Board of Directors, Part 1 - 10/12/2024

Tue 10 December 2024, 09:00 - 13:30

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 DCH BoD Part 1 December 2024.pdf (3 pages)
- 1b Draft Minutes BOD Part 1 09 10 2024.pdf (19 pages)
- 1c Action Log BoD PART 1 December 2024.pdf (2 pages)

09:30 - 09:35 (5 min)
3. Chair's Comments

09:35 - 09:45 (10 min)
4. CEO Report

09:45 - 09:55 (10 min)
5. Quality Committee Assurance Report

- Assurance Report QC 04 November 2024.pdf (2 pages)
- Assurance Report QC 26 November 2024.pdf (2 pages)

09:55 - 10:05 (10 min)
6. Maternity Safety Report

- 5.2a Marternityfront sheet Board November 2024 v0.1.pdf (2 pages)
- 5.2b Maternity Board Report Nov 2024 v0.1.pdf (23 pages)

10:05 - 10:15 (10 min)
7. Learning from Deaths Report Q2

- 5.3 24-25 Q2 Learning from Deaths Report Final - Board.pdf (24 pages)

10:15 - 10:25 (10 min)
8. Walkarounds Output Report

- 5.4 Front sheet Senior Leadership Walkaround November 2024.pdf (3 pages)

10:25 - 10:35 (10 min)
9. Safe Staffing Report – Annual Review

- 5.5a Front Sheet Safe Staffing annual report v0.1.pdf (2 pages)
- 8b. Annual Safe Staffing Report 2024.pdf (13 pages)
- 8c. Maternity Staffing report for QC Aug 2023.pdf (8 pages)

10:35 - 10:45
10 min

10. Finance and Performance Committee Assurance Report

- Assurance Report - DCH - FPC November 2024 - DU CH.pdf (3 pages)

10:45 - 10:55
10 min

11. Balanced Scorecard

- 6.2 Balanced Scorecard- An integrated report for the reporting month of Nov 2024 final.pdf (12 pages)

10:55 - 11:05
10 min

12. Finance Report

- 6.3a Finance report Front Sheet DCH Board November 2024.pdf (3 pages)
- 4b. Finance Report October 2024.pdf (15 pages)

11:05 - 11:15
10 min

13. Winter Plan

- 6.5a Winter Plan 2024-2025 Board Front Sheet.pdf (3 pages)
- 6.5b Winter Plan 2024-2025 FINAL DRAFT.pdf (31 pages)
- 6.5c Dorset ICS Winter Plan 2024-25.pdf (53 pages)

11:15 - 11:30
15 min

Break

11:30 - 11:40
10 min

14. People and Culture Committee Assurance Report

- People and Culture Committee in Common Assurance Report DCH November 2024.pdf (5 pages)

11:40 - 11:50
10 min

15. Guardian of Safe Working

- 7.2a GoSW 2425 Q2 Report Front Page Board.pdf (2 pages)
- 8aii. GoSW_APPENDICES 2425 Q2.pdf (3 pages)

11:50 - 12:00
10 min

16. Freedom to Speak Up Report

- 7.3 FTSU report Q1 and Q2 2024.pdf (7 pages)

12:00 - 12:10
10 min

17. Joint Workforce Wellbeing Strategy

- 7.4a Front Sheet DCH Board (Joint HWB Plan).pdf (1 pages)
- 7.4b Joint Workforce Wellbeing Plan 2024-27.pdf (21 pages)

12:10 - 12:20
10 min

18. GMC Survey Results and Action Plan

- 7.5a. GMC Survey PCC Front Sheet Nov 24.pdf (2 pages)
- 10b. GMC NTS for PCC Nov 24 (New Format).pdf (27 pages)

12:20 - 12:30
10 min

19. Strategy, Transformation and Partnership Committee Assurance Report

- Strategy Transformation and Partnerships CiC Assurance Report Nov 2024.pdf (2 pages)

12:30 - 12:40
10 min

20. Social Value Action Plan

- 8.2a Front Sheet and report - DCH Social Value Report (Nov 2024 - Board 10.12.24).pdf (1 pages)
- 8.2b DCH Social Value Programme report (Nov 2024) (Board 10.12.24).pdf (8 pages)
- 8.2c TD - DCH NHP SVROI Update 2024 (mid year).pdf (1 pages)
- 8.2d DCH Arts in Hospital - Delivering Social Value.pdf (2 pages)
- 8.2e.Social Value Activity Report (May-October 2024).pdf (4 pages)

12:40 - 12:50
10 min

21. One Dorset Provider Collaborative Update

- 8.3 DCH Trust Board Dec 2024 ODCP v2.pdf (9 pages)

12:50 - 13:00
10 min

22. Timetable and Milestones for Enabling Strategies

- 8.4 DCH BoD Dec 24 Enabling Plans update V2.0.pdf (8 pages)

13:00 - 13:10
10 min

23. Charitable Funds Committee Assurance Report

- 9.1 Assurance Report - DCH Charitable Funds Committee (19.11.24).pdf (2 pages)

13:10 - 13:20
10 min

24. Scheme of Delegation

13:20 - 13:25
5 min

25. Consent

25.1. DCH SubCo Quarterly Performance Report

- 10.2a DCH SubCo performance report Front Sheet.pdf (2 pages)
- 7. Performance Report Oct 2024.pdf (3 pages)

25.2. DCH SubCo Annual Report and Accounts

- 10.3a. Front sheet - DCH SubCo Annual Report and accounts 202324.pdf (2 pages)
- 3b. DCH SubCo Limited Annual Report and financial statements 2023-24.pdf (23 pages)
- 3c. DCH Subo Management Representation Letter.pdf (4 pages)
- 3d. DCH SubCo Audit Findings 2024.pdf (7 pages)
- 3e. DCH Subco Limited 2024 - Computation and tax disclosures 11.04.2024 from EY.pdf (8 pages)

25.3. Wessex Health Partners Annual Review 2023/24

- 10.4a. Front Sheet WHP annual review_QC 041124 Board.pdf (1 pages)
- 8b. WHP Annual Review 23 24 FINAL 1.0 11June24 FOR WHP BOARD REPORTING.pdf (44 pages)

25.4. Health and Safety Compliance Report

- 10.5 HS report Board 10122024.pdf (10 pages)

25.5. Modern Slavery Statement

- 10.6a. Joint Front Sheet - Slavery and Trafficking Nov 24.pdf (1 pages)
- 19b. Slavery and Human Trafficking Statement DCH Nov 24.pdf (3 pages)

