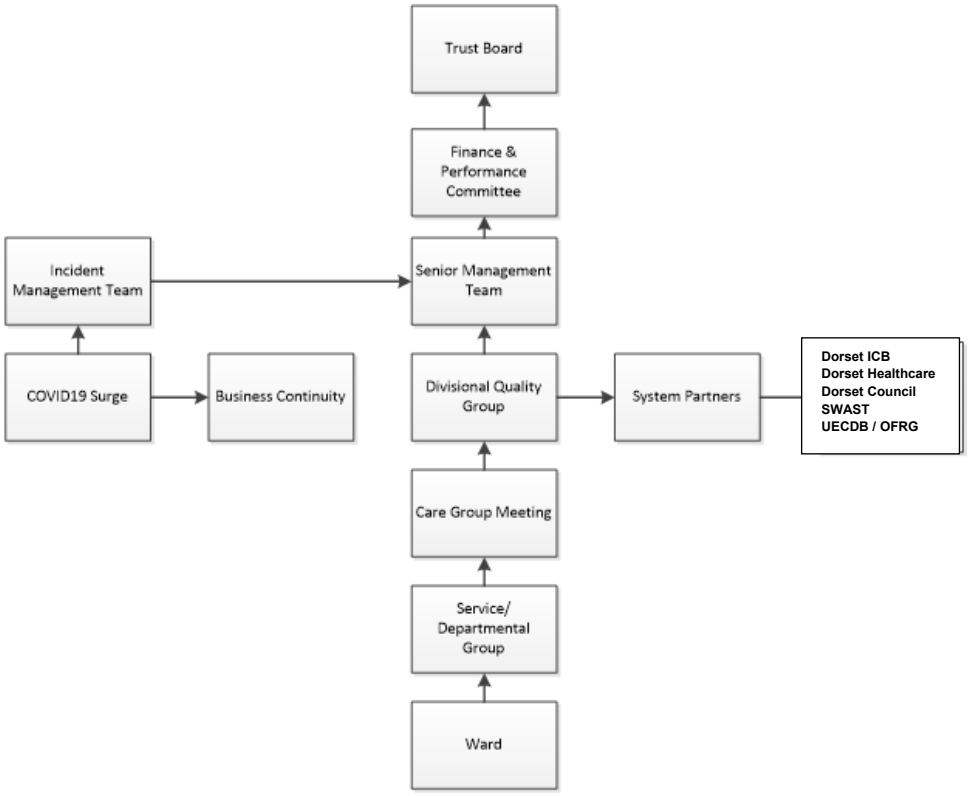
Action	Approach
1. Refreshed demand and capacity analysis	• Build on our BCF planning for intermediate care • Assessing surge capacity requirements in acute and community (health, social care and VCSE) • Impact of flow improvement (LOS reduction)
2. Targeted improvement in key areas *- Communication* *- Educations* *- Optimisation – ways of working*	• Mental health flow improvement • Focus on prevention and admission prevention • Linked to High impact change priority areas - (SDEC, UCR, Virtual Wards, ARI hubs) • Acute and intermediate care flow – early discharge planning and streamlined transfer of care • Optimise utilisation of what we have
3. Strengthened system resilience response	• Enhanced System Co-ordination Centre response • Refreshed escalation processes and risk share approach • Transient Risk Assessment Tool (linked to OPEL)
4. Planning ahead – foundations for next year	• End to end pathway review for UEC • Integrated neighbourhood teams (NAPC) • Integrated place-based intermediate care (Home First)

2.0. RESPONSIBILITIES

2.1 This Plan identifies the corporate and technical strategy for operational management when capacity is predicted to fall short of demand. **All staff without exception** have a shared responsibility to ensure that at times of heightened emergency activity, patient safety is not compromised.

2.2 Responsibilities of staff in relation to this plan are outlined in this document and through business continuity plans.

2.3 The governance process for communication and monitoring of the Winter Plan is: -



3. WINTER SCHEMES

The following outlines key schemes to be in place for winter 2024/25.

Scheme	Objectives	Timescale for Implementation	Partners Leading/Involved	Level of Impact (Safety, Patient Experience, Operational)	Expected Benefits	Performance Impact
Readmissions audit	1. Snapshot inpatient audit undertaken. 2. QI short term wins plan in place ahead of winter 3. Reduction of readmissions into acute care.	Part of wider patient flow strategy and demand and capacity re-design. Short, medium and long term priorities to be identified.	System Partners	High	• Reduced LOS, reduced NRTR, increased admission avoidance and reduction in readmission.	• Improvements in length of stay, improved patient experience and opportunities for earlier appropriate discharge.
High intensity user program in collaboration with Red Cross for Weymouth and Portland patients.	1. Identify high intensity users. 2. Prevention of frequent attendance 3. Better support network for patients	August 2024 onwards	Red Cross ICS- AAA program	High	• Identify the needs of HIU to avoid ED attendances • Improving resilience and wellbeing of our teams • Additional support for vulnerable patients on return home • Release pressure on care needs for people leaving hospital	• Reduce ED attendances • Reduce the risk of reattendances/readmission • Reduce the risk of inappropriate admissions • Reduce ED attendances

					• Reduce pressure on system partners and Acute Trust Front door services	• Reduce the risk of reattendances/readmissions. • Reduce the risk of inappropriate
Extend pathways for Acute Hospital at Home (Part of Virtual Wards model)	1. Increase remote monitoring in specialty pathways 2. Gynae pathway 3. Oncology pathway 4. Suspected stroke pathway 5. Paediatric Pathway (virtual wards)	Commence from October 2024-ongoing		High	• Increased capacity for acute patients • Improve collaboration across the system (acute/community services) • Restructured to compliment Home First future model. • Capacity to consistently extend pathways into a wider range of services. • Review and pull-out Pathway-1 (P1) patients daily	• Reduced length of stay for key services • Avoid admissions (SDEC pathway integration)
Extension of Front Door Pathways Baker,Abi 03/10/2024 16:29:16	1. Increased senior clinicians in ED/Triage during peaks 2. Implementation of UTC model & frailty SDEC as an alternative to ED 3. Increased specialities into	1 December 2024 ongoing	Links to working together programme for frailty, admission avoidance	High	• Support reduction of patients in ED and access to specialty support earlier • Increase morale for staff with the extension of speciality support and clinical guidance • Reduce corridor care and paramedic co-horting	• Improvement in ED performance and 4 hr safety standard. • Reduction in time to assessment and treatment. • Increase in admission avoidance. • Reduction in ambulance

	SDEC including Oncology 4. Increased use of Acute hospital at Home from front door services to avoid admission					
Reconfiguration of acute hospital bed base	5. Maximise efficiency of bed base 6. Avoid short stay (<48 hours) surgical admissions where alternative pathways 7. ED escalation space and protocols are in place	1 December 2024		High	• Reduce the risk of escalation space (including corridors) for inpatient care • Patients to receive their care in the right place on admission • Reduce length of stay	• ED 4 hour standard • Reduce the risk of elective cancellations

4. CAPACITY MANAGEMENT

4.1 ED Capacity Plan

Area	Capacity Numbers
Resus	4
Majors HC	5
Majors	10
F2S	11
Ambulance off load	6
EDAU	12 (including MH)
Waiting room	25 (including See and treat)
See and Treat and triage	2
Ledger room	1
Total	76

Escalation Capacity

Area	Capacity Numbers
Queue out (specialty patients for admission)	6
Queue in (ambulance corridor)	6
Total	12

See also Appendix 1 for ED escalation plan in support of redirecting patients, admission avoidance, rapid review of patients, and specialty referral escalation.

The department continues to manage capacity to manage ambulance handovers using Fit to Sit and the ambulance off load fast assessment bay. At times of escalation the department follows the Trust escalation policy using major incident corridor to queue out for stable patients and then queue in ambulance patients with support of SWAST providing a co-horting paramedic.

4.2 Inpatient Ward Capacity

The comparative inpatient bed base for winter 2023/24 and 2024/25 is shown in Appendix 3.

4.3 Critical Care

Critical Care will be able to provide care to a maximum of 18 patients

Due to the space available within each area, bed spaces will need to be sacrificed for equipment and the provision of complex care to deliver Level 3 care.

Phase	Location	Action	Cumulative Capacity
Business as Usual	Critical Care	Distribute 8 nurses according to patient acuity, with supernumerary NIC.	8 level 3 beds or 11 mixed beds (e.g. 5 level 3 + 6 level 2).
Escalation	Critical Care	Utilisation of all 12 bed spaces	12 beds (1 bed above funded capacity)
Pressure	Critical Care + South Wing Recovery	Use recovery for additional 2 bed spaces	14 beds
Emergency	Critical Care + South Wing Recovery + Theatres 3+4	Create up to two bed spaces in each South Wing Theatre	18 beds

If patient numbers exceed 14 mixed level 2 + 3, with no clear de-escalation of care with any of our inpatients within 12-24 hrs then the Major Incident: Mass Casualty framework should be referred to.

Prioritisation should be given to Critical Care step-downs, in balance with ED pressures, aiming for the allocation of a ward bed within the 4 hours GPIC standard. It should be noted (and actioned as appropriate) in the bed meeting, whether there is capacity to admit within the Stroke and Cardiology wards; if there is no capacity, this may add additional pressure to the Critical Care who may be called upon to temporarily (should be no more than 24hrs) care for Stroke/ Cardiology patients within their footprint. Critical Care need to retain the ability to admit a level 3 patient at all times; they will not be able to accommodate surge activity from other areas, such as Stroke or Cardiology without retaining this capacity

Adult Critical Care Escalation Plan-
http://sharepointapps/clinguide/CG%20docs1/2205-Adult-critical-care-esc-plan.pdf

4.4 Infection Prevention Control (IPC) Surge Plan

A plan has been established to manage the isolation of patients who are admitted with respiratory viruses such as COVID-19, Flu A and B and Respiratory Syncytial Virus (RSV) during the winter. Cohorting of infectious patients with the same confirmed respiratory infection can be considered when single rooms are in short supply. Infectious patients who must not be cohorted with others include:

- Those at increased risk of acquisition and adverse outcomes resulting from infection (e.g. immunocompromised).
- Individuals who are unlikely to comply with Transmission Based Precautions in a cohort setting.

The decision to enact the IPC Surge Plan would be triggered by the Trusts' Incident Management Team (IMT).

The decision to cohort infected patients is based on: -

- Number of COVID19+/Flu/RSV patients requiring admission / already in hospital
- Presenting need on admission
- The safe and effective isolation of patients, including patients with other infections.

- Capability to support Adult, ITU and Paediatric surge plans independently or simultaneously.
- The subsequent plan to reallocate staffing resources (4.5) is a key consideration in delivering the plan arising from the decision.

Trust Fluid Resistant Surgical Mask wearing Guidance:

Currently there is no requirement for wearing a surgical mask as part of normal working, unless caring for a patient requiring respiratory or protective precautions. As we move towards winter, the trust may need to change current mask wearing guidance. The guidance changes will depend on Nationally, Regionally and NHS Dorset system wide agreed triggers and follow a standardised approach. We will aim to align any guidance changes as a Dorset Integrated Care System, although this may not always be achievable depending on our own risk assessments and hierarchy of controls.

Dorset County Hospital (DCH) Infection Prevention Control IPC team collaboration with Dorset Health Care (DHC):

To support flow within the trust and wider community trust, Dorset Health Care IPC lead has agreed several IPC actions:

- DCH IPCT to attend all outbreak meetings during the winter and vice-versa. The aim of the attendance will be to ensure collaboration and the best use of empty beds throughout the two trusts. DHC IPC lead has agreed that the admission of certain respiratory infections into outbreak areas within the community hospitals, if they are the same organism, and this should be considered and agreed during the outbreak meetings. Following National guidance in relation to co-horting of infectious patients where appropriate.
- A consistent approach, with regards to IPC, when considering admissions into Dorset wide community hospitals.
- DHC have agreed to admit patients to continue isolation, and they will ensure action cards are updated and will share with DCH.
- If a ward has enough empty beds, to consider co-horting a group of patients from DCH with the same virus i.e., COVID 19 from an IPC perspective could be accommodated in extremis.
- Both DCH and DHC are both working to the same timeframe for stepping down the outbreaks and will be discussed as a group during outbreak meetings.
- The clinical judgement and expertise of the staff involved in a patient's management and the IPC team should be sought, particularly for the application of Transmission Based Precautions, isolation prioritization and when single rooms are in short supply. The patient must also be clinically stable prior to transfer.

De-escalation of covid-19, Flu and Respiratory Syncytial Virus (RSV) DCH inpatients

The IPCT can support and advise the medical teams to review and de-escalate depending on symptoms and the guidance below:

De-escalation of inpatient Covid 19 – Continue isolation for 5 full days after onset and then review de-escalation with medical team, who will look at resolution of fever and symptoms, unless the patient is immunosuppressed. If immunosuppressed, the patient will require initially a repeat 14-day covid PCR and then weekly covid PCR swabs, until covid PCR negative, please discuss with IPC/micro as required.

De-escalation of inpatient Flu - Continue isolation for 24 hours after resolution of fever and respiratory symptoms, minimum 5 days after onset.
If symptoms persist, isolation can be discontinued 7 days after onset unless the patient is immunosuppressed. If immunosuppressed, then discuss with IPC/ Micro.

De-escalation of inpatient RSV: For duration of respiratory symptoms, particularly if coughing. If symptoms persist, isolation can be discontinued 7 days after onset, unless the patient is immunosuppressed. Immunosuppressed patients may remain infectious for a longer time period. They should be discussed with the IPC team and will need two sets of negative RSV swabs (nose and throat) at least 24 hours apart before isolation restrictions are lifted.

IPC weekend working

During the winter months, and to be agreed by the IPC lead specialist nurse, the IPC team will cover reduced hours over the weekend, this will commence when deemed necessary. Dorset Health Care IPC team also plan to implement a similar weekend working plan.

4.5 **Ward Staffing Plan**

Mitigations are in place to provide safest staffing levels across ED and the inpatient ward areas.

The following strategies are being undertaken to support staffing of inpatient wards:

- Both divisions are actively recruiting to fill substantive vacant posts
  - Rolling health care support worker (HCSW) & registered nurse (RN) adverts continue together with a scholarship scheme to recruit young people wanting to start a health career. The Trust is also working with partners including DWP to support people wanting a career change into health – offering pathways to registration.
  - We are supporting retention initiatives such as career conversations, flexible working and employability skills workshops.
  - Approaching all bank staff to encourage them to consider a fixed term contract and for all substantive staff to take up a bank contract.
- 8-week roster planning and publication is in place to ensure staffing gaps are identified early facilitating early escalation to bank and low-cost agencies, in line with the high-cost agency reduction group.
- Use of bank and low-cost agencies and use of flexible/work life balance staff, including block booking, are the default to cover gaps and are being efficiently and effectively deployed to
  - support normal bed base.
  - provide additional cover for sickness and other absence.
  - escalation area needs.

- Rosters are monitored to support ward processes and ensure leave is spread across all weeks and gaps are proactively filled.
- Assessment of education / study leave based on pressures and known staffing levels.
- Plan for additional junior doctor cover, particularly post bank holidays and in support of areas where capacity is escalated.

4.6 **Elective Surgery**

All non-urgent inpatient elective surgery will stop from Tuesday 24 December 2024 until Thursday 2 January 2025.

From 3 January 2025, non-urgent inpatient elective surgery will be phased in to build up to normal levels of activity from the 13 January 2025. Phasing will be specific to accommodate individual requirements and will be based on plans at the time.

The Trust will continue with day case and 0 length of stay as appropriate.

Elective activity will continue through the winter period.

4.7 **Pathology**

The winter months see an increase in cases of Flu, Covid and other respiratory infections. To minimise the impact on patient flow rapid testing for COVID, Flu A/B and RSV will be available from a single patient swab processed on the GeneXpert platform based in ED and paediatrics. Post analytical processes have been optimised to ensure that results are made available as early as possible to help inform decisions to admit, discharge or cohort patients.

Our microbiology and infection control colleagues are paying close attention to the Mpox Clade I outbreak and ensuring that preparedness protocols are in place to respond to any potential cases.

Introduction of a harmonised IT across the Dorset pathology system has increased the ability to provide mutual aid thereby improving resilience of the service at Dorset County Hospital.

4.8 **Maternity**

In the event that increasing demand may increase the risk of closure of the Maternity Department at DCH, the Maternity Lead will arrange a resilience meeting with departments from neighbouring Trusts, University Hospitals Dorset NHS Foundation Trust, Yeovil District Hospital, Royal Devon & Exeter General Hospital and Salisbury District Hospital to discuss operational and patient safety risks, agree a plan for the following 24 hours and set a timescale for review. DCH may offer reciprocal support to other Trusts' who may be in a similar position.

4.9 **Bank Holiday Arrangements**

The divisional staffing plans for the bank holiday period will be submitted by 6th December 2024 and held by operational teams for reference. A copy will be held centrally on SharePoint for wider reference.

Emphasis is placed on managing annual leave requests in line with Trust policy, to ensure core services are adequately covered, with expected periods of increased activity around the Christmas and New Year period.

4.10 **Outbreak Plans**

The Infection Prevention and Control Team (IPCT) will continue to maintain daily ward rounds and will assess patients with known infections accordingly.

Outbreaks will be managed by the Infection Control Team in close co-operation with the operational and clinical site management teams in line with national and local policy.

Information relating to Respiratory infection prevalence in the hospital will continue to be fed through the hospital Incident Management Team (IMT) structure. The COVID19 outbreak plan is available on the Trusts' SharePoint site: -

dchftnhs.sharepoint.com/sites/ClinicalGuidance/CG docs1/Forms/LiveDocuments.aspx?id=%2Fsites%2FClinicalGuidance%2FCG docs1%2F2005-COVID-19-Outbreak-policy%2Epdf&parent=%2Fsites%2FClinicalGuidance%2FCG docs1

4.11 **Extended Services**

A range of operational and support services are extending or providing 7-day service cover over the winter period to enable increased flow and capacity for urgent care (Appendix 4).

5. ESCALATION

5.1 OPEL

OPEL parameter	Score						
	0	1	2	3	4	5	6
Mean ambulance handover time	<15 min		15–30 min		>30–60 min		>60 min
ED all-type 4-hour performance	>95%	76–95%	60–76%		≤60%		
ED all-type attendances	≤2%	>2–10%	>10–20%		>20%		
Majors and resuscitation occupancy (adult)	≤80%		>80-100%		>100–120%		>120%
Median time to treatment	≤60 min	>60–90 min	90–120 min		>120 min		
% of patients spending >12 hours in ED	≤2%	>2–5%	>5-10%		>10%		
% G&A bed occupancy	≤92%		>92–95%		>95–98%		>98%
% of open beds that are escalation beds	<2%	2–4%	4–6%		>6%		
% of beds occupied by patients no longer meeting criteria to reside	≤10%		>10–13%		>13–15%		>15%

The Operational Pressure Escalation Level (OPEL) is an indicator of the pressure that the Trust is under and will rise and fall in a controlled manner based on prevailing and anticipated 4 levels of pressure.

Reference to escalation points, action cards and different levels- Useful EPRR Documents - All Documents

This is supported by the Trust Emergency Department Escalation (EDEL) in Appendix 1.

5.2 Bed/flow Management Process

The Bed Management policy supports the management and operation of the hospital site and related functions, in accordance with Operational Pressure Escalation Level (OPEL) framework.

The bed management process has been reviewed throughout the year. Changes have been made that include:

- Revised bed meeting agenda
- Escalation process
- Senior divisional leadership support for every bed meeting
- Internal delays highlighted through the use of the Patient Action Tracker (PAT)
- Escalation of barriers to discharge through weekly ward huddles

6. LINKS TO SYSTEM OVERVIEW

The winter plan reflects and is part of the Dorset ICS approach to managing 'system discharge' and flow.

The System Leadership Board, Senior Executive Group/Integrated Neighbourhood Oversight Group; Urgent and Emergency Care Board (UEC); and Home First Board; all take responsibility for delivery of partnership arrangements to deliver flow.

The ICS winter plan has been produced and will cross reference to key parts of this document, notably, winter schemes, OPEL and system escalation and risk management.

Operationally, the Single Point of Access and Locality Clusters will continue to support hospital discharge and the assessment of patients in their own homes or in a community hospital, where patients require a period of rehabilitation prior to their return home (Appendix 6). Transfer of Care Hub is in place and is under constant review.

7. COMMUNICATION

The winter plan will be shared with staff across the organisation via divisional, departmental, and professional meetings for awareness and feedback. Particular emphasis will be on capacity and escalation processes, communication of information to/from flow (bed) meetings, and the implementation of winter schemes. Monitoring and control will be provided through: -

- Flow (bed) meetings (throughout the day)
- Weekly Ward huddles
- Daily Tactical Resilience Group (TRG) (daily)
- Strategic Resilience Group (SRG) - Stood up as required.
- Existing governance processes (risks, incidents, complaints, staff survey)

8. WINTER PLAN KEY RISKS SUMMARY

The winter plan is an iterative process, and models are in development. There remain a number of risks to service: -

Risk	Mitigation
IPC • COVID19 • Flu • RSV • Norovirus	COVID19/Flu/RSV IPC plan and supporting arrangements are well tested through the pandemic. Bed meetings/IPC will trigger the escalation response based on current predicted inpatient demand. ED, Critical Care, Paediatric and Adult inpatient ward escalation plans are in place. Ensure 75% uptake of vaccine for staff (flu). Ensure all frontline staff continue to adhere to IPC guidelines and Personal Protective Equipment (PPE) is available. Escalate to COVID19 / Flu Policy as directed by PHE. Risk assessment of patients in ED remains crucial for admission avoidance. IPCT will re-enforce infection control practice to inform clinical staff in the lead up to winter. Daily ward rounds and monitoring for increased incidence of loose stools will continue. Direct communication from ICB/S & UKHSA and neighbouring trusts will be

	shared for awareness and appropriate action by DCHFT. The Trust will work with providers to prevent the risk of infection to community hospitals and care homes.
Workforce vacancies and sickness	The People Division will support operational teams with management of sudden sickness and access to temporary staffing. Planning of agency and locum clinicians will include planning for gaps arising from vacancies, planned absence and sickness, including forecast gaps arising from a COIVID19 surge. Use of locum spend should be minimised wherever possible in favour of • Proactive recruitment to vacancies • Recruitment of non-traditional roles to mitigate risks • Short-term incentivisation for groups of staff to provide resilience for anticipated period of pressure Wellbeing services and processes continue to be promoted throughout the Trust. Increase in mental health first aiders to support staff. Teams operating at risk or in business continuity continue to be monitored and reviewed by service leads and immediately escalated through divisional structures if the risk worsens.
Admission numbers continue to grow & outstrip bed capacity (limited escalation capacity to extend bed base)	Same Day Emergency Care (SDEC) to increase referrals direct to GPs, 111 and SWAST with improved streaming from ED. Improved use of Acute Hospital at Home across the Trust and focus on early identification of patients from the front door. Winter schemes and Home First programme to deliver improvements to reduce length of stay/increase out of hospital capacity to support flow. To improve community and primary care provision for suitable patients to avoid conveyance to ED. Admission and attendance avoidance program to reduce ED attendances. Unplanned Escalation areas in extreme or serious pressure (OPEL 3 /4) require executive approval
High numbers of patients who do not meet the reason to reside criteria	Instigate OPEL 3 / 4 Serious Pressure Response Actions Internal improvements identified to reduce internal delays. Supporting information already available through the Patient Action Tracker and Business Intelligence reports. Daily escalation meetings in place
High numbers of patient presenting to ED with mental health conditions (no physical health needs)	Plan is in place for the use of EDAU to support the process and care for patients requiring mental health support or placement. Robust Psychiatric Liaison cover is imperative. Care coordination hubs to improve access to the right care in the right place avoiding ED. Improved triage from ED to the retreat and mental health services.
System-wide failure pushes pressures from	Joint working through system wide UEC Board and supporting action plans across the system through the ICS via resilience calls and actions. Escalation plan includes

neighbouring acute trusts	triggers for escalation through Divisions to Executive and then System discussions up to and including closure of ED to new presentations. UHD and DCH working jointly with SWAST to ensure patients are conveyed to the correct Trust as services reconfigure through NHP service redesign. Clear plan of movement of services across Dorset to plan for patient access and reduce patients accessing services in the wrong place.
Overcrowding in ED	Opening of UTC type model and increase of space of front door services, review of internal standards and specialty pathways out of ED. Fully embedded ED escalation plan.
Measles and Pertussis standard Operating procedures (SOP)	Please find below both the standard Operating procedure for Measles and pertussis. Nationally cases have been increasing during 2024, therefore these SOP's have been produced to support patient pathway and management of suspected and confirmed cases. dchftnhs.sharepoint.com/sites/ClinicalGuidance/CG docs1/Forms/LiveDocuments.aspx?id=%2Fsites%2FClinicalGuidance%2FCG docs1%2F2248-SOP-Measles%2Epdf&parent=%2Fsites%2FClinicalGuidance%2FCG docs1 dchftnhs.sharepoint.com/sites/ClinicalGuidance/CG docs1/Forms/LiveDocuments.aspx?id=%2Fsites%2FClinicalGuidance%2FCG docs1%2F2266-SOP-Pertussis%2Epdf&parent=%2Fsites%2FClinicalGuidance%2FCG docs1
Severe weather	Review local business continuity plans for staff and communicate plans in line with national guidance on expected weather conditions. Include weather warnings in bed meetings where appropriate.

Appendix 1: ED escalation plan

EMERGENCY DEPARTMENT ESCALATION

INTRODUCTION

This policy incorporates the Emergency Department (ED) escalation status setting, ED trigger points and associated action plans.

1. PURPOSE

To escalate crowding and pressure within the department to trigger a Trust wide response to decompress and reduce risk to patient safety within emergency care.

3. ESCALATION STATUS SETTING

The Escalation Status of the Emergency Department will be reviewed hourly using the triggers below. The ED escalation status will be reviewed by the Nurse in Charge (NIC) and will be notified to:

(1) Clinical site manager (CSM)

(2) ED office or ED Management Team bleep 788 (ED Matron, Assistant Service Manager and Deputy Divisional Director) out of hours on call manager through the CSM.

There are 7 triggers which help determine ED escalation status:

- Ambulance offload capacity
- ED arrivals
- Time to be seen by ED
- Specialty opinion and/ or referral for admission
- Time to admission or discharge
- Occupancy within ED
- Workforce

4. NORMAL WORKING

Normal working actions will be governed by the following:

- ED Internal Professional Standards
- ED Internal Clinical Standards
- ED Specialty Specific Agreements

5. ESCALATION ACTIONS

- There is an expectation that all staff within the Emergency Department will work to the Internal Professional Standards at all times. However, in departmental escalation there are additional actions which are expected. These should be performed by either the EPIC or the Nurse in Charge (or another appropriate individual as delegated by either of the aforementioned):

Trigger	Optimal working	Moderate compromise	Severe compromise	Extreme compromise
Ambulance Offload	• No offload delays • Ambulance handovers <15 mins • No queueing ***0 point***	• Ambulance handovers > 15 minutes to off load • And more than 3 queuing • And more than 3 inbound ***1 point (2 if >2 triggers)***	• Ambulance handovers >30 mins to off load in ED • And more than 5 queuing • No CAT 1 identified ***2 points (3 if >2 triggers)***	• Ambulance handovers >60 mins to off load in ED • And more than 7 queuing ***3 points***
ED Arrivals	• Meets average 3-week attendance presentations/hour • No surge presentations during each hour ***0 point***	• 2 consecutive hours of > than 3 week average presentations/hour • Expected patients diverted to ED ***1 point (2 if >2 triggers)***	• 2 consecutive hours of >10 attendance per hour ***2 points***	• >15 patients per hour ***3 points***
Time to be seen by ED	• Patients being seen by a clinician within 1 hour of arrival • Triage time <15 minutes ***0 point***	• Patients waiting between 1-2 hours to be seen by an ED clinician • Triage Time <30 minutes ***1 point (2 if >2 triggers)***	• Patients waiting between 2-3 hours to be seen by an ED clinician • Triage Time > 60 minutes • Time critical conditions >60 minutes to review ***2 point (3 if >2 triggers)***	• >4 hours to be seen by a clinician • >60 minutes to triage ***3 points (4 if >2 triggers)***
Speciality opinion and /or referral for admission	• Specialty opinion where required is occurring within 1 hours of arrival or 30 mins of referral ***1 point***	• Speciality opinion where required is occurring > 1 hours of arrival or 60 mins of referral ***2 points***	• Speciality opinion where required is occurring > 2 hours of arrival / 90 mins of referral ***3 points***	• Specialty opinion where required is occurring > 4 hours of arrival / 120 mins of referral ***4 points***
Time to admission or discharge	• Decision to admit or discharge within 2 hours • Inpatient capacity available for adults and children • Nil admitted and unallocated patients in ED for over 60 minutes • Patient transferred < 60 minutes after ED decision to admit ***1 point (2 if >2 triggers)***	• Decision to admit or discharge within 2 hours • Limited capacity in all specialty divisions • 5-6 referred/admitted and unallocated patients in ED over 60 minutes • Patient transferred > 60 minutes after ED decision to admit ***2 points (3 if >2 triggers)***	• Decision to admit or discharge is >2 hours from arrival • Limited capacity in all divisions • >7 referred/ admitted and unallocated patients in ED • Patient transferred >2 hrs after ED decision to admit ***3 points (4 if >2 triggers)***	• Decision to admit or discharge >3 hours • No capacity within divisions • >10 admitted and unallocated patients in ED • Patient transferred >4 hours after ED decision to admit ***4 points (5 if >2 triggers)***
Occupancy within ED (see optimal occupancy numbers below)	• All areas in ED have capacity • No patients in ED > 4 hours • WR has capacity to accommodate arrivals ***0 point***	• Any one area in ED at capacity • Only 1 resus space • >4 Patients in ED > 4 hours • Limited space in WR for new arrivals ***1 point (2 if >2 triggers)***	• Two areas In ED at capacity • Resus – no capacity • >8 patients in ED >4 hours • WR utilised for unwell patients ***2 points (3 if >2 triggers. 4 if >4 triggers)***	• No capacity across ED • >2 patients REQUIRING Resus (Resus FULL) • Full WRs, patients waiting outside to book in or for space ***points (4 if >2 triggers)***
Workforce (Nursing, Medical, ENP, administrative	• Nil deficits ***0 point***	• 1-2 Medica/Nursing staffing deficits • No skill mix compromised • Nil affect to service provision ***1 point (2 if >2 triggers)***	• 3 Medical/Nursing staffing deficits • Skill mix compromised • Inability to review and assess patients ***2 points (3 if >2 triggers)***	• > 4 Medical/Nursing staffing deficits • No Night SPR • Skill mix and patient ratio compromised • Inability to review and assess patients ***3 points (4 if >2 triggers)***

ED Status	Score
Level 1 – GREEN	0 – 6
Level 2 - AMBER	7 – 11
Level 3 - RED	12 – 17
Level 4 – BLACK	>18

Area	Occupancy	Area	Occupancy	Area	Occupancy
Resus	4	High Care	5	Cohort 1	5
Majors 1-11 + M/H Obs	12	FAB	6	Cohort 2	5
Fit to Sit	9	Waiting room +POD	?20+?15		
EDAU	11				

Actions and Key Responses

1	• Identify patients suitable for direct admission pathways • Identify patients suitable for SDEC, Discharge lounge and waiting room • Timely booking of transport • Divisions to ensure admitting capacity to facilitate flow • Patient to be transferred within 60 mins or prior to 4 hour target of ED decision to admit to an inpatient bed as per internal professional standard • Hospital Ambulance Liaison Officer (HALO) to review ambulance stack and keep department informed of potential conveyances. • Follow trust Ambulance escalation process • Follow Internal Professional Standards
	OUT OF HOURS (Including Weekend Bank Holidays): • EPIC/NIC -> Maintain contact with CSM regarding flow • EPIC and NIC to regularly communicate with each other

2	• **Complete actions in GREEN**
	• EPIC/NIC to conduct board round to identify, allocate and escalate:
	  ○ Consider paediatric direct admissions – ref to Paed escalation -> EPIC to liaise with Paeds Consultant/SpR
	  ○ Review patients and receive plans quickly to include x-ray, CT identification and booking
	  ○ Continue to review patient board/AGYLE hourly
	  ○ By clinical assessment/priority distribute patients to areas that have capacity within ED footprint occupancy
	  ○ EPIC/NIC review Medical and Nursing staffing resources and re-distribute accordingly
	• EPIC/NIC Escalation to ED Service Manager and ED Matron
	• Nurse In Charge (NIC), EPIC, ED Management bleep holder 788 and Clinical Site Manager (CSM) to conduct departmental huddles at **10:00 and 15:30.**
	• ED Matron ED Service Manager Escalate to CSM to assist downstream flow/availability
	• HALO to manage stack and queue/cohort on clinical priority
	• EPIC Review of patients in waiting room
	  ○ NIC/Reception staff to enforce 1 relative with vulnerable/young patients, no relatives with adult patients
	• NIC Review of triage times and redistribute triage support
	• ED Service Manager to Escalate any outstanding medical imaging to radiology, computerised tomography (CT) and Magnetic resonance imaging (MRI) to the relevant department
	• Matron-All transfers to move to Nurseless handover

	OUT OF HOURS (including weekend and Bank Holidays): • NIC Escalation to CSM and On call manager regarding areas of concern, speciality flow and bed availability
3	• **Complete actions in AMBER** • EPIC -> Hold clinically stable walk-in patients in the adult/paed waiting room who have been triaged to a clinical medium risk (Triage 3-5) • Service Managers – Request Specialty teams to attend ED and provide additional medical support-escalate non attendance of specialties • EPIC -> Paediatric patients to be escalated to Paed Consultant for direct assessment to PAU • ED Matron/Service Manger – Review staffing resources and request re-distribution of staff to ED: - Porters - Phlebotomy - Extension of current working hours (permanent and Agency staff) - Patient flow assistance through CSM /Matrons • Follow Ambulance SOP for clinical review of patients on Ambulances-dependent on available resource • Service Manager – Escalate referred and expected patients to Specialty teams • NIC, EPIC, Service Manager and Site Manager: - Conduct departmental huddles 3 hourly if appropriate - Duty Manager/CSM to undertake departmental risk assessment and consider a Trust level escalation • Escalation to Divisional Manager and ED Matron and to attend departmental huddles • ED Service Manger/NIC to liaise with SWAST Bronze to ensure HALO presence in ED if ambulance waits over 30 minutes or co horting enacted
	OUT OF HOURS (Including Weekends and Bank Holidays): • EPIC/NIC -> Registrar's of admitting Specialties to attend ED and review/clerk/admit/discharge patients direct in the ED

4	• **<u>Complete all actions in RED have been completed</u>** Matron and Service Manager-Review next 24-48 hours staffing - Service Manager Discuss with CSM, on call manager, Exec team to consider holding clinically stable patients awaiting transfer to wards outside of the ED footprint – Inpatient corridor or "boarding on wards". • Service Manager-Clinical Specialties to attended ED to clerk and pull expected/referred patients to in-patient areas or discharge within 30 mins. • Service Manager-Duty manager/Site manager ensure escalation to Executive team and discuss the balance of risk within the organisation: - Trust wide response - Enact full capacity protocol - Hold waiting ambulances at ED doors/stack ambulances - Executive on-call to discuss ambulance divert
	<u>OUT OF HOURS (including Weekends and Bank Holidays):</u> • EPIC/NIC Immediate departmental huddle to be undertaken with EPIC, NIC, Duty Manger, Site manager and exec on call • Duty Manager/exec on call to contact Specialty Consultants on call and all specialties to attend ED and review/clerk/admit/discharge patients in ED. • Duty Manager & Exec on call to review increasing ED Nurse/Medical staffing to above template after discussion with EPIC & NIC.

LEVEL	ED process /internal issue	Trust wide request from ED
4	Follow RED actions	Follow BLACK actions
3	Follow RED actions	Follow AMBER actions for the Trust actions
2	Follow AMBER actions	Follow AMBER actions
1	Follow GREEN actions	Follow GREEN actions

Appendix 2: UEC Recovery Plan

Recovery Plan For:	**UEC delivery plan**	**Background**	In January 2023, the national delivery plan for recovering urgent and emergency care services was published, with recognition that recovery of UEC is not confined to ED or ambulance services. It focuses on system and wider Trust collaboration to join up the recovery of elective, UEC and GP access. The plan was further updated in May 2024
Description of Improvement Required	As per the National UEC recovery plan guidance: • Increase Capacity • Grow workforce. • Speed up discharge • Expand new services in the community. • Help people access the right care. • Challenge unwarranted variation.		Year 2 plan guidance: • Maintain capacity from 23/24 • Increase the productivity of acute and non acute services across bedded and non bedded capacity, improving flow, LOS and clinical outcomes • Continuing to develop services that shift activity away from acute hospital settings to settings outside an acute hospital for patients with unplanned urgent needs, supporting proactive care, admission avoidance and hospital discharge.
Measuring progress	In addition to the headline ambitions, the planning guidance sets out that systems and regions should focus on reducing the number of over 12-hour waits in emergency departments (EDs), including for mental health patients awaiting admission to a mental health bed. NHS England will also be regularly considering the following supporting metrics in assessing performance and where additional support may be required: • reducing ambulance handover delays • reducing admitted and non-admitted time in EDs, with an intention of reducing long waits, particularly for mental health patients • maintaining average G&A core capacity across the year at the level achieved in the last quarter of 2023/24, equivalent to at least 99,500 beds nationally, allowing for seasonality • improving length of stay for all admitted patients (specifically emergency admissions with a length of stay of 1+ day) • reducing average delays post discharge ready date (combining the two published metrics (a) the percentage of patients discharged on their discharge-ready date and (b) the average delays for patients not discharged on their DRD) • improving length of stay in NHS commissioned community beds		
• **Current Level of Performance (baseline)**			**Risk Register Ref:**

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• Performance Recovery Target (at the point of full plan delivery)	• 76% of patients meeting 4 hr target by March 2024 • Reduction in ambulance handover delays. Not noted in national UEC recovery plan but >30 minutes handover delays target (95%) (Improved ambulance response times for CAT2 to 30 min on average by 2023/2024) • 12 hour target from time of arrival not Decision to Admit (DTA) • Improve A and E performance with 78% of patients meeting the 4 hr standard by March 2025 • Improve CAT 2 ambulance response times relative to 23/24 to an average of 30 minutes across 24/25.		Date Plan Started:	February 2023
Metric / Area	**Objective**	**Responsibility**	**Timescale**	**Status** **Red – Delayed** **Amber – On Track** **Green - Completed**
Same Day Emergency Care	• Service review against national benchmarking. (Nationally the average SDEC sees 13k attendances per 100k attendances in ED. • Target 70% of medical take through SDEC building to 90% in line with system providers. • Direct referrals from SWAST, 111 and GP to avoid ED Implementation of dedicated Frailty SDEC	Deputy Divisional Director of Operations / SDEC Matron/ Acute Medicine Clinical Lead	Initial capacity increase march 23 completed) Sept-24	
Ambulance delays	• System care co-ordination Hubs for admission avoidance and direct to specialty/ service. Joint SOP DCH and SWAST to provide clear agreement of responsibility and streamline process	Deputy Divisional Director of Operations	Sept-24	
ED improvement plan	• Streaming to alternative services including onsite UTC/ GP OOH service • Weekly targeted plan-capture all improvement opportunities EDAU SOP for clear guidance on agreed use and improvement of internal ED flow.	ED Matron/ Clinical lead/ Assistant Service Manager	Sept-24	
Data Quality and Digital	• Daily Breach validation for data assurance mitigating AGYLE • Ambulance data quality meetings with SWAST to mitigate the national XCAD concerns • ECDS implementation for SDEC and Frailty SDEC and V4 for ED EDS and PAT to include DRD for EDAU • Design and implementation of UTC and SDEC AGYLE modules including patient whiteboard	Digital Transformation / BI	July -24	

Quality and Patient Engagement	• GIRFT- system GIRFT meeting for virtual wards, acute medicine meeting TBC. • National benchmarking for virtual wards, ED and SDEC to review service against organisations of similar size. • CQC- review patient first and paediatric long term plan for ED • Nursing in escalation area SOP developed by divisional Heads of Nursing	Deputy Divisional Director of Operations	March-25	
Flow ward (MAUD) and future Emzone	Increase the size of MAUD pilot to include surgical pathways and explore the impact of larger footprint on LOS across the Trust	Deputy Divisional Director of Operations	Sept-24	
Virtual wards and AHAH	• To build on heart failure remote monitoring and develop new remote monitoring pathways • Introduce Specialty pathways including gynae, oncology, stroke, respiratory and frailty • Implementation of Trust wide PIC/MID line service • Increase to 40 VW beds by September 24 to meet the agreed system trajectory of 290 beds • Reduce LoS in COHO through AH@h support • Implement Step up pathways	Deputy Divisional Director of Operations/ AH@h Matron/ AH@h Lead	Sept-24	
Admission avoidance	• Expand Altogether Care front door pilot across inpatient services • Integrated neighbourhood model to remodel MIU and community services • UTC transformation program with onsite UTC at DCH • DCH healthwatch to understand patient journey and improve long term health conditions reducing the acuity of presentation. • Dorset X-Ray Car to reduce number of falls patients conveyed for imaging • Mental health work with retreat and *to redirect patients from ED*	Deputy Divisional Director of Operations/ ICS UEC Lead	March-25	
Crowding Prevention and Risk management	• An executive-led development of a professional standards document /MOU describing mutual expectations and behaviour of all specialties operating in the ED and adjacent spaces • EDEL levels escalation system for ED inline with system partners • Readmissions audit • Transfer of corridor to specialties including staffing corridor to spread front door risk (Portesham Unit) • Implement senior flow ambulance nurse to improve ambulance delays and XCAD data • Middle grade expansion plan in line with BC to reduce agency spend • Consultant expansion to 14 hour CSR cover through Business planning	Deputy Divisional Director of Operations/ ED clinical Lead/ ED Matron/ Divisional Director of Operations	Sept-24	

Risks to the delivery of the plan: (Risk, Risk Score, Mitigations)	• Estates • Finance • Digital	
Interdependencies	**NHP ED**	NHP ED to open Feb 2027
	Emzone	The UEC recovery plan focuses on future working and rightsizing for NHP ED with trial of emzone principles. Emzone modelling to be inline with UEC recovery plan.

Appendix 3 – Core and Escalated Bed Base

	Winter 2023/24		Winter 2024/25	
Ward	**Core bed base**	**Unfunded escalation beds available**	**Core bed base**	**Unfunded escalation beds available**
Ilchester (Acute Medicine)	33	0	33	0
Maud Alex	10	0	10	0
Cardiac Care Ward	18	0	18	0
Prince of Wales (Renal)	11	2 (dialysis)	13	0
Mary Anning Unit (Elderly Care)	46	2	38	0
Moreton (Respiratory)	26	0	23	3
Fortuneswell (Oncology)	17	0	17	3
Stroke	24	0	24	0
Ridgeway (Elective)	26 (From April 2024)	0	20 beds 4 chairs	0
Portesham Unit	14 (Until March 2024)	0	0	14
Purbeck (Trauma/Orthopaedic)	27	0	27	0
Lulworth (Surgery)	31	0	31	0
Abbotsbury (Surgery)	29	0	29	0
Evershot (General Medicine)	14	14	14	0
Unplanned Escalation Day Surgery ITU Surgery			 0 8	 12 4
Inpatient Total	**300 (Until March 2024) 312 (From April 2024)**	**18**	**309**	**36**
Medical Day Unit	12	0	12	0
Same Day Emergency Care (SDEC)	12	0	12	0
Acute Hospital at Home	45	0	45	0
Day Case & Community Total	**39**	**0**	**39**	**0**
Maternity	32	0	32	0
Kingfisher	14	0	14	0
Special Care Baby Unit (SCBU)	9	0	9	0
Children Total	**55**	**0**	**55**	**0**

For use with Executive Director authorisation only

Appendix 4 – Extended/7 Day Service Discharge Doctor

Service	Details	Extended Days/Hours	Contact Information
Acute Hospital at Home	New referrals accepted over the weekend.	Saturday and Sunday- 09.00-17.00	Ext. 4944
Discharge Lounge	Extended to weekends	10.00-16.00 Saturday and Sunday	Ext. 5748 or 5927
Discharge Multi-Disciplinary Team (MDT)	Team on site over the weekend to support patients who are ready to leave hospital. 0800-1600, includes access to Social Care	08.00-16.00 Saturday	discharge.team@dchft.nhs.uk ext. 3239
Trusted Assessor Role	Additional post to be extended into ED	Monday-Friday 09.00-17.00. Saturday 10.00-16.00.	Mobile contact via switchboard.
Medical Support	Additional junior doctor support at peak times. Additional twilight shift factored into rota.	Days	Internal bleep system
Pharmacy	On-site support	Saturday & Sunday 09.00-14.30	Ext. 5294
Same Day Emergency Care (SDEC	Plan for extended hours of operation to reduce in-patient admissions support admission avoidance across specialities	Monday to Friday 08:00-22:00 Saturday & Sunday 08.00 - 20.00	Lead Advanced Nurse Practitioner Andy Norman ext. 4522
Temporary Staffing	Support for temporary staffing at weekends	Saturday and Sunday 08.30-14:00	Staffing.enquiries@dchft.nhs.uk
Volunteers	Extension of First point	Monday-Friday 08.00-16.00	Via the discharge lounge.

Appendix 5A

Bed Meeting Agenda

Meeting held in the CSM office and TEAMS

Bed Meeting Agenda 08:30 – 08:45

Attendees Required: CSM, Support Services representative, Discharge Patient Liaison Officer (HTG), Infection Control representative, Trauma coordinator, On call manager, On call executive, Ward representative, Head of Operations, Matrons, ED representative, Manager of the day (both divisions), Discharge team representative, Ward representative, Theatre representative, Pharmacy representative, Temporary Staffing representative.

1. **Risks/reports from overnight (including 12-hour breaches).**

2. **Bed Status Including:**

   - **ED**
   - **ED referred patients without a bed**
   - **EDAU patients**
   - **ED patients for SDEC**
   - **CRCU status**
   - **Theatres and TCI requiring beds**
   - **Repatriations**
   - **EDD/CDD (Updated from wards)**
   - **Paeds & Maternity flow including closures and capped beds**
   - **All Additional open capacity – discuss plan ie: reviews required, ongoing use or de-escalation**
   - **IPC issues relating to flow**
   - **OPEL level and resilience: Is resilience report required?**

3. **Staffing update from staffing Matron**

4. **Urgent and Integrated Care update on operational concerns.** Patient safety and flow.

5. **Family Services & Surgical update on operational concerns.** Patient safety and flow.

6. **Transport**

7. **Support services**

8. **Partner agencies – SWAST issues etc**

9. **Actions:** Please state accountable individuals, response and time required.

Appendix 5B

Bed Meeting Agenda 14:00 – 14:15

Meeting held in the CSM office and TEAMS

Attendees Required: CSM, Support Services representative, Discharge Patient Liaison Officer (HTG), Infection Control representative, Trauma coordinator, On call manager, On call executive, Ward representative, Head of Operations, Matrons, ED representative, Manager of the day (both divisions), Discharge team representative, Ward representative, Theatre representative, Pharmacy representative, Temporary Staffing representative.

1. **Actions from last meeting.**
2. **Bed Status Including:**
    - **ED**
    - **ED referred patients without a bed**
    - **EDAU patients**
    - **ED patients for SDEC**
    - **CRCU status**
    - **Theatres and TCI/trauma requiring beds tomorrow**
    - **DSU activity**
    - **Repatriations**
    - **EDD/CDD –** outstanding and for next day.
    - **Paeds & Maternity flow including closures and capped beds**
    - **IPC**
    - **All Additional open capacity –** discuss plan i.e.: reviews required, ongoing use or de-escalation
    - **OPEL level and resilience:** Is resilience report required?
3. **Update from Staffing Matron**
4. **Urgent and Integrated Care update on operational concerns.** Patient safety and flow.
5. **Family Services & Surgical update on operational concerns.** Patient safety and flow.
6. **Partner agencies –** SWAST issues, ambulance handover delays etc
7. **Any other operational concerns.**
8. **Finalise night plan.**
9. **Actions:** Please state accountable individuals, response and time required.
10. **In exceptional circumstances arrange a 4pm bed meeting-** State who is required to attend.

Appendix 5C

Bed Meeting Agenda 16:00 – 16:15

Meeting held in the CSM office and TEAMS

Attendees Required: CSM, Discharge Patient Liaison Officer (HTG), On call manager, On call executive, Head of Operations, Matrons, ED representative, Manager of the day (both divisions), Discharge team representative, Theatre representative, Pharmacy representative, Temporary Staffing representative.

1. **Actions from last meeting.**
2. **Bed Status Including:**
    - **ED**
    - **ED referred patients without a bed**
    - **EDAU patients**
    - **ED patients for SDEC**
    - **CRCU status**
    - **Theatres and TCI/trauma requiring beds tomorrow**
    - **DSU activity**
    - **Repatriations**
    - **EDD/CDD –** outstanding and for next day.
    - **Paeds & Maternity flow including closures and capped beds**
    - **IPC**
    - **All Additional open capacity –** discuss plan i.e.: reviews required, ongoing use or de-escalation
    - **OPEL level and resilience:** Is resilience report required?
3. **Finalise night plan and discuss escalation areas.**
4. **Actions:** Please state accountable individuals, response and time required.

People and Culture Committee in Common Assurance Report for the meeting held on 23 September 2024

Chair:	Executive Lead:	Date of Next Meeting:
Frances West	**Nicola Plumb**	25 November 2024
Quoracy met?	Yes	
Purpose of the report	To assure the Board on the main items discussed by the People and Culture Committee in Common and, if necessary, escalate any matter(s) of concern or urgent business which the Committee is unable to conclude.	
Recommendation	To receive the report for **assurance.**	

Significant matters for assurance or escalation, including any implications for the Corporate Risk Register or Board Assurance Framework	• Receipt of the revised Board Assurance Framework and committee assigned risks, noting that there was a single set of strategic risks for both Trusts but a separate Board Assurance Framework for each Trust, due to the difference in assurances around those risks. A dynamic document that would be further developed and linked to the Corporate Risk Register for each Trust.
Key issues / matters discussed at the meeting	The committee received, discussed and noted the following reports: **Business calendar** • Workplan brings together PPC from DCH and any developments at DHC. **Committee in Common transition report** **DHC & DCH Strategic Overview and Introduction & People Priorities** **Workforce Key Performance Indicator Dashboard** **WTE reduction and workforce plans** • Within the financial context any system with a deficit position is required to look at WTE and reduce numbers to March 2023 figures. • Vacancy control panel at both trusts with external assessment to monitor vacancies. • Weekly basis system recovery group to look at WTE numbers. **Joint Belonging & Inclusion Strategy Priorities and timeframe** • Committee assured the priorities up to end of financial year and review remaining actions with joint people plan. • Committee requested more detail on supplemented plan and clarity on reporting back to PCC.

Equality, Diversity and Inclusion Annual Report

- Timing of the report was discussed and intention going forward is to align the timing of reports across both trusts. DCH report is to come in November and will align in future years.
- Committee noted and approved progress and recommend to the Board.

Guardian of safe working

- 2 main areas trauma and orthopaedics areas of exception reporting.
- Amount of immediate safety concerns increase from previous quarter. Related to feeling overwhelmed and understaffed.
- Areas of concerns remain as accommodation and access to IT but mitigated through local councils within the organisation.

Workforce Race Equality Standard & Workforce Disability Equality Standard

- WRES data at DCH have seen some improvements particularly in bullying and harassment.
- WDES noted that career opportunity declined and reasonable adjustments and targeting management awareness.
- Concern on how well represented the data is as still a low sample.

NHS Riot Response

- NHSE recommendation to the trusts were for DHC update the refusal to treat policy and DCH social media policy to be reviewed.

Mutually agreed resignation scheme (MARS)

- System wide financial pressures have resulted in a proposed MARS being considered across all Dorset NHS organisations to reduce staff numbers and pay bill.
- MARS is a form of voluntary severance and aims to increase the flexibility to the Trust during a period of change and service redesign in the current financial circumstances.
- Committee noted and approved the Scheme and recommend to the Board.

Board Assurance Framework

Escalations from sub-groups

Decisions made at the meeting	• To align the reporting across both trusts. • To agree the Inclusion and belonging priorities to the end of the calendar year.
Issues / actions referred to other committees / groups	• Recommend the MARS scheme to the Board for approval • Recommend the EDI annual report to the Board for noting.

Report to	Dorset County Hospital Board of Directors, Part 1	
Date of Meeting	09 October 2024	
Report Title	**Quarterly Guardian Report of Safe Working report: Doctors in Training (Apr 2024 – Jun 2024)**	
Prepared By	Dr Jill McCormick, Guardian of Safe Working	
Accountable Executive	Alastair Hutchinson, Chief Medical Officer, DCH	
Previously Considered By	People and Culture Committee in Common	
Action Required	**Approval**	-
	Assurance	X
	Information	-

Alignment to Strategic Objectives	Does this paper contribute to our strategic objectives	
Care	Yes	
Colleagues	Yes	
Communities		No
Sustainability		No
Implications	Describe the implications of this paper for the areas below	
Board Assurance Framework	SR1 – Safety and Quality SR2 – Culture SR3 – Workforce Capacity	
Financial	The guardian of safe working ensures that issues of compliance with safe working hours are addressed by the doctor and the employer or host organisation as appropriate. It provides assurance to the board of the employing organisation that doctors' working hours are safe.	
Statutory & Regulatory	Adhering to requirements of the Junior Doctor Contract 2016	
Equality, Diversity & Inclusion	People Plan Principle – we will improve safety and care by creating a culture of openness, innovation, and learning, where staff feel safe themselves	
Co-production & Partnership	The report is also shared with the Local Negotiating Committee for Medical and Dental staff once seen by PCC.	

Executive Summary

The production of a quarterly Guardian of Safe Working (GoSW) report to the Board is a requirement of the 2016 Junior Doctor Contract. The fourth quarterly report (this report) is also an annual report.

- The is the Quarter 1 Report submitted to the Trust Board by the new Guardian of Safe Working, dates from 01/04/2024 – 30/06/2024.
- It is the view of the GoSW that there is continued support from educational supervisors towards supporting the Exception Reporting system, when clinical need has demanded Junior Doctors work outside of their contractual role.
- In particular there were 61 reports received, 13 were Immediate Safety Concerns (an increase in 7 since the Q4 report of 2023/4).
- Trauma & Orthopaedics continue to have the greatest Exception Reporting (ER) numbers. However, a new rota has been created by one of the Orthopaedic Surgeons with the aim of addressing this issue.
- General medicine also remains to have a higher number of ERs, as this also now encompasses Medical/Clinical Oncology cover on Fortuneswell Ward. Concerns are related to staying later to finish ward rounds.
- Since the annual report we have had 1 junior doctors strike from 27th June 24 – 2nd July 2024, which is covered within this time period

Recommendation
The Board is requested to: • Receive the report for **assurance**

Title of Meeting	**Board of Directors, Part 1**
Date of Meeting	**09 October 2024**
Report Title	**Quarterly Guardian Report of Safe Working report: Doctors in Training (Apr 2024 – Jun 2024)**
Author	**Dr Jill McCormick, Guardian of Safe Working (GoSW)**

Executive summary

1. The is the Quarter 1 Report submitted to the Trust Board by the new Guardian of Safe Working, dates from 01/04/2024 – 30/06/2024.
2. In my limited time within this role there appears to be continued support from educational supervisors towards supporting the Exception Reporting system, when clinical need has demanded Junior Doctors work outside of their contractual role.
3. In particular there were 61 reports received, 13 were Immediate Safety Concerns (an increase in 7 since the Q4 report of 2023/4).
4. Trauma & Orthopaedics continue to have the greatest Exception Reporting (ER) numbers. However a new rota has been created by Miss Rebecca Mills, Orthopaedic Surgeon to attempt at addressing this issue.
5. General medicine also remains to have a higher number of ERs, as this also now encompasses Medical/Clinical Oncology cover on Fortuneswell Ward. Concerns are related to staying later to finish ward rounds.
6. Since the annual report we have had 1 junior doctors strike from 27th June 24 – 2nd July 2024, which is covered within this time period.

Introduction

All eligible doctors in training between April and June 2024 were working under the terms of the 2016 Junior Doctors Contract with 2019 Updates (“the 2016 Contract”) and as such have had access to formally report occasions when their actual working pattern diverged from their contracted work schedules, as “Exception Reports”, for review by the Trust’s Guardian of Safe Working (GoSW).

All work schedules provided to doctors in training within 2024 complied with contractual commitments under the 2016 Contract.

The provision of three quarterly reports and one annual report from the Guardian of Safe Working is a contractual requirement outline in the T&CS of the 2016 Contract.

High level data for Dorset County Hospital NHS trust

Number of training post (total): 203

Number of doctors in training post (total): 168.9

Annual average vacancy rate among this staff group: 36.3

Amount of time available in job plan for Guardian of Safe Working 1 PA

Amount of job planned time for educational supervisor 0.25 PA per trainee

Exception reports

Exception reports by department				
Specialty	No. exceptions carried over from last report (Q4)	No. exceptions raised	No. exceptions closed	No. exceptions outstanding (from June '24)
Acute Medicine	1	6 (2 ISC)	5	1
Anaesthetics	0	1	0	1
Cardiology	0	0	0	0
Renal	0	0	0	0
Emergency Dept	0	5	3	2
Gastroenterology	0	4 (1 ISC)	4	0
General Medicine	0	12	7	5
General Practice	0	6	1	0
General Surgery	0	1	0	1
Geriatric Medicine	2	9 (1 ISC)	4	5
Haematology	0	1	1	0
Obstetrics & Gynaecology	0	1 (1 ISC)	0	1
Respiratory Medicine	0	1 (1 ISC)	1	0
Trauma & Orthopaedics	1	19 (7 ISC)	4	15
Total	4	61 (13 ISC)	30	31

Exception reports by grade				
Grade	No. exceptions carried over from last report (Q4)	No. exceptions raised	No. exceptions closed	No. exceptions outstanding (from June '24)
F1	3	14 (4 ISC)	8	6
F2	1	22 (6 ISC)	6	16
CT1	0	10	6	4
CT2	0	4 (1 ISC)	4	0
ST1	0	6 (2 ISC)	4	2
ST3	0	5	5	0
Total	4	61	33	28

Exception reports (response time) **this is a formal requirement of the annual report*			
	Addressed within 48 hours	Addressed within 7 days	Addressed in longer than 7 days
CT1	3	3	4
CT2	4	0	0
F1	3	3	8
F2	1	3	18
ST1	1	1	4
ST2	0	0	0
ST3+	1	4	0
Total	13	14	34

Work schedule reviews

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

Exception Reports taken to Level 1 Work Schedule Review

Specialty	IMT 1	ST1
Acute Medicine	1	
Geriatric Medicine		1
Total	**1**	**1**

Rota	Total
2023 F1 Med 03/04/2024 - 06/08/2024	
2023 F2 MED 03/04/2024 - 06/08/2024	
Total	**2**

Both of these remain open

Vacancies

Appendix 1 Details all vacancies among the medical training grades during the Q1 of this year, split by specialty and grade.
Appendix 2 – Exception report submission since 2023/4 until Q1 of 2024/4
Appendix 3 – Exception report submission since 2016 – 2023/2024

Fines

There were no fines levied during this period.

Qualitative information

Part of overseeing the Exception Reporting mechanism involves a constant awareness of under reporting and a constant effort to promote appropriate engagement with the mechanism via the Medical Director, DME, GoSW, GMC regional officer and the local BMA representatives.

Within the Q1 Report there were 61 Exception Reports. 13 were Immediate Safety Concerns (ISC), 43 related to hours of working, 3 related to education opportunities, and 13 related to service support available to a doctor.

Within the Immediate Safety Concerns, main themes were related to understaffing within wards from a surgical Rota, Orthopaedics and Medicine, and mostly came from FY1 / FY2, 1 IMT and 1 Orthopaedic STR. Outcomes discussed with education supervisors suggested prioritization within clinical work, consultants have acted down in once instance, and the rota co-ordinator in medicine is to try and fill shifts with locums to maintain staffing levels, as much as possible, which is continuous. This highlights that despite doctors raising concerns, educational supervisors are listening, and plans are made to attempt to address issues.

Clinical pressures in Trauma and Orthopaedics (T&O) have been again raised in this report, with similar Gurdian Reports, as there were 19 ERs (and 13 ISC). This was escalated to Divisional Director of Division B, Miss Audrey Ryan and Miss Rebecca Mills, Orthopaedic Consultant, and she has spent a considerable amount of her own time developing a new rota to improve the surgical experience for trainees by splitting the on call rota into General surgery/Urology and Orthopaedics/ENT for On-call, and we shall await to see if this shows improvement in trainee experience.

The next area to make particular note of is General Medicine, which now encompasses Medical and clinical oncology oversight in the Fortuneswell Ward. Again themes are around work load, staying late. This is an ongoing area of discussion for junior doctor allocation, between the Haemato-oncology junior trainee post, and a locally employed doctor.

Junior Doctor Forum (June 2024)

A Junior Doctors Forum (JDF) continues to meet regularly and I had the pleasure of chairing the first meeting at the end of June 2024. A couple of areas to also mention from this meeting which do fall into the remit of Gurdian of Safe Working and I would like to highlight.

We had the Freedom to Speak Up Gurdian, Lynn Patterson join us to remind Junior Doctors of her role and responsibilities. She also introduced the junior doctor champions within the hospital, Midhun Paul, Htet Arkar Soe Win, and Fiza Azam and of course re-iterating the importance of raising concerns.

Other issues raised were sickness cover on weekends and how to escalate through manager of the day, and a working group looking at locum rates for cover.

Accommodation is still a big issue for Junior Doctors and with an increase in rates, but no quality improvement. And lastly there were a few areas of concern in working conditions for junior doctors in particular wards, with reduced access to computers or a working environment outside of reviewing patients.

Issues Arising

1. There was a delay in issuing a surgical work schedule for August 2024 rotation within Division B for new starting FY1 doctors. Due to the department being without a business manager causing a delay in the required rota information being made available. An apology letter was sent to the Junior Doctors from Carol Mogford, Medical HR advisor, on behalf of the trust in an open and transparent manner, and if any doctors were struggling with shifts support was to made available.
2. T&O remains to be a concern, but through appropriate escalation and excellent engagement and a hard work from Miss Rebecca Mills a new work schedule has been adopted and we shall continue to monitor the situation.
3. Within General Medicine (which now incorporates Medical and Clinical Oncology), further work is needed to establish a better working pattern for Junior Doctors assigned, especially with cover in Fortuneswell ward.

1. Summary

The new Guardian acknowledges the Trust's compliance with the safeguarding aspects of the 2016 Contract; recognises good practice within the Trust and a concerted effort to support Junior Doctors with a reduced workforce, and encourages ongoing ER to further highlight issues. The Gurdian will closely monitor the T&O trainees experience, and look further into General Medicine/ Oncology.

2. Recommendations

The Guardian asks the Board to receive the annual report for assurance of compliance with the safeguarding aspects of the 2016 Junior Doctors Contract.

APPENDICES

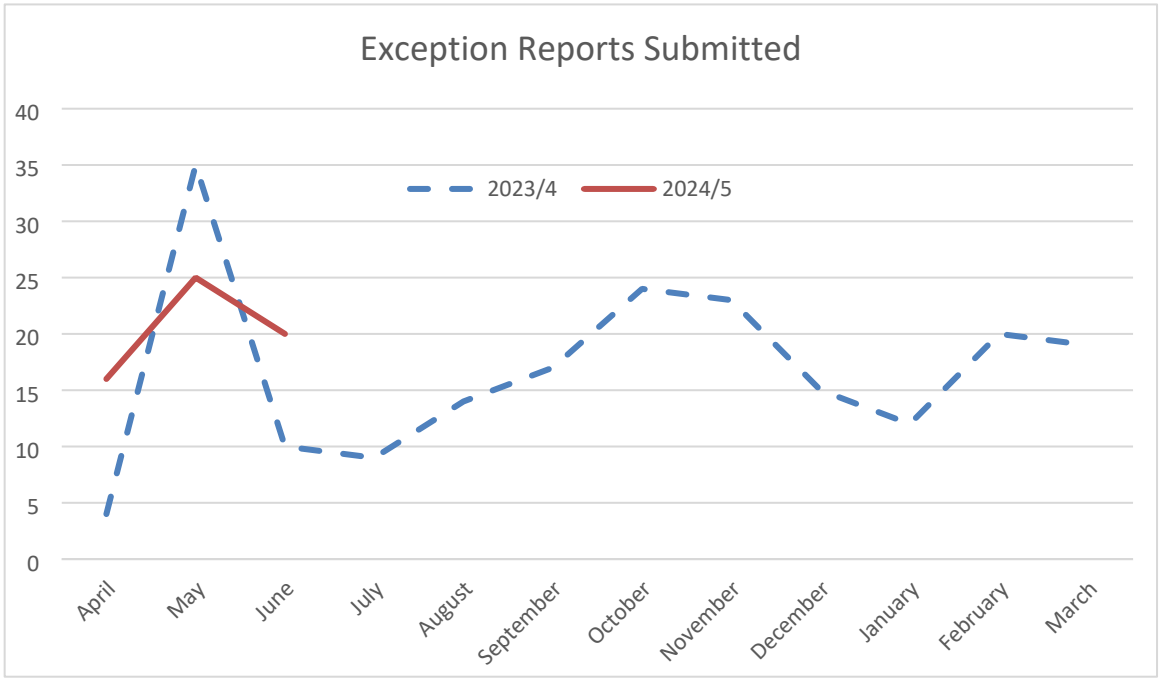
QUARTERLY GUARDIAN REPORT ON SAFE WORKING HOURS: DOCTORS IN TRAINING

APRIL 24 – JUNE 24

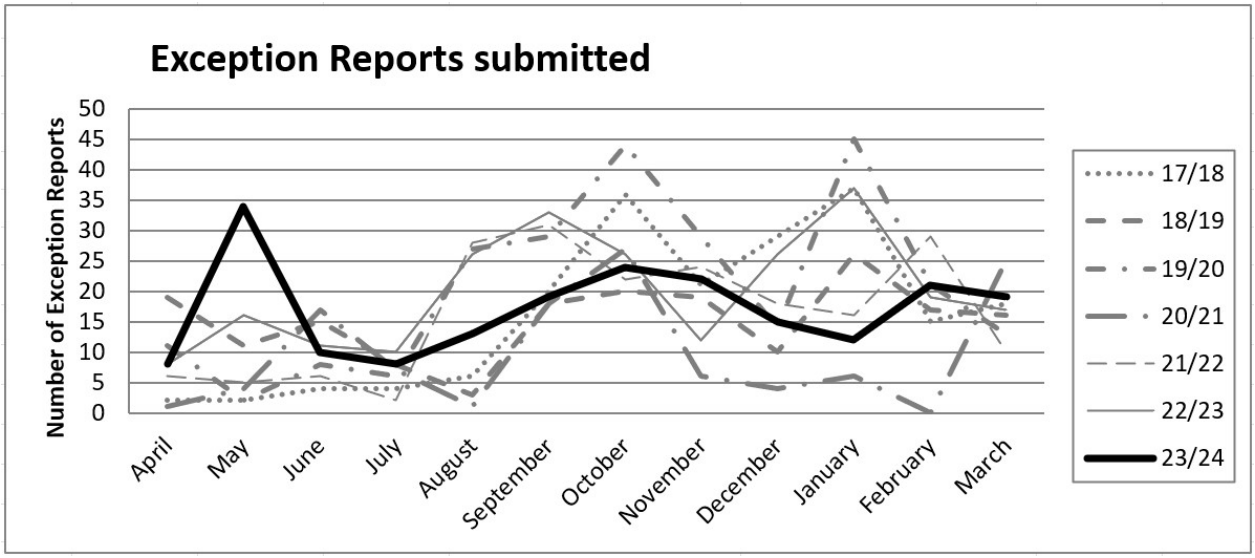
Appendix 1 – Trainee Vacancies within the Trust

Department	Grade	Rotation Dates	Apr 24	May 24	June 24	Average Q1
Paediatrics	ST3	Sept	0	0	0	0
Paediatrics	ST4+	Sept	0.7	0.7	0.7	0.7
O&G	ST1	Oct	0	0	0	0
O&G	ST3+	Oct	0.8	0.8	0.8	0.8
ED	ST3+	Sept and Feb	0.2	0.2	0.2	0.2
Surgery	CT1	Aug	0	0	0	0
Surgery	CT2	Aug	1	1	1	1
Surgery	ST3+	Oct	0	0	0	0
Orthopaedics	ST3+	Sept	1	1	1	1
Anaesthetics	CT1/2	Aug	1.2	1.2	1.2	1.2
Anaesthetics	ST3+	Aug and Feb	1.2	1.2	0.2	1.2
Clinical Radiology	ST1/2	Aug and Feb	0	0	0	0
Medicine	CT1/2	Aug	5.5	5.5	5.5	5.5
Medicine COE	ST3+	March	0.4	0.4	0.4	0.4
Medicine Diab/Endo	ST3+	Aug	1	1	1	1
Medicine Gastro	ST3+	Sept	0	0	0	0
Medicine Resp	ST3+	Aug	0	0	0	0
Medicine Cardio	ST3+	Feb	0.2	0.2	0.2	0.2
Medicine Renal	ST3+	Aug	0	0	0	0
Haematology	ST3+	Sept	0.4	0.4	0.4	0.4
Med/Surg	FY1	Aug	4	4	4	4
Med/Surg	FY2	Aug	0.6	0.6	0.6	0.6
GPST	ST1	Aug & Feb	14	14	14	14
GPST	ST2	Aug & Feb	0.6	0.6	6	0.6
GPST	ST3	Aug & Feb	2.5	2.5	2.5	2.5
Orthodontics	ST3+	March	1	1	1	1
Ophthalmology	ST3	Aug	0	0	0	0
Total			36.3	36.3	40.7	36.3

Appendix 2 – Exception Report submission since 2023/24 and the first Q1 of 2024/5



Appendix 3 – Exception Report submission since introduction of the 2016 Contract



Report to	Dorset County Hospital Board of Directors, Part 1	
Date of Meeting	09 October 2024	
Report Title	Workforce Race Equality Standard (WRES) Report 2024	
Prepared By	Jan Wagner, EDIB Lead & Julie Barber, Head of OD	
Accountable Executive	Nicola Plumb, Joint Chief People Officer	
Previously Considered By	People & Culture Committee in Common on 23 September 2024 where the report was recommended for submission to the Board in line with the Public Sector Equality Duty and statutory reporting	
Action Required	**Approval**	X
	Assurance	-
	Information	-

Alignment to Strategic Objectives	Does this paper contribute to our strategic objectives	
Care	Yes	Staff who feel included perform better in the workplace & positively impacts on the patient experience
Colleagues	Yes	Staff recommend DCH as a place to work, teamwork is improved & supports sustainable workforce.
Communities	Yes	Understanding of diverse staff groups contributes to shaping health & care services
Sustainability	Yes	Skill mix of diverse staff supports releasing time to care & contributes to productivity & effectiveness
Implications	Describe the implications of this paper for the areas below	
Board Assurance Framework	SR2 – Culture SR3 – Workforce Capacity Demonstrates 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.	
Financial	Non-compliance with the PSED would create risks for the organisation in terms of reputation and potential fines.	
Statutory & Regulatory	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.	
Equality, Diversity & Inclusion	The WRES Report 2024 signals our intention to truly value our diverse range of staff & sets out DCH annual performance against the WRES metrics for 2023/24. 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.	

Co-production & Partnership	Championing Equality, Diversity and Inclusion is a key ambition of the Trust's Social Value pledge. Supports delivery of equitable services that are informed by engagement and involvement.

Executive Summary

The attached report 'Dorset County Hospital - Workforce Race Equality Standard (WRES) 2023/4 sets out Dorset County Hospital's annual performance against the WRES metrics for 2023/24.

WRES is mandated by the NHS Standard Contract and applies to all NHS Trusts and Foundation Trusts. The data and narrative will be published on our public website, along with our action plan, in line with regulatory requirements.

The WRES is a data-based standard and uses a series of nine indicators (measures) as a strategic framework for NHS Trusts to address racial inequality. The measures aim to improve the representation and experiences of BME staff across all levels in the NHS, with a key focus on improving representation at senior levels.

The nine indicators encompass workforce data (Indicators 1-4), Staff Survey data (Indicators 5-8) and Board representation (Indicator 9).

Key findings

Overall, we have seen improvements in FIVE indicators and declines in THREE. The final indicator (9) has incomplete data due to the introduction of joint roles across the federation of Dorset County Hospital & Dorset Healthcare, resulting in incomplete ESR information.

Please see the detailed table in the main report attached which includes analysis, next steps and actions.

Recommendation

The Board is asked to approve the Workforce Race Equality Standard data and action plan, and next steps and is receiving this report for assurance and information.

Workforce Race Equality Standard Report

2023-24

Introduction

This report provides an analysis of our annual performance against the Workforce Race Equality Standard (WRES) metrics for 2023-24. The data, along with our action plan, will be publicly available on our website in compliance with regulatory requirements.

The WRES was established by the NHS Equality and Diversity Council (EDC) as a strategic framework for NHS Trusts to address racial equality. Its introduction followed Roger Kline's influential 2014 report, *'The Snowy White Peaks of the NHS'*, which highlighted the connection between high-quality patient care and a workforce that mirrors the diversity of the local community.