13:25 - 13:30
5 min

26. Questions from the Public

13:30 - 13:30
0 min

27. AOB and meeting closes

Meeting of the Board of Directors (Part 1) of Dorset County Hospital NHS Foundation Trust Tuesday 10th December 2024 at 9.00am to 1.30pm 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	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: Margaret Blankson	Verbal	David Clayton-Smith	Information	
	b) Conflicts of Interests	Verbal	David Clayton-Smith	Information	
	c) Minutes of the Meeting dated 09 October 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.	**Quality**				
5.1.	**Quality Committee Assurance Report**	Enclosure	Claire Lehman	Assurance	9.45-9.55
5.2.	**Maternity Safety Report** (November QC)	Enclosure	Dawn Dawson (Jo Hartley)	Assurance	9.55-10.05
5.3.	**Learning from Deaths Report Q2** (November QC)	Enclosure	Alastair Hutchison (Julie Doherty)	Approval	10.05-10.15
5.4.	**Walkarounds Output Report** (November QC)	Enclosure	Dawn Dawson	Assurance	10.15-10.25
5.5.	**Safe Staffing Report – Annual Review** (November QC)	Enclosure	Dawn Dawson	Approval	10.25-10.35
6.	**Finance and Performance**				
6.1.	**Finance and Performance Committee Assurance Report**	Enclosure	Dave Underwood	Assurance	10.35-10.45
6.2.	**Balanced Scorecard (incl. elective tiering)**	Enclosure	Anita Thomas Executives	Assurance	10.45-10.55
6.3.	**Finance Report** (November FPC)	Enclosure	Chris Hearn	Assurance	10.55-11.05
6.4.	**Winter Plan**	Enclosure	Anita Thomas	Approval	11.05-11.15
	Coffee Break 11.15-11.30				
7.	**People and Culture**				
7.1.	**People and Culture Committee Assurance Report**	Enclosure	Frances West	Assurance	11.30-11.40
7.2.	**Guardian of Safe Working**	Enclosure	Alastair Hutchison	Assurance	11.40-11.50

	(November PCC)		(Jill McCormick)		
7.3.	**Freedom to Speak Up Report** (November PCC)	Enclosure	Nicola Plumb (Lynn Patterson)	Assurance	11.50-12.00
7.4.	**Joint Workforce Wellbeing Strategy** (November PCC)	Enclosure	Nicola Plumb	Assurance	12.00-12.10
7.5.	**GMC Survey Results and Action Plan** (November PCC)	Enclosure	Alastair Hutchison	Approval	12.10-12.20
8.	**Strategy, Transformation and Partnership**				
8.1.	**Strategy, Transformation and Partnership Committee Assurance Report**	Enclosure	David Clayton-Smith	Assurance	12.20-12.30
8.2.	**Social Value Action Plan** (November STPC)	Enclosure	Nick Johnson (Simon Pearson)	Assurance	12.30-12.40
8.3.	**One Dorset Provider Collaborative Update**	Enclosure	Nick Johnson (Ben Print)	Assurance	12.40-12.50
8.4.	**Timetable and Milestones for Enabling Strategies** (November STPC)	Enclosure	Nick Johnson	Assurance	12.50-1.00
9.	**Governance**				
9.1.	**Charitable Funds Committee Assurance Report**	Enclosure	Dave Underwood	Assurance	1.00-1.10
10.	**CONSENT SECTION**				All items 1.10-1.15
	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.				
10.1.	**DCH SubCo Quarterly Performance Report** (November FPC)	Enclosure	Nick Johnson	Information	
10.2.	**DCH SubCo Annual Report and Accounts** (November FPC)	Enclosure	Nick Johnson	Information	
10.3.	**Wessex Health Partners Annual Review 2023/24** (November QC)	Enclosure	Alastair Hutchison	Information	
10.4.	**Health and Safety Compliance Report** (November FPC)	Enclosure	Chris Hearn	Information	
10.5.	**Modern Slavery Statement** (November FPC)	Enclosure	Chris Hearn	Approval	
11.	**Questions from the Public**	Verbal	David Clayton-Smith		1.15-1.20
	In addition to being able to ask questions about discussion at the meeting, members of the public are also able to submit any other questions they may have about the trust in advance of the meeting to Abigail.baker@dchft.nhs.uk				
12.	**Any Other Business** Nil notified	Verbal	David Clayton-Smith	Information	1.20
13.	**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 **9.30am** on **Tuesday 11th February 2025** 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
- Finance Update
- Revenue support request update
- Capital Forecast 2024/25 at month eight
- Scheme of Delegation
- UEC Transformation Programme (with Newton)
- New Hospital Programme Associated Schemes Capital Spend (incl. generator)
- Electronic Health Record
- Cyber Security Update

Minutes of a public (Part 1) meeting of the Board of Directors of Dorset County Hospital NHS Foundation Trust held at 9am on 9th October 2024 at Board Room, Trust Headquarters, Dorset County Hospital and via MS Teams videoconferencing.

Present:		
David Clayton-Smith	DCS	Trust Chair (Chair)
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
Stephen Tilton	ST	Non-Executive Director (via Teams)
David Underwood	DU	Non-Executive Director
Frances West	FW	Non-Executive Director
In Attendance:		
Abi Baker	AB	Corporate Governance Manager (Minutes)
Michelle Board	MBo	Associate Professor of Adult Nursing, Bournemouth University (item BoD24/094)
Rebecca Dew	RD	Research Assistant, Bournemouth University (item BoD24/094)
Judy Gillow	JG	Non-Executive Director, University Hospitals Dorset (Observing)
Jill McCormick	JM	Guardian of Safe Working (item BoD24/116)
Abi Lowe	AL	Graduate Management Trainee (observing)
Andy Miller	AM	Divisional Director of Operations, Urgent and Integrated Care Division (for Anita Thomas)
Adam Nicholls	AN	Clinical Divisional Director, Urgent and Integrated Care Division (via videoconference)
Helena Posnett	HP	Consultant in Public Health (via Teams) (item BoD24/110)
Hannah Robinson	HR	Head of Patient Experience, Armed Forces Lead (item BoD24/094)
Vikki Tweedy	VT	Advanced Nurse Practitioner Dementia (item BoD24/094)
Members of the Public:		
Alan Clark	AC	Governor (via videoconference)
Judy Crabb	JC	Governor (via videoconference)
Kathryn Harrison	KH	Lead Governor (via videoconference)
Jean-Pierre Lambert	JPL	Governor (via videoconference)
Anne Link	AL	Governor (via videoconference)
Apologies:		
Margaret Blankson	MB	Non-Executive Director
Anita Thomas	AT	Chief Operating Officer