Dorset's Black and Minority Ethnic (BME) population remains at approximately 5%, yet BME staff at Dorset County Hospital Foundation Trust make up 18.7% of the workforce, a rise of 3.7% from last year. This figure is likely to continue to grow in the coming years due to increased international recruitment to fill critical roles.

Launched on 1 April 2015, the WRES aims to improve the representation and experience of BME staff across all levels of NHS organisations, with a focus on scrutinising and improving BME representation at senior levels. Within the WRES framework, White staff are defined as those identifying as White British, White Irish, or White Other (Ethnic codes A, B, and C), while BME staff include all other ethnic categories, excluding 'not stated'.

The WRES is comprised of nine indicators, encompassing workforce data (Indicators 1-4), Staff Survey data (Indicators 5-8), and Board representation (Indicator 9):

1. Percentage of BME staff.
2. Relative likelihood of White candidates compared to BME candidates being appointed from shortlisting across all posts.
3. Relative likelihood of BME staff compared to White staff entering the formal disciplinary process.
4. Relative likelihood of White staff compared to BME staff accessing non-mandatory training and CPD.
5. Percentage of staff experiencing harassment, bullying, or abuse from patients, relatives, or the public in the last 12 months.
6. Percentage of staff experiencing harassment, bullying, or abuse from colleagues in the last 12 months.
7. Percentage of staff believing that their trust provides equal opportunities for career progression or promotion.
8. Percentage of staff personally experiencing discrimination from a manager, team leader, or other colleagues.
9. BME board membership.

The data for Dorset County Hospital's 2023-24 WRES submission is based on staff with recorded ethnicity in the Trust's Electronic Staff Records (ESR), with ethnicity data available for 96% of our workforce.

- **Indicator 1** is drawn from ESR data as of 31 March 2024.
- **Indicators 2-3** are based on HR records from 1 April 2023 to 31 March 2024.
- **Indicator 4** reflects ESR data from 1 April 2023 to 31 March 2024.
- **Indicators 5-8** are derived from the national NHS Staff Survey conducted between early October and early December 2023, with results published on 9 March 2024.
- **Indicator 9** is based on ESR data as of 31 March 2024.

The average response rate for BME staff on survey indicators (5-8) was 22%, representing 209 respondents. This is 5.3% **below** the national average of 27.3%.

As part of the NHS standard contract, compliance with WRES is mandatory, ensuring accountability in our efforts to improve racial equality. Non-compliance poses significant risks, not only to the Trust's reputation but, more importantly, to the wellbeing of our workforce.

Overview of changes since 2023/24 data

Fostering an inclusive culture at Dorset County Hospital (DCH) has been a central objective within our People Plan and has renewed focus with the launch of a joint Inclusion & Belonging Strategy, outlining collaborative approaches to improving staff experience across DCH and Dorset Healthcare (DHC), with whom we have a federated alliance. Over the past year, our initiatives to enhance inclusivity have gained significant momentum. We have expanded training on conscious inclusion and inclusive leadership, which have been delivered collaboratively across all NHS Trusts in Dorset, ensuring that these essential skills are widely accessible.

The Overseas Staff Network continues to thrive, now supporting over 400 members across various levels, providing vital assistance to international staff. Meanwhile, the Ethnic Diversity Network has recently elected a new chair and is in the process of relaunching to better support our diverse workforce.

Amidst the current nationwide protests, the CEO has publicly reaffirmed the Trust's commitment to supporting all staff, underscoring our dedication to creating a safe and supportive environment.

Overall, the organisation has seen improvements in five of the WRES indicators, with further progress required in three areas (including more accurate data for Indicator 9). Detailed data can be found in **Annexes A and B**, and our Action Plan is shown at **Annex C**.

Narrative and Implication of the data

Key Indicator 1: *Percentage of staff in each of the AfC Bands 1-9 or Medical & Dental subgroups and VSM (including Executive Board members) compared with the % of staff in the overall workforce*

The number of ethnically diverse staff has risen significantly from 679 in 2022/23 to 905 by the end of March 2024, representing a 3.41% **increase**. This growth reflects ongoing efforts to recruit and retain a more diverse workforce, enhancing the representation of BME staff across all levels. To build on this progress, targeted mentorship and development programmes will support the career advancement of BME staff, particularly at senior levels.

Key Indicator 2: *Relative likelihood of White staff being appointed from shortlisting compared to BME staff*

The disparity in appointment rates following shortlisting has **widened** substantially, with White staff now 5.57 times more likely to be appointed than BME staff, compared to a ratio of 1.51 in the previous year. This significant **decline** highlights an urgent need to address bias in recruitment processes and ensure equitable opportunities for all candidates. We will prioritise the implementation of diverse recruitment panels and anti-bias training for hiring managers to reduce this gap.

Key Indicator 3: *Relative likelihood of BME staff entering the formal disciplinary process compared to White staff (Note: This Indicator will be based on data from a two-year rolling average of the current year and the previous year)*

The likelihood of BME staff entering the formal disciplinary process compared to their White counterparts has **increased** from a nil ratio last year, with a current ratio of 1.2, indicating that disparities remain. To reduce this gap, we will review disciplinary procedures to identify potential biases and provide additional training on fair and consistent application of these processes. Two new workshops for managers are planned for Autumn 2024, one focusing on early action to prevent situations declining, and one focused on fair application of formal proceses.

Key Indicator 4: *Relative likelihood of White staff accessing non-mandatory training & CPD compared to BME staff*

The likelihood ratio has **reduced** from 1.05 to 0.81, indicating that BME staff now have better access to non-mandatory training and CPD opportunities. This positive shift demonstrates progress towards more equitable professional development. To ensure there are no disparities across the workforce, we will work to maintain

the visibility of available CPD opportunities and encourage proactive participation among BME staff through targeted outreach and support.

Key Indicator 5: *Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months*

The percentage of ethnically diverse staff experiencing harassment, bullying, or abuse has **decreased** by 7.8% to 22%, narrowing the gap between White and BME staff to 4%. This improvement suggests that efforts to create a safer work environment are having a positive impact. However, continued focus on anti-bullying campaigns, support services, and clear reporting mechanisms is essential to further reduce these negative experiences and support affected staff.

Key Indicator 6: Percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months

The percentage of staff experiencing harassment, bullying, or abuse from colleagues has **decreased** by 6.6%, dropping from 32.4% to 25.8%, which is the lowest rate recorded in the last five years. The gap between White and BME staff for this indicator has also narrowed to 3.2%, showing reduced disparity. This positive trend indicates progress towards a more respectful workplace environment. However, to continue this momentum, we will work to enhance support systems, such as mediation services and conflict resolution training, and ensure that all staff feel empowered to report incidents without fear of retaliation.

Key Indicator 7: Percentage of staff believing that the Trust provides equal opportunities for career progression and promotion

The percentage of BME staff who believe that the Trust provides equal opportunities for career progression and promotion has **increased significantly** by 12.3% from the previous year to 59.3%, while the belief among White staff decreased by 2.7% to 58.1%. This improvement for our BME staff reflects positive developments in inclusivity efforts. To build on this success, we will work to expand mentorship programmes and career development initiatives tailored to BME staff, ensuring sustained progress and bridging any remaining perception gaps. Whilst the disparity gap is at an all-time low of 1.2%, there is more work to do across the whole workforce to improve career progression and promotion opportunities.

Key Indicator 8: *In the last 12 months have you personally experienced discrimination at work from any of the following? Manager/Team Leader or other colleagues.*

18% of ethnically diverse staff reported experiencing discrimination from managers, team leaders, or colleagues, an **increase** of 1.4% from the previous year. The disparity rate remains similar to last year, with white counterparts reporting 10.2% less experiences of discrimination. This highlights ongoing challenges in fostering an inclusive environment for BME staff. Addressing this requires targeted training for managers on bias, better support mechanisms for reporting discrimination, and clear accountability measures to ensure discriminatory behaviours are effectively addressed.

Key Indicator 9: *Percentage difference between the organisation's Board voting membership & its overall workforce*

This year, it was not possible to provide reliable data for this indicator due to the introduction of new joint roles, which affected access to the necessary ESR data for DHC Board members. This limitation underscores the need for robust data management and accessibility strategies. Moving forward, it is essential to establish clear protocols for data collection and access, particularly during periods of organisational change, to ensure transparency and continued progress in monitoring Board diversity.

The data submitted to the national WRES team is shown in Annex B.

Next steps

Whilst the WRES framework provides valuable insights, it does not fully capture the experiences of our ethnically diverse staff. The 2023 Staff Survey respondents represent only a portion of our BME workforce, highlighting the need for broader engagement and more consistent data collection. Moving forward, our focus

will be on enhancing opportunities for staff to voice their experiences, particularly in areas such as civility, career progression, and professional development. We aim to record, monitor, and address concerns more comprehensively to foster a truly inclusive environment. Our key areas of focus will include:

- **Enhance Communication and Engagement on WRES**: We will increase communication efforts around the WRES, ensuring that all staff understand its importance and how it impacts our commitment to equity. This will include regular updates, targeted communications, and staff forums to discuss progress and challenges.

- **Encourage Participation in Staff Surveys**: To gain a more accurate picture of our workforce, we will actively encourage more staff to participate in the staff survey and declare their ethnicity. We will implement targeted outreach and awareness campaigns to improve response rates and ensure all voices are heard.

- **Establish a Panel to Address Bullying and Harassment**: We will recommend the development of a dedicated panel to investigate reported incidents of bullying and harassment. This panel will work closely with staff networks to provide an impartial and transparent approach to managing concerns, reinforcing our commitment to a safe and respectful workplace.

- **Expand Development and Mentorship Opportunities**: In line with our strategic goals, we will enhance mentorship and career development programmes specifically for BME staff, ensuring equitable access to opportunities that support professional growth and leadership progression.

Annex A

WRES Indicators	2020/21	2021/22	2022/23	2023/24
Indicator 1 Percentage of staff in each of the AfC Bands 1-9 or Medical & Dental subgroups and VSM (including Executive Board members) compared with the % of staff in the overall workforce **See Annex B for detailed breakdown for 2023/24**	White: 3474 BME: 380 Unknown: 196 Total staff: 4052 **Overall BME %: 9.38**	White: 3486 BME: 564 Unknown: 199 Total staff: 4249 **Overall BME %: 13.27**	White: 3564 BME: 679 Unknown: 186 Total staff: 4429 **Overall BME %: 15.33**	White: 3693 BME: 905 Unknown: 231 Total staff: 4829 **Overall BME %: 18.74**
Indicator 2 Relative likelihood of being appointed from shortlisting across all posts ***Relative likelihood of White staff being appointed from shortlisting compared to BME staff***	White: 382 (53%) BME: 83 (47%) **Difference: 6%** ***Likelihood ratio: 1.12***	White: 1324 (69%) BME: 427 (68%) **Difference: 1%** ***Likelihood ratio: 1.01***	White: 1122 (44%) BME: 263 (29%) **Difference: 15%** ***Likelihood ratio: 1.51***	White: 928 (25%) BME: 384 (4%) **Difference: 21%** ***Likelihood ratio: 5.57***
Indicator 3 The relative likelihood of staff entering the formal disciplinary process, as measured by entry into a formal disciplinary investigation ***Relative likelihood of BME staff entering the formal disciplinary process compared to White staff***	White: 19 (0.55%) BME: 3 (0.79%) **Difference: 0.24%** ***Likelihood ratio: 1.44***	White: 17 (1%) BME: 3 (1%) **Difference: 0%** ***Likelihood ratio: 1***	White: 17 0.4%) BME: 6(0.8%) **Difference: 0%** ***Likelihood ratio: 0***	White: 17 (0.46%) BME: 5 (0.55%) **Difference: 0.09%** ***Likelihood ratio: 1.2***
Indicator 4 Relative likelihood of staff accessing non-mandatory training and CPD ***Relative likelihood of White staff accessing non-mandatory training & CPD compared to BME staff***	White: 379 (10.91%) BME: 46 (12.11%) ***Likelihood ratio: 0.90***	White: 1573 (57%) BME: 316 (60%) ***Likelihood ratio: 0.95***	White: 2779 (77%) BME: 503 (74%) **Difference: 3%** ***Likelihood ratio: 1.05***	White: 2156 (58.38%) BME: 651 (71.93%) **Difference: 13.55%** ***Likelihood ratio: 0.81***

Indicator 5 % of staff experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months	White: 21.4% BME: 27.5% **Difference: 6.1%**	White: 24.5% BME: 34% **Difference: 9.5%**	White: 25% BME: 29.8% **Difference: 4.8%**	White: 18% BME: 22% **Difference: 4%**
Indicator 6 % of staff experiencing harassment, bullying or abuse from staff in the last 12 months	White: 26.2% BME: 40.4% **Difference: 14.2%**	White: 26.0% BME: 29.1% **Difference: 3.1%**	White: 24.9% BME: 32.4% **Difference: 7.5%**	White: 22.6% BME: 25.8% **Difference: 3.2%**
Indicator 7 % of staff believing that the Trust provides equal opportunities for career progression and promotion	White: 90.5% BME: 67.2% **Difference: 23.3%**	White: 62.6% BME: 55% **Difference: 7.6%**	White: 60.7% BME: 47% **Difference: 13.7%**	White: 58.1% BME: 59.3% **Difference: 1.2%**
Indicator 8 In the last 12 months have you personally experienced discrimination at work from any of the following? Manager/Team Leader or other colleagues	White: 6.6% BME: 20.0% **Difference: 13.4%**	White: 5.6% BME: 18.7% **Difference: 13.1%**	White: 6.1% BME: 16.6% **Difference: 10.5%**	White: 7.8% BME: 18% **Difference: 10.2%**
Indicator 9 % **difference** between the organisation's Board voting membership & its **overall workforce**	White: 86.7% **Difference: 0.9%** BME: 13.3% **Difference: 4.0%**	White: 93% **Difference: 13%** BME: 7% **Difference: -8%**	White: 91% **Difference: 10%** BME: 8.3% **Difference: -4.2%**	White: 71.43% **Difference: -5%** BME: 7.14% **Difference: -12%**

Annex B Workforce Metrics – Indicator 1

2023-24 Workforce data

		Snapshot of data as at 31st MARCH 2024						
		White staff		BME staff		Ethnicity Unknown or Null		Overall
	Measure	# White	% White	# BME	% BME	# Unknown/ Null	% Unknown/ Null	Total
1a) Non Clinical Staff								
Under Band 1	Headcount	0	0.0%	0	0.0%	0	0.0%	0
Bands 1	Headcount	10	83.3%	2	16.7%	0	0.0%	12
Bands 2	Headcount	316	82.3%	53	13.8%	15	3.9%	384
Bands 3	Headcount	195	92.0%	8	3.8%	9	4.2%	212
Bands 4	Headcount	131	92.9%	6	4.3%	4	2.8%	141
Bands 5	Headcount	85	85.9%	11	11.1%	3	3.0%	99
Bands 6	Headcount	56	82.4%	10	14.7%	2	2.9%	68
Bands 7	Headcount	56	94.9%	1	1.7%	2	3.4%	59
Bands 8a	Headcount	47	90.4%	3	5.8%	2	3.8%	52
Bands 8b	Headcount	23	95.8%	0	0.0%	1	4.2%	24
Bands 8c	Headcount	11	91.7%	0	0.0%	1	8.3%	12
Bands 8d	Headcount	1	50.0%	1	50.0%	0	0.0%	2
Bands 9	Headcount	8	100.0%	0	0.0%	0	0.0%	8
VSM	Headcount	4	50.0%	0	0.0%	4	50.0%	8
Cluster 1: AfC Bands <1 to 4	Auto-Calculated	652	87.0%	69	9.2%	28	3.7%	749
Cluster 2: AfC bands 5 to 7	Auto-Calculated	197	87.2%	22	9.7%	7	3.1%	226
Cluster 3: AfC bands 8a and 8b	Auto-Calculated	70	92.1%	3	3.9%	3	3.9%	76
Cluster 4: AfC bands 8c to VSM	Auto-Calculated	24	80.0%	1	3.3%	5	16.7%	30
Total Non-Clinical	Auto-Calculated	943	87.2%	95	8.8%	43	4.0%	1081
1b) Clinical Staff								
Under Band 1	Headcount	0	0.00%	0	0.00%	0	0.00%	0
Bands 1	Headcount	0	0.00%	0	0.00%	0	0.00%	0
Bands 2	Headcount	491	81.83%	93	15.50%	16	2.67%	600
Bands 3	Headcount	503	88.40%	53	9.31%	13	2.28%	569
Bands 4	Headcount	115	61.83%	66	35.48%	5	2.69%	186
Bands 5	Headcount	353	52.61%	264	39.34%	54	8.05%	671
Bands 6	Headcount	484	83.74%	77	13.32%	17	2.94%	578
Bands 7	Headcount	316	92.40%	17	4.97%	9	2.63%	342
Bands 8a	Headcount	72	90.00%	2	2.50%	6	7.50%	80
Bands 8b	Headcount	21	100.00%	0	0.00%	0	0.00%	21
Bands 8c	Headcount	8	100.00%	0	0.00%	0	0.00%	8
Bands 8d	Headcount	2	100.00%	0	0.00%	0	0.00%	2
Bands 9	Headcount	2	100.00%	0	0.00%	0	0.00%	2
VSM	Headcount	1	100.00%	0	0.00%	0	0.00%	1
Cluster 1: AfC Bands <1 to 4	Auto-Calculated	1109	81.8%	212	15.6%	34	2.5%	1355
Cluster 2: AfC bands 5 to 7	Auto-Calculated	1153	72.5%	358	22.5%	80	5.0%	1591
Cluster 3: AfC bands 8a and 8b	Auto-Calculated	93	92.1%	2	2.0%	6	5.9%	101
Cluster 4: AfC bands 8c to VSM	Auto-Calculated	13	100.0%	0	0.0%	0	0.0%	13
Total Clinical	Auto-Calculated	2368	77.4%	572	18.7%	120	3.9%	3060
Medical & Dental Staff, Consultants	Headcount	124	62.00%	51	25.50%	25	12.50%	200
of which Senior Medical Managers	Headcount	1	33.33%	0	0.00%	2	66.67%	3
Medical & Dental Staff, Non-Consultants career grade	Headcount	59	40.69%	74	51.03%	12	8.28%	145
Medical & Dental Staff, Medical and dental trainee grades	Headcount	197	57.77%	113	33.14%	31	9.09%	341
Medical & Dental Staff, Other		2	100.00%	0	0.00%	0	0.00%	2
Total Medical and Dental	Auto-Calculated	382	55.52%	238	34.59%	68	9.88%	688
Number of staff in workforce	Auto-Calculated	3693	76.48%	905	18.74%	231	4.78%	4829

Annex C – WRES Action Plan 2024-25

Our focus remains on enhancing inclusion for all staff, recognising that a diverse and equitable workforce is fundamental to delivering outstanding care to our patients. By prioritising the experiences and development of our ethnically diverse staff, we aim to create a work environment where all individuals feel valued, respected, and empowered to reach their full potential. This commitment not only strengthens our organisational culture but also directly impacts the quality of care we provide, as a diverse workforce brings a wide range of perspectives, skills, and ideas.

The following key actions have been directly derived from the Dorset County Hospital (DCH) Inclusion & Belonging Action Plan. Timescales for each action are included in this plan. Each action aligns with specific WRES indicators, targeting the areas where disparities have been identified. By focusing on these targeted interventions, we aim to reduce inequalities, foster a culture of fairness, and ensure that all staff have equal opportunities to thrive within the Trust.

Objective 1: Recruitment & Retention

Aim: To eliminate the gap between White and BME staff being appointed following shortlisting (WRES Indicator 2).

- **Redesign and Implement Recruitment and Selection Training**
  Enhance training for recruiting managers to include knowledge of unconscious bias, reasonable adjustments, and gender topics, ensuring an inclusive approach in recruitment.

Objective 2: Bullying & Harassment

Aim: To reduce the disparity in experiences of bullying, harassment, and discrimination between BME and non-BME staff (WRES Indicators 5, 6 & 8).

- **Zero Tolerance Approach to Bullying, Harassment, and Discrimination**
  Implement a measurable zero-tolerance approach to reduce incidents, supported by leadership commitment and enhanced reporting systems.

- **Develop and Implement Staff-on-Staff Reporting Systems**
  Work with the Freedom to Speak Up Guardian (FTSUG) to establish a reliable reporting system, ensuring transparent handling of bullying and harassment cases.

Objective 3: Career Progression and Promotion

Aim: To ensure BME staff believe the Trust provides equal opportunities for career progression and promotion (WRES Indicator 7).

- **Embed Career Conversations in Appraisals**
  Embed structured career conversations in the appraisal process to promote development opportunities tailored to BME staff.

Objective 4: Inclusive Resourcing and Talent Development

Aim: Increase representation of BME staff in higher AfC bandings (WRES Indicator 1).

- **Improve Diverse Panel Compositions and Interview Processes**
  Collaborate with staff networks to enhance interview panel diversity and refine questions, ensuring equitable assessment processes.

These actions are directly aligned with the DCH Inclusion & Belonging Action Plan and the WRES indicators, focusing on addressing disparities and promoting an inclusive culture.

Measures of Success

We will assess our progress on the WRES action plan and our broader Equality, Diversity, and Inclusion (EDI) efforts by measuring against realistic and achievable targets. This approach will allow us to continuously learn, develop, and refine our strategies over time. By cross-referencing our actions with relevant data and documents, we will ensure that all areas are progressed in a measurable way. A dedicated dashboard of inclusion metrics will be established to provide ongoing monitoring and evaluation of our progress.

Success will be evidenced by the following outcomes, as measured by our key tools:

- **Visible Commitment to EDI from Leadership**: Board members and leaders at all levels will consistently demonstrate their commitment to equality, diversity, and inclusion, reflecting these values in their actions and decisions.
- **Integration of EDI in Decision-Making**: Board and Committee papers will routinely identify equality-related impacts and outline how these are mitigated and managed, ensuring EDI considerations are embedded in all strategic decisions.
- **Safe and Respectful Workplace**: Staff will report feeling safe from abuse, harassment, bullying, and physical violence while at work. This will be monitored through data sources including the Staff Opinion Survey (SOS), Quarterly Staff Surveys, Electronic Staff Records (ESR), the Equality Delivery System (EDS 2022), WRES, and WDES.
- **Perceptions of Fair Career Opportunities**: Staff will increasingly believe that the Trust provides equal opportunities for career progression and promotion, as evidenced by improved ratios in shortlist-to-hire data.
- **Positive Workplace and Patient Experience**: Staff will recommend the Trust as a great place to work and receive care, reflecting a positive and inclusive workplace culture as measured through the SOS and Quarterly Staff Surveys.
- **Increased Diversity in Leadership**: There will be a marked increase in the diversity of senior management and leadership structures, with improvements noted at Bands 8a and above, tracked through a clear trajectory of progress in workforce demographics.
- **Enhanced Patient Satisfaction**: People using Trust services will consistently report positive experiences, as captured through the Friends and Family Test (FFT) and other patient feedback mechanisms.

Report to	Dorset County Hospital Board of Directors, Part 1	
Date of Meeting	09 October 2024	
Report Title	Dorset County Hospital - Workforce Disability Equality Standard (WDES) Report 2024	
Prepared By	Jan Wagner, EDIB Lead & Julie Barber, Head of OD	
Accountable Executive	Nicola Plumb, Joint Chief People Officer	
Previously Considered By	People & Culture Committee in Common on 23 September 2024 where the report was recommended for submission to the Board in line with the Public Sector Equality Duty and statutory reporting	
Action Required	**Approval**	X
	Assurance	-
	Information	-

Alignment to Strategic Objectives	Does this paper contribute to our strategic objectives	
Care	Yes	Staff who feel included perform better in the workplace & positively impacts on the patient experience
Colleagues	Yes	Staff recommend DCH as a place to work, teamwork is improved & supports sustainable workforce.
Communities	Yes	Understanding of diverse staff groups contributes to shaping health & care services
Sustainability	Yes	Skill mix of diverse staff supports releasing time to care & contributes to productivity & effectiveness
Implications	Describe the implications of this paper for the areas below	
Board Assurance Framework	SR2 – Culture SR3 – Workforce Capacity Demonstrates 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.	
Financial	Non-compliance with the PSED would create risks for the organisation in terms of reputation and potential fines.	
Statutory & Regulatory	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.	
Equality, Diversity & Inclusion	The WDES Report 2024 signals our intention to truly value our disabled staff & sets out DCH annual performance against the WDES metrics for 2023/24. 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.	

Co-production & Partnership	Championing Equality, Diversity and Inclusion is a key ambition of the Trust's Social Value pledge. Supports delivery of equitable services that are informed by engagement and involvement.

Executive Summary

The attached report 'Dorset County Hospital - Workforce Disability Equality Standard (WDES) 2023/4 sets out Dorset County Hospital's annual performance against the WDES metrics for 2023/24.

WDES is mandated by the NHS Standard Contract and applies to all NHS Trusts and Foundation Trusts. The data and narrative will be published on our public website, along with our action plan, in line with regulatory requirements.

The WDES is a data-based standard and uses a series of ten measures (metrics) to improve the experiences of disabled staff in the NHS.

Key findings

Overall, we have seen improvements from last year in SEVEN metrics and declines in TWO metrics It has not been possible to fully analyse metric 10 (percentage difference between the organisation's Board voting membership and overall workforce) due to the introduction of joint roles across the federation, resulting in incomplete ESR information.

Please see the detailed table in the main report which includes analysis, next steps and actions.

Recommendation

The Board is asked to approve the Workforce Disability Equality Standard data and action plan, and next steps and is receiving this report for assurance and information.

Workforce Disability Equality Standard Report

2023-24

Introduction

The Workforce Disability Equality Standard (WDES) Report for the year 2023-24 provides an overview of our organisation's progress and performance in fostering an inclusive and equitable working environment for staff with disabilities. This report marks a continuation of our commitment to transparency and accountability, adhering to the WDES framework mandated by the NHS Standard Contract.

The WDES is a tool designed to drive improvements in the workplace experiences and career prospects of disabled staff within NHS Trusts and Foundation Trusts. It consists of ten metrics that draw upon data from various sources, including local recruitment and HR data, staff records, and the annual NHS Staff Survey. Additionally, metric 9b asks for narrative evidence of actions taken, to be written into the Trust's WDES annual report. These metrics enable us to evaluate our performance systematically, identify areas of concern, and implement targeted actions to enhance the working conditions for our disabled employees.

The data and insights presented in this report cover the period from 1st April 2023 to 31st March 2024, reflecting the most recent analysis of our workforce demographics. The data will be published on our public website, along with our action plan, in line with regulatory requirements.

The NHS Workforce Disability Equality Standard Metrics

The ten key metrics comprise workforce metrics (1-3), Staff Survey metrics (4-9a) and a metric based on Board representation (10).

	The NHS Workforce Disability Equality Standard Metrics
1	Percentage of staff in each of the AfC Bands 1-9 or Medical & Dental subgroups and VSM (including Executive Board members) compared with the % of staff in the overall workforce
2	Relative likelihood of non-Disabled staff compared to Disabled staff being appointed from shortlisting across all posts
3	Relative likelihood of Disabled staff compared to non-disabled staff entering the formal capability process, as measured by entry into the formal capability procedure.
4	Percentage of Disabled staff compared to non-disabled staff experiencing harassment, bullying or abuse *I. From patients/service users, their relatives or other members of the public* II. *From Managers* III. *From other colleagues*
5	Percentage of Disabled staff compared to non-disabled staff believing that the Trust provides equal opportunities for career progression and promotion
6	Percentage of Disabled staff compared to non-disabled staff saying they have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties
7	Percentage of Disabled staff compared to non-disabled staff saying that they are satisfied with the extent to which their organisation values their work
8	Percentage of Disabled staff saying that their employer has made adequate adjustment(s) to enable them to carry out their work
9	NHS Staff Survey and the engagement of Disabled Staff *Part (a): The engagement score for Disabled staff, compared to non-disabled staff* *Part (b): Has your Trust taken action to facilitate the voices of Disabled staff in your organisation to be heard?*
10	Percentage difference between the organisation's Board voting membership and its organisation's overall workforce, disaggregated: *(a) By Voting Membership of the Board* (b) *By Executive membership of the Board*

The 2023-24 WDES data for Dorset County Hospital is based on staff disability information recorded in the Trust's Electronic Staff Records (ESR). Our latest data indicates that **4.88%** of our workforce has disclosed a disability (an increase in 0.5% from last year). There are ongoing efforts to improve transparency and disclosure rates among staff.

- **Indicator 1** is based on data recorded on ESR as of the snapshot date of 31st March 2024.
- **Indicators 2 and 3** rely on HR records covering the period from 1st April 2023 to 31st March 2024.
- **Indicators 4 through 9** are informed by the NHS Staff Survey, conducted over a two-month period from early October to early December 2023, with the survey results published on 30th March 2024.
- **Indicator 10** is similarly based on ESR data as of 31st March 2024.

Our organisation remains committed to creating an environment where all staff, regardless of disability status, can thrive and contribute meaningfully to our shared mission. This report not only outlines our achievements but also highlights the challenges we continue to face in our journey towards full inclusivity.

Overview of changes since 2022/23 data

Fostering an inclusive culture at Dorset County Hospital (DCH) remains a central focus of our new Inclusion and Belonging Strategy (jointly launched with Dorset Healthcare with whom we have a federated alliance). Over the past year, our efforts to support this goal have seen some progress, particularly through the initiatives led by our disability staff support network, Without Limits. The network has played a vital role in raising awareness of disability issues, contributing significantly to the development of a Health Passport and Reasonable Adjustment Guidance. Additionally, we have delivered targeted training for line managers to better equip them in supporting staff with disabilities, including those with autism.

Despite these positive steps, there is a pressing need to enhance the experience of our staff with disabilities. Encouraging greater disclosure of disabilities remains a priority, as our current data shows that only a small percentage of staff have shared their disability status. This disclosure is crucial for accurately tracking our progress and identifying areas where further improvements are necessary. In response, we are committed to implementing a comprehensive Reasonable Adjustment Policy and are actively discussing the establishment of a centralised, trust-wide budget to better support department leaders and staff requiring adjustments.

While we have observed an encouraging improvement in the relative likelihood of disabled staff being recruited compared to non-disabled staff, our recent engagement survey results reveal ongoing challenges. Disabled staff continue to report a need for better career development opportunities, a stronger sense of being valued, and more accessible workplace adjustments. Additionally, there is a clear need to amplify the influence and visibility of our disability and neurodiversity networks. Addressing these areas will be critical as we strive to create a genuinely inclusive environment for all staff at DCH.

Narrative – the implications of the data

The data is attached at Annex A and the WDES Action Plan is shown at Annex B. These actions and associated timescales have been incorporated into the EDI Action Plan which supports the implementation of our Joint Inclusion & Belonging Strategy.

Metric 1: *Percentage of staff in each of the AfC Bands 1-9 or Medical & Dental subgroups and VSM (including Executive Board members) compared with the % of staff in the overall workforce*

The proportion of staff identifying as having a disability has **risen** from 4.28% in 2022/23 to **4.88%** in 2023/24, marking an overall increase of 0.5%. Among clinical staff, the percentage identifying as having a disability has similarly **increased**, from 3.9% in 2022/23 to 5.2% in 2023/24.

Due to low ESR disclosure numbers, no conclusions can be drawn from this data. A breakdown of workforce data for 2023-24 is shown at Annex A.

Metric 2: *Relative likelihood of non-Disabled staff compared to Disabled staff being appointed from shortlisting across all posts*

The relative likelihood ratio of non-disabled staff being appointed from shortlisting compared to disabled staff has **decreased** from 1.14 in 2022/23 to 0.56 in 2023/24. However, we have yet to return to the figures seen in 2020/21, when the ratio stood at 0.38.

Metric 3: *Relative likelihood of Disabled staff compared to non-disabled staff entering the formal capability process, as measured by entry into the formal capability procedure.*

The relative likelihood of disabled staff entering the formal capability process has **decreased** from 4.24 in 2022/23 to **2.83** in 2023/24.

It is important to note that high relative likelihoods can be influenced by the small proportion of the workforce who have declared a disability on the Electronic Staff Record (ESR). If the number of disabled staff in the capability process is small (for instance, fewer than 10 cases**), it is unlikely to indicate any systemic issues.** This year, there was only one case within the Trust involving a member of staff identifying as disabled.

Note on Metrics 4a- 9a
It is important to note that while the ESR records show that **4.88%** of staff have a disability, Metrics 4-9a are derived from our Staff Survey, where **29.83%** of staff have identified themselves as disabled or having a long-term condition. These figures represent a significant portion of our staff who have responded to the 2023 Staff Survey.

Metric 4a: *Percentage of Disabled staff compared to non-disabled staff experiencing harassment, bullying or abuse*

(i) From patients/service users, their relatives or other members of the public

The data indicates a 6% **reduction** in the number of disabled staff reporting harassment, bullying, or abuse from patients, their relatives, or the public, with 22.8% of disabled staff reporting such behaviour. However, the disparity between disabled and non-disabled staff has **increased** by 1.4% to 5.7%, due to non-disabled staff reporting an even greater reduction on this metric.

(ii) From Managers

There was a 1.5% **decrease** from the previous year in the percentage of disabled staff who reported experiencing harassment, bullying, or abuse from managers, with 14.5% of disabled staff affected. The disparity between disabled and non-disabled staff **increased** by 1.0% to 7%.

(iii) From other colleagues

The data shows a 4.6% **decrease** from last year, with 24.2% of disabled staff reporting harassment, bullying, or abuse from other colleagues. The disparity gap between disabled and non-disabled staff **decreased** by from 9.9% to 6.2%.

These metrics remains a critical area for ongoing attention to reduce staff experiences of harassment, bullying or abuse from all perpetrators.

Metric 4b: *Percentage of Disabled staff compared to non-disabled staff saying the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it*

53.6% of disabled staff said that they reported incidents of harassment, bullying, or abuse—a 1.6% **increase** from the previous year, continuing the positive trend over consecutive years. All staff will continue to be encouraged to report such incidents, allowing us to target action more effectively.

Metric 5: *Percentage of Disabled staff compared to non-disabled staff believing that the Trust provides equal opportunities for career progression and promotion*

55.3% of disabled staff reported on this metric, reflecting a 3.8% **decrease** from the previous year. However, the Trust's Staff Survey results for both disabled and non-disabled staff remain above the national average for Acute Trusts. The disparity gap between disabled and non-disabled staff **increased** by from 0.5% to 4.0%.

Metric 6: *Percentage of Disabled staff compared to non-disabled staff saying they have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties*

The data reveals a 4.1% **decrease** for disabled staff, with 24.5% indicating they felt pressured to work despite not feeling well enough. The disparity gap between disabled and non-disabled staff has **reduced** from to 10.5% to 6.5%.

Metric 7: *Percentage of Disabled staff compared to non-disabled staff saying that they are satisfied with the extent to which their organisation values their work*

Satisfaction among disabled staff slightly **increased** by 0.3%, with 36.8% expressing satisfaction. Additionally, the gap between disabled and non-disabled staff **increased** from 9.9% to 11.6%, with non-disabled staff reporting a bigger increase in feeling valued.

Metric 8: *Percentage of Disabled staff saying that their employer has made adequate adjustment(s) to enable them to carry out their work*

This metric shows a further **reduction** of 1.6% from the previous year, in contrast to the national average, which has increased by 1.6%.

Metric 9: *NHS Staff Survey and the engagement of Disabled Staff*

Part (a): The engagement score for Disabled staff, compared to non-disabled staff

This year, the engagement score for disabled staff has slightly **improved** to 6.71 likewise for non-disabled staff (to 7.19), with the disparity remaining 0.5% between the two staff groups.

Part (b): Has your Trust taken action to facilitate the voices of Disabled staff in your organisation to be heard?

We answered 'yes' to this question. The 'Without Limits' Staff Support Network plays a pivotal role in advocating for its members, ensuring they receive the necessary adjustments and a supportive work environment. The network chair has a standing agenda item on the Equality, Diversity, and Inclusion (EDI) steering group.

The network has already made commendable progress in enhancing the experience of disabled staff, including: (a) Supporting the development of Reasonable Adjustment Guidance (b) Co-designing a Health Passport available to all staff

Metric 10: *Percentage difference between the organisation's Board voting membership and its organisation's overall workforce.*

This year, it was not possible to extract reliable data for comparison purposes on this metric due to the introduction of new joint roles and lack of access to the ESR data for members on the DHC ESR system. **The submitted data can be found in Annex A.**

Next steps

With the board's approval of the new joint **Workforce Inclusion & Belonging Strategy**, our next steps will focus on aligning the following activities with the WDES indicators, with the aim of achieving measurable improvements over the next 12-18 months:

- Develop and implement a Reasonable Adjustment Policy, ideally supported by a centralised trust budget for reasonable adjustments.
- Participate in the NHS Employers Diversity in Health and Care Partners Programme.
- Enhance awareness around supporting colleagues with disabilities and making reasonable adjustments, incorporating this into the induction process for new managers.
- Strengthen support for neurodivergent staff, enabling them to excel in their roles.
- Collaborate with staff networks to improve the diversity of panel compositions and interview questions.
- Review and refine the system for making Reasonable Adjustment requests.

Further details can be found in Annex B.

Our Workforce Inclusion & Belonging strategy and action plan are regularly reviewed and refined, with progress measured using both quantitative and qualitative data as part of the monthly People Dashboard.

The WDES findings will be shared with the 'Without Limits' Staff Network and the EDI steering group to ensure that our Action Plan fully addresses the needs of disabled staff and identifies any additional areas for improvement across the Trust.

Annex A - WDES National Metrics Report

Detailed below is the organisation's WDES data which was submitted in May 2024 covering the period 1 April 2023 – 31 March 2024.
Where data is available, year-on-year comparisons have been made.

Metric 1: Percentage of staff in AfC pay bands or medical and dental subgroups and very senior managers (including Executive Board members) compared with the percentage of staff in the overall workforce. (Data source: ESR)

Note: *Due to the low percentage of staff recorded as having a disability on the ESR (4.88%), it has not been possible to draw meaningful conclusions from this data. Additionally, this low percentage raises concerns about potentially identifying individuals at specific grades. As a result, the majority of the data for Metric 1 has been presented in aggregate form.*

NON-CLINICAL				
	DISABLED	NOT DISABLED	UNSPECIFIED	TOTAL
Below Band 1	0	0	0	0
Band 1	0	8	4	12
Band 2	21	322	41	384
Band 3	11	180	21	212
Band 4	9	109	23	141
Band 5	4	85	10	99
Band 6	1	60	7	68
Band 7	5	46	8	59
Band 8 - Range A	2	46	4	52
Band 8 - Range B	0	20	4	24
Band 8 - Range C	0	10	2	12
Band 8 - Range D	0	2	0	2
Band 9	1	6	1	8
All other	0	4	4	8
Total	54	901	129	1084

CLINICAL				
	DISABLED	NOT DISABLED	UNSPECIFIED	TOTAL
Below Band 1	0	0	0	0
Band 1	0	0	0	0
Band 2	46	514	40	600
Band 3	28	484	57	569
Band 4	13	154	19	186
Band 5	30	576	65	671
Band 6	30	477	71	578
Band 7	11	279	52	342
Band 8 - Range A	1	60	19	80
Band 8 - Range B	0	18	3	21
Band 8 - Range C	1	6	1	8
Band 8 - Range D	0	1	1	2
Band 9	0	2	0	2
VSM	0	1	0	1

All other	1	8	1	10
Total	161	2580	329	3070

CLINICAL				
	DISABLED	NOT DISABLED	UNSPECIFIED	TOTAL
Consultant	2	137	61	200
Non-Consultant Career Grade	5	118	22	145
Trainee Grade	14	276	51	341
Total	21	531	134	686

WORKFORCE TOTAL	236	4012	592	4840

Metric 2: Relative likelihood of non-Disabled staff compared to Disabled staff being appointed from shortlisting across all posts

(Data source: Trust's recruitment & ESR data)

Relative likelihood of non-Disabled staff compared to Disabled staff being appointed from shortlisting	**Relative likelihood in 2022-23**	**Relative likelihood in 2023-24**	A figure below 1.00 indicates that Disabled staff are more likely than non-Disabled staff to be appointed from shortlisting
	1.14	**0.56**	

Metric 3: Relative likelihood of Disabled staff compared to non-disabled staff entering the formal capability process, as measured by entry into the formal capability procedure.

(Data source: Trust's HR data)

Relative likelihood of Disabled staff compared to non-Disabled staff entering	**Relative likelihood in 2022-23**	**Relative likelihood in 2023-24**	A figure above 1.00 indicates that Disabled staff are more likely than non-Disabled staff to enter the formal capability process
	4.24	**2.83**	

Metric 4: Percentage of Disabled staff compared to non-disabled staff experiencing harassment, bullying or abuse

(Data source: Q.13a-d, NHS Staff Survey)

4a: % of Disabled staff compared to non-disabled staff experiencing harassment, bullying or abuse from:	**2021**				**2022**			**2023**	
	Disabled staff	Non-disabled staff	% points difference (+/-)	Disabled staff	Non-disabled staff	% points difference (+/-)	Disabled staff	Non-disabled staff	% points difference (+/-)
(i) Patients/service users, their	32.4	23.4	-9	28.8	24.5	-4.3	22.8	17.1	-5.7

relatives or other members of the public									
(ii) Managers	17.2	9.2	-8	16.0	9.9	-6.1	14.5	7.5	-7
(iii) Other colleagues	26.5	20.4	-6.1	28.8	18.9	-9.9	24.2	18.0	-6.1
4b: % of Disabled staff compared to non-disabled staff saying the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it	50.8	44.2	-6.6	52.0	42.0	-10.0	53.6	51.6	-2

Metric 5: Percentage of Disabled staff compared to non-disabled staff believing that the Trust provides equal opportunities for career progression and promotion (*Data source: Q.14, NHS Staff Survey)*

2021			2022				2023	
Disabled Staff	**Non-disabled staff**	**Difference (+/-)**	**Disabled Staff**	**Non-disabled staff**	**Difference (+/-)**	**Disabled Staff**	**Non-disabled staff**	**Difference (+/-)**
60.7	61.7	-1	59.1	58.6	0.5	55.3	59.3	-4

Metric 6: Percentage of Disabled staff compared to non-disabled staff saying they have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties. *(Data source: Q11e, NHS Staff Survey)*

2021			2022				2023	
Disabled Staff	**Non-disabled staff**	**Difference (+/-)**	**Disabled Staff**	**Non-disabled staff**	**Difference (+/-)**	**Disabled Staff**	**Non-disabled staff**	**Difference (+/-)**
27.8	19.6	- 8.2	28.6	18.0	-10.6	24.5	18.0	-6.5

Metric 7: Percentage of Disabled staff compared to non-disabled staff saying that they are satisfied with the extent to which their organisation values their work *(Data source: Q5f, NHS Staff Survey)*

2021			2022				2023	
Disabled Staff	**Non-disabled staff**	**Difference (+/-)**	**Disabled Staff**	**Non-disabled staff**	**Difference (+/-)**	**Disabled Staff**	**Non-disabled staff**	**Difference (+/-)**
39.8	47.0	-7.2	36.5	46.4	-9.9	36.8	48.4	-11.6

Metric 8: Percentage of Disabled staff saying that their employer has made adequate adjustment(s) to enable them to carry out their work

(Data source: Q.26b, NHS Staff Survey – *this question only includes the responses of Disabled staff*)

2021	2022	2023
74.1	71.9	70.3

Metric 9: NHS Staff Survey and the engagement of Disabled Staff

Part (a): The engagement score for Disabled staff, compared to non-disabled staff. The score for disabled staff has **increased** again this year with disparity remaining at -0.5%.

2021			2022				2023	
Disabled Staff	**Non-disabled staff**	**Difference (+/-)**	**Disabled Staff**	**Non-disabled staff**	**Difference (+/-)**	**Disabled Staff**	**Non-disabled staff**	**Difference (+/-)**
6.9	7.2	-0.3	6.6	7.1	-0.5	6.7	7.2	-0.5

(Data source: NHS Staff Survey)

Part (b): Has your Trust taken action to facilitate the voices of Disabled staff in your organisation to be heard? **Yes.**

We were asked to provide at least one practical example of current action being taken in the last 12 months to engage with Disabled staff: *We have a 'Without Limits ' Staff Support Network who meet regularly to advocate for their members to have the necessary adjustments and supportive environment at work. The network chair has a standing agenda item at the EDI steering group.*

(Data source: WDES Submission, May 2024)

Part (b): Has your Trust taken action to facilitate the voices of Disabled staff in your organisation to be heard? **Yes.**

We were asked to provide at least one practical example of current action being taken in the last 12 months to engage with Disabled staff: *The Without Limits staff network group have been co-creating a Health Passport and Reasonable Adjustment Guidance for staff to be able to declare any support needs that they may have.*

(Data source: WDES Submission, May 2024)

Metric 10: Percentage difference between the organisation's Board voting membership and its organisation's overall workforce, disaggregated).

This year, it was not possible to extract reliable data for comparison purposes on this metric due to the introduction of new joint roles and lack of access to the ESR data for members on the DHC ESR system.

Snapshot as at 31/3/24	Disabled %	Non-disabled %	Disability unknown %
Total Board members	6.67	66.67	26.67
By Voting Membership of the Board	7.14	71.43	21.43
By Non-Voting Membership of the Board	0.00	50.00	100
By Executive Membership of the Board	0	50	50
By Non-Executive Membership of the Board	14.29	85.71	0
Difference (Total Board – Overall Workforce)	**2**	-16	14
Difference (Voting membership – Overall Workforce)	**2**	-11	9
Difference (Executive membership – Overall workforce)	**-5**	-33	38

(Data source: WDES Submission, May 2024)

Annex B – WDES Action Plan (EDI Plan and Priorities)

Conscious Inclusion and Collective Responsibility

1. **Zero Tolerance for Bullying, Harassment, and Discrimination (WDES Metric 4)**:
    - We will enforce a measurable zero-tolerance approach to bullying, harassment, and discrimination, directly addressing WDES Metrics 4a, 4b, 4c, and 4d, which focus on the experiences of disabled staff with these behaviours. This will be supported by a clear statement from our Chief Executive and the development of a staff-on-staff reporting system in collaboration with the Freedom to Speak Up Guardian (FTSUG) to improve data quality and support timely action.
2. **Active Bystander Training (WDES Metric 4)**:
    - To further address WDES Metrics 4a through 4d, we will roll out Active Bystander training across the Trust, empowering all staff to challenge inappropriate behaviours and support colleagues who may be experiencing harassment or discrimination.
3. **Task and Finish Groups (WDES Metric 4)**:
    - Establish Task and Finish Groups to ensure that incidents of harassment, bullying, or abuse, particularly those affecting disabled staff, are promptly reported and effectively addressed. This initiative aligns with WDES Metrics 4a to 4d, focusing on improving the reporting and support mechanisms for affected staff.
4. **Respect and Resolution Policy (WDES Metric 4)**:
    - We will develop and implement a new Respect and Resolution policy, which will contribute to WDES Metric 4b by ensuring a cohesive approach to resolving conflicts and supporting disabled staff who experience harassment, bullying, or discrimination.

Inclusive Resourcing and Talent Development

1. **Diverse Panel Compositions and Recruitment Training (WDES Metrics 2 and 5)**:
    - To support WDES Metric 2 (related to the likelihood of disabled staff being appointed from shortlisting) and WDES Metric 5 (concerning equal opportunities for career progression), we will improve the diversity of recruitment panels, particularly for roles at Band 6 and above. Additionally, we will redesign recruitment and selection training to include unconscious bias, reasonable adjustments, and gender awareness.
2. **Positive Action Programmes (WDES Metric 5)**:
    - We will expand positive action programmes, such as Beyond Difference, specifically targeting WDES Metric 5 by supporting the career progression of underrepresented and marginalised groups, including disabled staff.
3. **Career Conversations and Transparency (WDES Metric 5)**:

- Embedding structured career conversations as part of the annual performance appraisal process, we will also introduce greater transparency in promotion, pay, and reward processes. These actions are directly aligned with WDES Metric 5, which measures perceptions of equal opportunities for career advancement among disabled staff.

Equity by Design (Policy, Processes, Practices)

1. **Review and Revise Equality Impact Assessments (EIA) (WDES Metrics 1, 3, and 5)**:
    - We will review and enhance our EIA framework to ensure it is fully embedded as a decision-making tool, impacting WDES Metric 1 (workforce representation), Metric 3 (entry into the formal capability process), and Metric 5 (career progression), by systematically removing barriers that disproportionately affect disabled staff.
2. **Support for Staff with Disabilities (WDES Metrics 7 and 8)**:
    - Occupational Health will continue to support staff who have disabilities or long-term health conditions, ensuring they receive the necessary reasonable adjustments, directly addressing WDES Metric 8. We will also promote Access to Work, further supporting the ability of disabled staff to perform their roles effectively.
3. **Just and Learning Culture (WDES Metrics 4 and 6)**:
    - Launch an awareness campaign to foster a Just and Learning Culture, addressing WDES Metrics 4 (bullying and harassment) and 6 (pressure from managers to work despite not feeling well enough) by ensuring that our policies and practices promote an inclusive and supportive environment.

Inclusive Leadership

1. **Conscious Inclusion and Leadership Training (WDES Metrics 5 and 9)**:
    - To enhance WDES Metric 5 (career progression) and Metric 9 (engagement), all line managers and HR team members will undergo Conscious Inclusion and Inclusive Leadership training, ensuring they are equipped to support diverse teams effectively and foster an environment where disabled staff can thrive.
2. **EDI Objectives for Leaders (WDES Metric 9)**:
    - Including specific, measurable Equality, Diversity, and Inclusion (EDI) objectives in the annual appraisals of all leaders will directly contribute to WDES Metric 9 by holding leaders accountable for fostering an inclusive culture and improving engagement among disabled staff.
3. **Engagement with Staff Networks (WDES Metric 9)**:
    - Senior management and Board members will engage regularly with staff networks, supporting WDES Metric 9 by actively listening to and addressing the concerns of disabled staff, ensuring their voices are heard at the highest levels of decision-making.

These actions are strategically aligned with the Workforce Disability Equality Standard (WDES) metrics and are designed to create a more inclusive environment, addressing specific areas where disabled staff have reported challenges, and ensuring continuous improvement across the Trust.

Measures of Success

Our progress in Equality, Diversity, and Inclusion (EDI) will be systematically evaluated against realistic and achievable targets, allowing us to continuously learn, develop, and improve. By cross-referencing our action plan with data and key documents, we will ensure all initiatives are effectively implemented and their impact is measurable. A comprehensive dashboard of inclusion metrics will be established for ongoing monitoring of progress.

Evidence of success will be demonstrated through the following outcomes:

- **Leadership Commitment**: Board members and leaders at all levels will visibly and consistently demonstrate their commitment to equality, diversity, and inclusion, as evidenced by their participation in training, strategic initiatives, and the integration of EDI objectives into their performance appraisals.
- **Inclusive Governance**: Board and Committee papers will routinely include assessments of equality-related impacts, with clear strategies for mitigation and management, ensuring that EDI considerations are embedded in all decision-making processes.
- **Safe and Supportive Work Environment**: Staff will report feeling safe from abuse, harassment, bullying, and physical violence at work, as reflected in data from the Staff Survey, quarterly staff surveys, Employee Relations data, and WRES & WDES metrics.
- **Fair Career Progression**: Staff will express confidence in the Trust's provision of equal opportunities for career progression and promotion, supported by improvements in shortlist-to-hire data, particularly for underrepresented groups.
- **Positive Workplace Culture**: The Trust will be recommended by staff as a great place to work and receive care, as indicated by the Staff Survey, quarterly surveys, and qualitative feedback.
- **Diverse Leadership**: There will be a marked increase in the diversity of senior management and leadership structures, with demonstrable progress in workforce demographics, particularly at Band 8a and above, in line with a clearly defined trajectory of progress.
- **Improved Staff Experiences**: Disabled staff and those from other underrepresented groups will report improved experiences in the workplace, evidenced by increased engagement scores, satisfaction with reasonable adjustments, and a reduction in negative outcomes as per WDES and WRES metrics.
- **Positive Service Feedback**: Patients and service users will consistently report positive experiences of the Trust's services, as reflected in Friends and Family Test (FFT) results and other patient feedback mechanisms.

These measures of success will guide our EDI efforts, ensuring that we not only meet our WDES obligations but also foster a truly inclusive and supportive environment for all staff and service users.

INTEGRITY | RESPECT | TEAMWORK | EXCELLENCE

NHS
Dorset County Hospital
NHS Foundation Trust

Escalation Report

Committee: Risk and Audit Committee

Date of Meeting: 17th September 2024

Presented by: Stuart Parsons

Significant risks / issues for escalation to Board for action	• The emerging risk relating to fire safety. • Recommendation for the Board to approve the Risk and Audit Committee Terms of Reference • Recommendation for the Board to approve the Standing Financial Instructions including updates to Scheme of Delegation

Key issues / other matters discussed by the Committee	The committee considered the following items:
	• Risk and Audit Committee Terms of Reference
	• Board Assurance Framework, noting the revised template and risk-on-a-page view.
	• Corporate Risk Register
	• Engagement of External Auditors for Non-Audit Services Policy Review
	• Standing Financial Instructions including updates to Scheme of Delegation
	• External Audit progress reports, technical update and benchmarking, noting:
	  ○ The inclusion of enhanced Taskforce for Climate related Financial Disclosures within the recently published Group Accounting Manual for 2024/25, and a broader discussion around addressing climate risk at a system level.
	• Internal Audit Progress and Follow up Reports noting:
	  ○ Updates on the Nurse Agency Reduction and Data Quality RTT audits
	  ○ Global risk landscape report
	  ○ Dorset ICS Advisory report
	• Health and Safety Steering Group Annual Report
	• Sub-group escalations from Health, Safety, Fire and Security Group noting an emerging risk in relation to fire safety.
	• ICB Audit Committee Escalation Report
	• Annual Review of External Audit

Decisions made by the Committee	• Approval of the Engagement of External Auditors for Non-Audit Services Policy Review
Implications for the Corporate Risk Register or the Board Assurance Framework (BAF)	• The revised Board Assurance Framework was reviewed. • The Corporate risk register was reviewed.
Items / issues for referral to other Committees	•

Report to	DHC - Trust Board DCH – Trust Board	
Date of Meeting	DHC - 2 October 2024 DCH – 9 October 2024	
Report Title	Audit Committee Terms of Reference	
Prepared By	Jenny Horrabin Joint Director of Corporate Affairs	
Accountable Executive	Jenny Horrabin Joint Director of Corporate Affairs	
Previously Considered By	DHC Audit Committee – 11 September 2024 DCH Risk and Audit Committee – 17 September 2024	
Action Required	**Approval**	X
	Assurance	-
	Information	-

Alignment to Strategic Objectives	Does this paper contribute to our strategic objectives	
Care	Yes	
Colleagues	Yes	
Communities		No
Sustainability		No
Implications	Describe the implications of this paper for the areas below	
Board Assurance Framework	No specific BAF risks implications. The Audit Committee has responsibility for oversight of the BAF.	
Financial	No financial implications arising from the BAF	
Statutory & Regulatory	The Audit Committee is a statutory committee	
Equality, Diversity & Inclusion	There are no specific EDI implications arising from this report	
Co-production & Partnership	There are no implications for co-production and partnership	

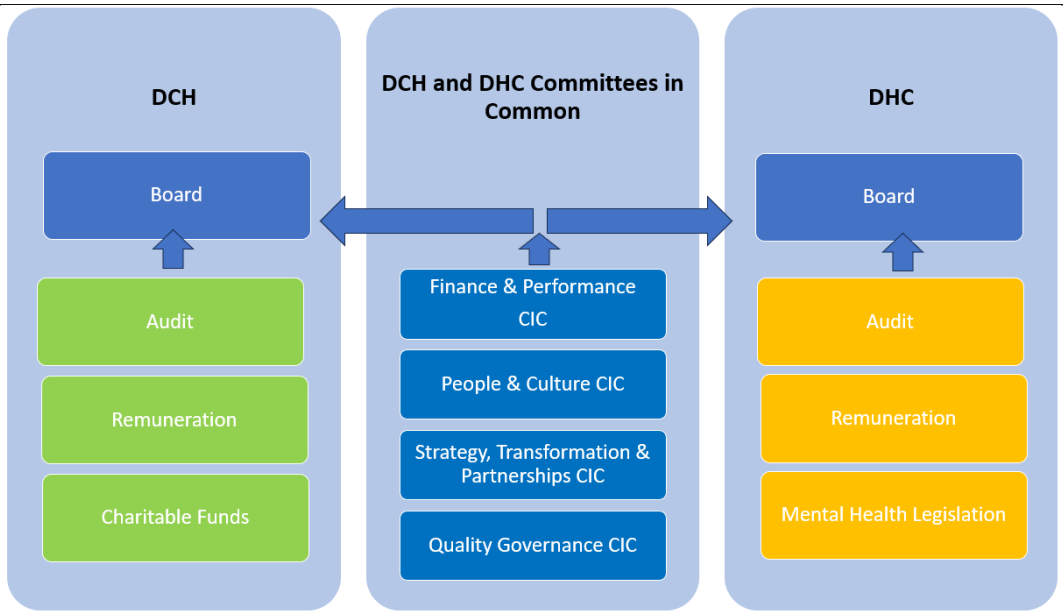
Executive Summary

Executive Summary

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 It was agreed that each organisation would retain a separate Audit Committee but that the scope and membership of the Committees would be reviewed to ensure greater alignment. At the same time the Healthcare Financial Management Association (HFMA) released an updated NHS Audit Committee Handbook, which included an updated model Audit Committee Terms of Reference.

1.5 The Joint Director of Corporate Affairs reviewed the DCH and DHC Terms of Reference and compared to the model and then met with the respective Chairs of Audit to review and agree the proposed amendments. The final set of amendments was shared with the respective Chairs of Audit in August 2024.

1.6 The revised Terms of Reference for DCH and DHC, together with a comparison of the two existing Terms of Reference to the HFMA Model Terms of Reference was presented to and approved by the respective Committees in September 2024. Appendix One contains the Terms of Reference for this Trust.

1.6 Key changes include:

- Some movement in responsibilities into and out of the Committee. These have been agreed by each Committee and will be built into the work plans across all Committees for November 2024.
- Change for DCH to 'Audit Committee' from 'Risk and Audit Committee' (with no change for DHC)
- Change in membership to be Non-Executive only (with no change for DHC)

Recommendation

The Board is requested to:

- Approve the revised Audit Committee Terms of Reference
- Note that a revised work plan will be presented to the November meeting of the Audit Committee
- Note that all work plans will be aligned for November 2024 to ensure that all movements of responsibilities between Committees is complete.

Dorset County Hospital NHS Foundation Trust
Audit Committee / Risk and Audit Committee

TERMS OF REFERENCE Final for Approval Oct 24

1. Constitution	The board hereby resolves to establish a committee of the board to be known **as the 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.
2. 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 cooperate 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.
3. Responsibilities	**A. Governance, risk management and internal control** i. The committee shall review the adequacy and effectiveness of the system of governance, risk management and internal control, across the whole of the organisation's activities (clinical and non-clinical), that supports the achievement of the organisation's objectives. ii. 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 opinion, external audit opinion or other appropriate independent assurances, prior to submission to the board • the underlying assurance processes that indicate the degree of achievement of the organisation's objectives, the effectiveness of the management of principal risks and the appropriateness of the above disclosure statements • the policies for ensuring compliance with relevant regulatory, legal and code of conduct requirements and any related reporting and self-certifications, including the NHS Code of Governance and NHS Provider licence • the policies and procedures for all work related to counter fraud, bribery and corruption as required by the NHSCFA. • Approval of amendments to the Standing Order and Standing Financial Instructions and Scheme of Delegation. iii. 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 directors and managers as appropriate, concentrating on the over-arching systems of governance, risk management and internal control, together with indicators of their effectiveness. iv. This will be evidenced through the committee's use of an effective assurance framework to guide its work and the audit and assurance functions that report to it.

v. As part of its integrated approach, the committee will have effective relationships with other key committees so that it understands processes and linkages. However, these other committees must not usurp the committee's role.

B. Internal audit

i. The committee shall ensure that there is an effective internal audit function that meets the *Public sector internal audit standards, 2017* and provides appropriate independent assurance to the committee, accountable/ accounting officer and board. This will be achieved by:

- considering the provision of the internal audit service and the costs involved
- reviewing and approving the annual internal audit plan and more detailed programme of work, ensuring that this is consistent with the audit needs of the organisation as identified in the assurance framework
- considering the major findings of internal audit work (and management's response), and ensuring coordination between the internal and external auditors to optimise the use of audit resources
- ensuring that the internal audit function is adequately resourced and has appropriate standing within the organisation
- monitoring the effectiveness of internal audit and carrying out an annual review.

C. External audit

i. The committee shall review and monitor the external auditor's independence and objectivity and the effectiveness of the audit process. In particular, the committee will review the work and findings of the external auditors and consider the implications and management's responses to their work. This will be achieved by:

- considering the appointment and performance of the external auditors, as far as the rules governing the appointment permit (and make recommendations to the board when appropriate)
- discussing and agreeing with the external auditors, before the audit commences, the nature and scope of the audit as set out in the annual plan
- discussing with the external auditors their evaluation of audit risks and assessment of the organisation and the impact on the audit fee
- reviewing all external audit reports, including the report to those charged with governance (before its submission to the board) and any work undertaken outside the annual audit plan, together with the appropriateness of management responses
- ensuring that there is in place a clear policy for the engagement of external auditors to supply non-audit services.

ii. The Committee shall develop and agree with the Council of Governors the criteria for the appointment, re-appointment and removal of the External Auditors and make recommendations to

	the Council of Governors in relation to the appointment and re-appointment of External Auditors. **D. Other assurance functions** i. The committee shall review the findings of other significant assurance functions, both internal and external to the organisation, where relevant to the governance, risk management and assurance of the organisation. ii. These may include, but will not be limited to, any reviews by Department of Health and Social Care arm's length bodies or regulators/ inspectors (for example, the Care Quality Commission, NHS Resolution) and professional bodies with responsibility for the performance of staff or functions (for example, Royal Colleges, accreditation bodies). iii. In addition, the committee will review the work of other committees within the organisation, whose work can provide relevant assurance to the committee's own areas of responsibility. In particular, this will include any committees covering safety/ quality, for which assurance from clinical audit can be assessed, and risk management. **E. Counter fraud** i. The committee shall satisfy itself that the organisation has adequate arrangements in place for counter fraud, bribery and corruption that meet NHSCFA's standards and shall review the outcomes of work in these areas. ii. With regards to the local counter fraud specialist it will review, approve and monitor counter fraud work plans, receiving regular updates on counter fraud activity, monitor the implementation of action plans and discuss NHSCFA quality assessment reports. **F. Management** i. The committee shall request and review reports, evidence and assurances from directors and managers on the overall arrangements for governance, risk management and internal control. ii. The committee may also request specific reports from individual functions within the organisation (for example, compliance reviews or accreditation reports). **G. Financial reporting** i. The committee shall monitor the integrity of the financial statements of the organisation and any formal announcements relating to its financial performance. ii. The committee should ensure that the systems for financial reporting to the board, including those of budgetary control, are subject to review as to the completeness and accuracy of the information provided. iii. The committee shall approve retrospectively review losses and special payments. iv. The committee shall review the annual report and financial statements before submission to the board, or on behalf of the board where appropriate delegated authority is place, 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 misstatements in the financial statements

	• significant judgements in preparation of the financial statements • significant adjustments resulting from the audit • letters of representation • explanations for significant variances. **H. System for raising concerns** i. The committee shall annually review the effectiveness of the arrangements in place for allowing staff (and contractors) to raise (in confidence) concerns about possible improprieties in any area of the organisation (financial, clinical, safety or workforce matters) and ensure that any such concerns are investigated proportionately and independently, and in line with the relevant policies. Regular and ongoing review shall be the responsibility of the People and Culture Committee. **I. Governance regulatory compliance** i. The committee shall review the organisation's reporting on compliance with the *NHS Provider Licence*, *NHS code of governance* and the fit and proper persons test. ii. The committee shall satisfy itself that the organisation's policy, systems and processes for the management of conflicts, (including gifts and hospitality and bribery) are effective including receiving reports relating to non-compliance with the policy and procedures relating to conflicts of interest. iii. The committee shall satisfy itself that the organisation's policy, systems and processes for the management of Freedom of Information requests are effective including receiving reports relating to non-compliance with regulatory requirements. iv. The Committee will maintain annual oversight of Data Security and Protection compliance (receipt of annual submission).
4. Accountability Arrangements	The committee shall report to the board on how it discharges its responsibilities. The minutes of the committee's meetings shall be formally recorded by the secretary and available for the board, with an assurance report from then Committee provided to the Board. The chair of the committee shall draw to the attention of the board any issues that require disclosure to the full board, or require executive action. The committee will report to the board at least annually on its work in support of the annual governance statement, specifically commenting on the: • fitness for purpose of the assurance framework • completeness and 'embeddedness' of risk management in the organisation • effectiveness of governance arrangements • appropriateness of the evidence that shows that the organisation is fulfilling regulatory requirements relating to its existence as a functioning business. This annual report should also describe how the committee has fulfilled its terms of reference and give details of any significant issues that the committee considered in relation to the financial statements and how they were addressed.

	An annual committee effectiveness evaluation will be undertaken and reported to the committee and the board.
5. Membership / Attendance	**Membership** • The committee shall be appointed by the board from amongst its independent, non-executive directors and shall consist of not less than three members one of whom shall possess recent, relevant financial experience. • The Committee Chair will not be the senior independent director of the Trust or the deputy chair of the Board. **Attendance** • The Joint Chief Finance Officer and appropriate internal and external audit representatives shall normally attend meetings. • The counter fraud specialist (LCFS) will attend a minimum of two committee meetings a year. • The Joint Executive Director of Corporate Affairs may attend meetings. • The Accountable Officer should be invited to attend meetings and should discuss at least annually with the committee the process for assurance that supports the governance statement. They should also attend when the committee considers the draft annual governance statement and the annual report and accounts. • Other executive directors/ managers should be invited to attend, particularly when the committee is discussing areas of risk or operation that are the responsibility of that director/ manager. • Governors will be invited to attend meetings of the Committee, with a nominated Governor assigned to the Committee. • Representatives from other organisations (for example, the NHS Counter Fraud Authority (NHSCFA)) and other individuals may be invited to attend on occasion, by invitation. • A nominated person shall be secretary to the committee and shall attend to take minutes of the meeting and provide appropriate support to the chair and committee members. • At least once a year the committee should meet privately with the internal auditors, external auditors and LCFS either separately or together. Additional meetings may be scheduled to discuss specific issues if required. •
6. Quorum	• A quorum shall be two of the three independent members. One of the members will be appointed chair of the committee by the board. The chair of the organisation itself shall not be a member of the committee.
7. Administrative Support	The committee shall be supported administratively by its secretary. Their duties in this respect will include: • agreement of agendas with the chair and attendees • preparation, collation and circulation of papers in good time • inviting additional attendees to meetings as required • taking the minutes and helping the chair to prepare reports to the board • keeping a record of matters arising and issues to be carried forward • arranging meetings for the chair: for example, with the internal/ external auditors or local counter fraud specialists

8. Frequency of Meeting	The Committee will meet at least four times per annum, with a possible additional meeting to specifically review the annual report and accounts at appropriate times in the reporting and audit cycle. The chair of the committee, board, accountable officer, external auditors or head of internal audit may request an additional meeting if they consider that one is necessary. To assist in the management of business over the year an annual workplan will be maintained, capturing the main items of business at each scheduled meeting.
9. Access	The head of internal audit and representative of external audit have a right of direct access to the chair of the committee. This also extends to the local counter fraud specialist, as well as the security management specialist.
10. Date Approved	These terms of reference will be reviewed at least annually and more frequently if required. Any proposed amendments to the terms of reference will be submitted to the board for approval. • Approved by Audit Committee 17 September 2024 • Approved by Dorset County Hospital Foundation Trust Board on 9 October 2024

Report to	Dorset County Hospital Board of Directors, Part 1	
Date of Meeting	9th October 2024	
Report Title	DCH – Scheme of Delegation Review and update	
Prepared By	Tyrell Bowcher, Head of Financial Management DCH	
Accountable Executive	Chris Hearn, Chief Financial Officer	
Previously Considered By	Recommended for approval by Risk and Audit Committee – 17th September 2024	
Action Required	**Approval**	Y
	Assurance	-
	Information	-

Alignment to Strategic Objectives	Does this paper contribute to our strategic objectives	
Care	Yes	
Colleagues	Yes	
Communities	Yes	
Sustainability	Yes	
Implications	Describe the implications of this paper for the areas below	
Board Assurance Framework	SR6 – Finance	
Financial	No impact to financial plan. Aids financial sign off from most appropriate and knowledgeable colleague.	
Statutory & Regulatory	Update to authorisation limits set out in Trust policies.	
Equality, Diversity & Inclusion	n/a	
Co-production & Partnership	Review and alignment to DHC limits, allows for process improvement re joint working	

Executive Summary

The Trust's Standing Financial Instructions (SFIs) Scheme of Delegation limits relating to Income, Expenditure and Procurement Limits have been reviewed with updates proposed (Appendix 1). Following review and agreement, all proposed changes will align our approval limits to those of Dorset HealthCare to aid collaborative working and ease of sign off for joint Executives and Committees.

It is proposed that these revised limits are effective immediately. All changes are highlighted in yellow within Appendix 1.

A summary of the changes are as follows:

- To avoid confusion and provide clarity several titles have been reworded and rows removed where approval is covered in others section of the Scheme of Delegation. These do not change pre-existing approval limits but remove conflicting information and provide clarity where needed.
- An additional approval column has been added to cover the role of Head of Financial Management to add capacity for approval across the finance team while maintaining significant approvals with CFO and Deputy CFO. Approval limits added where appropriate across all categories of the Scheme of Delegation.
- A new limit is proposed for approving income contracts and non-pay expenditure to allow for informed sign off by key budget holders, request for £250k approval limit (affecting 9 senior Trust managers).

- In addition, where currently one executive (excluding CEO who has higher limits) is able to approve income contracts and expenditure up to £1m, a new limit is proposed to allow two executives to sign off income contracts and expenditure up to £3m.

- The Trust's Procurement and Tendering Limits were aligned to Dorset HealthCare's limits in April 2023, these have since been updated. This proposal is to realign and adopt updated limits to ease process and recognise significant inflationary increases.

The paper provides the details of these changes and changes are highlighted in yellow in the proposed Scheme of Delegation (Appendix 1).

On 17th September 2024 the Risk and Audit committee recommend these proposed changes for approval by Board.

These updates will be communicated to the Trust via presentation at the Senior Leadership Group and cascaded to all staff with direct involvement adhering to and monitoring these limits.

Recommendation

The Board are recommended to:

- APPROVE the proposed updates to the Trust's Scheme of Delegation.

BOARD – 9th October 2024
DCH – Scheme of Delegation Review and update

Executive Summary

The Trust's Standing Financial Instructions (SFIs) Scheme of Delegation limits relating to Income, Expenditure and Procurement Limits have been reviewed with updates proposed (Appendix 1). Following review and agreement, all proposed changes will align our approval limits to those of Dorset HealthCare to aid collaborative working and streamline the sign off process for joint Executives and Committees.

1. Introduction

1.1 The Scheme of Delegation has been reviewed and the Board are asked to approve recommended changes to remove conflicting information and ensure senior staff have a reasonable and appropriate sign off limit.

1.2 Income and expenditure limits were reviewed and compared to approval limits held at Dorset HealthCare, following agreement across the Trust's this proposal aligns the limits across both providers. This will streamline the sign off process from the joint Executives and committees.

1.3 Procurement and tendering limits were aligned to Dorset HealthCare back in 2023, these have since had an update at Dorset HealthCare. This proposal is to realign and adopt updated limits to ease process and recognise significant inflationary increases.

2. Income and Expenditure approval changes

2.1 To avoid confusion and remove conflicting information several titles have been reworded and rows removed where approval is covered in others section of the Scheme of Delegation. These do not change pre-existing approval limits but remove contradictory information and provide clarity where needed.

2.2 A new limit is proposed for approving income and expenditure to allow for informed sign off by key budget holders, request for £250k approval limit. This will allow the budget managers with the detailed knowledge and specialty to make relevant decisions about their services. There are 9 roles within the Trust which are detailed as Budget Holders.

2.3 In addition, where currently one executive (excluding CEO who has higher limits) is able to approve income contracts and expenditure up to £1m, a new limit is

proposed to allow two executives to sign off income contracts and expenditure up to £3m.

2.4 Both 2.2 and 2.3 limits are aligned to Dorset HealthCare.

2.5 A new column has added to introduce limits across income and expenditure categories for the role of Head of Financial Management, to add capacity for approval across the finance team while maintaining significant approvals with CFO and Deputy CFO. The approval limits are as follows:

- £25k approval for new capital business cases
- £250k approval for authorization of Virement
- £2.5m approval to invest surplus cash
- Approval of all petty cash disbursements
- £15k approval of disposal or condemnation of capital assets
- £500 approval for Others losses exc. Damage to buildings
- £100 approval of ex-gratia payments
- £500k approval for income contracts
- Approval of debtor request forms and authorization of credit notes
- £50k approval of non-pay expenditure
- Approval of purchase credit notes
- £50k approval of procurement waivers

3. Procurement and Tendering limits

3.1 The Trust's Procurement and Tendering Limits were aligned to Dorset HealthCare's limits in April 2023, these have since been updated. This proposal is to realign and adopt updated limits to ease process and recognise significant inflationary increases.