BoD24/094	**Patient Story**	
	DD introduced the patient story which focused on research to understand dementia in veterans. HR outlined her role as armed forces lead for the trust and the trust's focus on developing support for the armed forces community. Of note HR highlighted the partnership with the Dorset Royal British Legion, work relating to armed forces mental health, work to gain	

	reaccreditation with the Veterans Covenant Healthcare Alliance, and work with Dorset HealthCare (DHC) in this space. VT outlined her career as a dementia specialist nurse and that she enjoyed meeting and learning about people as part of her job. Her observations of patients during Covid-19 made her question whether there was a link between dementia and veterans and resulted in her researching this with colleagues at Bournemouth University. MBo described the complexities relating to veterans with dementia, the overlap with delirium, post-traumatic stress disorder, and the importance of identifying veterans in order to meet their health needs. VT and MBo's work had been funded by Dementia Research UK. The Board watched a video about the work which took place in creative workshops, with veteran patients with dementia diagnoses with a view to further understanding the relation between those two factors and how best to support and meet the needs of those individuals. The meeting heard that veterans could be more at risk of developing dementia due to the risk factors that they were exposed to. FW commended the work of the project with the aim to improve patient experience and asked whether additional research was being conducted in to other groups that worked in bonded ways, such as first responders. MBo described that there was little research in this area but noted that many of the veterans they had met had gone on to work in other services, such as police. CL commended the work, noted the impact of the project on health inequalities and highlighted the need to mitigate against the potential risk of expanding health inequalities by focusing on specific groups of people. MBr thanked HR, VT and MBo for their presentation and work, noting that it demonstrated the importance of partnership working. He encouraged Board members to reflect on how work such as this could be resourced, noting that it aligned to the principles of the trust's strategy. Finally, MBr reflected that dementia should be considered in the context of a system-wide approach, and on the various interventions that were available to support people living with dementia.	
	Resolved that: the Patient Story be received for information.	
BoD24/095	**Formalities**	
	The Chair declared the meeting open and quorate and welcomed governors to the meeting. Apologies for absence were received from Margaret Blankson and Anita Thomas.	
BoD24/096	**Conflicts of Interest**	
	There were no conflicts of interest declared in the business to be transacted on the agenda.	
BoD24/097	**Minutes of the Meeting held on the 31st July 2024**	
	The Minutes of the meeting dated 31st July 2024 were approved as an accurate reflection of the meeting.	

	Resolved: that the minutes of the meeting held on 31st July 2024 were approved.	
BoD24/098	**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.	
BoD24/099	**Chair's Comments**	
	DCS reflected on the work that had been undertaken since the last Board meeting, including the Annual General and Annual Members Meeting which had received positive feedback, and the first committees in common with DHC which had felt natural. DCS thanked MBr for his open, transparent and honest communication style and noted the focus by executives on the trust's financial position.	
	Resolved: that the Chair's comments be received for information.	
BoD24/100	**CEO Update**	
	MBr took the report as read, highlighting the below points: • The winter vaccination programme had begun, and staff were encouraged to get vaccinated. • A recent joint Board Development Session had focused on the recently approved Inclusion and Belonging Strategy. The discussions had been thought provoking and would feed in to future work of the board and help to share conversations. • The approval of the Joint Strategy offered and exciting step forward in providing a sense of direction for the two trusts. The new Board Assurance Framework offered further coherency in the strategic approach to fulfil the strategy. • Progress with the New Hospitals Programme, despite the national review of the programme. • Completion of the redevelopment of Ridgeway Ward as part of the changing pathway for orthopaedic patients. • Services remained very busy and had been at OPEL 4 in the last week. There was a slightly better position today but, overall, high levels of emergency admissions were being sustained at an increase of 13% compared to last year. This was in spite of work around admissions avoidance. Executives had commissioned work to look in to this to understand what could be done to improve the position. Updates would be shared with the Board in due course. • Discharges continued to be delayed particularly for patients with no criteria to reside, with a variance to the plan of 15 to 20 patients. • The financial position of the Dorset system continued to be an area of focus and would be discussed in both parts of the Board meeting today. The position was described as very difficult, with a possibility that a deficit to the plan would be reported. Asked about the response to the Darsi report, MBr referred to the previously circulated report, noting that a national engagement plan would	

	be developed to ensure that local people would be involved in the 10-year plan. Further updates would be provided in due course. It was further noted that the new joint strategy and much of the work of the two Trusts was aligned with the Darsi report, particularly the integrated neighbourhood teams (INT) transformational work. The challenge to create long term, strategic, transformational change whilst meeting short term financial requirements was noted as a risk. MBr confirmed that no additional winter funding was expected this year. EJ asked whether there had been any cancellations of elective procedures since ridgeway ward opened. MBr confirmed that there had been some low-level cancellations in order to support capacity and patient experience. Tangentially, SP asked for a review of the investment on the redesign of ridgeway ward, to understand whether it had delivered as expected in terms of capacity. An update would be provided to February's Board meeting. ST commended the hard work of NJ and CH's teams over the years to progress the New Hospital Programme. MBr noted that the Trust was working closely with GP colleagues to understand the impact of GP action.	**CH**
	Resolved: that the CEO Update be received for information.	
BoD24/101	**Board Assurance Framework** and **Corporate Risk Register**	
	Board Assurance Framework Providing context to the paper, JH outlined that the joint strategy and strategic risks were approved by both Boards in July. It had been agreed that there would be two separate Board Assurance Frameworks, but both aligned to those joint strategic risks. A Board Assurance Framework template had been developed and had been presented to the Audit Committees of both Trusts and to the committees in common. There were ten strategic risks, all with an unmitigated and a mitigated risk score, and all with an executive lead. All risks had been reviewed at Joint Executive Management Team meeting (JEMT) and the document was a live, dynamic document which incorporated feedback received at committees. The Corporate Risk Register had not yet been updated so included references to the old Board Assurance Framework but would be updated in due course. Board members commended the work to refresh the Board Assurance Framework, noting that the risk-on-a-page view enabled committees and the Board to have a formal disciplined review of the elements that required attention. They were eager to see the Corporate Risk Register revised in a similar format. As the chair of Audit Committee, SP highlighted the importance of the Board Assurance Framework being a live document with actions taken to improve controls and assurances. He encouraged all chairs to challenge and seek assurance from the Board Assurance Framework.	

	MBr requested that the Finance and Performance Committee in Common reviewed strategic risks five (estates) and six (finance) to check whether the risk scores should be increased, owing to the financial position and the risk around fire safety. A similar query was raised regrading strategic risk four (capacity and demand). DCS noted the importance of the Board Assurance Framework being discussed at the start of the meeting, to give assurance that the issues discussed in the rest of the meeting are recognised, quantified, and work was being done to resolve them. **Corporate Risk Register** DD outlined that the report contained information up to the end of August. Each committee had reviewed their own risks, and the full paper was presented to Audit Committee. There were 12 new risks between June and August. Of note, five risks related to digital matters. There were four risks with reduced scores and 48 risks were closed in the reporting period. DD's and JH's teams would map the Corporate Risk Register to the new Board Assurance Framework. MBr highlighted that risk 1914 had been calculated incorrectly. DD would review this.	**FPCIC**
	Resolved: that the Board Assurance Framework and Corporate Risk Register be received for assurance.	
BoD24/102	**Working Together Programme Committee Assurance Report** **And** **Strategy, Transformation and Partnership Committee Assurance Report**	
	DCS noted the change in committee name and focus in the reporting period. He felt that the committee would be very effective and highlighted the need to ensure that transformational change actually happened and was not just talked about. The committee had responsibility for ensuring that there were delivery plans in place, that they moved forward, and that there was cross-departmental coordination in regard to these plans. DCS highlighted the following key areas for awareness of the Board: • The Joint Improvement Framework (JIF) which helped to prioritise the transformational work across the two trusts, given that there was not the capacity to do everything. • The One Transformation Approach which empowered and enabled all staff across the two trusts to be involved in transformation. • The frailty flagship programme and provider collaborative were also discussed at the committee. NJ reflected on the cohesiveness that the Strategy, Transformation and Partnership Committee in Common offered in bringing together a number of workstreams in to one place. A number of these workstreams would be discussed later on this agenda. DU raised the matter of a number of risks relating to digital matters, and felt it was important for Board members to understand the prioritisations made by the Digital Transformation Assurance Group (DTAG). NJ highlighted a recent digital prioritisation workshop had reviewed 175	

	projects and shortlisted 68 but needed to reduce this further. The final output from those discussions would be returned to Strategy, Transformation and Partnership Committee in Common when ready. Quality impact assessments and risks would be considered as part of this prioritisation work.	
	Resolved: that the Working Together Programme Committee Assurance Report and Strategy, Transformation and Partnership Committee Assurance Report be received for assurance.	
BoD24/103	**Strategy Launch and Implementation**	
	Following the approval of the joint strategy at the last Board meeting, the paper outlined the launch and implementation process for feedback and comments. The strategy was formally launched in the week beginning 30th September and positive feedback had been received to date. Staff were starting to reflect on the strategy and what it means for them and their service. The strategy was now available on the Trust website, had been shared with key partners and the associated culture and engagement programme was detailed in the paper. NJ described the strategy as evolutionary and as a tool to guide decision making over the coming months and years. Alongside the strategy, there were four enabling strategies which would be developed over the next six months; clinical, people, digital and estates/infrastructure. These would be returned to committees and Board in draft form for discussion and input and the final versions would be approved by the Board. The JIF would empower colleagues to improve the ways they work and would allow great, existing quality improvement workstreams to be built upon and would allow improvement to be directed towards the strategic objectives of the strategy. Finally, a set of strategic metrics were being developed to help measure progress; these would need to have a good connection with performance reporting. DCS asked how Board members would know that teams have had the opportunity to become involved in the implementation of the strategy, recognising that it had only recently been launched. DD outlined recent events with ward leaders and matrons where the strategy had been discussed. Those members of staff had recognised that their input in the development stage was included in the document and the final strategy had landed well with them. NP reflected on the transition period the strategy was in and that the next step was to make it feel different in reality. As initiatives were brought through that echoed the vision and mission statements it would feel like a refresh of the organisations. MBr reflected that the strategy was aiming to achieve revolution through evolution and the progress that had been made in creating a coherent centre from which both Trusts could work. It was important for the strategy to be socialised with staff, but with a focus on the impact for them.	

	EJ cautioned against having too many strategies as this could cause confusion. Instead, she felt there should be one strategy with supporting plans.	
	Resolved that: the Strategy Launch and Implementation be received for assurance.	
BoD24/104	**One Transformation Approach Progress Update**	
	NJ outlined this as one of the key deliveries of the strategy and described this as a strategic transformation portfolio approach. The new strategy offered the chance to review transformation programmes and to ensure they were aligned to the new strategic objectives and outcomes Furthermore there was not the capacity within the Trust to deliver everything, so it was important to prioritise programmes and track their impact to ensure they were making a difference. The One Transformation Approach considered all these elements and offered the ability to achieve these goals. Under the approach as many transformation programmes as possible had been prioritise against a set of criteria and the key portfolios had subsequently been agreed as place and neighbourhoods, mental health, sustainable services, and working together. Each of those portfolios had sets of programmes and projects within them. This work had been presented to the Transformation Improvement Board and Strategy, Transformation and Partnership Committee in Common, the output of which was detailed on page 113 of the papers. Also detailed in the paper were the projects that were not a priority for the trust at present. The meeting heard that this did not mean they were not important or that there would not be progress, they may be overseen by other colleagues in the trust, but it was a clear signal that they would not be progressed using the engine of joint transformation. Subject to endorsement from the Board the next step was to realign current capacity, within the transformation team and across the trust, against the new portfolios. NJ reflected that the approach would not solve all the problems the trust was dealing with but would offer a better chance to deliver key strategic transformation. The Board discussed the de-prioritised programmes, noting that it might be useful to keep track of their progress in case they could be prioritised again. DU reflected that being able to de-prioritise showed a level of maturity in understanding that it was not possible to do everything, and in focusing resources on the areas that needed it most. Board members approved the priorities outlined in the paper.	
	Resolved that: the One Transformation Approach Progress Update be approved.	
BoD24/105	**Our Dorset Provider Collaborative Update**	
	NJ outlined that the report set out the current activity against the 2024/25 workplan. The report was taken as read, but NJ highlighted two key points.	

	Firstly, the Our Dorset Provider Collaborative (ODPC) and programmes therein were affected by the amount of time and focus that each trust could put in to it. This was noted given the additional activity required across the system and should be paid attention to. Secondly, a Chair and NED oversight forum had been planned and postponed a number of times, all for good reasons, but this was an important forum to hold and would offer the chance for discussions between providers included in the ODPC. The ODPC was a key vehicle for delivering strategic change across the provider landscape and some discussions between Chairs and NEDs would help move the work forward. As the board observer from University Hospitals Dorset (UHD), and as a former DCH Board member, JG expressed how impressed she was with the progress made at the Trust and with collaborative work across the system. It was helpful for each trust to understand each other's priorities and to maximise the opportunities to work together.	
	Resolved: that the Our Dorset Provider Collaborative Update be received for assurance.	
BoD24/106	**Quality Committee Assurance Report**	
	CL highlighted the following key aspects from the report: • The number of risks relating to digital matters, including in coding, friends and family test, and safeguarding • Continuing issues with renal transport over the last year. Various routes to address this with the ICB had been made but no resolution was clear yet. 10% of patients were not receiving a good service. DD highlighted that a response had been received from the ICB following the escalation to them and that an improvement plan and assurance measures were now in place. • High rate of emergency readmissions which was impacting patient flow • The option of an inhouse provision was being explored for the friends and family test. Lower response rate at present was due to the use of paper questionnaires whilst between providers. Noting that it was good to hear an update from the ICB on the renal transport issue, EJ highlighted that the Frances Report had founds hundreds of cation plans but no improvements being made. For this group of particularly vulnerable patients it was important to find a different solution. In Somerset EJ had recently seen adverts for volunteer drivers and wondered if this could be explored for this issue. MBr noted the update from the ICB and would continue to raise with ICB colleagues.	
	Resolved: that the Quality Committee Assurance Report be received for assurance.	
BoD24/107	**Maternity Update**	
	DD highlighted the following key points from the report: • Good progress around carbon monoxide monitoring, although slightly below target this month	