3.2 Summary of changes:

- Redefine nature of spend from current Revenue and Capital classifications to 'Products & Services' and 'Building & Estates Engineering' in alignment to procurement regulations
- One offer requirement for all contracts up to £10k (previously one quote up to £5k and 2 quotes up to £10k for Capital contracts)
- Three quote requirement for all contracts over £10k and up to £25k (previously three quotes up to £30k for Capital and two quotes up to £20k for Revenue contracts)

- Relevant full tender requirement for Building & Estates above £100k (previously £30k for comparable Capital contracts)

4. Recommendation

The Board is recommended to:

- **APPROVE** the proposed updates to the Trust's Scheme of Delegation.

Name and Title of Author: Tyrell Bowcher – Head of Financial Management
Date: 26/09/2024

Table B – Delegated Financial Limits

DELEGATED FINANCIAL LIMITS (£) (unless otherwise stated, all figures are inclusive of VAT irrespective of recovery arrangements.)													
	Board of Directors	Finance and Performance Committee	Senior Leadership Group	Capital Planning & Space	Chief Executive Officer	Chief Financial Officer	Other Executive Officer	Deputy Director of Finance	Delegated Budget Holders (A)	Delegated Budget Managers	Department/ Ward Delegated	Head of Financial Management	Senior Finance Management 8b and above
1. Approval Process and Delegated Limits													
Initial Revenue and Capital Budget - approval	Yes	No	No	No	No	No	No	No	No	No	No	No	No
Capital approval outside of initial budget													
Approval of new capital business case proposals (within approved total capital budget but subject to critical patient need)	Yes	£500 000	No	£250 000	£50 000	£50 000	No	£50 000	No	No	No	£25 000	£25 000
Revenue approval process outside of initial budget													
Authorisation to Proceed to Bid for new business	Yes	£500 000	No	No	£250 000	£50 000	No	No	No	No	No	No	No
New Revenue Business cases - Approval outside planning cycle	Yes	£500 000	£250 000	No	£50 000	£50 000	No	No	No	No	No	No	No
2. Budget Virement													
Authorisation of Virement (adjustments to budgets) from Reserves/Additional Income	Yes	No	No	No	£2 000 000	£1 000 000	No	£500 000	No	No	No	£250 000	£25 000
Authorisation of Virement (adjustments to budgets) within Divisions	Yes	No	No	No	£2 000 000	£1 000 000	No	£500 000	£20 000	No	No	£250 000	£30 000
3. Cash and Banking													
Investment of Surplus Operating Cash	Yes	No	No	No	£25 000 000	£25 000 000	No	£5 000 000	No	No	No	£2 500 000	No
Petty Cash Disbursements	No	No	No	No	No	Yes	Yes	Yes	No	No	No	Yes	Yes
4. Capital Assets													
Disposal and Condemnations of Capital Assets - Items obsolete, unserviceable, irreparable or cannot be cost-effectively repaired	Yes	No	No	No	Yes	£50 000	No	£25 000	No	No	No	£15 000	No
All leases and ALL property purchase contracts and Termination: Where Board approval to the business case has been given and procurement process has been followed: For leases authorisation level relates to cost over total contract period.	Yes	No	No	No	250000	£250 000	No	No	No	No	No	No	No
5. Losses and Special Payments (reported to Audit Committee)													
Losses													
Fruitless payments (including abandoned Capital Schemes) and constructive losses	Yes	No	No	No	Yes	Yes	£5 000	No	No	No	No	No	No
Other Losses													
Losses of cash due to theft, fraud, overpayment & others.	Yes	No	No	No	Yes	Yes	£5 000	£5 000	No	No	No	£500	No
Bad debts and claims abandoned.	Yes	No	No	No	Yes	Yes	£5 000	£5 000	No	No	No	£500	No
Damage to buildings, fittings, furniture and equipment and loss of equipment and property in stores and in use	Yes	No	No	No	Yes	Yes	£20 000	No	No	No	No	No	No
Culpable causes (eg fraud, theft, arson).	Yes	No	No	No	Yes	Yes	£5 000	£5 000	No	No	No	£500	No
Special Payments													
Compensation payments by Court Order	Yes	No	No	No	Yes	Yes	£5 000	No	No	No	No	No	No
Extra contractual payments to contractors	Yes	No	No	No	Yes	Yes	£5 000	No	No	No	No	No	No
Ex-gratia Payments:-													
To patients / staff for loss of personal effects	Yes	No	No	No	£10 000	£5 000	£1 000	£1 000	No	No	No	£100	No
Other ex-gratia payments	Yes	No	No	No	£10 000	£5 000	£1 000	£1 000	No	No	No	£100	No
6. Patients Property (Release of property of a deceased patient)													
Up to £5,000	Production of Probate or Letters of Administration shall be required before any of the property is released												
Over £5,000	Forms of indemnity shall be obtained												
7. Income	**Threshold limits represent the contract's lifetime value**												
Renewal of existing contracts and new contracts with business case approval	Yes	No	No	No	£10 000 000	£1 000 000	One approval - £1,000,000 Two approvals - £3,000,000	£1 000 000	£250 000	No	No	£500 000	No
Debtor Request Forms	N/A	No	No	No	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes
Authorisation of credit notes/Cancellation of invoices	N/A	No	No	No	Yes	Yes	No	Yes	No	No	No	Yes	Yes
8. Non-Pay Expenditure	**Threshold limits represent the contract's lifetime value**												
Authorisation of Non-Pay Expenditure - including invoice approval, award, signing of contract, contract variations, change notices and requisitioning etc *(In addition to approval, all Purchase orders need agreement and sign off from either a member of the Procurement team or a senior Finance colleague (8b and above).)*	Yes	No	No	No	£5 000 000	£1 000 000	One approval - £1,000,000 Two approvals - £3,000,000	£1 000 000	£250 000	£30 000	£100	£50 000	£30 000
Authorisation of Purchase credit notes	N/A	No	No	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Waiving procurement requirements detailed in Section 11 (Ex VAT)	Yes	£500 000	No	No	£250 000	£150 000	No	£75 000	No	No	No	£50 000	No

Sections 9a and 9b are ex VAT unless otherwise specified.	**Threshold limits represent the contract's lifetime value e.g. a 5-year contract of £25,000 per year requires £125,000 method and authorisation.**
9.a Procurement Process for Products & Services	
Quotations for all purchases : 1 written quote	under £10,000
Quotations - where possible, obtain a minimum of 3 written quotations	£10,000 to <£25,000
Formal quotation process run by procurement - Minimum number invited to quote -3	£25,000 to <£75,000
Formal Local Tender- Minimum number invited to tender -4	£75,001 to Procurement Regulation Thresholds excluding VAT
The Procurement Regulation processes apply	over Procurement Regulation Thresholds excluding VAT
9.b Procurement Process for Building & Estates Engineering Procurement (Works);	
Quotations for all purchases : 1 written quote	under £10,000
Quotations - where possible, obtain a minimum of 3 written quotations	£10,000 to <£25,000
Formal quotation process run by procurement - Minimum number invited to quote -3	£25,000 to <£100,000
Formal Local Tender- Minimum number invited to tender -4	£100,001 to Procurement Regulation Thresholds including VAT
The Procurement Regulation processes apply	over Procurement Regulation Thresholds including VAT

	Charitable Funds Committee	Chair plus Chief Financial Officer	Deputy Director of Finance	Nominated Fund Manager
10. Funds Held on Trust				
Expenditure authorisation (per request)	Yes	£10 000	£2 000	£500

INTEGRITY | RESPECT | TEAMWORK | EXCELLENCE

NHS
Dorset County Hospital
NHS Foundation Trust

Escalation Report

Executive / Committee: Charitable Funds Committee

Date of Meeting: 18 September 2024

Presented by: Dave Underwood

Significant risks / issues for escalation to Committee / Board for action	• **Charitable funding – Capital Projects – please see below.** • **Charitable funding – NHS core requirements – please see below.**
Key issues / matters discussed at the Committee	**DCHC Charitable Funds Committee (18.9.24)** • **CFC Terms of Reference review (3yr)** Proposal supported in principle to appoint Community co-opted member for the committee. Other minor revisions discussed. • **Charitable funding – Capital Projects** DCH Charity periodically funds major projects across the Trust to enhance patient care. Two projects in particular have received large funding from the Charity – the Prince of Wales ward redevelopment, and the Purbeck Dementia Day Room – neither of which are currently being used for the purpose intended by the charitable funds that were provided. Issues considered for charity governance relating to the intended use of funds versus the operational practicalities for an NHS Trust. Committee discussed this matter in detail. **Actions agreed by committee:** • **Charity/Finance to develop additional guiding principles to be added to the Charitable Funds Expenditure Policy and Standing Financial Instructions SFIs), for granting charitable funding for significant Trust projects. Updated Policies to be approved by Charitable Funds Committee and agreed with the Trust.** • **Charity/Finance to liaise with POW and Purbeck service managers to ascertain whether the Trust have plans to return these facilities to the use intended by provision of charitable funding. Written confirmation of plans be provided by service managers to Charitable Funds Committee and plans monitored.** • **Charity/Finance to arrange for external audit of DCHC grant-making processes.**

- **Charitable funding – NHS core requirements**
  Due to NHS/Trust financial pressures, recent increase in number of proposals asking for charitable funding for items that may be considered should be funded by NHS core budgets. Committee discussed this matter in detail.

  Actions agreed by committee:

- **Letter to be shared with the Executive Team, then the Council of Governors (pending appointment of Community member to CFC) asking their thoughts on CFC's proposed interim approach to funding such items.**

- **Charity to advise Maternity to submit their application (£48K for baby resuscitation equipment) for consideration by CFC (subject to support from both the Executive and COG).**

- **Committee agreed to set up designated, restricted fund (using funds from General Fund) to support Trust prioritised capital items for interim period between now and the end of the financial year. To be reviewed in Trust budgeting for next year.**

- **Charity/Finance to develop additional guiding principles to be added to the Charitable Funds Expenditure Policy and Standing Financial Instructions SFIs), for granting charitable funding for prioritised Trust capital items. Updated Policies to be approved by Charitable Funds Committee and agreed with the Trust.**

- **DCH Charity Finance/Income 24/25 reports (M4)**
  M4 (July) reports 2024/25 were received.
  Total income as of end Jul £262,114. Unrestricted funds were £250,756 providing a surplus of £30,756 against the reserves target of £220,000. Major legacy pending (est. value c£825K) for the General Fund.

- **DCHC Reserves Policy**
  Committee supported an increase in the charity's annual reserves level from £220k to £240k, to support additional fundraising resource for the ED/CrCU capital appeal.

- **£2.5M Capital Appeal (ED/CrCU)** progress report received.
  £477K income/pledges to date as of end Aug 2024.
  Proposal supported to commit £500K of the major legacy in support of the ED/CrCU capital appeal.

Decisions made by the Committee	• **DCHC Reserves Policy** Committee supported an increase in the charity's annual reserves level from £220k to £240k, to support additional fundraising resource for the ED/CrCU capital appeal. • **Major legacy:** DCHC notified of gift in Will pending for General Fund, value est. c.£825K. Proposal received to commit £500K of this legacy in support of the ED/CrCU capital appeal. Proposal supported by CFC.
Implications for the Corporate Risk Register or the Board Assurance Framework (BAF)	• Nil
Items / issues for referral to other Committees	• Nil

ICB Board Report

Reporting Committee:	ICB Board
Date of Meeting:	5 September 2024
Meeting Chair:	Jenni Douglas Todd, ICB Chair

Decisions made by the Board	• The Board approved the addition of the new risk on Social Mobility to the Board Assurance Framework and the adoption of an 'open' risk appetite for regulatory risks.
Key Messages	• Welcomed the Board Story video and deep dive paper on the ICS core purpose of tackling inequalities in outcomes, experience and access, discussing the progress that was being made, embedding Health Inequalities into everything we do, and considering the role of the Board and agreeing next steps. • In terms of key challenges, the Board noted the financial pressures for the second half of the year, the potential impact of GP collective action, and the operational challenges regarding 65 week waits. • Welcomed the energy and intent underpinning the Inward Investment Strategy 2024-27, but the ICB Board did not approve the adoption of the strategy and requested further work on matters relating to routes for attracting social funding, prioritisation, strategic alignment, reputational impact, and the governance framework. • Received the Clinical Plan Implementation Plan noting the progress with the cardiovascular, respiratory, and frailty and falls clinical networks. The Board looked forward to seeing SMART objectives coming back to the Board from the clinical networks. • Welcomed the recovery plans from the Bournemouth, Christchurch and Poole Council area to address No Criteria to Reside and suggested regular future reporting into the Board via the Integrated Performance Report. • Received the ICS Equality, Diversity and Inclusion Report and considered the Board's role in leading on change in this area. The Board agreed to allocate time at upcoming dates to discuss the ambition and role of the Board in more detail. • Welcomed the positive feedback from the Annual Assessment of the ICB, noting that the report would now be published alongside the ICB's Annual Report and Accounts on the ICB's website.
Summary of items received by the Board	• Board Story and Deep Dive on the ICS core purpose of Tackling Inequalities in Outcomes, Experience and Access

- Board Assurance Framework
- Chief Executive Officer Report
- Committee Escalation Reports
- Inward Investment Strategy
- Clinical Plan Implementation Plan
- No Criteria to Reside - Bournemouth, Christchurch and Poole Council Approach
- Integrated Care System (ICS) Equality, Diversity and Inclusion Report
- ICB Annual Assessment 2023-24 Outcome
- Consent Items:
    - Data Security and Protection Toolkit Annual Report
    - Safeguarding Children and Adults Annual Report
    - Children in Care and Care Leavers Annual Report

Report to	Dorset County Hospital Board of Directors, Part 1	
Date of Meeting	09 October 2024	
Report Title	Premises Assurance Model update - DCH	
Prepared By	Terry May, Interim Head of Estates and Facilities Andrew Kersley, Asset & Compliance Officer	
Accountable Executive	Chris Hearn, Chief Finance Officer	
Previously Considered By	Previous update noted at: DCH Finance and Performance Committee – 22/7/24 DCH Trust Board – 31/7/24 Finance and Performance Committee in Common – 23/9/24	
Action Required	**Approval**	Y
	Assurance	-
	Information	-

Alignment to Strategic Objectives	Does this paper contribute to our strategic objectives	
Care	Yes	
Colleagues		No
Communities		No
Sustainability	Yes	
Implications	Describe the implications of this paper for the areas below	
Board Assurance Framework	SR5 – Estates	
Financial	Value for money in use of resources	
Statutory & Regulatory	Compliance with statutory estates and safety policies	
Equality, Diversity & Inclusion	n/a	
Co-production & Partnership	n/a	

Executive Summary

This report provides an overview of the final version of the Trusts' Premises Assurance Model output and advises on action being taken to address areas of improvement, and seeks FPC and Board approval to submit to NHS England in September 2024.

The Premises Assurance Model (PAM) is a self-assessment tool that supports in assessing how safely and efficiently Trust Estate and Facilities are run. This is a mandatory annual submission to NHS England.

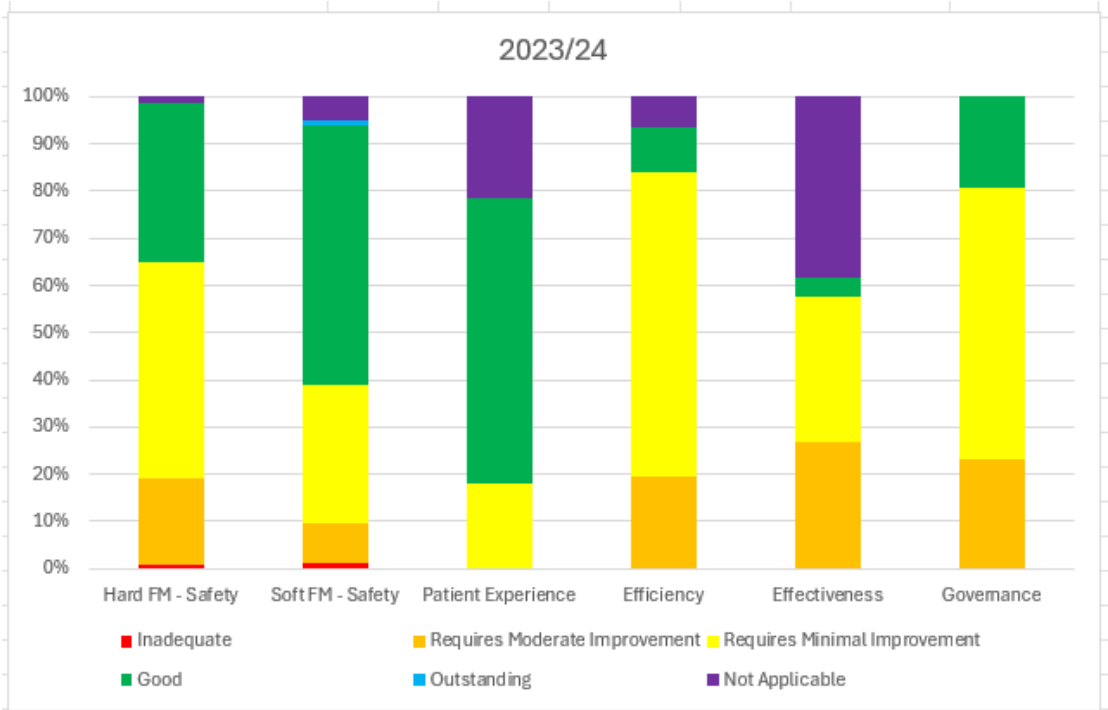
Following presentation in July 2024 to FPC and Board, the final PAM proposed submission, along with updates from this previous conversation, are being brought to FPC and Board for approval to submit to NHSE.

For context the evaluation tool is organised into six key domains: -

- Hard Facilities Management Safety
- Soft Facilities Management Safety
- Patient Experience
- Efficiency
- Effectiveness
- Organisational Governance

The Trust scores itself on compliance across several categories in each of these areas, based on comparing current status against the criteria set. The below chart provides a high-level summary of compliance across each domain.

It is proposed that the Trust will commission a third-party specialist from FY 24/25 to audit the Trusts PAM scores for additional assurance.



	Hard FM - Safety	Soft FM - Safety	Patient Experience	Efficiency	Effectiveness	Governance
Inadequate	1	1	0	0	0	0
Requires Moderate improvement	28	7	0	6	7	6
Requires Minor improvement	69	24	5	20	8	15
Good	51	45	17	3	1	5
Outstanding	0	1	0	0	0	0
Not Applicable	2	4	6	2	10	0

The inadequate scores for Hard and Soft FM safety relate to:

- Risk assessments linked to fire safety.
- Maintenance linked to catering services.

With the context of the PAM being a self-assessment checklist, both of these areas are undergoing rapid improvements within the compliance and safety groups as part of internal governance.

Appendix 1 of this report details the submission and summarises key actions to improve compliance on areas where required.

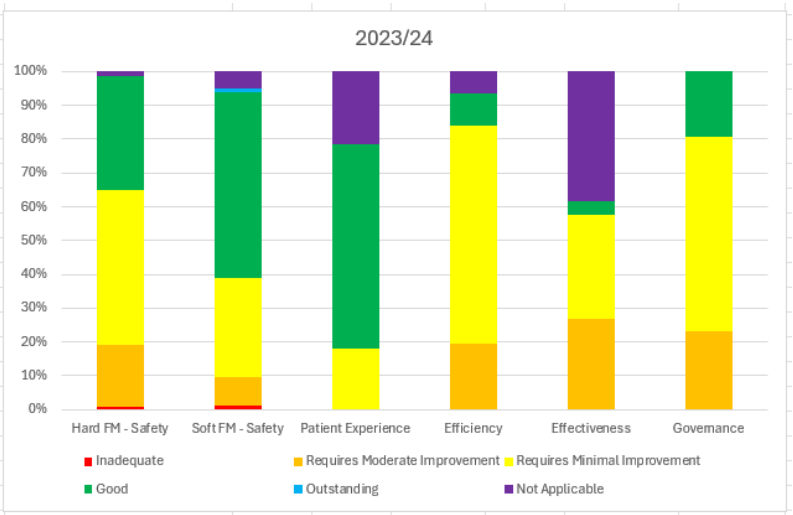
Recommendation

The Board are recommended to:

- Approve the proposed final version Premises Assurance Model and status for submission to NHSE.

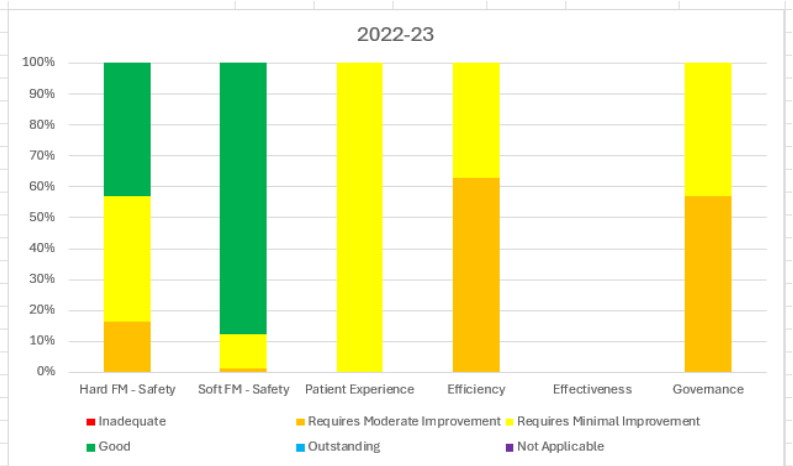
The self assessment output for 2023/24, along with 2022/23 to show a comparison, are shown below, with further assessment detailed in appendix 1:

2023/24:



	Hard FM - Safety	Soft FM - Safety	Patient Experience	Efficiency	Effectiveness	Governance
Inadequate	1	1	0	0	0	0
Requires Moderate improvement	28	7	0	6	7	6
Requires Minor improvement	69	24	5	20	8	15
Good	51	45	17	3	1	5
Outstanding	0	1	0	0	0	0
Not Applicable	2	4	6	2	10	0

2022/23:



	Hard FM - Safety	Soft FM - Safety	Patient Experience	Efficiency	Effectiveness	Governance
Inadequate	0	0	0	0	0	0
Requires Moderate improvement	23	1	0	17	0	29
Requires Minor improvement	57	8	15	10	0	22
Good	60	64	0	0	0	0
Outstanding	0	0	0	0	0	0
Not Applicable	0	0	0	0	0	0

Appendix 1 - Overview of scoring for PAM 2024

This appendix shows the PAM submission for 2024, along with scoring for each element. The top line shows the scoring for 2023 and to bottom line the scoring for 2024. There are notes under each point but these are not submitted and are used for internal purposes only.

	Self Assessment Question (SAQ) Subject	Applicable?	1. Policy & Procedures	2. Roles and Responsibilities	3. Risk Assessment	4. Maintenance	5. Training and Development	6. Resilience, Emergency & Business Continuity Planning	7. Review Process	8. Costed Action Plans
SH1	Estates and Facilities Operational Management	Applicable	4. Requires moderate improvement	4. Requires moderate improvement	4. Requires moderate improvement	4. Requires moderate improvement	3. Requires minimal improvement	4. Requires moderate improvement	4. Requires moderate improvement	4. Requires moderate improvement
		Applicable	3. Requires minimal improvement	4. Requires moderate improvement	2. Good	3. Requires minimal improvement	2. Good	2. Good	3. Requires minimal improvement	4. Requires moderate improvement
		• Operational Management is conducted in accordance with existing Policies and Procedures. A review programme is being developed. • Reorganisation planning is underway and Job Descriptions and development form part of this. • Additional resources have joined the trust to fulfil the necessary functions of all operational management responsibilities. • The MICAD system is being further developed to improve data retention and compliance								
SH2	Design, Layout and Use of Premises	Applicable	4. Requires moderate improvement	3. Requires minimal improvement	3. Requires minimal improvement	3. Requires minimal improvement	3. Requires minimal improvement	2. Good	4. Requires moderate improvement	4. Requires moderate improvement
		Applicable	4. Requires moderate improvement.	3. Requires minimal improvement	4. Requires moderate improvement	3. Requires minimal improvement	2. Good	2. Good	4. Requires moderate improvement	4. Requires moderate improvement
		• Has moved forward in the last 12 months but there is still work to be done • There are still risks for both Asbestos and water safety • There is currently no 6 facet survey completed • Project and Operations teams aim to develop and deliver appropriate designs for the Trust with E&F objectives aligned to support DCH strategic objectives • The hurried delivery of our planned major construction and refurbishment programme and urgent Covid mitigations has exposed difficulties in assuring compliance particularly relating to C3I (Command, Control, Communications, Information) and resolution is ongoing. • Circumstances have caused the review process for some elements related to operational assessment to be delayed.								

	Self Assessment Question (SAQ) Subject	Applicable?	1. Document Management System in Place	2. Approval of documents	3. Review of documents	4: Availability of documents	5. Legibility of Documents	6: Document Control	7. Obsolescence	8. Costed Action Plans
SH3	Estates and Facilities Document Management	Applicable	4. Requires moderate improvement	3. Requires minimal improvement	3. Requires minimal improvement	3. Requires minimal improvement	2. Good	4. Requires moderate improvement	3. Requires minimal improvement	4. Requires moderate improvement
		Applicable	4. Requires moderate improvement	3. Requires minimal improvement	3. Requires minimal improvement	3. Requires minimal improvement	2. Good	4. Requires moderate improvement	3. Requires minimal improvement	4. Requires moderate improvement
		• Documentation is controlled only by author/owner using largely undocumented or historic practice. Deficiencies have been identified as resulting from the scope and scale of current and future operations. Reorganisation planning is underway and the development of electronic document management form part of this. • Documents and records are held in a variety of on and off-site locations including with external provider databases. Most Asset registers and records require significant investment to bring up to date. Better use is being made of MICAD. Additional dedicated personnel should be recruited								
	Self Assessment Question (SAQ) Subject	**Applicable?**	**1. Policy & Procedures**	**2. Roles and Responsibilities**	**3. Risk Assessment**	**4. Maintenance**	**5. Training and Development**	**6. Resilience, Emergency & Business Continuity Planning**	**7. Review Process**	**8. Costed Action Plans**
SH4	Health & Safety at Work	Applicable	4. Requires moderate improvement	3. Requires minimal improvement	4. Requires moderate improvement		3. Requires minimal improvement	4. Requires moderate improvement	3. Requires minimal improvement	3. Requires minimal improvement
		Applicable	3. Requires minimal improvement	3. Requires minimal improvement	4. Requires moderate improvement		3. Requires minimal improvement	3. Requires minimal improvement	3. Requires minimal improvement	3. Requires minimal improvement
		• Systems and procedures in place to ensure safe working environment and practices, largely and increasingly formal but with some legacy practices to be reviewed. Hazards are identified, risks mitigated and staff suitably trained, supervised and informed • Some risk assessments required but all have been identified • Maintenance Contractors are required to align with all DCH safety and working practices. • Capital Projects and other departments are understood to operate under separate arrangements which should be fully aligned with Estates provisions.								

	Self Assessment Question (SAQ) Subject	Applicable?	1. Policy & Procedures	2. Roles and Responsibilities	3. Risk Assessment	4. Maintenance	5. Training and Development	6. Resilience, Emergency & Business Continuity Planning	7. Review Process	8. Costed Action Plans
SH5	Asbestos	Applicable	3. Requires minimal improvement	4. Requires moderate improvement	3. Requires minimal improvement		3. Requires minimal improvement	4. Requires moderate improvement	2. Good	4. Requires moderate improvement
		Applicable	4. Requires moderate improvement	3. Requires minimal improvement	3. Requires minimal improvement		3. Requires minimal improvement	3. Requires minimal improvement	3. Requires minimal improvement	4. Requires moderate improvement
		• Management procedures have been updated and in place • New asbestos survey company appointed • Spend of ~£230,000 spread over 5 years								
SH6	Medical Gas Systems	Applicable	2. Good	2. Good	2. Good	2. Good	2. Good	2. Good	2. Good	2. Good
		Applicable	2. Good	2. Good	2. Good	2. Good	2. Good	2. Good	2. Good	2. Good
		• Well managed and resourced • Authorising Engineer indicates good practice through the Trust with well-trained AP's and good records for permit work. • Trust uptake of training for clinical staff improving								
SH7	Natural Gas and specialist piped systems	Applicable	2. Good	2. Good	2. Good	2. Good	2. Good	2. Good	2. Good	2. Good
		Applicable	2. Good	2. Good	2. Good	2. Good	2. Good	2. Good	2. Good	2. Good
		• Natural gas and specialist systems, e.g., medical vacuum, are managed and maintained in accordance with legislation and regulation primarily by BIS (Bought In Service).								
SH8	Water Safety Systems	Applicable	2. Good	2. Good	3. Requires minimal improvement	4. Requires moderate improvement	2. Good	2. Good	2. Good	3. Requires minimal improvement
		Applicable	2. Good	2. Good	3. Requires minimal improvement	4. Requires moderate improvement	2. Good	3. Requires minimal improvement	2. Good	3. Requires minimal improvement
		• Water safety is delivered in accordance with HSE L8, HSG 274 and HTM 04-01 under the guidance of an external Authorising Engineer (Water) and internal assurance structures. • Two RP's on site and new water engineer recruited. Water Engineer to be trained as AP. Fitters also trained as CP's								

	Self Assessment Question (SAQ) Subject	Applicable?	1. Policy & Procedures	2. Roles and Responsibilities	3. Risk Assessment	4. Maintenance	5. Training and Development	6. Resilience, Emergency & Business Continuity Planning	7. Review Process	8. Costed Action Plans
SH9	Electrical Systems	Applicable	2. Good	2. Good	2. Good	2. Good	2. Good	3. Requires minimal improvement	2. Good	3. Requires minimal improvement
		Applicable	3. Requires minimal improvement	2. Good	3. Requires minimal improvement	2. Good	2. Good	2. Good	3. Requires minimal improvement	3. Requires minimal improvement
		• EICR (Electrical Installation Condition Reports) are ongoing. • Infrastructure development has somewhat mitigated unreliability of local supply which continues to present concern for continuity of service in short, medium and long term. • Major changes to HV network for increased capacity have been progressed alongside existing strategic capital development.								
SH10	Mechanical Systems and Equipment	Applicable	3. Requires minimal improvement	3. Requires minimal improvement	3. Requires minimal improvement	4. Requires moderate improvement	3. Requires minimal improvement	3. Requires minimal improvement	4. Requires moderate improvement	2. Good
		Applicable	2. Good	2. Good	3. Requires minimal improvement	4. Requires moderate improvement	3. Requires minimal improvement	3. Requires minimal improvement	4. Requires moderate improvement	4. Requires moderate improvement
		• Backlog and upcoming lifecycle maintenance requirements present an increasing threat to the integrity and reliability of equipment. • Progress made on some Major infrastructure replaced/refurbished but focus needs to be made on additional equipment								
SH11	Ventilation, Air Conditioning and Refrigeration Systems	Applicable	3. Requires minimal improvement	3. Requires minimal improvement	3. Requires minimal improvement	2. Good	3. Requires minimal improvement	3. Requires minimal improvement	3. Requires minimal improvement	4. Requires moderate improvement
		Applicable	3. Requires minimal improvement	3. Requires minimal improvement	3. Requires minimal improvement	3. Requires minimal improvement	3. Requires minimal improvement	3. Requires minimal improvement	3. Requires minimal improvement	4. Requires moderate improvement
		• >90% of AHU's are >20 years old and present a growing concern, especially in light of recent HTM revisions. • Changes in ventilation requirements present significant challenges as does an historic issue with overheating due primarily to solar gain. • No formal alignment with DSEAR (Dangerous Substances and Explosive Atmospheres Regs) although a SSoW is due for development due to the site requirement on storage and use of Class 0 fuels (LPG). Significant upgrades being made to Class 3 (Kerosene) fuel storage to mitigate potential spills and bring in line with guidance.								