	• Positively, the trust was performing below the national target this month for third degree tears, and post-partum haemorrhage • Three baby losses in month, including one term baby. All processes were being followed to review these. • The team had been working hard to achieve all actions outstanding from the CQC visit. The CQC and NHS England insight team were welcomed to the unit on 30th September. They had reviewed action plans, spoke to staff, women, and parents and had stepped the service down from enhanced to routine surveillance. DD commended the phenomenal work for the team to reach this point. • The team were now working hard to achieve Maternity Incentive Scheme (MIS) compliance and had until November to do so Questions and challenges were raised around assigning risks to teams rather than specific individuals and the need to improve lifecycle management of infrastructure, particularly in relation to risk 1825 regarding ventilators. On the latter point DD and CH confirmed that discussions about this were ongoing in a number of forums, including JEMT, Charitable Funds Committee and Finance and Performance Committee in Common, noting the finite resources of the trust. CH would further raise this at Medical Devices Committee to consider how this was reported and articulated. MBr further reflected on the backlog of estates maintenance and the need to understand the scope and impact of this over the next three years. CH advised that this was already underway within capital planning with a view to moving to a proactive space.	
	Resolved: that the Maternity Update be received for assurance.	
BoD24/108	**Learning from Deaths Report Q1**	
Baker,Abi 09/12/2024 13:00:34	AH outlined that, positively, the Summary Hospital-level Mortality Indicator (SHMI) had been within the expected range for the past year and was on an overall downwards trend. The graph on page 168 showed the prediction for the coming months and it was expected that the trust would reach its target in March. One thing that could affect this is coding. At present the coding team were going well, but this had fluctuated over recent years and had impacted the SHMI. In order to mitigate past concerns about the accuracy of the SHMI there were two key areas where excess deaths might be observed. First in the rate of cardiac arrests per 1,000 hospital admissions and secondly, in the mortality rate in intensive care. The trust was performing well in both regards. Maternity data was now included in the report as well as learning from inquests and coroners comments. SP sought assurance that there was a level of independence and scrutiny within mortality and morbidity (M&M) meetings. AH outlined that there where a selection of cases were reviewed, as opposed to all cases, there were processes in place to ensure there was a genuine random sample. Whilst there were elements of independence in the meetings, the meetings were an in-house process to promote openness and honesty amongst peers. AH was working to improve the processes around M&M meetings.	

	EJ reflected that the learning from M&M meetings could be better aligned to Patient Safety Incident Response Framework (PSIRF) and the report could better capture real learning rather than actions from mortality reviews. The meeting heard that PSIRF was relatively new at the trust and that embedding this cultural change took time, but that there was learning to be had from DHC.	
	Resolved: that the Learning from Deaths Report Q1 be approved for publication.	
BoD24/109	**National Patient Survey Results**	
	DD outlined that the survey was undertaken in November 2023. The results had been received in the summer but had been embargoed until August although work to address the results had already begun. Of note, DD highlighted: • The low response to the question about quality of care, noting that this question was not asked directly but learned about in other ways e.g. patient volunteers visiting wards to learn about their experience • Patients reported a lack of clarity regarding what would happen once discharged. An action plan for this was included in the paper and would be monitored through the patient experience committee. EJ challenged that patient experience was everyone's business and that the nursing teams alone should not be responsible for actions. DD would work with AH and AT around this.	
	Resolved: that the National Patient Survey Results be received for assurance.	
BoD24/110	**Health Inequalities Report**	
	The report was presented for assurance, but approval of governance arrangements was also required. HP provided an update on the health inequalities work taking place across DCH and DHC. In particular she noted: • The role of the trusts to tackle health inequalities through prevention, to optimise equality and fairness, and to address the wider determinants of health • Progress in areas including treating tobacco dependency, mental health and health literacy • Work to strengthen equality and quality impact assessments (EQIA) • Link to key system pieces of work, including a project called 'I am more than' and work to improve equality of access to research • A joint steering group had been set up to consider what could be delivered over the coming year, noting the changing structures in the trusts and the work of the Strategy, Transformation and Partnership Committee in Common. The group will elevate conversations in to a more strategic space. MBr expressed his thanks to HP, adding that the steering group would bring the good work taking place across both trusts in to one space and	

	would report in to the Strategy, Transformation and Partnership Committee in Common. The Board would receive updates on health inequalities work through this route. MBr reflected that this work could be more place-based by developing a pan-Dorset group on health inequalities, in conjunction with local authorities. The Board approved the governance arrangements of the health inequalities steering group.	
	Resolved: that the Health Inequalities Report be received for assurance. **It was further resolved that the governance arrangements of the health inequalities steering group be approved.**	
BoD24/111	**Finance and Performance Committee Assurance Report**	
	DU highlighted the following aspects of the report: • The inaugural meeting of the committee reviewed the Board Assurance Framework and strategic risks assigned to the committee • The benefit of two sets of NEDs was noted • Discussion around fire compliance, noting the work underway to improve the position • Seasonal surge plan, Premises Assurance Model (PAM) and Emergency Preparedness, Resilience & Response (EPRR) Annual Assurance Report were all recommended to Board for approval • Endorsement of option four of the clinical coding workforce strategy • Cost improvement programme (CIP) deep dive, noting the 5% target and work to engage staff to understand that everyone had a role to deliver the CIP. Noting the risk around fire compliance, EJ sought further assurance that the EPRR was fully compliant. She further sought additional detail around the PAM noting the backwards deviation. CH noted that the new joint director of estates and facilities (DM) was providing a great deal of focus on compliance and next year's PAM would include an independent view to validate the trust's self-assessment. MBr added that the EPRR already included an external assessment which should provide additional assurance about the results, but that further assurance around the arrangements for evacuation in the event of a fire could be provided to Finance and Performance Committee in Common.	**FPCIC**
	Resolved: that the Finance and Performance Committee Assurance Report be received for assurance.	
BoD24/112	**Balanced Scorecard**	
Baker,Abi 09/12/2024 13:00:34	AM highlighted the following key aspects of the report in relation to quality and performance: • A focus on improving emergency readmissions with a slight reduction in this regard • Timeliness of electronic discharge summaries remained below target • The 28-day target for cancer was achieved and within normal limits of the trajectory	

	• 31-day cancer target was not achieved • 62-day standard was achieved • 2 theatre utilisation targets had improved and continued to improve but had not kept pace with national or regional comparators. The escalation process had moved to weekly and was being overseen by AT • DM01 standard was behind trajectory, but a recovery plan was in place for cardiology which was the main area of concern. The backlog was expected to be recovered by February 2025. • Elective waiting list was showing special cause variation. The longest waits were reducing the but the overall size of the waiting list was increasing • Ambulance handover times had increased, and was reflected of the seasonal variation over the summer period • In spite of seasonal variation over the summer, the ED 4-hour standard had been met. In relation to people, NP highlighted the focus on improving appraisal completion rates and that this was slowly improving. Sickness absence, turnover, and vacancies had all increased slightly but there were no immediate concerns. There was further focus on the staff survey and staff vaccinations. Finances would be discussed more fully later in the agenda, but CH highlighted a significant reduction in agency spend, a reasonable cash balance, and a focus on developing sustainability metrics. DCS reflected that a number of the issues raised in the report were already known about and discussed in committee. MBr noted a possible error in the report relating to the 28-day standard; this was written as being achieved, but the number was below the target. He further noted the focus on reducing 65 week-waits and that the national target was for this to be eliminated by the end of September. Industrial action had prevented that target being reached, but a reduction was expected over the coming months and the trust was in close conversation with the system in this regard.	
	Resolved: that the Balanced Scorecard be received for assurance.	
BoD24/113	**Finance Report**	
Baker,Abi 09/12/2024 13:00:34	CH presented the finance report to the end of month five. He noted the full year breakeven plan and the efficiency target of 5%, and drew the Boards attention to the following key aspects of the report: • Month five delivered a deficit of £490,000 which was broadly in line with plan, given the phasing of the breakeven plan over the year. Two key elements to the deficit were that the CIP was back weighted towards the end of the year, and that the performance and productivity element of the plan was also phased towards the end of the year. • Year to date position was £500,000 away from plan, with a total deficit of £6.9m. A surplus of this amount was required to achieve the year-end breakeven position.	