	Self Assessment Question (SAQ) Subject	Applicable?	1. Policy & Procedures	2. Roles and Responsibilities	3. Risk Assessment	4. Maintenance	5. Training and Development	6. Resilience, Emergency & Business Continuity Planning	7. Review Process	8. Costed Action Plans
SH12	Lifts, Hoists and Conveyance Systems	Applicable	3. Requires minimal improvement	3. Requires minimal improvement	2. Good	2. Good	2. Good	3. Requires minimal improvement	2. Good	3. Requires minimal improvement
		Applicable	3. Requires minimal improvement	3. Requires minimal improvement	2. Good	2. Good	2. Good	3. Requires minimal improvement	2. Good	3. Requires minimal improvement
		• Written Schemes and statutory inspections, including Thorough Examinations, are carried out in accordance with LOLER (lifting Operations and Lifting Equipment Regs).								
SH13	Pressure Systems	Applicable	4. Requires moderate improvement	3. Requires minimal improvement	4. Requires moderate improvement	2. Good	4. Requires moderate improvement	3. Requires minimal improvement	3. Requires minimal improvement	4. Requires moderate improvement
		Applicable	4. Requires moderate improvement	3. Requires minimal improvement	4. Requires moderate improvement	2. Good	4. Requires moderate improvement	3. Requires minimal improvement	3. Requires minimal improvement	4. Requires moderate improvement
		• There are a limited number of Pressure Systems at DCH and currently no formal SSoW although several staff have significant experience in this area and operate all system in accordance with PSSR (Pressure System Safety Regs)								
SH14	Fire Safety	Applicable	2. Good	2. Good	2. Good	3. Requires minimal improvement	3. Requires minimal improvement	2. Good	2. Good	2. Good
		Applicable	4. Requires moderate improvement	4. Requires moderate improvement	5. Inadequate	4. Requires moderate improvement	4. Requires moderate improvement	3. Requires minimal improvement	4. Requires moderate improvement	Not applicable
		• Installation of L1 system throughout main site and peripheral buildings is complete • FRA (Fire Risk Assessments) are not currently up to date or compliant, plan in place to refresh all FRA's using new software approach • Significant legacy issues regarding programme for fire doors and compartmentation								
SH15	Medical Devices and Equipment	Applicable	2. Good	2. Good	2. Good	2. Good	2. Good	2. Good	2. Good	Not applicable
		Applicable	2. Good	2. Good	2. Good	2. Good	2. Good	2. Good	2. Good	Not applicable
		• Medical devices continues to be a very well maintained department								
SH16	Resilience, Emergency and Business Continuity Planning	Applicable	2. Good	2. Good	2. Good	2. Good	3. Requires minimal improvement		3. Requires minimal improvement	2. Good
		Applicable	2. Good	3. Requires minimal improvement	3. Requires minimal improvement	3. Requires minimal improvement	3. Requires minimal improvement		2. Good	4. Requires moderate improvement
		• Estates REBCP plan in place and currently under routine review. • Desktop exercise has taken place and more have been planned								

	Self Assessment Question (SAQ) Subject	Applicable?	1. Policy & Procedures	2. Roles and Responsibilities	3. Risk Assessment	4. Maintenance	5. Training and Development	6. Resilience, Emergency & Business Continuity Planning	7. Review Process	8. Costed Action Plans
SH17	Safety Alerts	Applicable	2. Good	3. Requires minimal improvement	2. Good		2. Good	3. Requires minimal improvement	2. Good	2. Good
		Applicable	3. Requires minimal improvement	2. Good	3. Requires minimal improvement		3. Requires minimal improvement	2. Good	3. Requires minimal improvement	3. Requires minimal improvement
		• Currently managed through Risk and Estates Teams. • Improvements to C3I processes to transfer function to eDRM Team								
SH18	Externally supplied estate	Applicable	3. Requires minimal improvement	3. Requires minimal improvement	3. Requires minimal improvement	3. Requires minimal improvement	2. Good	2. Good	2. Good	3. Requires minimal improvement
		Applicable	2. Good	2. Good	2. Good	3. Requires minimal improvement	3. Requires minimal improvement	2. Good	2. Good	3. Requires minimal improvement
		• Improvements and adaptations being made incrementally to compliance requirements and practices. • Further work required in relation to competency checks and RA's for contractors.								
SAQ No.	**Self Assessment Question (SAQ) Subject**	**Applicable?**	**1. Policy & Procedures**	**2. Roles and Responsibilities**	**3. Risk Assessment**	**4. Maintenance**	**5. Contractor Compliance**	**6. Resilience, Emergency & Business Continuity Planning**	**7. Review Process**	**8. Costed Action Plans**
SH19	Contractor Management for Soft and Hard FM services	Applicable	3. Requires minimal improvement	3. Requires minimal improvement	3. Requires minimal improvement	3. Requires minimal improvement	2. Good	2. Good	2. Good	2. Good
		Applicable	3. Requires minimal improvement	3. Requires minimal improvement	2. Good	3. Requires minimal improvement	3. Requires minimal improvement	3. Requires minimal improvement	3. Requires minimal improvement	2. Good
		• Full revision of management provisions currently underway. • Formal CDM IOSH training delivered for all staff engaging with BIS. • Difficulties with C3I on Projects causing challenges particularly safety arrangements and practices. • Develop to full compliance under IPR								

SAQ No.	Self Assessment Question (SAQ) Subject	Applicable?	1. Policy & Procedures	2. Roles and Responsibilities	3. Risk Assessment	4. Maintenance	5. Training and Development	6. Resilience, Emergency & Business Continuity Planning	7. Review Process	8. Costed Action Plans
SS1	Catering services	Applicable	3. Requires minimal improvement	3. Requires minimal improvement	2. Good	2. Good	2. Good	3. Requires minimal improvement	2. Good	Not applicable
		Applicable	4. Requires moderate improvement	3. Requires minimal improvement	2. Good	5. Inadequate	2. Good	3. Requires minimal improvement	3. Requires minimal improvement	4. Requires moderate improvement
		• Catering services are well developed and managed with suitable and sufficient management provisions in place • Maintenance issues due to age of equipment								
SS2	Decontamination process	Applicable	2. Good	2. Good	2. Good	2. Good	2. Good	2. Good	2. Good	Not applicable
		Applicable	2. Good	3. Requires minimal improvement	2. Good	3. Requires minimal improvement	2. Good	2. Good	2. Good	3. Requires minimal improvement
		• Policies and procedures are scheduled through QMS Systems, e.g., as per ISO13485:2016, and are routinely reviewed and reported. • All roles are assigned with responsibilities as a minimum as defined in HTM 01-01, etc. • Risks are raised to the Risk Register when timely resolution is not available, e.g., Decon Lifecycle Replacement, DATIX 980. • Lifecycle due for most equipment (CAP up to £500,000 over 5 years)								
SS3	Waste and Recycling Management	Applicable	2. Good	2. Good	2. Good	2. Good	2. Good	2. Good	2. Good	Not applicable
		• All arrangements in place to meet current obligations. Changing sustainability needs and/or future-proofing are routinely considered and addressed where necessary.								
SS4	Cleanliness and Infection Control	Applicable	2. Good	2. Good	2. Good	2. Good	3. Requires minimal improvement	2. Good	2. Good	Not applicable
		Applicable	2. Good	1. Outstanding	2. Good	2. Good	3. Requires minimal improvement	2. Good	2. Good	Not applicable
		• Cleanliness and infection control arrangements in place and rigorously followed. • Internal and external audit processes are in place, carried through with escalation routes available and routinely used.								
SS5	Laundry and Linen Services	Applicable	2. Good	2. Good	2. Good	2. Good	2. Good	2. Good	2. Good	2. Good
		Applicable	4. Requires moderate improvement	2. Good	3. Requires minimal improvement	2. Good	3. Requires minimal improvement	2. Good	4. Requires moderate improvement	Not applicable
		• Outsourced service with arrangements in place and reviewed regularly								

SS6	Security Management	Applicable	2. Good	2. Good	2. Good	2. Good	3. Requires minimal improvement	4. Requires moderate improvement	2. Good	3. Requires minimal improvement
		Applicable	3. Requires minimal improvement	3. Requires minimal improvement	2. Good	2. Good	2. Good	2. Good	3. Requires minimal improvement	3. Requires minimal improvement
		• Security to be brought in-house from January 2023 with interim SLA agreed with incumbent security supplier. • Security now mainly in-house and additional costs in place to do this • Phase 2 including the use of body cams and stab vests								
SAQ No.	**Self Assessment Question (SAQ) Subject**	**Applicable?**	**1. Policy & Procedures**	**2. Roles and Responsibilities**	**3. Risk Assessment**	**4. Maintenance**	**5. Training and Development**	**6. Resilience, Emergency & Business Continuity Planning**	**7. Review Process**	**8. Costed Action Plans**
SS7	Transport Services	Applicable	2. Good	2. Good	2. Good	2. Good	3. Requires minimal improvement	2. Good	2. Good	3. Requires minimal improvement
		Applicable	2. Good	2. Good	3. Requires minimal improvement	3. Requires minimal improvement	3. Requires minimal improvement	2. Good	2. Good	3. Requires minimal improvement
		• Audit completed by TIAA • Action Plan in place for all gaps that were found going forward • Call barrier and car park incidents are now on Datix								
SS8	Pest control	Applicable	2. Good	2. Good	2. Good	2. Good	2. Good	2. Good	2. Good	Not applicable
		Applicable	2. Good	2. Good	2. Good	2. Good	2. Good	2. Good	2. Good	Not applicable
		• Pest control services provided by contractors • Measures for the control of birds and control of secondary infection control hazards have been introduced.								
SS9	Portering services	Applicable	2. Good	2. Good	2. Good	2. Good	2. Good	2. Good	2. Good	Not applicable
		Applicable	2. Good	2. Good	2. Good	3. Requires minimal improvement	3. Requires minimal improvement	2. Good	3. Requires minimal improvement	2. Good
		• Portering services provided internally								
SS10	Telephony and switchboard services	Applicable	2. Good	2. Good	2. Good	2. Good	2. Good	2. Good	2. Good	Not applicable
		Applicable	2. Good	2. Good	2. Good	2. Good	2. Good	2. Good	2. Good	Not applicable
		• All Policy, processes, etc., are in place with well trained and motivated staff. Some concerns regarding resilience in case of major incident but mitigations in place. • ICT is complex and developing rapidly requiring regular reassessment of the suitability and reliability of installation.								

Sections updated by:

Andrew Kersley	All Sections
Terry May	All Sections
Jason Chambers	SH4, SH17
Colin Carver	SH6, SH7, SH13
Toby Markin	SH8, SH10, SH11
Michael Millis	SH9, SH12
Angus Nairn	SH14
Anthony Petrou	SH15
Ian Kilroy	SH16, SS6
Thomas Cooper	SS1
Fiona Sallows	SS2
Darren Hallett	SS3
Sarah Jenkins	SS4, SS5, SS8
Lee Clarke	SS6, SS9
Chloe Markin	SS7
Hannah Robinson	P1, P2, P3, P4, P5, P6
Beverly Lagden	E4

Report to	Dorset County Hospital Board of Directors, Part 1	
Date of Meeting	09 October 2024	
Report Title	Emergency Preparedness, Resilience & Response (EPRR) Annual Assurance Report 2024	
Prepared By	Ian Kilroy, Head of Emergency Planning & Security Management	
Accountable Executive	Anita Thomas, Chief Operating Officer & Accountable Emergency Officer	
Previously Considered By	Emergency Planning Resilience Group Finance and Performance Committee in Common	
Action Required	**Approval**	-
	Assurance	**X**
	Information	-

Alignment to Strategic Objectives	Does this paper contribute to our strategic objectives	
Care		**No**
Colleagues	**Yes**	
Communities	**Yes**	
Sustainability	**Yes**	
Implications	Describe the implications of this paper for the areas below	
Board Assurance Framework	SR1 – Safety and Quality SR10 – Cyber Security Meeting the standards provides assurance to the Board that all appropriate steps have been taken to ensure policies, procedures, training and compliance are all in place to plan for and manage emergency situations that may threaten the safety of patients and staff.	
Financial	Nil	
Statutory & Regulatory	Required by NHS England	
Equality, Diversity & Inclusion	Nil	
Co-production & Partnership	Nil	

Executive Summary

On Mon 15 Jul 2024, the Emergency Planning Resilience Group (EPRG) was presented with the latest update on Incident Response Plans (IRP) and explained the current position statement relating to NHS England Emergency Preparedness Resilience Response (EPRR) Core Standards. No internal comments to challenge the changes to the updates.

On 16 Sep 2024, the EPRG was presented with the latest update of the NHS England EPRR Core Standards (Deep Dive Cyber Security) to discuss, change and ratify the plans for the NHS England EPRR Core Standards and compliance report.

Following internal DCH meetings and liaison, the Trust has been internally assessed as being 100% **Full** compliance across all the 66 Emergency Preparedness, Resilience and Response (EPRR) Assurance Core Standards – Attached.

These rational decisions to explain the compliance position are based upon evidence base examples, practical input and planned subjects to meet the criteria. Link to all evidence-based information (148 items) is available on the S Drive, Operations Directorate, Emergency Planning and uploaded to Future NHS framework, as required by NHS Dorset (ICB)

This assessment will now be taken to the ICB's confirm and challenge meeting with NHSE in Oct 2024 for further external scrutiny and final confirmation as an element of the wider ICB EPRR Assurance process.

Recommendation

The Board is requested to:

- Receive the report for **assurance**

EMERGENCY PREPAREDNESS, RESILIENCE & RESPONSE (EPRR) ANNUAL ASSURANCE 2023/4

Executive Summary

- On Mon 15 Jul 2024, the Emergency Planning Resilience Group (EPRG) was presented with the latest update on Incident Response Plans (IRP) and explained the current position statement relating to NHS England EPRR Core Standards. No comments to challenge the changes to the update.

- On 16 Sep 2024, the EPRG was presented with the update of the NHS England EPRR Core Standards (Deep Dive Cyber Security) to discuss, change and ratify the plans for the NHS England EPRR Core Standards and compliance report.

- The deep dive in cyber security has been redacted from this report as sensitive information not suitable for the public domain. This detail is available to Board members in September's Finance and Performance Committee papers.

- Following internal meetings, the Trust has been assessed as being 100% **Full** compliance across all the 66 Emergency Preparedness, Resilience and Response (EPRR) Assurance Core Standards – Attached.

- These rational decisions to explain the compliance position are based upon evidence base examples, practical input and planned subjects to meet the criteria. Link to all evidence-based information (105 items) is available on the S Drive, Operations Directorate, Emergency Planning and uploaded to Future NHS framework, as required.

- This assessment will be taken to the ICB's confirm and challenge meeting in Oct 2024 and shared with NHSE for further scrutiny and final confirmation as an element of the wider ICS EPRR Assurance process

- Appended to this report is the EPRR Assurance Spreadsheet identifying the 66 EPRR Core standards and RAG rated compliance.

- The Board are asked to receive the results for assurance.

Recommendation

The Board is recommended to: receive the report for **Assurance**

Name and Title of Author: Ian Kilroy – Head of Emergency Preparedness, Resilience, and Response (EPRR)
Date: 16 Sep 2024

Appendices

Appendix 1 – NHS Core Standards EPRR

EPRR Core Standards August 2024 – Current Submission Proposal

Ref	Domain	Standard name	Standard Detail	Supporting Information - including examples of evidence	Organisational Evidence	Self-assessment RAG	Action to be taken	Lead
Domain 1 - Governance								
1	Governance	Senior Leadership	The organisation has appointed an Accountable Emergency Officer (AEO) responsible for Emergency Preparedness Resilience and Response (EPRR). This individual should be a board level director within their individual organisation, and have the appropriate authority, resources and budget to direct the EPRR portfolio.	Evidence • Name and role of appointed individual • AEO responsibilities included in role/job description	Evidence • Name and role of appointed individual AEO (Anita Thomas - Chief Operating Officer) • Name and role of appointed individual Deputy AEO (Adam Savin) • AEO responsibilities included in role/job description (YES) • http://sharepoint/departments/emergencyplanning/SitePages/Home.aspx	Fully compliant	EPRG Governance Additional evidence link - Future NHS Domains 1	IK

Ref	Domain	Standard name	Standard Detail	Supporting Information - including examples of evidence	Organisational Evidence	Self-assessment RAG	Action to be taken	Lead
2	Governance	EPRR Policy Statement	The organisation has an overarching EPRR policy or statement of intent. This should take into account the organisation's: • Business objectives and processes • Key suppliers and contractual arrangements • Risk assessment(s) • Functions and / or organisation, structural and staff changes.	The policy should: • Have a review schedule and version control • Use unambiguous terminology • Identify those responsible for ensuring policies and arrangements are updated, distributed and regularly tested and exercised • Include references to other sources of information and supporting documentation. Evidence Up to date EPRR policy or statement of intent that includes: • Resourcing commitment • Access to funds • Commitment to Emergency Planning, Business Continuity, Training, Exercising etc.	Evidence The policy should: • Have a review schedule and version control (YES) • Use unambiguous terminology (YES) • Identify those responsible for ensuring policies and arrangements are updated, distributed and regularly tested and exercised (YES - p. 9 para. 7.4 / 7.5) • Include references to other sources of information and supporting documentation. (YES - p.7 para. 6.0) Evidence • Up to date EPRR policy or statement of intent (April 2023) that includes: • Resourcing commitment (YES, p. 8. para 7.1 - revised EPRR Policy doc) • Access to funds (YES, p. 8. para 7.1 - revised EPRR Policy doc) • Commitment to Emergency Planning, Business Continuity, Training, Exercising etc. (YES. p. 9 etc)	Fully compliant	EPRG Governance	IK

Ref	Domain	Standard name	Standard Detail	Supporting Information - including examples of evidence	Organisational Evidence	Self-assessment RAG	Action to be taken	Lead
3	Governance	EPRR board reports	The Chief Executive Officer ensures that the Accountable Emergency Officer discharges their responsibilities to provide EPRR reports to the Board, no less than annually. The organisation publicly states its readiness and preparedness activities in annual reports within the organisation's own regulatory reporting requirements	These reports should be taken to a public board, and as a minimum, include an overview on: • training and exercises undertaken by the organisation • summary of any business continuity, critical incidents and major incidents experienced by the organisation • lessons identified and learning undertaken from incidents and exercises • the organisation's compliance position in relation to the latest NHS England EPRR assurance process. Evidence • Public Board meeting minutes • Evidence of presenting the results of the annual EPRR assurance process to the Public Board • For those organisations that do not have a public board, a public statement of readiness and preparedness activities.	Evidence • Emergency Planning Resilience Group (EPRG) meets every 3 months. • Terms of Reference defined and ratified at EPRG • Sources are escalated to the Finance & Performance Committee (FPC) Report • Annually EPRR Core Standards are completed and an Annual Report submitted to EPRG	Fully compliant	EPRG Governance	IK

Ref	Domain	Standard name	Standard Detail	Supporting Information - including examples of evidence	Organisational Evidence	Self-assessment RAG	Action to be taken	Lead
4	Governance	EPRR work programme	The organisation has an annual EPRR work programme, informed by: • current guidance and good practice • lessons identified from incidents and exercises • identified risks • outcomes of any assurance and audit processes The work programme should be regularly reported upon and shared with partners where appropriate.	Evidence • Reporting process explicitly described within the EPRR policy statement • Annual work plan	Evidence • Reporting process explicitly described within the EPRR policy statement (YES - 14.6 - 16.0) • EPRR & SRM work programme developed for EPRG	Fully compliant	EPRG Governance	IK
5	Governance	EPRR Resource	The Board / Governing Body is satisfied that the organisation has sufficient and appropriate resource to ensure it can fully discharge its EPRR duties.	Evidence • EPRR Policy identifies resources required to fulfil EPRR function; policy has been signed off by the organisation's Board • Assessment of role / resources • Role description of EPRR Staff/ staff who undertake the EPRR responsibilities • Organisation structure chart • Internal Governance process chart including EPRR group	Evidence • Revised EPRR Policy (v. 1.4) 2022 • Head of EPRR Role Profile established with reviewed JD • Senior Business Manager - Central Operations Support	Fully compliant	EPRG Governance	IK
6	Governance	Continuous improvement	The organisation has clearly defined processes for capturing learning from incidents and exercises to inform the review and embed into EPRR arrangements.	Evidence • Process explicitly described within the EPRR policy statement • Reporting those lessons to the Board/ governing body and where the improvements to plans were made • participation within a regional process for sharing lessons with partner organisations	Evidence • Revised EPRR Policy (v. 1.4) 2022. • Lessons learnt process initially established through EPRG • On Call Management working Group established. • Structured debrief process designed • Post Incident Tracker established and monitored	Fully compliant	EPRG Governance	IK

Ref	Domain	Standard name	Standard Detail	Supporting Information - including examples of evidence	Organisational Evidence	Self-assessment RAG	Action to be taken	Lead
					through EPRG • Post Incident Survey module implemented and reviewed at EPRG • Escalation Reports issued from EPRG to FPC			
Domain 2 - Duty to risk assess								
7	Duty to risk assess	Risk assessment	The organisation has a process in place to regularly assess the risks to the population it serves. This process should consider all relevant risk registers including community and national risk registers.	• Evidence that EPRR risks are regularly considered and recorded • Evidence that EPRR risks are represented and recorded on the organisations corporate risk register • Risk assessments to consider community risk registers and as a core component, include reasonable worst-case scenarios and extreme events for adverse weather	Evidence • Corporate Risk Register - DATIX Risk Management software system - references all known EPRR Risks.	Fully compliant	EPRG Governance Additional evidence link - Future NHS Domain 2	IK
8	Duty to risk assess	Risk Management	The organisation has a robust method of reporting, recording, monitoring, communicating, and escalating EPRR risks internally and externally	Evidence • EPRR risks are considered in the organisation's risk management policy • Reference to EPRR risk management in the organisation's EPRR policy document	Evidence • EPRR Risks considered in Trust Risk Management Policy and reports update at the EPRG • http://sharepoint/departments/emergencyplanning/EPRR%20Risk%20Register/Forms/AllItems.aspx	Fully compliant	EPRG Governance	IK
Domain 3 - Duty to maintain Plans								

Ref	Domain	Standard name	Standard Detail	Supporting Information - including examples of evidence	Organisational Evidence	Self-assessment RAG	Action to be taken	Lead
9	Duty to maintain plans	Collaborative planning	Plans and arrangements have been developed in collaboration with relevant stakeholders including emergency services and health partners to enhance joint working arrangements and to ensure the whole patient pathway is considered.	Partner organisations collaborated with as part of the planning process are in planning arrangements Evidence • Consultation process in place for plans and arrangements • Changes to arrangements as a result of consultation are recorded	Evidence • Engagement with ICB/NHS England and LHRP new group and planning agenda agreed and implemented. http://sharepoint/departments/emergencyplanning/Specific%20Response%20Plans/Forms/AllItems.aspx	Fully compliant	EPRG Governance Additional evidence link - Future NHS Domain 3	IK
10	Duty to maintain plans	Incident Response	In line with current guidance and legislation, the organisation has effective arrangements in place to define and respond to Critical and Major incidents as defined within the EPRR Framework.	Arrangements should be: • current (reviewed in the last 12 months) • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	Evidence • Current Major Incident Response Plan currently reviewed, ratified and governed from the EPRG. (Amendments at Ridgeway Ward works)	Fully compliant	EPRG Governance	IK

Ref	Domain	Standard name	Standard Detail	Supporting Information - including examples of evidence	Organisational Evidence	Self-assessment RAG	Action to be taken	Lead
11	Duty to maintain plans	Adverse Weather	In line with current guidance and legislation, the organisation has effective arrangements in place for adverse weather events.	Arrangements should be: • current • in line with current national UK Health Security Agency (UKHSA) & NHS guidance and Met Office or Environment Agency alerts • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required • reflective of climate change risk assessments • cognisant of extreme events e.g. drought, storms (including dust storms), wildfire.	Evidence •Heatwave Plan / Cold Weather Plan reviewed, ratified and governed from the EPRG. (Reference of NHS England Adverse weather included)	Fully compliant	EPRG Governance	IK

Ref	Domain	Standard name	Standard Detail	Supporting Information - including examples of evidence	Organisational Evidence	Self-assessment RAG	Action to be taken	Lead
12	Duty to maintain plans	Infectious disease	In line with current guidance and legislation, the organisation has arrangements in place to respond to an infectious disease outbreak within the organisation or the community it serves, covering a range of diseases including High Consequence Infectious Diseases.	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required Acute providers should ensure their arrangements reflect the guidance issued by DHSC in relation to FFP3 Resilience in Acute setting incorporating the FFP3 resilience principles. https://www.england.nhs.uk/coronavirus/secondary-care/infection-control/ppe/ffp3-fit-testing/ffp3-resilience-principles-in-acute-settings/	Evidence •IPC Plans - Various on SharePoint e.g. Infection Prevent focussed Plans. •http://sharepointapps/clinguide/Pages/index.aspx?View={DEBF5C00-FCDD-410F-AD87-1A4F7BF4CB47}&SelectedID=36. https://staffnet.dchft.nhs.uk/clinical-departments/IPC/Pages/Infection%20Prevention%20and%20Control.aspx	Fully compliant	EPRG Governance	IK

Ref	Domain	Standard name	Standard Detail	Supporting Information - including examples of evidence	Organisational Evidence	Self-assessment RAG	Action to be taken	Lead
13	Duty to maintain plans	New and emerging pandemics	In line with current guidance and legislation and reflecting recent lessons identified, the organisation has arrangements in place to respond to a new and emerging pandemic	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	Evidence • Pandemic Plan (Influenza) reviewed, ratified and governed from the EPRG (Changed to Pandemic Plan with IPC input)	Fully compliant	EPRG Governance	IK

Ref	Domain	Standard name	Standard Detail	Supporting Information - including examples of evidence	Organisational Evidence	Self-assessment RAG	Action to be taken	Lead
14	Duty to maintain plans	Countermeasures	In line with current guidance and legislation, the organisation has arrangements in place to support an incident requiring countermeasures or a mass countermeasure deployment	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required Mass Countermeasure arrangements should include arrangements for administration, reception and distribution of mass prophylaxis and mass vaccination. There may be a requirement for Specialist providers, Community Service Providers, Mental Health and Primary Care services to develop or support Mass Countermeasure distribution arrangements. Organisations should have plans to support patients in their care during activation of mass countermeasure arrangements. Commissioners may be required to commission new services to support mass countermeasure distribution locally, this will be dependant on the incident.	Evidence • Countermeasures Plan - Updated and ratified, via the Extra Ordinary EPRG in Aug 2023 and Jul 2024	Fully compliant	EPRG Governance	IK

Ref	Domain	Standard name	Standard Detail	Supporting Information - including examples of evidence	Organisational Evidence	Self-assessment RAG	Action to be taken	Lead
15	Duty to maintain plans	Mass Casualty	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to incidents with mass casualties.	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required Receiving organisations should also include a safe identification system for unidentified patients in an emergency/mass casualty incident where necessary.	Evidence • Mass Casualties Plan reviewed and ratified at EPRG in Aug 2023 and Jul 2024	Fully compliant	EPRG Governance	IK
16	Duty to maintain plans	Evacuation and shelter	In line with current guidance and legislation, the organisation has arrangements in place to evacuate and shelter patients, staff and visitors.	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	Evidence • Evacuation & Shelter Plan - Updated and ratified via the Extra Ordinary EPRG in Aug 2023 and Jul 2024	Fully compliant	EPRG Governance	IK

Ref	Domain	Standard name	Standard Detail	Supporting Information - including examples of evidence	Organisational Evidence	Self-assessment RAG	Action to be taken	Lead
17	Duty to maintain plans	Lockdown	In line with current guidance, regulation and legislation, the organisation has arrangements in place to control access and egress for patients, staff and visitors to and from the organisation's premises and key assets in an incident.	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	Evidence • Lockdown Plan reviewed and governed from the EPRG, via the Extra Ordinary EPRG in Aug 2023. Also updated at the H&S, Fire and Security Committee.	Fully compliant	EPRG Governance	IK
18	Duty to maintain plans	Protected individuals	In line with current guidance and legislation, the organisation has arrangements in place to respond and manage 'protected individuals' including Very Important Persons (VIPs),high profile patients and visitors to the site.	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	Evidence • VIP Plan updated, via the EPRG in May 2024	Fully compliant	EPRG Governance	IK

Ref	Domain	Standard name	Standard Detail	Supporting Information - including examples of evidence	Organisational Evidence	Self-assessment RAG	Action to be taken	Lead
19	Duty to maintain plans	Excess fatalities	The organisation has contributed to, and understands, its role in the multiagency arrangements for excess deaths and mass fatalities, including mortuary arrangements. This includes arrangements for rising tide and sudden onset events.	Arrangements should be: • current • in line with current national guidance in line with DVI processes • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	Evidence • Dorset LRF Mass Fatalities Plan	Fully compliant	EPRG Governance	IK
Domain 4 - Command and control								
20	Command and control	On-call mechanism	The organisation has resilient and dedicated mechanisms and structures to enable 24/7 receipt and action of incident notifications, internal or external. This should provide the facility to respond to or escalate notifications to an executive level.	• Process explicitly described within the EPRR policy statement • On call Standards and expectations are set out • Add on call processes/handbook available to staff on call • Include 24 hour arrangements for alerting managers and other key staff. • CSUs where they are delivering OOHs business critical services for providers and commissioners	Evidence • EPRR Policy / On Call Manager & Executive Rota SOP reviewed • On Call Manager & Executive Handbook issued. • On Call Management Working Group established with TOR/Agenda/Share point resources improved. • http://sharepoint/departments/emergencyplanning/Training%20Materials/Forms/AllItems.aspx	Fully compliant	EPRG Governance Additional evidence link - Future NHS Domain 4	IK

Ref	Domain	Standard name	Standard Detail	Supporting Information - including examples of evidence	Organisational Evidence	Self-assessment RAG	Action to be taken	Lead
21	Command and control	Trained on-call staff	Trained and up to date staff are available 24/7 to manage escalations, make decisions and identify key actions	• Process explicitly described within the EPRR policy or statement of intent The identified individual: • Should be trained according to the NHS England EPRR competencies (National Minimum Occupational Standards) • Has a specific process to adopt during the decision making • Is aware who should be consulted and informed during decision making • Should ensure appropriate records are maintained throughout. • Trained in accordance with the TNA identified frequency.	Evidence • Updated EPRR Policy document /all staff issued with & briefed on OCM / OCE handbook (See previous for copy of decision log book / JDM • Resilience Staff App launched • E Learning On Call Management launched	Fully compliant	EPRG Governance	IK
Domain 5 - Training and exercising								

Ref	Domain	Standard name	Standard Detail	Supporting Information - including examples of evidence	Organisational Evidence	Self-assessment RAG	Action to be taken	Lead
22	Training and exercising	EPRR Training	The organisation carries out training in line with a training needs analysis to ensure staff are current in their response role.	Evidence • Process explicitly described within the EPRR policy or statement of intent • Evidence of a training needs analysis • Training records for all staff on call and those performing a role within the ICC • Training materials • Evidence of personal training and exercising portfolios for key staff	Evidence • Updated EPRR Policy document /all staff issued with & briefed on OCM / OCE handbook. • Proposed TNA for On Call Management Group agreed at EPRG. • Dorset LRF accessible for On Call Management Group. • PDP issued to all OCE/OCM. Survey completed • E Learning of On Call Management & Business Continuity issued to all OCE/OCM and monitored on monthly basis • PoHC Training published through Education Centre and monitored at the EPRG • Training Record Developed	Fully compliant	EPRG Governance Additional evidence link - Future NHS Domain 5	IK

Ref	Domain	Standard name	Standard Detail	Supporting Information - including examples of evidence	Organisational Evidence	Self-assessment RAG	Action to be taken	Lead
23	Training and exercising	EPRR exercising and testing programme	In accordance with the minimum requirements, in line with current guidance, the organisation has an exercising and testing programme to safely* test incident response arrangements, (*no undue risk to exercise players or participants, or those patients in your care)	Organisations should meet the following exercising and testing requirements: • a six-monthly communications test • annual table top exercise • live exercise at least once every three years • command post exercise every three years. The exercising programme must: • identify exercises relevant to local risks • meet the needs of the organisation type and stakeholders • ensure warning and informing arrangements are effective. Lessons identified must be captured, recorded and acted upon as part of continuous improvement. Evidence • Exercising Schedule which includes as a minimum one Business Continuity exercise • Post exercise reports and embedding learning	Evidence • Between Feb 2023 - Jul 2024; Industrial Action ICC responses involving JD, HC, RCN, SWASFT, Firewall, ED water spillage events have been routinely active live exercises and testing the processes of EPRR covering ICC, OCM/OCE responsibilities, BC Plans, MIRP, Communications and Liaison with external health groups.	Fully compliant	EPRG Governance	IK

Ref	Domain	Standard name	Standard Detail	Supporting Information - including examples of evidence	Organisational Evidence	Self-assessment RAG	Action to be taken	Lead
24	Training and exercising	Responder training	The organisation has the ability to maintain training records and exercise attendance of all staff with key roles for response in accordance with the Minimum Occupational Standards. Individual responders and key decision makers should be supported to maintain a continuous personal development portfolio including involvement in exercising and incident response as well as any training undertaken to fulfil their role	Evidence • Training records • Evidence of personal training and exercising portfolios for key staff	Evidence • Training Records of PRPS trained staff / loggists / OCM's / new Portfolio's of evidence.	Fully compliant	EPRG Governance	IK
25	Training and exercising	Staff Awareness & Training	There are mechanisms in place to ensure staff are aware of their role in an incident and where to find plans relevant to their area of work or department.	As part of mandatory training Exercise and Training attendance records reported to Board	Evidence • EPRG - TNA shared	Fully compliant	EPRG Governance	IK
Domain 6 - Response								

Ref	Domain	Standard name	Standard Detail	Supporting Information - including examples of evidence	Organisational Evidence	Self-assessment RAG	Action to be taken	Lead
26	Response	Incident Co-ordination Centre (ICC)	The organisation has in place suitable and sufficient arrangements to effectively coordinate the response to an incident in line with national guidance. ICC arrangements need to be flexible and scalable to cope with a range of incidents and hours of operation required. An ICC must have dedicated business continuity arrangements in place and must be resilient to loss of utilities, including telecommunications, and to external hazards. ICC equipment should be tested in line with national guidance or after a major infrastructure change to ensure functionality and in a state of organisational readiness. Arrangements should be supported with access to documentation for its activation and operation.	• Documented processes for identifying the location and establishing an ICC • Maps and diagrams • A testing schedule • A training schedule • Pre identified roles and responsibilities, with action cards • Demonstration ICC location is resilient to loss of utilities, including telecommunications, and external hazards • Arrangements might include virtual arrangements in addition to physical facilities but must be resilient with alternative contingency solutions.	Evidence • ICC plan - Reviewed and ratified, via the Extra Ordinary EPRG in Aug 2023 and Jul 2024 at EPRG	Fully compliant	EPRG Governance Additional evidence link - Future NHS Domain 6	IK
27	Response	Access to planning arrangements	Version controlled current response documents are available to relevant staff at all times. Staff should be aware of where they are stored and should be easily accessible.	Planning arrangements are easily accessible - both electronically and local copies	Evidence • SharePoint / hard copies - ICC / Mini ICC	Fully compliant	EPRG Governance	IK

Ref	Domain	Standard name	Standard Detail	Supporting Information - including examples of evidence	Organisational Evidence	Self-assessment RAG	Action to be taken	Lead
28	Response	Management of business continuity incidents	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to a business continuity incident (as defined within the EPRR Framework).	• Business Continuity Response plans • Arrangements in place that mitigate escalation to business continuity incident • Escalation processes	Evidence • Process for maintenance and review of Business Continuity Plans are governed by the EPRG	Fully compliant	EPRG Governance	IK
29	Response	Decision Logging	To ensure decisions are recorded during business continuity, critical and major incidents, the organisation must ensure: 1. Key response staff are aware of the need for creating their own personal records and decision logs to the required standards and storing them in accordance with the organisations' records management policy. 2. has 24 hour access to a trained loggist(s) to ensure support to the decision maker	• Documented processes for accessing and utilising loggists • Training records	Evidence • Loggists Database developed and awareness package available • http://sharepoint/departments/emergencyplanning/Training%20Materials/Forms/AllItems.aspx?RootFolder=%2Fdepartments%2Femergencyplanning%2FTraining%20Materials%2FOn%20Call%20Management%5FLoggist%20Training%20Resources&FolderCTID=0x0120006AD6B1DFE0A4C0448D2170E4E7E3AEB0&View={6EF76331-AB15-43ED-AA07-3E4F9F748B8A} • Loggist Training sessions implemented	Fully compliant	EPRG Governance	IK
30	Response	Situation Reports	The organisation has processes in place for receiving, completing, authorising and submitting situation reports (SitReps) and briefings during the response to incidents including bespoke or incident dependent formats.	• Documented processes for completing, quality assuring, signing off and submitting SitReps • Evidence of testing and exercising • The organisation has access to the standard SitRep Template	Evidence • Revised ICC Plan and evidence based Sit Reps through SCC routinely covering IA, Bronze, Systems Resilience network.	Fully compliant	EPRG Governance	IK

Ref	Domain	Standard name	Standard Detail	Supporting Information - including examples of evidence	Organisational Evidence	Self-assessment RAG	Action to be taken	Lead
31	Response	Access to 'Clinical Guidelines for Major Incidents and Mass Casualty events'	Key clinical staff (especially emergency department) have access to the 'Clinical Guidelines for Major Incidents and Mass Casualty events' handbook.	Guidance is available to appropriate staff either electronically or hard copies	Evidence • Issued to ED Facilitator • Copy in ED and issued to share point	Fully compliant	EPRG Governance	IK
32	Response	Access to 'CBRN incident: Clinical Management and health protection'	Clinical staff have access to the 'CBRN incident: Clinical Management and health protection' guidance. (Formerly published by PHE)	Guidance is available to appropriate staff either electronically or hard copies	Evidence • Issued to ED Facilitator • Copy in ED and issued to share point	Fully compliant	EPRG Governance	IK
Domain 7 - Warning and informing								

Ref	Domain	Standard name	Standard Detail	Supporting Information - including examples of evidence	Organisational Evidence	Self-assessment RAG	Action to be taken	Lead
33	Warning and informing	Warning and informing	The organisation aligns communications planning and activity with the organisation's EPRR planning and activity.	• Awareness within communications team of the organisation's EPRR plan, and how to report potential incidents. • Measures are in place to ensure incidents are appropriately described and declared in line with the NHS EPRR Framework. • Out of hours communication system (24/7, year-round) is in place to allow access to trained comms support for senior leaders during an incident. This should include on call arrangements. • Having a process for being able to log incoming requests, track responses to these requests and to ensure that information related to incidents is stored effectively. This will allow organisations to provide evidence should it be required for an inquiry.	Evidence • Media & Comms Strategy Document & current Major Incident Response Plan - details incident types / 24/7 comms call out via switchboard / ICC administrative processes in place for tracking actions / incoming requests / information etc.	Fully compliant	EPRG Governance Additional evidence link - Future NHS Domain 7	IK

Ref	Domain	Standard name	Standard Detail	Supporting Information - including examples of evidence	Organisational Evidence	Self-assessment RAG	Action to be taken	Lead
34	Warning and informing	Incident Communication Plan	The organisation has a plan in place for communicating during an incident which can be enacted.	• An incident communications plan has been developed and is available to on call communications staff • The incident communications plan has been tested both in and out of hours • Action cards have been developed for communications roles • A requirement for briefing NHS England regional communications team has been established • The plan has been tested, both in and out of hours as part of an exercise. • Clarity on sign off for communications is included in the plan, noting the need to ensure communications are signed off by incident leads, as well as NHSE (if appropriate).	Evidence • Action Cards and Response Plans, via share point review	Fully compliant	EPRG Governance	IK

Ref	Domain	Standard name	Standard Detail	Supporting Information - including examples of evidence	Organisational Evidence	Self-assessment RAG	Action to be taken	Lead
35	Warning and informing	Communication with partners and stakeholders	The organisation has arrangements in place to communicate with patients, staff, partner organisations, stakeholders, and the public before, during and after a major incident, critical incident or business continuity incident.	• Established means of communicating with staff, at both short notice and for the duration of the incident, including out of hours communications • A developed list of contacts in partner organisations who are key to service delivery (local Council, LRF partners, neighbouring NHS organisations etc) and a means of warning and informing these organisations about an incident as well as sharing communications information with partner organisations to create consistent messages at a local, regional and national level. • A developed list of key local stakeholders (such as local elected officials, unions etc) and an established a process by which to brief local stakeholders during an incident • Appropriate channels for communicating with members of the public that can be used 24/7 if required • Identified sites within the organisation for displaying of important public information (such as main points of access) • Have in place a means of communicating with patients who have appointments booked or are receiving treatment. • Have in place a plan to communicate with inpatients and their families or care givers.	Evidence • Action Card and Response Plan	Fully compliant	EPRG Governance	IK

Ref	Domain	Standard name	Standard Detail	Supporting Information - including examples of evidence	Organisational Evidence	Self-assessment RAG	Action to be taken	Lead
				• The organisation publicly states its readiness and preparedness activities in annual reports within the organisations own regulatory reporting requirements				