	• The key drivers of the deficit were inflationary pressures above planned levels, industrial action, and operational pressures including the number of patents with no criteria to reside. • Positively, there had been a significant reduction in agency spend • The 5% efficiency target totalled £14.4m. At month five £2.6m had been delivered, with a large degree identified and in place for the remainder of the year. • An incredibly pressured capital envelope for the year, with large builds on Fortuneswell and east wing theatre taking up half of the capital budget. £7.5m remained for all other areas, including backlog maintenance for estates and digital. • A cash balance of £8.8m. Further discussion about the possible need to draw down cash support would be had in part two of the meeting. A number of steps were being taking to improve the financial position, including: • A weekly financial recovery group had bene set up with executives and directors looking at ways to rapidly improve the financial position. This reported in to the system recovery group, chaired by the ICB to ensure there was appropriate scrutiny. • Strengthening of the Recruitment Control Panel overseeing vacancies, whilst allowing posts that were critical to the delivery of operational services to be recruited to ensure that high quality services were maintained. • Value Delivery Board with an internal audit showing good controls to identify efficiencies, whilst recognising this needed to go further • CH and his deputy were meeting with teams across the trust to ensure that staff were aware of the financial pressures and felt supported to address the issue within their services. The Board discussed the overspend on substantive staff over the year and particularly in September, noting the pressure to reduce whole-time equivalent numbers. The reduction in temporary staffing was noted as a factor in increasing substantive staffing which was more cost-effective than agency staffing. The increased operational demand was also noted as a contributing factor. CH confirmed that the Value Delivery Board mapped out three years of efficiencies so was already preparing for next year's efficiency ask, with a focus on increasing the proportion of recurrent savings. MBr reflected on the increasing difficulty with meeting high CIP targets year on year, particularly in the context of a block-payment arrangements where payment had not increased but demand had increased by as much as 13%. This was the problem the healthcare system was facing, and it was affecting the trust more so as a smaller trust providing healthcare to a rural population. Conversations were ongoing with the system about how to make the trust financially sustainable.	
	Resolved: that the Finance Report be received for assurance.	
BoD24/114	**Operational Resilience and Capacity Plan (Winter) 2024/25**	

	AM outlined the plan, noting that the newton strategic work had informed the plan, but that there was no Dorset-wide system plan yet, but that this was currently in development. Once the system plan had been agreed the trust specific plan would be returned to Finance and Performance Committee in Common and Board for final approval. The plan focused on out of hospital support, virtual wards, and acute hospital at home (AHAH) services, rather than increasing bed services, as adding beds could be inefficient and make the hospital more difficult to manage. It was noted that the hospital was already in a pressured period, having had 19 escalation beds in August. MBr reflected on the different approach to winter planning this year in the NHS compared to past years, noting that there was no additional funding expected this year. The plan presented here was robust and the teams should be commended for the work to improve patient flow. MBr recommended that the Board endorsed the plan, but that they should also see the system plan once produced and some of the additional figures around bed modelling. The Board discussed whether the plan should be approved at this stage, or whether it should be approved once the system plan was finalised. DU highlighted that AT had proposed at Finance and Performance Committee in Common that the plan be approved and that it could be amended in the coming months if needed, following the finalisation of the system plan. The meeting heard that electives services were phased from 3rd January as it was expected that in early January there would be little activity other than emergency, and that elective activity would be increased in the third and fourth weeks of the month, and that this was normal practice. EJ sought assurance around the provision of extended pathways under AHAH detailed on page 240 of the papers. AM confirmed that these would only be provided where clinically appropriate and not for pregnancy or gynaecological cancer. The national increase in virtual beds was noted. EJ requested further detail in the paper about the benefits and risks of virtual ward provision. CL asked how engaged local communities had been in the challenges facing the NHS this winter, whilst being mindful not to widen health inequalities by discouraging people from seeking support when needed. MBr described that this was usually undertaken at a system level, and this was expected again this year. The trust was engaged in those conversations with the system. DCS summarised that the proposal was for the Board to approve the plan, subject to receiving the system plan.	
	Resolved: that the Operational Resilience and Capacity Plan (Winter) 2024/25 be approved subject to receiving the Dorset system plan.	
BoD24/115	**People and Culture Committee Assurance Report**	
	FW highlighted the following key points from the report:	

	• The first meeting of the committee in common and the different ways in which each trust oversaw people and culture matters before the development of the committee. • The new Board Assurance Framework enabled the committee to gain assurance around the risks the committee owned • The benefits of having joint and trust-specific NEDs on the committee. MB and Suresh Ariaratnam would work together over the coming months to develop trust specific expertise. • It was noted that the NHS advise following the summer riots had focused on international staff, but MB had reminded the committee that British staff from black and minority ethnicity backgrounds were also impacted by the riots. • The informal meetings of the committees would be used to develop the knowledge of committee members and to receive deep dives on specific topics.	
	Resolved: that the People and Culture Committee Assurance Report be received for assurance.	
BoD24/116	**Guardian of Safe Working**	
	JM joined the meeting for this item. She outlined the changed in terminology by the BMA from 'junior doctors' to 'resident doctors'. JM highlighted that there were 61 exception reports raised in the reporting period, 13 of which were immediate safety concerns typically relating to a doctor feeling overworked or not having enough support. 43 of the reports related to hours worked. Reports mostly came from trauma and orthopaedics but there had been a reduction in this period compared to previous reports, owing to support from a clinician with setting rotas. The report detailed vacancies amongst trainee grades in the trust, with a large number in GP and medicine/care of the elderly. JM highlighted to the Board the issue of accommodation which had previously been noted and continued to be an area of upset amongst resident doctors. There had been a reduction in the size of communal areas and an increase in cost. AH added that the overall number of resident doctors had started to increase as NHS England had now opened foundation year one (FY1) posts to anyone globally with the right qualifications. This provided additional flexibility to the trust, but the number of FY1 doctors arriving was not known until three months before they joined. As such additional FY1 posts had to be created to accommodate the numbers being received and there was an additional impact on the ability to provide supervision on a regular basis. Board members considered that the increase in exception reporting was indicative of an open culture and noted that they were a useful tool to plan for safety. Furthermore, the rotation of many resident doctors in August meant that it was likely there would be a peak at this time of year. In relation to the accommodation concerns, CH would include the chief registrar in works around the trust's accommodation strategy and	