Ref	Domain	Standard name	Standard Detail	Supporting Information - including examples of evidence	Organisational Evidence	Self-assessment RAG	Action to be taken	Lead
36	Warning and informing	Media strategy	The organisation has arrangements in place to enable rapid and structured communication via the media and social media	• Having an agreed media strategy and a plan for how this will be enacted during an incident. This will allow for timely distribution of information to warn and inform the media • Develop a pool of media spokespeople able to represent the organisation to the media at all times. • Social Media policy and monitoring in place to identify and track information on social media relating to incidents. • Setting up protocols for using social media to warn and inform • Specifying advice to senior staff to effectively use social media accounts whilst the organisation is in incident response	Evidence • Media & Comms Strategy Document & current Major Incident Response Plan - details incident types / 24/7 comms call out via switchboard / ICC administrative processes in place for tracking actions / incoming requests / information etc.	Fully compliant	EPRG Governance	IK
Domain 8 - Cooperation								
37	Cooperation	LHRP Engagement	The Accountable Emergency Officer, or a director level representative with delegated authority (to authorise plans and commit resources on behalf of their organisation) attends Local Health Resilience Partnership (LHRP) meetings.	• Minutes of meetings • Individual members of the LHRP must be authorised by their employing organisation to act in accordance with their organisational governance arrangements and their statutory status and responsibilities.	Evidence • Minutes from LHRP Execs meeting Sept 2022, Jun 2023.	Fully compliant	EPRG Governance Additional evidence link - Future NHS Domain 8	IK

Ref	Domain	Standard name	Standard Detail	Supporting Information - including examples of evidence	Organisational Evidence	Self-assessment RAG	Action to be taken	Lead
38	Cooperation	LRF / BRF Engagement	The organisation participates in, contributes to or is adequately represented at Local Resilience Forum (LRF) or Borough Resilience Forum (BRF), demonstrating engagement and co-operation with partner responders.	• Minutes of meetings • A governance agreement is in place if the organisation is represented and feeds back across the system	Evidence • Dorset LRF Training & Exercising Capability Group - Action & Decision Log • Access for training packages to DCH OCE/OCM staff to assist decisions making and awareness qualifications	Fully compliant	EPRG Governance	IK
39	Cooperation	Mutual aid arrangements	The organisation has agreed mutual aid arrangements in place outlining the process for requesting, coordinating and maintaining mutual aid resources. These arrangements may include staff, equipment, services and supplies. In line with current NHS guidance, these arrangements may be formal and should include the process for requesting Military Aid to Civil Authorities (MACA) via NHS England.	• Detailed documentation on the process for requesting, receiving and managing mutual aid requests • Templates and other required documentation is available in ICC or as appendices to IRP • Signed mutual aid agreements where appropriate	Evidence • DCHFT Mutual Aid access points through LHRP/LA/SWASFT/Police/FRS/ PHE connections	Fully compliant	EPRG Governance	IK
43	Cooperation	Information sharing	The organisation has an agreed protocol(s) for sharing appropriate information pertinent to the response with stakeholders and partners, during incidents.	• Documented and signed information sharing protocol • Evidence relevant guidance has been considered, e.g. Freedom of Information Act 2000, General Data Protection Regulation 2016, Caldicott Principles, Safeguarding requirements and the Civil Contingencies Act 2004	Evidence • DCHFT Mutual Aid access points through LHRP/LA/SWASFT/Police/FRS/ PHE connections	Fully compliant	EPRG Governance	IK
Domain 9 - Business Continuity								

Ref	Domain	Standard name	Standard Detail	Supporting Information - including examples of evidence	Organisational Evidence	Self-assessment RAG	Action to be taken	Lead
44	Business Continuity	BC policy statement	The organisation has in place a policy which includes a statement of intent to undertake business continuity. This includes the commitment to a Business Continuity Management System (BCMS) that aligns to the ISO standard 22301.	The organisation has in place a policy which includes intentions and direction as formally expressed by its top management. The BC Policy should: • Provide the strategic direction from which the business continuity programme is delivered. • Define the way in which the organisation will approach business continuity. • Show evidence of being supported, approved and owned by top management. • Be reflective of the organisation in terms of size, complexity and type of organisation. • Document any standards or guidelines that are used as a benchmark for the BC programme. • Consider short term and long term impacts on the organisation including climate change adaption planning	Evidence • Reviewed and updated BC Management Policy Document v 1.10 October 2022 • http://sharepoint/departments/emergencyplanning/BCM/Forms/AllItems.aspx	Fully compliant	EPRG Governance Additional evidence link - Future NHS Domain 9	IK

Ref	Domain	Standard name	Standard Detail	Supporting Information - including examples of evidence	Organisational Evidence	Self-assessment RAG	Action to be taken	Lead
45	Business Continuity	Business Continuity Management Systems (BCMS) scope and objectives	The organisation has established the scope and objectives of the BCMS in relation to the organisation, specifying the risk management process and how this will be documented. A definition of the scope of the programme ensures a clear understanding of which areas of the organisation are in and out of scope of the BC programme.	BCMS should detail: • Scope e.g. key products and services within the scope and exclusions from the scope • Objectives of the system • The requirement to undertake BC e.g. Statutory, Regulatory and contractual duties • Specific roles within the BCMS including responsibilities, competencies and authorities. • The risk management processes for the organisation i.e. how risk will be assessed and documented (e.g. Risk Register), the acceptable level of risk and risk review and monitoring process • Resource requirements • Communications strategy with all staff to ensure they are aware of their roles • alignment to the organisations strategy, objectives, operating environment and approach to risk. • the outsourced activities and suppliers of products and suppliers. • how the understanding of BC will be increased in the organisation	Evidence • See BC Policy - 3.0 BCMS - Scope & Objectives / 5.0 Roles & Responsibilities / 1.1 Requirements for BC / 15.1 Risk Assessment	Fully compliant	EPRG Governance	IK

Ref	Domain	Standard name	Standard Detail	Supporting Information - including examples of evidence	Organisational Evidence	Self-assessment RAG	Action to be taken	Lead
46	Business Continuity	Business Impact Analysis/Assessment (BIA)	The organisation annually assesses and documents the impact of disruption to its services through Business Impact Analysis(es).	The organisation has identified prioritised activities by undertaking a strategic Business Impact Analysis/Assessments. Business Impact Analysis/Assessment is the key first stage in the development of a BCMS and is therefore critical to a business continuity programme. Documented process on how BIA will be conducted, including: • the method to be used • the frequency of review • how the information will be used to inform planning • how RA is used to support. The organisation should undertake a review of its critical function using a Business Impact Analysis/assessment. Without a Business Impact Analysis organisations are not able to assess/assure compliance without it. The following points should be considered when undertaking a BIA: • Determining impacts over time should demonstrate to top management how quickly the organisation needs to respond to a disruption. • A consistent approach to performing the BIA should be used throughout the organisation. • BIA method used should be robust enough to ensure the information is collected consistently and impartially.	Evidence • EPRR policy document - 12.2 • BIA Process; Strategic & Tactical BC / CI Plan - Appendix B - Identifies prioritised Critical Services; Operational (Ward/Departmental) BIA's • http://sharepoint/departments/emergencyplanning/BCM/Forms/AllItems.aspx?RootFolder=%2Fdepartments%2Femergencyplanning%2FBCM%2FBusiness%20Impact%20Analysis%20Documents&FolderCTID=0x01200012BB27809D69B54792ECA96BF2547B66&View={CCE096E4-E4D0-4833-A816-84C5395E4667}	Fully compliant	EPRG Governance	IK

Ref	Domain	Standard name	Standard Detail	Supporting Information - including examples of evidence	Organisational Evidence	Self-assessment RAG	Action to be taken	Lead
47	Business Continuity	Business Continuity Plans (BCP)	The organisation has business continuity plans for the management of incidents. Detailing how it will respond, recover and manage its services during disruptions to: • people • information and data • premises • suppliers and contractors • IT and infrastructure	Documented evidence that as a minimum the BCP checklist is covered by the various plans of the organisation. Ensure BCPS are Developed using the ISO 22301 and the NHS Toolkit. BC Planning is undertaken by an adequately trained person and contain the following: • Purpose and Scope • Objectives and assumptions • Escalation & Response Structure which is specific to your organisation. • Plan activation criteria, procedures and authorisation. • Response teams roles and responsibilities. • Individual responsibilities and authorities of team members. • Prompts for immediate action and any specific decisions the team may need to make. • Communication requirements and procedures with relevant interested parties. • Internal and external interdependencies. • Summary Information of the organisations prioritised activities. • Decision support checklists • Details of meeting locations • Appendix/Appendices	Evidence • Governed through the EPRG http://sharepoint/departments/emergencyplanning/BCM/Forms/AllItems.aspx	Fully compliant	EPRG Governance	IK

Ref	Domain	Standard name	Standard Detail	Supporting Information - including examples of evidence	Organisational Evidence	Self-assessment RAG	Action to be taken	Lead
48	Business Continuity	Testing and Exercising	The organisation has in place a procedure whereby testing and exercising of Business Continuity plans is undertaken on a yearly basis as a minimum, following organisational change or as a result of learning from other business continuity incidents.	Confirm the type of exercise the organisation has undertaken to meet this sub standard: • Discussion based exercise • Scenario Exercises • Simulation Exercises • Live exercise • Test • Undertake a debrief Evidence Post exercise/ testing reports and action plans	Evidence • Between Feb 2023 - Jun 2024; Industrial Actions, ICC responses involving JD, HC, RCN, SWASFT, Firewall, ED water spillage, Bed Management BAU events have been routinely active live exercises and testing the processes of EPRR covering ICC, OCM/OCE responsibilities, BC Plans, MIRP, Communications and Liaison with external health groups.	Fully compliant	EPRG Governance	IK
49	Business Continuity	Data Protection and Security Toolkit	Organisation's Information Technology department certify that they are compliant with the Data Protection and Security Toolkit on an annual basis.	Evidence • Statement of compliance • Action plan to obtain compliance if not achieved	Evidence • Certification of full compliance in email from Simon Brown (Head of DTI)	Fully compliant	EPRG Governance	IK
50	Business Continuity	BCMS monitoring and evaluation	The organisation's BCMS is monitored, measured and evaluated against established Key Performance Indicators. Reports on these and the outcome of any exercises, and status of any corrective action are annually reported to the board.	• Business continuity policy • BCMS • performance reporting • Board papers	Evidence • BCMS Internal Audit Checklist. • BC approach, delivery and monitoring governed at the EPRG. • Direction issued, updates completed (61), support offered to service managers. • EPRR Drop in sessions issued.	Fully compliant	EPRG Governance	IK

Ref	Domain	Standard name	Standard Detail	Supporting Information - including examples of evidence	Organisational Evidence	Self-assessment RAG	Action to be taken	Lead
51	Business Continuity	BC audit	The organisation has a process for internal audit, and outcomes are included in the report to the board. The organisation has conducted audits at planned intervals to confirm they are conforming with its own business continuity programme.	• process documented in EPRR policy/Business continuity policy or BCMS aligned to the audit programme for the organisation • Board papers • Audit reports • Remedial action plan that is agreed by top management. • An independent business continuity management audit report. • Internal audits should be undertaken as agreed by the organisation's audit planning schedule on a rolling cycle. • External audits should be undertaken in alignment with the organisations audit programme	Evidence • BOD Audit completed, recognised and response plan implemented through EPRG	Fully compliant	EPRG Governance	IK

Ref	Domain	Standard name	Standard Detail	Supporting Information - including examples of evidence	Organisational Evidence	Self-assessment RAG	Action to be taken	Lead
52	Business Continuity	BCMS continuous improvement process	There is a process in place to assess the effectiveness of the BCMS and take corrective action to ensure continual improvement to the BCMS.	• process documented in the EPRR policy/Business continuity policy or BCMS • Board papers showing evidence of improvement • Action plans following exercising, training and incidents • Improvement plans following internal or external auditing •Changes to suppliers or contracts following assessment of suitability Continuous Improvement can be identified via the following routes: • Lessons learned through exercising. • Changes to the organisations structure, products and services, infrastructure, processes or activities. • Changes to the environment in which the organisation operates. • A review or audit. • Changes or updates to the business continuity management lifecycle, such as the BIA or continuity solutions. • Self assessment • Quality assurance • Performance appraisal • Supplier performance • Management review • Debriefs • After action reviews • Lessons learned through exercising or live incidents	Evidence • Governed, compliance checked and managed through EPRG • Improvements of BIA/BC Plans, Audit, Tests, EPRG governance and PDCA approach • Post Exercise Report for E&F presented at EPRG • BC Master Document is monitored and presented at the EPRG • BIA improved (57) • BRP improved (57) • Awareness sessions implemented - BC Awareness • BCMS Share point improved • E Learning Package - Developed and Implemented	Fully compliant	EPRG Governance	IK

Ref	Domain	Standard name	Standard Detail	Supporting Information - including examples of evidence	Organisational Evidence	Self-assessment RAG	Action to be taken	Lead
53	Business Continuity	Assurance of commissioned providers / suppliers BCPs	The organisation has in place a system to assess the business continuity plans of commissioned providers or suppliers; and are assured that these providers business continuity arrangements align and are interoperable with their own.	• EPRR policy/Business continuity policy or BCMS outlines the process to be used and how suppliers will be identified for assurance • Provider/supplier assurance framework • Provider/supplier business continuity arrangements This may be supported by the organisations procurement or commercial teams (where trained in BC) at tender phase and at set intervals for critical and/or high value suppliers	Evidence • Liaison with Procurement and Logistics, DCHFT	Fully compliant	EPRG Governance	IK
Domain 10 - CBRN								
55	Hazmat/CBRN	Governance	The organisation has identified responsible roles/people for the following elements of Hazmat/CBRN: - Accountability - via the AEO - Planning - Training - Equipment checks and maintenance Which should be clearly documented	Details of accountability/responsibility are clearly documented in the organisation's Hazmat/CBRN plan and/or Emergency Planning policy as related to the identified risk and role of the organisation	Evidence • HAZMAT CBRE reviewed through the Extra Ordinary EPRG • EPRR Policy available and updated • BCMS Policy available and updated • CBRN Initial Operational Response Aide Memoir practically issued to ED Staff • IOR Guidance issued to ED Staff	Fully compliant	EPRG Governance Additional evidence link - Future NHS Domain 10	IK

Ref	Domain	Standard name	Standard Detail	Supporting Information - including examples of evidence	Organisational Evidence	Self-assessment RAG	Action to be taken	Lead
56	Hazmat/CBRN	Hazmat/CBRN risk assessments	Hazmat/CBRN risk assessments are in place which are appropriate to the organisation type	Evidence of the risk assessment process undertaken - including - i) governance for risk assessment process ii) assessment of impacts on staff iii) impact assessment(s) on estates and infrastructure - including access and egress iv) management of potentially hazardous waste v) impact assessments of Hazmat/CBRN decontamination on critical facilities and services	Evidence • EPRR Risk Register updated	Fully compliant	EPRG Governance	IK
57	Hazmat/CBRN	Specialist advice for Hazmat/CBRN exposure	Organisations have signposted key clinical staff on how to access appropriate and timely specialist advice for managing patients involved in Hazmat/CBRN incidents	Staff are aware of the number / process to gain access to advice through appropriate planning arrangements. These should include ECOSA, TOXBASE, NPIS, UKHSA Arrangements should include how clinicians would access specialist clinical advice for the on-going treatment of a patient	Evidence • ED Facilitator Staff (Trainers) • Head of EPRR • Medical Engineering - RAMGENE specialist areas • Links to SWASFT Specialist CBRNe • Link to CBRNe Police/FRS/PHE/LA	Fully compliant	EPRG Governance	IK

Ref	Domain	Standard name	Standard Detail	Supporting Information - including examples of evidence	Organisational Evidence	Self-assessment RAG	Action to be taken	Lead
58	Hazmat/CBRN	Hazmat/CBRN planning arrangements	The organisation has up to date specific Hazmat/CBRN plans and response arrangements aligned to the risk assessment, extending beyond IOR arrangements, and which are supported by a programme of regular training and exercising within the organisation and in conjunction with external stakeholders	Documented plans include evidence of the following: • command and control structures • Collaboration with the NHS Ambulance Trust to ensure Hazmat/CBRN plans and procedures are consistent with the Ambulance Trust's Hazmat/CBRN capability • Procedures to manage and coordinate communications with other key stakeholders and other responders • Effective and tested processes for activating and deploying Hazmat/CBRN staff and Clinical Decontamination Units (CDUs) (or equivalent) • Pre-determined decontamination locations with a clear distinction between clean and dirty areas and demarcation of safe clean access for patients, including for the off-loading of non-decontaminated patients from ambulances, and safe cordon control • Distinction between dry and wet decontamination and the decision making process for the appropriate deployment • Identification of lockdown/isolation procedures for patients waiting for decontamination • Management and decontamination processes for contaminated patients and fatalities in line with the latest guidance • Arrangements for staff	Evidence • HAZMAT CBRNe reviewed through EPRG • EPRR Policy available and updated • BCMS Policy available and updated • CBRN Initial Operation Response Aide Memoir practically issued to ED Staff • IOR Guidance issued to ED Staff • SWASFT Audit CBRNe Oct 2022	Fully compliant	EPRG Governance	IK

Ref	Domain	Standard name	Standard Detail	Supporting Information - including examples of evidence	Organisational Evidence	Self-assessment RAG	Action to be taken	Lead
				decontamination and access to staff welfare • Business continuity plans that ensure the trust can continue to accept patients not related/affected by the Hazmat/CBRN incident, whilst simultaneously providing the decontamination capability, through designated clean entry routes • Plans for the management of hazardous waste • Hazmat/CBRN plans and procedures include sufficient provisions to manage the stand-down and transition from response to recovery and a return to business as usual activities • Description of process for obtaining replacement PPE/PRPS - both during a protracted incident and in the aftermath of an incident				

Ref	Domain	Standard name	Standard Detail	Supporting Information - including examples of evidence	Organisational Evidence	Self-assessment RAG	Action to be taken	Lead
59	Hazmat/CBRN	Decontamination capability availability 24 /7	The organisation has adequate and appropriate wet decontamination capability that can be rapidly deployed to manage self presenting patients, 24 hours a day, 7 days a week (for a minimum of four patients per hour) - this includes availability of staff to establish the decontamination facilities There are sufficient trained staff on shift to allow for the continuation of decontamination until support and/or mutual aid can be provided - according to the organisation's risk assessment and plan(s) The organisations also has plans, training and resources in place to enable the commencement of interim dry/wet, and improvised decontamination where necessary.	Documented roles for people forming the decontamination team - including Entry Control/Safety Officer Hazmat/CBRN trained staff are clearly identified on staff rotas and scheduling pro-actively considers sufficient cover for each shift Hazmat/CBRN trained staff working on shift are identified on shift board Collaboration with local NHS ambulance trust and local fire service - to ensure Hazmat/CBRN plans and procedures are consistent with local area plans Assessment of local area needs and resource	Evidence • HAZMAT CBRNe reviewed through the EPRG • EPRR Policy available and updated • BCMS Policy available and updated • CBRN Initial Operation Response Aide Memoir practically issued to ED Staff • IOR Guidance issued to ED Staff • EPRR CBRNe specialist Action Cards in place	Fully compliant	EPRG Governance	IK

Ref	Domain	Standard name	Standard Detail	Supporting Information - including examples of evidence	Organisational Evidence	Self-assessment RAG	Action to be taken	Lead
60	Hazmat/CBRN	Equipment and supplies	The organisation holds appropriate equipment to ensure safe decontamination of patients and protection of staff. There is an accurate inventory of equipment required for decontaminating patients. Equipment is proportionate with the organisation's risk assessment of requirement - such as for the management of non-ambulant or collapsed patients • Acute providers - see Equipment checklist: https://www.england.nhs.uk/wp-content/uploads/2018/07/eprr-decontamination-equipment-check-list.xlsx • Community, Mental Health and Specialist service providers - see guidance 'Planning for the management of self-presenting patients in healthcare setting': https://webarchive.nationalarchives.gov.uk/20161104231146/https://www.england.nhs.uk/wp-content/uploads/2015/04/eprr-chemical-incidents.pdf	This inventory should include individual asset identification, any applicable servicing or maintenance activity, any identified defects or faults, the expected replacement date and any applicable statutory or regulatory requirements (including any other records which must be maintained for that item of equipment). There are appropriate risk assessments and SOPs for any specialist equipment Acute and ambulance trusts must maintain the minimum number of PRPS suits specified by NHS England (24/240). These suits must be maintained in accordance with the manufacturer's guidance. NHS Ambulance Trusts can provide support and advice on the maintenance of PRPS suits as required. Designated hospitals must ensure they have a financial replacement plan in place to ensure that they are able to adequately account for depreciation in the life of equipment and ensure funding is available for replacement at the end of its shelf life. This includes for PPE/PRPS suits, decontamination facilities etc.	Evidence • Suits • Portakabin • Maintenance	Fully compliant	EPRG Governance	IK

Ref	Domain	Standard name	Standard Detail	Supporting Information - including examples of evidence	Organisational Evidence	Self-assessment RAG	Action to be taken	Lead
61	Hazmat/CBRN	Equipment - Preventative Programme of Maintenance	There is a preventative programme of maintenance (PPM) in place, including routine checks for the maintenance, repair, calibration (where necessary) and replacement of out of date decontamination equipment to ensure that equipment is always available to respond to a Hazmat/CBRN incident. Equipment is maintained according to applicable industry standards and in line with manufacturer's recommendations The PPM should include where applicable: - PRPS Suits - Decontamination structures - Disrobe and rerobe structures - Water outlets - Shower tray pump - RAM GENE (radiation monitor) - calibration not required - Other decontamination equipment as identified by your local risk assessment e.g. IOR Rapid Response boxes There is a named individual (or role) responsible for completing these checks	Documented process for equipment maintenance checks included within organisational Hazmat/CBRN plan - including frequency required proportionate to the risk assessment • Record of regular equipment checks, including date completed and by whom • Report of any missing equipment Organisations using PPE and specialist equipment should document the method for it's disposal when required Process for oversight of equipment in place for EPRR committee in multisite organisations/central register available to EPRR Organisation Business Continuity arrangements to ensure the continuation of the decontamination services in the event of use or damage to primary equipment Records of maintenance and annual servicing Third party providers of PPM must provide the organisations with assurance of their own Business Continuity arrangements as a commissioned supplier/provider under Core Standard 53	Evidence • Suits • Portakabin • Maintenance	Fully compliant	EPRG Governance	IK

Ref	Domain	Standard name	Standard Detail	Supporting Information - including examples of evidence	Organisational Evidence	Self-assessment RAG	Action to be taken	Lead
62	Hazmat/CBRN	Waste disposal arrangements	The organisation has clearly defined waste management processes within their Hazmat/CBRN plans	Documented arrangements for the safe storage (and potential secure holding) of waste Documented arrangements - in consultation with other emergency services for the eventual disposal of: - Waste water used during decontamination - Used or expired PPE - Used equipment - including unit liners Any organisation chosen for waste disposal must be included in the supplier audit conducted under Core Standard 53	Evidence • HAZMAT Plan	Fully compliant	EPRG Governance	IK

Ref	Domain	Standard name	Standard Detail	Supporting Information - including examples of evidence	Organisational Evidence	Self-assessment RAG	Action to be taken	Lead
63	Hazmat/CBRN	Hazmat/CBRN training resource	The organisation must have an adequate training resource to deliver Hazmat/CBRN training which is aligned to the organisational Hazmat/CBRN plan and associated risk assessments	Identified minimum training standards within the organisation's Hazmat/CBRN plans (or EPRR training policy) Staff training needs analysis (TNA) appropriate to the organisation type - related to the need for decontamination Documented evidence of training records for Hazmat/CBRN training - including for: - trust trainers - with dates of their attendance at an appropriate 'train the trainer' session (or update) - trust staff - with dates of the training that that they have undertaken Developed training programme to deliver capability against the risk assessment	Evidence • Training Records of PRPS trained staff - Excel spreadsheet	Fully compliant	EPRG Governance	IK

Ref	Domain	Standard name	Standard Detail	Supporting Information - including examples of evidence	Organisational Evidence	Self-assessment RAG	Action to be taken	Lead
64	Hazmat/CBRN	Staff training - recognition and decontamination	The organisation undertakes training for all staff who are most likely to come into contact with potentially contaminated patients and patients requiring decontamination. Staff that may make contact with a potentially contaminated patients, whether in person or over the phone, are sufficiently trained in Initial Operational Response (IOR) principles and isolation when necessary. (This includes (but is not limited to) acute, community, mental health and primary care settings such as minor injury units and urgent treatment centres) Staff undertaking patient decontamination are sufficiently trained to ensure a safe system of work can be implemented	Evidence of trust training slides/programme and designated audience Evidence that the trust training includes reference to the relevant current guidance (where necessary) Staff competency records	Evidence • Training Package - EPRR, IOR Suits, MIRP, Threats • Annual and refresher package managed and co-ordinated from ED, DCH	Fully compliant	EPRG Governance	IK

Ref	Domain	Standard name	Standard Detail	Supporting Information - including examples of evidence	Organisational Evidence	Self-assessment RAG	Action to be taken	Lead
65	Hazmat/CBRN	PPE Access	Organisations must ensure that staff who come in to contact with patients requiring wet decontamination and patients with confirmed respiratory contamination have access to, and are trained to use, appropriate PPE. This includes maintaining the expected number of operational PRPS available for immediate deployment to safely undertake wet decontamination and/or access to FFP3 (or equivalent) 24/7	Completed equipment inventories; including completion date Fit testing schedule and records should be maintained for all staff who may come into contact with confirmed respiratory contamination Emergency Departments at Acute Trusts are required to maintain 24 Operational PRPS	Evidence • Accessible via ED	Fully compliant	EPRG Governance	IK
66	Hazmat/CBRN	Exercising	Organisations must ensure that the exercising of Hazmat/CBRN plans and arrangements are incorporated in the organisations EPRR exercising and testing programme	Evidence • Exercising Schedule which includes Hazmat/CBRN exercise • Post exercise reports and embedding learning	Evidence • As part of the EPRG Training work programme - DCH	Fully compliant	EPRG Governance	IK

EPRR Core Standards August 2023 – Previous Submission

Ref	Domain	Standard name	Standard Detail	Acute Providers	Supporting Information - including examples of evidence	Organisational Evidence
Domain 1 - Governance						
1	**Governance**	**Senior Leadership**	The organisation has appointed an Accountable Emergency Officer (AEO) responsible for Emergency Preparedness Resilience and Response (EPRR). This individual should be a board level director within their individual organisation, and have the appropriate authority, resources and budget to direct the EPRR portfolio.	Y	Evidence • Name and role of appointed individual • AEO responsibilities included in role/job description	Evidence • Name and role of appointed individual (Anita Thomas - Chief Operating Officer) • AEO responsibilities included in role/job description (YES) •http://sharepoint/departments/emergencyplanning/SitePages/Home.aspx

2	**Governance**	**EPRR Policy Statement**	The organisation has an overarching EPRR policy or statement of intent. This should take into account the organisation's: • Business objectives and processes • Key suppliers and contractual arrangements • Risk assessment(s) • Functions and / or organisation, structural and staff changes.	Y	The policy should: • Have a review schedule and version control • Use unambiguous terminology • Identify those responsible for ensuring policies and arrangements are updated, distributed and regularly tested and exercised • Include references to other sources of information and supporting documentation. <u>Evidence</u> Up to date EPRR policy or statement of intent that includes: • Resourcing commitment • Access to funds • Commitment to Emergency Planning, Business Continuity, Training, Exercising etc.	Evidence The policy should: • Have a review schedule and version control (YES) • Use unambiguous terminology (YES) • Identify those responsible for ensuring policies and arrangements are updated, distributed and regularly tested and exercised (YES - p. 9 para. 7.4 / 7.5) • Include references to other sources of information and supporting documentation. (YES - p.7 para. 6.0) Evidence • Up to date EPRR policy or statement of intent (April 2023) that includes: • Resourcing commitment (YES, p. 8. para 7.1 - revised EPRR Policy doc) • Access to funds (YES, p. 8. para 7.1 - revised EPRR Policy doc) • Commitment to Emergency Planning, Business Continuity, Training, Exercising etc. (YES. p. 9 etc.)

3	**Governance**	**EPRR board reports**	The Chief Executive Officer ensures that the Accountable Emergency Officer discharges their responsibilities to provide EPRR reports to the Board, no less than annually. The organisation publicly states its readiness and preparedness activities in annual reports within the organisation's own regulatory reporting requirements	Y		Evidence • EPRG meets every 3 months. • Sources are escalated to the Finance & Performance Report. • Annually EPRR Core Standards are completed and an Annual Report submitted.
4	**Governance**	**EPRR work programme**	The organisation has an annual EPRR work programme, informed by: • current guidance and good practice • lessons identified from incidents and exercises • identified risks • outcomes of any assurance and audit processes The work programme should be regularly reported upon and shared with partners where appropriate.	Y	<u>Evidence</u> • Reporting process explicitly described within the EPRR policy statement • Annual work plan	Evidence • Reporting process explicitly described within the EPRR policy statement (YES - 14.6 - 16.0) • EPRR Work programme drafted for Jul 2023 EPRG

5	**Governance**	**EPRR Resource**	The Board / Governing Body is satisfied that the organisation has sufficient and appropriate resource to ensure it can fully discharge its EPRR duties.	Y	Evidence • EPRR Policy identifies resources required to fulfil EPRR function; policy has been signed off by the organisation's Board • Assessment of role / resources • Role description of EPRR Staff/ staff who undertake the EPRR responsibilities • Organisation structure chart • Internal Governance process chart including EPRR group	Evidence • Revised EPRR Policy (v. 1.4) 2022 • Head of EPRR Role Profile established with reviewed JD (Feb 2023) • New Business Manager role developed to support EPRR/BCMS portfolios (Sep 2023)

Ref	Domain	Standard name	Standard Detail	Acute Providers	Supporting Information - including examples of evidence	Organizational Evidence
6	Governance	Continuous Improvement	The organisation has clearly defined processes for capturing learning from incidents and exercises to inform the review and embed into EPRR arrangements.	Y	Evidence • Process explicitly described within the EPRR policy statement • Reporting those lessons to the Board/ governing body and where the improvements to plans were made • participation within a regional process for sharing lessons with partner organisations	Evidence • Revised EPRR Policy (v. 1.4) 2022. • Lessons learnt process initially established through EPRG • On Call Management working Group established. • Structured debrief process designed - http://sharepoint/departments/emergencyplanning/Training%20Materials/Forms/AllItems.aspx?RootFolder=%2Fdepartments%2Femergencyplanning%2FTraining%20Materials%2FStructured%20Debrief%20Guidance&FolderCTID=0x0120006AD6B1DFE0A4C0448D2170E4E7E3AEB0&View={6EF76331-AB15-43ED-AA07-3E4F9F748B8A}
Domain 2 - Duty to risk assess						
7	Duty to risk assess	Risk assessment	The organisation has a process in place to regularly assess the risks to the population it serves. This process should consider all relevant risk registers including community and national risk registers.	Y	• Evidence that EPRR risks are regularly considered and recorded • Evidence that EPRR risks are represented and recorded on the organisations corporate risk register • Risk assessments to consider community risk registers and as a core component, include reasonable worst- case scenarios and extreme events for adverse weather	Evidence • Corporate Risk Register - DATIX Risk Management software system - references all known EPRR Risks.

8	**Duty to risk assess**	**Risk Management**	The organisation has a robust method of reporting, recording, monitoring, communicating, and escalating EPRR risks internally and externally	Y	Evidence • EPRR risks are considered in the organisation's risk management policy • Reference to EPRR risk management in the organisation's EPRR policy document	Evidence • EPRR Risks considered in Trust Risk Management Policy and reports update at the EPRG •http://sharepoint/departments/emergencyplanning/EPRR%20Risk%20Register/Forms/AllItems.aspx
Domain 3 - Duty to maintain Plans						
9	**Duty to maintain plans**	**Collaborative planning**	Plans and arrangements have been developed in collaboration with relevant stakeholders to ensure the whole patient pathway is considered.	Y	Partner organisations collaborated with as part of the planning process are in planning arrangements Evidence • Consultation process in place for plans and arrangements • Changes to arrangements as a result of consultation are recorded	Evidence •Previous Mass Casualty Consultation (LHRP T&F Group) / Mass Fatalities Consultation (LRF) (as per std 38 - LRF Engagement) •Engagement with ICB/NHS England and LHRP new group and planning agenda agreed and implemented. http://sharepoint/departments/emergencyplanning/Specific%20Response%20Plans/Forms/AllItems.aspx
10	**Duty to maintain plans**	**Incident Response**	In line with current guidance and legislation, the organisation has effective arrangements in place to define and respond to Critical and Major incidents as defined within the EPRR Framework.	Y	Arrangements should be: • current (reviewed in the last 12 months) • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	Evidence • Current Major Incident Response Plan currently being reviewed and governed from the EPRG.

11	**Duty to maintain plans**	**Adverse Weather**	In line with current guidance and legislation, the organisation has effective arrangements in place for adverse weather events.	Y	Arrangements should be: • current • in line with current national UK Health Security Agency (UKHSA) & NHS guidance and Met Office or Environment Agency alerts • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required • reflective of climate change risk assessments • cognizant of extreme events e.g. drought, storms (including dust storms), wildfire.	Evidence •Heatwave Plan / Cold Weather Plan to be reviewed and governed from the EPRG

Ref	Domain	Standard name	Standard Detail	Acute Providers	Supporting Information - including examples of evidence	Organisational Evidence
Domain 1 - Governance						
12	**Duty to maintain plans**	**Infectious disease**	In line with current guidance and legislation, the organisation has arrangements in place to respond to an infectious disease outbreak within the organisation or the community it serves, covering a range of diseases including High Consequence Infectious Diseases.	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required Acute providers should ensure their arrangements reflect the guidance issued by DHSC in relation to FFP3 Resilience in Acute setting incorporating the FFP3 resilience principles. https://www.england.nhs.uk/coronavirus/secondary-care/infection-control/ppe/ffp3-fit-testing/ffp3-resilience-principles-in-acute-settings/	Evidence •IPC Plans - Various on SharePoint e.g. Infection Prevent focused Plans. •http://sharepointapps/clinguide/Pages/index.aspx?View={DEBF5C00-FCDD-410F-AD87-1A4F7BF4CB47}&SelectedID=36. https://staffnet.dchft.nhs.uk/clinical-departments/IPC/Pages/Infection%20Prevention%20and%20Control.aspx
13	**Duty to maintain plans**	**New and emerging pandemics**	In line with current guidance and legislation and reflecting recent lessons identified, the organisation has arrangements in place to respond to a new and emerging pandemic	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	Evidence • Pandemic Influenza Plan being reviewed and governed from the EPRG

14	**Duty to maintain plans**	**Countermeasures**	In line with current guidance and legislation, the organisation has arrangements in place to support an incident requiring countermeasures or a mass countermeasure deployment	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required Mass Countermeasure arrangements should include arrangements for administration, reception and distribution of mass prophylaxis and mass vaccination. There may be a requirement for Specialist providers, Community Service Providers, Mental Health and Primary Care services to develop or support Mass Countermeasure distribution arrangements. Organisations should have plans to support patients in their care during activation of mass countermeasure arrangements. Commissioners may be required to commission new services to support mass countermeasure distribution locally, this will be dependent on the incident.	Evidence • Countermeasures Plan - To be updated via the Extra Ordinary EPRG in Aug 2023
15	**Duty to maintain plans**	**Mass Casualty**	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to incidents with mass casualties.	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required Receiving organisations should also include a safe identification system for unidentified patients in an emergency/mass casualty incident where necessary.	Evidence • Mass Casualty Plan - To be updated via the Extra Ordinary EPRG in Aug 2023

16	**Duty to maintain plans**	**Evacuation and shelter**	In line with current guidance and legislation, the organisation has arrangements in place to evacuate and shelter patients, staff and visitors.	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	Evidence • Evacuation & Shelter Plan - finish updating via the Extra Ordinary EPRG in Aug 2023

Ref	Domain	Standard name	Standard Detail	Acute Providers	Supporting Information - including examples of evidence	Organisational Evidence
17	**Duty to maintain plans**	**Lockdown**	In line with current guidance, regulation and legislation, the organisation has arrangements in place to control access and egress for patients, staff and visitors to and from the organisation's premises and key assets in an incident.	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	Evidence • Lockdown Plan being reviewed and governed from the EPRG, via the Extra Ordinary EPRG in Aug 2023
18	**Duty to maintain plans**	**Protected individuals**	In line with current guidance and legislation, the organisation has arrangements in place to respond and manage 'protected individuals' including Very Important Persons (VIPs), high profile patients and visitors to the site.	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	Evidence • Op Consort / Carbon Steeple & VIP/VVIP Plan, via the Extra Ordinary EPRG in Aug 2023

19	**Duty to maintain plans**	**Excess fatalities**	The organisation has contributed to, and understands, its role in the multiagency arrangements for excess deaths and mass fatalities, including mortuary arrangements. This includes arrangements for rising tide and sudden onset events.	Y	Arrangements should be: • current • in line with current national guidance in line with DVI processes • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	Evidence • Dorset LRF Mass Fatalities Plan
Domain 4 - Command and control						
20	**Command and control**	**On-call mechanism**	The organisation has resilient and dedicated mechanisms and structures to enable 24/7 receipt and action of incident notifications, internal or external. This should provide the facility to respond to or escalate notifications to an executive level.	Y	• Process explicitly described within the EPRR policy statement • On call Standards and expectations are set out • Add on call processes/handbook available to staff on call • Include 24-hour arrangements for alerting managers and other key staff. • CSUs where they are delivering OOHs business critical services for providers and commissioners	Evidence • EPRR Policy / On Call Manager & Executive Rota SOP reviewed • On Call Manager & Executive Handbook. • On Call Management Working Group established with TOR/Agenda/Share point resources improved. • http://sharepoint/departments/emergencyplanning/Training%20Materials/Forms/AllItems.aspx

21	**Command and control**	**Trained on-call staff**	Trained and up to date staff are available 24/7 to manage escalations, make decisions and identify key actions	Y	• Process explicitly described within the EPRR policy or statement of intent The identified individual: • Should be trained according to the NHS England EPRR competencies (National Minimum Occupational Standards) • Has a specific process to adopt during the decision making • Is aware who should be consulted and informed during decision making • Should ensure appropriate records are maintained throughout. • Trained in accordance with the TNA identified frequency.	Evidence • Updated EPRR Policy document /all staff issued with & briefed on OCM / OCE handbook (See previous for copy of decision logbook / JDM
Domain 5 - Training and exercising						

Ref	Domain	Standard name	Standard Detail	Acute Providers	Supporting Information - including examples of evidence	Organisational Evidence
22	**Training and exercising**	**EPRR Training**	The organisation carries out training in line with a training needs analysis to ensure staff are current in their response role.	Y	Evidence • Process explicitly described within the EPRR policy or statement of intent • Evidence of a training needs analysis • Training records for all staff on call and those performing a role within the ICC • Training materials • Evidence of personal training and exercising portfolios for key staff	Evidence • Updated EPRR Policy document /all staff issued with & briefed on OCM / OCE handbook. • TNA drafted at EPRG. • Dorset LRF accessible for On Call Management Group. • E Learning Package designed, developed and to be implemented.