	recognised that there was learning about how to better communicate and engage with key stakeholders.	
	Resolved: that the Guardian of Safe Working report be received for assurance.	
BoD24/117	**Workforce Race Equality Standard & Workforce Disability Equality Standard**	
	NP referred to the previously circulated reports. In relation to the Workforce Race Equality Standard (WRES) NP drew the Board's attention to the below: • Indicator two showing a deteriorating position (relative likelihood of white candidates compared to BME candidates being appointed from shortlisting across all posts). This was the same at DHC. Discussions with multicultural networks had shown an interest in embedding learning and awareness around bias. • Indicator three showing a deteriorating position (Relative likelihood of BME staff entering the formal disciplinary process compared to white staff). • Indicator eight showing an increase in BME staff experiencing increased discrimination compared to white staff. • An action plan was in place to address the above concerns and were included in the equality and inclusion priorities recently agreed. In terms of the Workforce Disability Equality Standard (WDES) NP highlighted the following metrics as cause for concern: • Metric five, regarding equal opportunities for disabled and non-disabled staff. • Metric eight, regarding reasonable adjustments made for disabled staff NP describe the high degree of ambition and progress to be made following these reports and that there was a commitment to improve the areas of concern. The need to be able to measure the qualitative actions was noted. Boted members discussed indicator two in the WRES, noting that this included internationally employed nurses. DU questioned the accuracy of this piece of data given the increase in internationally employed nurses. Board members further noted possible inaccuracies with data in the WRES and WDES. NP would look in to this. MBr reflected on the importance of these reports and their alignment to the trust's ambitions and the type of culture we wanted. There was much more work to do in this regard, but there were signs of progress and change in some of the metrics. The Board approved the Workforce Race Equality Standard & Workforce Disability Equality Standard, subject to final data checks.	**NP**
	Resolved: that the Workforce Race Equality Standard & Workforce Disability Equality Standard be approved.	

BoD24/118	**Risk and Audit Committee Assurance Report**	
	SP highlighted the following key points: • Change of the committee name to Audit Committee • Discussion about the fire safety risk, noting that further discussion took place at Finance and Performance Committee in Common a week after Risk and Audit Committee met, where further assurance was provided. • Review of the updated Standing Financial Instructions (SFIs) • Internal Audit report including a draft advisory report on the ICS, which was pending final management comments on the findings • The improvements to the new Board Assurance Framework CH noted that the fire safety risk had been reported to Audit Committee in the first instance as the current formal forum, but that in the revised committee structure the matter would sit with Finance and Performance Committee in Common. Following the meeting CH and DD met to review actions rapidly and he was working with DM to review the detail of the risk. Whilst it was understood to not be an immediate risk as initially thought, there was rapid work to improve the position. It was proposed that October's informal Finance and Performance Committee in Common would have a deep dive in to the matter for assurance.	
	Resolved: that the Risk and Audit Committee Assurance Report be received for assurance.	
BoD24/119	**Risk and Audit Committee Terms of Reference**	
	JH outlined that the revised terms of reference provided alignment with the DHC Audit Committee and was reviewed in line with the HFMA audit committee handbook. Key changes included a name change from Risk and Audit Committee to Audit Committee, and that membership was NED-only with executives attending as attendees. Compliance in relation to freedom of information and the Data Security Protection Toolkit now reported in to the committee. The Board approved the Audit Committee terms of reference.	
	Resolved: that the Risk and Audit Committee Terms of Reference be approved.	
BoD24/120	**Scheme of Delegation Review and update**	
	CH outlined that the scheme of delegation and SFIs were updated to align with DHC, given the new committees in common. This was presented to September's Audit Committee where it was approved, following assurance being received that they were appropriate. Asked about the impact on the financial recovery position, CH provided further assurance that all spends were appropriately scrutinised at the appropriate level and that he and his deputies in each trust had oversight of spend. This was support by a recent internal audit. The Board approved the updated scheme of delegation.	

	Resolved: that the Scheme of Delegation Review and update be approved.	
BoD24/121	**Charitable Funds Committee Assurance Report**	
	DU highlighted the following key points from the report: • Committee terms of reference were being updated and would be presented to the Board for final approval. One change included the addition of a community co-opted member of the committee. This would be someone who would represent the views of the community. In the first instance this member may be drawn from the Council of Governors. • Due to operational pressures in the hospital, some facilities which had been heavily invested in by the charity were being used for purposes other than originally intended and without an agreed timescale to return to the intended use. The charity needed to be mindful of the clear guidelines around this. • The charity had seen a number of applications for funding for items which should be covered by the NHS budget. The charity had agreed until the end of the financial year to put a proportion of its general-purpose funds to support with capital activities that could not be afforded by the trust. This included funding resuscitaires in maternity. • A major legacy donation of £825,000 was pending, £500,000 of which would be allocated to the ED and Critical Care appeal. By the end of the calendar year the appeal was likely to sit at £1m. The Board discussed the use of charitable funds for core NHS requirements. CH noted that he and DD would ensure there were appropriate links between Charitable Funds Committee and Medical Devices Committee. The Board noted that funding for basic safety equipment, such as resuscitaires, should come from the trust although recognised the constrained financial situation that meant funding as needed from the charity. However, if the charity was not able to fund this then the trust would have to find a solution as soon as possible. MBr confirmed that this had been discussed extensively at a recent JEMT.	
	Resolved: that the Charitable Funds Committee Assurance Report be received for assurance.	
	CONSENT SECTION	
	The following items were taken without discussion. No questions had been previously raised by Board members prior to the meeting.	
BoD24/122	**ICB Board Report**	
	Resolved: that the ICB Board Report be received for information.	
BoD24/123	**Premises Assurance Model**	
	Resolved: that the Premises Assurance Model be approved.	
BoD24/124	**Emergency Preparedness, Resilience & Response (EPRR) Annual Assurance Report 2024**	

	Resolved: that the Emergency Preparedness, Resilience & Response (EPRR) Annual Assurance Report 2024 be received for assurance.	
BoD24/125	**Questions from the Public**	
	JPL sought assurance that NEDs had sufficient information to make informed decisions on the trade-off between capacity and financial constraints (strategic risks four and six). He further asked in which areas the deficit was most concentrated. On the latter point, MBr advised that due to the block contracting arrangements there was no one area that had a bigger deficit than others and that the 5% CIP target needed to be achieved across the trust, but that achieving the CIP year on year was proving difficult. On the first point, MBr recognised that there was a relationship between capacity and finance and there was risk in the trade-off, considering the various agendas that needed to be considered including safety, capacity, providing care in the right environment and finances. MBr drew attention to the discussions at committees as supporting those decisions, as well as the EQIA process for financial changes. SP added that he had had discussions with CH about the work to understand whether there was an underlying deficit in running the hospital because of the population and demographics served. EJ further described that NEDs triangulated the information they received in various forums, including committees and Board meetings, and had discussions with other NEDs about areas that required further assurance. EJ reflected of the Boards commitment to safety as the priority for the trust. Reflecting on the discussions had today, KH thanked the board for the huge amount of hard work going on, noting that the discussions provided assurance for them and that it made it easy for governors to talk about the trust in a positive light.	
BoD24/126	**Any Other Business**	
	None raised.	
BoD24/127	**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.	
BoD24/128	**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 the **Board Room, Trust Headquarters, Dorset County Hospital, Dorchester** and via **MS Teams.**	