23	**Training and exercising**	**EPRR exercising and testing programme**	In accordance with the minimum requirements, in line with current guidance, the organisation has an exercising and testing programme to safely* test incident response arrangements, (*no undue risk to exercise players or participants, or those patients in your care)	Y	Organisations should meet the following exercising and testing requirements: • a six-monthly communication test • annual tabletop exercise • live exercise at least once every three years • command post exercise every three years. The exercising programme must: • identify exercises relevant to local risks • meet the needs of the organisation type and stakeholders • ensure warning and informing arrangements are effective. Lessons identified must be captured, recorded and acted upon as part of continuous improvement. <u>Evidence</u> • Exercising Schedule which includes as a minimum one Business Continuity exercise • Post exercise reports and embedding learning	Evidence • Previously; 1. 6 monthly communications tests (Ex. Toucan / Toucan 2) 2. Annual Tabletop exercise? (ICS Incident Response Plan Exercise/DCC SAG Camp Bestival Exercise) 3. Live exercise at least once every 3 years (Live Covid -19 Pandemic Response) EPRR Training & Exercising Programme 2022/23 4. Command Post exercise (Live Covid-19 Pandemic Responses 5. Ex Big Ben (21/10/22). • Between Feb 2023 - Jul 2023; Industrial Action ICC responses involving JD, HC, RCN, SWASFT, Firewall, ED water spillage events have been routinely active live exercises and testing the processes of EPRR covering ICC, OCM/OCE responsibilities, BC Plans, MIRP, Communications and Liaison with external health groups.
24	**Training and exercising**	**Responder training**	The organisation has the ability to maintain training records and exercise attendance of all staff with key roles for response in accordance with the Minimum Occupational Standards. Individual responders and key decision makers should be supported to maintain a continuous personal development portfolio including involvement in exercising and incident response as well as any training undertaken to fulfil their role	Y	<u>Evidence</u> • Training records • Evidence of personal training and exercising portfolios for key staff	Evidence • Training Records of PRPS trained staff / loggists / OCM's / new Portfolios of evidence.

25	**Training and exercising**	**Staff Awareness & Training**	There are mechanisms in place to ensure staff are aware of their role in an incident and where to find plans relevant to their area of work or department.	Y	As part of mandatory training Exercise and Training attendance records reported to Board	Evidence • EPRG - TNA drafted
Domain 6 - Response						
26	**Response**	**Incident Co-ordination Centre (ICC)**	The organisation has in place suitable and sufficient arrangements to effectively coordinate the response to an incident in line with national guidance. ICC arrangements need to be flexible and scalable to cope with a range of incidents and hours of operation required. An ICC must have dedicated business continuity arrangements in place and must be resilient to loss of utilities, including telecommunications, and to external hazards. ICC equipment should be tested in line with national guidance or after a major infrastructure change to ensure functionality and in a state of organisational readiness. Arrangements should be supported with access to documentation for its activation and operation.	Y	• Documented processes for identifying the location and establishing an ICC • Maps and diagrams • A testing schedule • A training schedule • Pre identified roles and responsibilities, with action cards • Demonstration ICC location is resilient to loss of utilities, including telecommunications, and external hazards • Arrangements might include virtual arrangements in addition to physical facilities but must be resilient with alternative contingency solutions.	Evidence • ICC plan - due for review via the Extra Ordinary EPRG in Aug 2023
27	**Response**	**Access to planning arrangements**	Version controlled current response documents are available to relevant staff at all times. Staff should be aware of where they are stored and should be easily accessible.	Y	Planning arrangements are easily accessible - both electronically and local copies	Evidence • SharePoint / hard copies - ICC / Mini ICC

Ref	Domain	Standard name	Standard Detail	Acute Providers	Supporting Information - including examples of evidence	Organisational Evidence
28	Response	Management of business continuity incidents	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to a business continuity incident (as defined within the EPRR Framework).	Y	Business Continuity Response plans Arrangements in place that mitigate escalation to business continuity incident Escalation processes	Evidence • Process for maintenance and review of Business Continuity Plans are governed by the EPRG
29	Response	Decision Logging	To ensure decisions are recorded during business continuity, critical and major incidents, the organisation must ensure: 1. Key response staff are aware of the need for creating their own personal records and decision logs to the required standards and storing them in accordance with the organisations' records management policy. 2. has 24 hour access to a trained loggist(s) to ensure support to the decision maker	Y	• Documented processes for accessing and utilising loggists • Training records	Evidence • Loggists Database developed and awareness package available • http://sharepoint/departments/emergencyplanning/Training%20Materials/Forms/AllItems.aspx?RootFolder=%2Fdepartments%2Femergencyplanning%2FTraining%20Materials%2FOn%20Call%20Management%5FLoggist%20Training%20Resources&FolderCTID=0x0120006AD6B1DFE0A4C0448D2170E4E7E3AEB0&View={6EF76331-AB15-43ED-AA07-3E4F9F748B8A}
30	Response	Situation Reports	The organisation has processes in place for receiving, completing, authorising and submitting situation reports (SitReps) and briefings during the response to incidents including bespoke or incident dependent formats.	Y	• Documented processes for completing, quality assuring, signing off and submitting SitReps • Evidence of testing and exercising • The organisation has access to the standard SitRep Template	Evidence • Revised ICC Plan and evidence-based Sit Reps through SCC routinely covering IA, Bronze, Systems Resilience network.
31	Response	Access to 'Clinical Guidelines for Major	Key clinical staff (especially emergency department) have access to the 'Clinical Guidelines for Major Incidents and Mass Casualty events' handbook.	Y	Guidance is available to appropriate staff either electronically or hard copies	Evidence • Issued to ED Facilitator • Copy in ED and issued to share point

		Incidents and Mass Casualty events'				
32	**Response**	**Access to 'CBRN incident: Clinical Management and health protection'**	Clinical staff have access to the 'CBRN incident: Clinical Management and health protection' guidance. (Formerly published by PHE)	Y	Guidance is available to appropriate staff either electronically or hard copies	Evidence • Issued to ED Facilitator • Copy in ED and issued to share point
Domain 7 - Warning and informing						
33	**Warning and informing**	**Warning and informing**	The organisation aligns communications planning and activity with the organisation's EPRR planning and activity.	Y	• Awareness within communications team of the organisation's EPRR plan, and how to report potential incidents. • Measures are in place to ensure incidents are appropriately described and declared in line with the NHS EPRR Framework. • Out of hours communication system (24/7, year-round) is in place to allow access to trained comms support for senior leaders during an incident. This should include on-call arrangements. • Having a process for being able to log incoming requests, track responses to these requests and to ensure that information related to incidents is stored effectively. This will allow organisations to provide evidence should it be required for an inquiry.	Evidence • Media & Comms Strategy Document & current Major Incident Response Plan - details incident types / 24/7 comms call out via switchboard / ICC administrative processes in place for tracking actions / incoming requests / information etc.

34	**Warning and informing**	**Incident Communication Plan**	The organisation has a plan in place for communicating during an incident which can be enacted.	Y	• An incident communications plan has been developed and is available to on call communications staff • The incident communications plan has been tested both in and out of hours • Action cards have been developed for communications roles • A requirement for briefing NHS England regional communications team has been established • The plan has been tested, both in and out of hours as part of an exercise. • Clarity on sign off for communications is included in the plan, noting the need to ensure communications are signed off by incident leads, as well as NHSE (if appropriate).	Evidence • Action Card and Response Plans, via share point review

Ref	Domain	Standard name	Standard Detail	Acute Providers	Supporting Information - including examples of evidence	Organisational Evidence
35	**Warning and informing**	**Communication with partners and stakeholders**	The organisation has arrangements in place to communicate with patients, staff, partner organisations, stakeholders, and the public before, during and after a major incident, critical incident, or business continuity incident.	Y	• Established means of communicating with staff, at both short notice and for the duration of the incident, including out of hours communications • A developed list of contacts in partner organisations who are key to service delivery (local Council, LRF partners, neighboring NHS organisations etc.) and a means of warning and informing these organisations about an incident as well as sharing communications information with partner organisations to create consistent messages at a local, regional and national level. • A developed list of key local stakeholders (such as local elected officials, unions etc.) and an established a process by which to brief local stakeholders during an incident • Appropriate channels for communicating with members of the public that can be used 24/7 if required • Identified sites within the organisation for displaying of important public information (such as main points of access) • Have in place a means of communicating with patients who have appointments booked or are receiving treatment. • Have in place a plan to communicate with inpatients and their families or care givers. • The organisation publicly states its readiness and preparedness activities in annual reports within the organisations own regulatory reporting requirements	Evidence • Action Card and Response Plan

36	**Warning and informing**	**Media strategy**	The organisation has arrangements in place to enable rapid and structured communication via the media and social media	Y	Having an agreed media strategy and a plan for how this will be enacted during an incident. This will allow for timely distribution of information to warn and inform the media • Develop a pool of media spokespeople able to represent the organisation to the media at all times. • Social Media policy and monitoring in place to identify and track information on social media relating to incidents. • Setting up protocols for using social media to warn and inform • Specifying advice to senior staff to effectively use social media accounts whilst the organisation is in incident response	Evidence • Media & Comms Strategy Document & current Major Incident Response Plan - details incident types / 24/7 comms call out via switchboard / ICC administrative processes in place for tracking actions / incoming requests / information etc.
Domain 8 - Cooperation						
37	**Cooperation**	**LHRP Engagement**	The Accountable Emergency Officer, or a director level representative with delegated authority (to authorise plans and commit resources on behalf of their organisation) attends Local Health Resilience Partnership (LHRP) meetings.	Y	• Minutes of meetings • Individual members of the LHRP must be authorised by their employing organisation to act in accordance with their organisational governance arrangements and their statutory status and responsibilities.	Evidence • Minutes from LHRP Execs meeting Sept 2022, Jun 2023.
38	**Cooperation**	**LRF / BRF Engagement**	The organisation participates in, contributes to, or is adequately represented at Local Resilience Forum (LRF) or Borough Resilience Forum (BRF), demonstrating engagement and co-operation with partner responders.	Y	• Minutes of meetings • A governance agreement is in place if the organisation is represented and feeds back across the system	Evidence • Dorset LRF Training & Exercising Capability Group - Action & Decision Log • Access for training packages to DCH OCE/OCM staff to assist decisions making and awareness qualifications

39	**Cooperation**	**Mutual aid arrangements**	The organisation has agreed mutual aid arrangements in place outlining the process for requesting, coordinating, and maintaining mutual aid resources. These arrangements may include staff, equipment, services and supplies. In line with current NHS guidance, these arrangements may be formal and should include the process for requesting Military Aid to Civil Authorities (MACA) via NHS England.	Y	• Detailed documentation on the process for requesting, receiving and managing mutual aid requests • Templates and other required documentation are available in ICC or as appendices to IRP • Signed mutual aid agreements where appropriate	Evidence • DCHFT Mutual Aid access points through LHRP/LA/SWASFT/Police/FRS/PHE connections
40	**Cooperation**	**Arrangements for multi area response**	The organisation has arrangements in place to prepare for and respond to incidents which affect two or more Local Health Resilience Partnership (LHRP) areas or Local Resilience Forum (LRF) areas.	Y	• Detailed documentation on the process for coordinating the response to incidents affecting two or more LHRPs • Where an organisation sits across boundaries the reporting route should be clearly identified and known to all	Evidence • DCHFT Mutual Aid access points through LHRP/LA/SWASFT/Police/FRS/PHE connections

Ref	Domain	Standard name	Standard Detail	Acute Providers	Supporting Information - including examples of evidence	Organisational Evidence
43	**Cooperation**	**Information sharing**	The organisation has an agreed protocol(s) for sharing appropriate information pertinent to the response with stakeholders and partners, during incidents.	Y	• Documented and signed information sharing protocol • Evidence relevant guidance has been considered, e.g. Freedom of Information Act 2000, General Data Protection Regulation 2016, Caldicott Principles, Safeguarding requirements and the Civil Contingencies Act 2004	Evidence • DCHFT Mutual Aid access points through LHRP/LA/SWASFT/Police/FRS/PHE connections
Domain 9 - Business Continuity						
44	**Business Continuity**	**BC policy statement**	The organisation has in place a policy which includes a statement of intent to undertake business continuity. This includes the commitment to a Business Continuity Management System (BCMS) that aligns to the ISO standard 22301.	Y	The organisation has in place a policy which includes intentions and direction as formally expressed by its top management. The BC Policy should: • Provide the strategic direction from which the business continuity programme is delivered. • Define the way in which the organisation will approach business continuity. • Show evidence of being supported, approved and owned by top management. • Be reflective of the organisation in terms of size, complexity and type of organisation. • Document any standards or guidelines that are used as a benchmark for the BC programme. • Consider short term and long term impacts on the organisation including climate change adaption planning	Evidence • Reviewed and updated BC Management Policy Document v 1.10 October 2022 • http://sharepoint/departments/emergencyplanning/BCM/Forms/AllItems.aspx

45	**Business Continuity**	**Business Continuity Management Systems (BCMS) scope and objectives**	The organisation has established the scope and objectives of the BCMS in relation to the organisation, specifying the risk management process and how this will be documented. A definition of the scope of the programme ensures a clear understanding of which areas of the organisation are in and out of scope of the BC programme.	Y	BCMS should detail: • Scope e.g. key products and services within the scope and exclusions from the scope • Objectives of the system • The requirement to undertake BC e.g. Statutory, Regulatory and contractual duties • Specific roles within the BCMS including responsibilities, competencies and authorities. • The risk management processes for the organisation i.e. how risk will be assessed and documented (e.g. Risk Register), the acceptable level of risk and risk review and monitoring process • Resource requirements • Communications strategy with all staff to ensure they are aware of their roles • alignment to the organisation's strategy, objectives, operating environment and approach to risk. • the outsourced activities and suppliers of products and suppliers. • how the understanding of BC will be increased in the organisation	Evidence • See BC Policy - 3.0 BCMS - Scope & Objectives / 5.0 Roles & Responsibilities / 1.1 Requirements for BC / 15.1 Risk Assessment

46	**Business Continuity**	**Business Impact Analysis/Assessment (BIA)**	The organisation annually assesses and documents the impact of disruption to its services through Business Impact Analysis(es).	Y	The organisation has identified prioritised activities by undertaking a strategic Business Impact Analysis/Assessments. Business Impact Analysis/Assessment is the key first stage in the development of a BCMS and is therefore critical to a business continuity programme. Documented process on how BIA will be conducted, including: • the method to be used • the frequency of review • how the information will be used to inform planning • how RA is used to support. The organisation should undertake a review of its critical function using a Business Impact Analysis/assessment. Without a Business Impact Analysis organisations are not able to assess/assure compliance without it. The following points should be considered when undertaking a BIA: • Determining impacts over time should demonstrate to top management how quickly the organisation needs to respond to a disruption. • A consistent approach to performing the BIA should be used throughout the organisation. • BIA method used should be robust enough to ensure the information is collected consistently and impartially.	Evidence • EPRR policy document - 12.2 • BIA Process; Strategic & Tactical BC / CI Plan - Appendix B - Identifies prioritised Critical Services; Operational (Ward/Departmental) BIA's • http://sharepoint/departments/emergencyplanning/BCM/Forms/AllItems.aspx?RootFolder=%2Fdepartments%2Femergencyplanning%2FBCM%2FBusiness%20Impact%20Analysis%20Documents&FolderCTID=0x01200012BB27809D69B54792ECA96BF2547B66&View={CCE096E4-E4D0-4833-A816-84C5395E4667}

Ref	Domain	Standard name	Standard Detail	Acute Providers	Supporting Information - including examples of evidence	Organisational Evidence

47	**Business Continuity**	**Business Continuity Plans (BCP)**	The organisation has business continuity plans for the management of incidents. Detailing how it will respond, recover and manage its services during disruptions to: • people • information and data • premises • suppliers and contractors • IT and infrastructure	Y	Documented evidence that as a minimum the BCP checklist is covered by the various plans of the organisation. Ensure BCPS are Developed using the ISO 22301 and the NHS Toolkit. BC Planning is undertaken by an adequately trained person and contain the following: • Purpose and Scope • Objectives and assumptions • Escalation & Response Structure which is specific to your organisation. • Plan activation criteria, procedures and authorisation. • Response teams roles and responsibilities. • Individual responsibilities and authorities of team members. • Prompts for immediate action and any specific decisions the team may need to make. • Communication requirements and procedures with relevant interested parties. • Internal and external interdependencies. • Summary Information of the organisations prioritised activities. • Decision support checklists • Details of meeting locations • Appendix/Appendices	Evidence • Governed through the EPRG • http://sharepoint/departments/emergencyplanning/BCM/Forms/AllItems.aspx
48	**Business Continuity**	**Testing and Exercising**	The organisation has in place a procedure whereby testing and exercising of Business Continuity plans is undertaken on a yearly basis as a minimum, following organisational change or because of learning from other business continuity incidents.	Y	Confirm the type of exercise the organisation has undertaken to meet this substandard: • Discussion based exercise • Scenario Exercises • Simulation Exercises • Live exercise • Test • Undertake a debrief <u>Evidence</u> Post exercise/ testing reports and action plans	Evidence • Between Feb 2023 - Jul 2023; Industrial Action ICC responses involving JD, HC, RCN, SWASFT, Firewall, ED water spillage, Bed Management BAU events have been routinely active live exercises and testing the processes of EPRR covering ICC, OCM/OCE responsibilities, BC Plans, MIRP, Communications and Liaison with external health groups.

49	**Business Continuity**	**Data Protection and Security Toolkit**	Organisation's Information Technology department certify that they are compliant with the Data Protection and Security Toolkit on an annual basis.	Y	Evidence • Statement of compliance • Action plan to obtain compliance if not achieved	Evidence • Certification of full compliance in email from Simon Brown (Head of IMT)
50	**Business Continuity**	**BCMS monitoring and evaluation**	The organisation's BCMS is monitored, measured and evaluated against established Key Performance Indicators. Reports on these and the outcome of any exercises, and status of any corrective action are annually reported to the board.	Y	• Business continuity policy • BCMS • performance reporting • Board papers	• Evidence • BCMS Internal Audit Checklist. • BC approach, delivery and monitoring governed at the EPRG. • Direction issued, updates completed (61), support offered to service managers. • EPRR Drop-in sessions issued.
51	**Business Continuity**	**BC audit**	The organisation has a process for internal audit, and outcomes are included in the report to the board. The organisation has conducted audits at planned intervals to confirm they are conforming with its own business continuity programme.	Y	• process documented in EPRR policy/Business continuity policy or BCMS aligned to the audit programme for the organisation • Board papers • Audit reports • Remedial action plan that is agreed by top management. • An independent business continuity management audit report. • Internal audits should be undertaken as agreed by the organisation's audit planning schedule on a rolling cycle. • External audits should be undertaken in alignment with the organisations audit programme	Evidence • BOD Audit completed, recognised and response plan implemented through EPRG

Ref	Domain	Standard name	Standard Detail	Acute Providers	Supporting Information - including examples of evidence	Organisational Evidence
52	**Business Continuity**	**BCMS continuous improvement process**	There is a process in place to assess the effectiveness of the BCMS and take corrective action to ensure continual improvement to the BCMS.	Y	• process documented in the EPRR policy/Business continuity policy or BCMS • Board papers showing evidence of improvement • Action plans following exercising, training and incidents • Improvement plans following internal or external auditing •Changes to suppliers or contracts following assessment of suitability Continuous Improvement can be identified via the following routes: • Lessons learned through exercising. Changes to the organisations structure, products nd services, infrastructure, processes or activities. • Changes to the environment in which the organisation operates. • A review or audit. • Changes or updates to the business continuity management lifecycle, such as the BIA or continuity solutions. • Self-assessment • Quality assurance • Performance appraisal • Supplier performance • Management review • Debriefs • After action reviews • Lessons learned through exercising or live incidents	Evidence • Governed, compliance checked and managed through EPRG • Improvements of BIA/BC Plans, Audit, Tests, EPRG governance and PDCA approach

53	**Business Continuity**	**Assurance of commissioned providers / suppliers BCPs**	The organisation has in place a system to assess the business continuity plans of commissioned providers or suppliers; and are assured that these providers business continuity arrangements align and are interoperable with their own.	Y	• EPRR policy/Business continuity policy or BCMS outlines the process to be used and how suppliers will be identified for assurance • Provider/supplier assurance framework • Provider/supplier business continuity arrangements This may be supported by the organisations procurement or commercial teams (where trained in BC) at tender phase and at set intervals for critical and/or high value suppliers	Evidence • Liaison with Procurement and Logistics, DCHFT
Domain 10 - CBRN						
56	**Hazmat/CBRN**	**Governance**	The organisation has identified responsible roles/people for the following elements of Hazmat/CBRN: - Accountability - via the AEO - Planning - Training - Equipment checks and maintenance Which should be clearly documented	Y	Details of accountability/responsibility are clearly documented in the organisation's Hazmat/CBRN plan and/or Emergency Planning policy as related to the identified risk and role of the organisation	Evidence • HAZMAT CBRNe being reviewed through the Extra Ordinary EPRG • EPRR Policy available and updated • BCMS Policy available and updated • CBRN Initial Operation Response Aide Memoir practically issued to ED Staff • IOR Guidance issued to ED Staff
57	**Hazmat/CBRN**	**Hazmat/CBRN risk assessments**	Hazmat/CBRN risk assessments are in place which are appropriate to the organisation type	Y	Evidence of the risk assessment process undertaken - including - i) governance for risk assessment process ii) assessment of impacts on staff iii) impact assessment(s) on estates and infrastructure - including access and egress iv) management of potentially hazardous waste v) impact assessments of Hazmat/CBRN decontamination on critical facilities and services	Evidence • EPRR Risk Register updated
58	**Hazmat/CBRN**	**Specialist advice for Hazmat/CBRN exposure**	Organisations have signposted key clinical staff on how to access appropriate and timely specialist advice for managing patients involved in Hazmat/CBRN incidents	Y	Staff are aware of the number / process to gain access to advice through appropriate planning arrangements. These should include ECOSA, TOXBASE, NPIS, UKHSA Arrangements should include how clinicians would access specialist clinical advice for the on-going treatment of a patient	Evidence • ED Facilitator Staff (Trainers) • Head of EPRR • Medical Engineering - RAMGENE specialist areas • Links to SWASFT Specialist CBRNe • Link to CBRNe Police/FRS/PHE/LA

Ref	Domain	Standard name	Standard Detail	Acute Providers	Supporting Information - including examples of evidence	Organisational Evidence
59	**Hazmat/CBRN**	**Hazmat/CBRN planning arrangements**	• The organisation has up to date specific Hazmat/CBRN plans and response arrangements aligned to the risk assessment, extending beyond IOR arrangements, and which are supported by a programme of regular training and exercising within the organaisation and in conjunction with external stakeholders	Y	Documented plans include evidence of the following: • command and control structures • Collaboration with the NHS Ambulance Trust to ensure Hazmat/CBRN plans and procedures are consistent with the Ambulance Trust's Hazmat/CBRN capability • Procedures to manage and coordinate communications with other key stakeholders and other responders • Effective and tested processes for activating and deploying Hazmat/CBRN staff and Clinical Decontamination Units (CDUs) (or equivalent) • Pre-determined decontamination locations with a clear distinction between clean and dirty areas and demarcation of safe clean access for patients, including for the off-loading of non-decontaminated patients from ambulances, and safe cordon control • Distinction between dry and wet decontamination and the decision-making process for the appropriate deployment • Identification of lockdown/isolation procedures for patients waiting for decontamination • Management and decontamination processes for contaminated patients and fatalities in line with the latest guidance • Arrangements for staff decontamination and access to staff welfare • Business continuity plans that ensure the trust can continue to accept patients not related/affected by the Hazmat/CBRN incident, whilst simultaneously providing the decontamination capability, through designated clean entry routes	Evidence • HAZMAT CBRNe being reviewed through the Extra Ordinary EPRG • EPRR Policy available and updated • BCMS Policy available and updated • CBRN Initial Operation Response Aide Memoir practically issued to ED Staff • IOR Guidance issued to ED Staff • SWASFT Audit CBRNe Oct 2022

					• Plans for the management of hazardous waste • Hazmat/CBRN plans and procedures include sufficient provisions to manage the stand-down and transition from response to recovery and a return to business-as-usual activities • Description of process for obtaining replacement PPE/PRPS - both during a protracted incident and in the aftermath of an incident	
60	**Hazmat/CBRN**	**Decontamination capability availability 24/7**	The organisation has adequate and appropriate wet decontamination capability that can be rapidly deployed to manage self presenting patients, 24 hours a day, 7 days a week (for a minimum of four patients per hour) - this includes availability of staff to establish the decontamination facilities There are sufficient trained staff on shift to allow for the continuation of decontamination until support and/or mutual aid can be provided - according to the organisation's risk assessment and plan(s) The organisations also have plans, training and resources in place to enable the commencement of interim dry/wet, and improvised decontamination where necessary.	Y	Documented roles for people forming the decontamination team - including Entry Control/Safety Officer Hazmat/CBRN trained staff are clearly identified on staff rotas and scheduling pro-actively considers sufficient cover for each shift Hazmat/CBRN trained staff working on shift are identified on shift board Collaboration with local NHS ambulance trust and local fire service - to ensure Hazmat/CBRN plans and procedures are consistent with local area plans Assessment of local area needs and resource	Evidence • HAZMAT CBRNe being reviewed through the Extra Ordinary EPRG • EPRR Policy available and updated • BCMS Policy available and updated • CBRN Initial Operation Response Aide Memoir practically issued to ED Staff • IOR Guidance issued to ED Staff • EPRR CBRNe specialist Action Cards in place

61	**Hazmat/CBRN**	**Equipment and Supplies**	The organisation has adequate and appropriate wet decontamination capability that can be rapidly deployed to manage self presenting patients, 24 hours a day, 7 days a week (for a minimum of four patients per hour) - this includes availability of staff to establish the decontamination facilities There are sufficient trained staff on shift to allow for the continuation of decontamination until support and/or mutual aid can be provided - according to the organisation's risk assessment and plan(s) The organisations also has plans, training, and resources in place to enable the commencement of interim dry/wet, and improvised decontamination where necessary.	Y	Documented roles for people forming the decontamination team - including Entry Control/Safety Officer Hazmat/CBRN trained staff are clearly identified on staff rotas and scheduling pro-actively considers sufficient cover for each shift Hazmat/CBRN trained staff working on shift are identified on shift board Collaboration with local NHS ambulance trust and local fire service - to ensure Hazmat/CBRN plans and procedures are consistent with local area plans Assessment of local area needs and resource	Evidence • HAZMAT CBRNe being reviewed through the Extra Ordinary EPRG • EPRR Policy available and updated • BCMS Policy available and updated • CBRN Initial Operation Response Aide Memoir practically issued to ED Staff • IOR Guidance issued to ED Staff • EPRR CBRNe specialist Action Cards in place

Ref	Domain	Standard name	Standard Detail	Acute Providers	Supporting Information - including examples of evidence	Organisational Evidence
62	**Hazmat/CBRN**	**Equipment - Preventative Programme of Maintenance**	• There is a preventative programme of maintenance (PPM) in place, including routine checks for the maintenance, repair, calibration (where necessary) and replacement of out of date decontamination equipment to ensure that equipment is always available to respond to a Hazmat/CBRN incident. • • Equipment is maintained according to applicable industry standards and in line with manufacturer's recommendations • • The PPM should include: • - PRPS Suits • - Decontamination structures • - Disrobe and rerobe structures • - Water outlets • - Shower tray pump • - RAM GENE (radiation monitor) - calibration not required • - Other decontamination equipment as identified by your local risk assessment e.g. IOR Rapid Response boxes • • There is a named individual (or role) responsible for completing these checks	Y	Documented process for equipment maintenance checks included within organisational Hazmat/CBRN plan - including frequency required proportionate to the risk assessment • Record of regular equipment checks, including date completed and by whom • Report of any missing equipment Organisations using PPE and specialist equipment should document the method for its disposal when required Process for oversight of equipment in place for EPRR committee in multisite organisations/central register available to EPRR Organisation Business Continuity arrangements to ensure the continuation of the decontamination services in the event of use or damage to primary equipment Records of maintenance and annual servicing Third party providers of PPM must provide the organisations with assurance of their own Business Continuity arrangements as a commissioned supplier/provider under Core Standard 53	Evidence • Suits • Portakabin • Maintenance
63	**Hazmat/CBRN**	**Waste disposal arrangements**	The organisation has clearly defined waste management processes within their Hazmat/CBRN plans	Y	Documented arrangements for the safe storage (and potential secure holding) of waste Documented arrangements - in consultation with other emergency services for the eventual disposal of: - Waste water used during decontamination - Used or expired PPE - Used equipment - including unit liners	Evidence • HAZMAT Plan

					Any organisation chosen for waste disposal must be included in the supplier audit conducted under Core Standard 53	
64	**Hazmat/CBRN**	**Hazmat/CBRN training resource**	The organisation must have an adequate training resource to deliver Hazmat/CBRN training which is aligned to the organisational Hazmat/CBRN plan and associated risk assessments	Y	Identified minimum training standards within the organisation's Hazmat/CBRN plans (or EPRR training policy) Staff training needs analysis (TNA) appropriate to the organisation type - related to the need for decontamination. Documented evidence of training records for Hazmat/CBRN training - including for: - trust trainers - with dates of their attendance at an appropriate 'train the trainer' session (or update) - trust staff - with dates of the training that that they have undertaken Developed training program to deliver capability against the risk assessment	Evidence • Training Records of PRPS trained staff - Excel spreadsheet
65	**Hazmat/CBRN**	**Staff training - recognition and decontamination**	The organisation undertakes training for all staff who are most likely to come into contact with potentially contaminated patients and patients requiring decontamination. Staff that may make contact with potentially contaminated patients, whether in person or over the phone, are sufficiently trained in Initial Operational Response (IOR) principles and isolation when necessary. (This includes (but is not limited to) acute, community, mental health and primary care settings such as minor injury units and urgent treatment centres) Staff undertaking patient decontamination are sufficiently trained to ensure a safe system of work can be implemented	Y	Evidence of trust training slides/programme and designated audience Evidence that the trust training includes reference to the relevant current guidance (where necessary) Staff competency records	Evidence • Training Package - EPRR, IOR Suits, MIRP, Threats • Annual and refresher package managed and coordinated from ED, DCH

66	**Hazmat/CBRN**	**PPE Access**	Organisations must ensure that staff who come in to contact with patients requiring wet decontamination and patients with confirmed respiratory contamination have access to, and are trained to use, appropriate PPE. This includes maintaining the expected number of operational PRPS available for immediate deployment to safety undertake wet decontamination and/or access to FFP3 (or equivalent) 24/7	Y	Completed equipment inventories; including completion date Fit testing schedule and records should be maintained for all staff who may come into contact with confirmed respiratory contamination. Emergency Departments at Acute Trusts are required to maintain 24 Operational PRPS	Evidence • Accessible via ED
67	**Hazmat/CBRN**	**Exercising**	Organisations must ensure that the exercising of Hazmat/CBRN plans and arrangements are incorporated in the organisations EPRR exercising and testing programme	Y	Evidence • Exercising Schedule which includes Hazmat/CBRN exercise • Post exercise reports and embedding learning	Evidence • As part of the EPRG Training work programme - DCH

Deep Dive 2023					
Ref	**Domain**	**Standard**	**Deep Dive question**	**Further information**	**Organisational Evidence - Please provide details of arrangements in order to capture areas of good practice or further development. (Use comment column if required)**
DD1	EPRR Training	EPRR TNA	All response roles, including health commander roles described within all EPRR plans, frameworks and arrangements (including business continuity) are included in the organisation's Training Needs Assessment (TNA).	Training needs analysis roles includes incident response roles and health commanders	Evidence • TNA undertaken. • Delivered at EPRG. • E Learning Package designed. • On Call Package developed - JESIP aide memoir, On Call Guidance, OCM Working Group, Log Notebook. Training Record
DD2	EPRR Training	Minimum Occupational Standards	The organisation's operational, tactical and strategic health commanders TNA and portfolios are aligned, at least, to the Minimum Occupational Standards and using the Principles of Health Command course to support at the strategic level.	Health Commander portfolios	MOS reviewed and part of TNA
DD3	EPRR Training	EPRR staff training	The organisation has included within their TNA those staff responsible for the writing, maintaining, and reviewing EPRR plans and arrangements (including Business Continuity and incident communication).	Training needs analysis roles includes EPRR staff	Evidence • TNA undertaken. • Delivered at EPRG. • E Learning Package designed. • Corporate Induction designed for inclusion of EPRR • Link of EPRR with HAZMAT/CBRNe ED Training Package • EPRR Share point reviewed and changes - Action Cards, BCMS, IRP, EPRG ToR, OCM Working Group • On Call Package developed - JESIP aide memoir, On Call Guidance, OCM Working Group, Log Note book. Training Record

DD4	EPRR Training	Senior Leadership Training	Those within the organisation that are accountable for the oversight of EPRR arrangements are included in a TNA.	Training needs analysis roles includes AEO and any of those with delegated authority.	Evidence • On Call Management Group issued Booklets and access to E Learning Package.
DD5	EPRR Training	Access to training materials	Those identified in the organisations EPRR TNA(s) have access to appropriate courses to maintain their own competency and skills.	For example: On-call or nominated command staff have access to Principles of Health Command training. Access to UKHSA e-learning and courses offered	Evidence • Access to share point and additional Dorset LRF Package.
DD6	EPRR Training	Training Data	The organisation monitors, and can provide data on, the number of staff (including health commanders) trained in any given role against the minimum number required as defined in the TNA.	Organisational training records	TBC
DD7	EPRR Training	Monitoring	Compliance with the organisations TNA is monitored and managed through established EPRR governance arrangements at board level and multi-agency level.	Board level reports highlighting training compliance within EPRR TNAs. LHRP reports highlighting training compliance within EPRR TNAs.	TBC
DD8	EPRR Training	JESIP doctrine	The Organisations delivered / commissioned EPRR training is aligned to JESIP joint doctrine	Download the Joint Doctrine - JESIP Website	Evidence • Accessible and Staff/Commander guidance printed. • JESIP App accessible for all staff.
DD9	EPRR Training	Continuous Improvement process	In line with continuous improvement processes, the organisation has a clearly defined process for embedding learning from incidents and exercises in organisationally delivered / commissioned EPRR Training	Organisation has a process in place whereby relevant training material is reviewed following an update to EPRR plans and arrangements. Continuous improvement trackers.	
DD10	EPRR Training	Evaluation	The organisations delivered / commissioned EPRR training is subject to evaluation and lessons identified from participants so as to improve future training delivery.	Evaluation data and evidence of changes based on the feedback. Feedback from peer assessment.	Evidence • Evaluation Forms to be designed post planned Exercises