Action Log – Board of Directors Part 1

Presented on: 10 December 2024

Minute	Item	Action	Owner	Timescale	Outcome	Remove? Y/N
Meeting dated: 09th October 2024						
BoD24/100	**CEO Update**	An investment review of the ridgeway ward redesign to be returned to Board.	CH	February 2025	Post investment appraisal will take place through 2025/26 business planning and reported through to Finance and Performance Committee as part of this process	**N**
BoD24/117	**Workforce Race Equality Standard & Workforce Disability Equality Standard**	The accuracy of some of the data in the WRES and WDES to be reviewed.	NP	December 2024	Update awaited	
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 February's board meeting, as part of a wider agenda item.	**N**
BoD24/016	**Board Subcommittee Escalation Reports**	A review of the Charitable Funds Committee Terms of Reference to be undertaken	JeH	September 2024	Complete – Terms of Reference updated and considered by Charitable Funds Committee	**Y**

Actions from Committees…(Include Date)						

Actions to Committees…(Include Date)						
BoD24/101 (October 2024)	**Board Assurance Framework** and **Corporate Risk Register**	Finance and Performance Committee in Common reviewed strategic risks five (estates) and six (finance) to check whether the risk scores should be increased, owing to the financial position and the risk around fire safety	Finance and Performance Committee in Common	November 2024	Complete – discussed at November 2024 Finance and Performance Committee and revised scores to be included in Q2 update	**Y**
BoD24/111 (October 2024)	**Finance and Performance Committee Assurance Report**	Further assurance around the arrangements for evacuation in the event of a fire could be provided to Finance and Performance Committee in Common	Finance and Performance Committee in Common	November 2024	Discussed and assurance received through Finance and Performance Committee in Common. Full detail below.	**Y**

BoD24/111 (relating to evacuation arrangements):
Work has been progressing to reduce the risk to our patients, visitors and staff in relation to fire and smoke:

1. A revised twice daily clutter audit process has been implemented.
2. Recruitment of a second fire operative to conduct fire risk assessment and evacuation plan reviews is due to conclude shortly.
3. A meeting has been held with the Fire Safety Group, Authorising Engineer and Local Area Fire and Rescue Safety Advisors to share our position and action plan to resolve. All stakeholders were assured we understood the gap and have a robust plan to resolve this.
4. A meeting has been held with the fire compartmentation contractor, who surveyed and undertook a number of fire stopping projects across the site. They have agreed to provide as built drawings showing compartmentation breaches and what remediation has taken place. Also, they have been provided with our prioritisation and requested to work with our Fire officer to propose a 3 to 5 year plan.
5. A full fire door survey is underway.
6. The SCART audit and Statute tracker is progressing well and providing E&F with confidence in terms of our compliance position.
7. Weekly fire alarm testing has been contracted out until we are confident with our maintenance system for this statutory requirement.
8. The education centre is working with our Fire officer to manage training in a more efficient manner, and ensure future training is recorded on ESR.
9. A weekly meeting to review the Fire Action Tracker is occurring, which reports into the Fire Safety Group and Health and Safety Committee.
10. Inquiries have been sent for the 2025/2026 external PAM.

In summary, considerable progress is being made and will continue until compliance reaches high levels and risk is reduced to a minimum.

Dorset County Hospital
NHS Foundation Trust

Quality Committee Assurance Report
for the meeting held on Monday 04 November 2024

Chair	Claire Lehman, NED
Executive Lead	Dawn Dawson, Chief Nursing Officer Alastair Hutchison, Chief Medical Officer
Quoracy met?	Yes
Purpose of the report	To provide assurance on the main items discussed and, if necessary, escalate any matter(s) of concern or urgent business.
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	• Committee noted further assurance required for the Consent Action Plan and Progress Update and a further update will come to the quality committee in • Committee noted partial assurance on the ophthalmology risk.

Key issues / matters discussed at the meeting	The committee received, discussed and noted the following reports:
	• Chief Nursing and Chief Medical Officer update
	• Quality report including:
	  ○ There was a CPE outbreak in CCU, now resolved
	  ○ Grade 2 pressure ulcers increasing and utilising risk assessment tools rolled out across all wards and consistency with DHC. New training programme on ESR for all trained staff and expand look at mattress replacements.
	  ○ Complaints policy live and will move to PHSO guidelines with focus on early resolution
	• Maternity and Neonatal Quality and Safety Report, noting:
	  ○ 3 incidents of third degree incidents
	  ○ All cases of babies put onto a neonatal ward has been reported
	  ○ Charity has supported the procurement of the resuscitaires.
	  ○ Thematic analysis of theatre use – positive results with good outcomes.
	  ○ Perinatal mortality review tool) report Q2
	• Consent Action Plan and Progress update
	• Wessex Health Partners Annual Review 2023/24
	• Ophthalmology Update
	• The following Escalation Reports were received, noting the improvement in the quality of reports, and the assurance this provided the committee:
	  ○ Clinical Effectiveness Committee
	  ○ Patient Safety Committee

	○ Infection Prevention and Control Committee ○ End of Life Committee ○ Safeguarding Committee
Decisions made at the meeting	• Approval of the Perinatal mortality review tool) report Q2
Issues / actions referred to other committees / groups	• Renal transport ongoing issues and importance of the voice of patient • Feedback workaround for Friends and Family and seen an uptake • Note the work around ophthalmology and how this is progressing

Dorset County Hospital
NHS Foundation Trust

Quality Committee Assurance Report
for the meeting held on Monday 26 November 2024

Chair	Claire Lehman, NED
Executive Lead	Dawn Dawson, Chief Nursing Officer Alastair Hutchison, Chief Medical Officer
Quoracy met?	Yes
Purpose of the report	To provide assurance on the main items discussed and, if necessary, escalate any matter(s) of concern or urgent business.
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	• A general theme across a number of reports relating to IT. This included the Friends and Family Test (FFT), Agyle and Electronic Health Record. • A general theme of public health implications across a number of reports • Ongoing work to develop a Quality Committee in Common with Dorset HealthCare.

Key issues / matters discussed at the meeting	The committee received, discussed and noted the following reports:
	• Chief Nursing and Chief Medical Officer update
	• Quality report including:
	  ○ Launch of a new infection prevention and control education framework.
	  ○ The continued work for the Electronic Discharge Summary (EDS) task and finish group to understand and resolve the reasons for delayed EDS.
	  ○ Publication of the new complaints policy
	• Maternity and Neonatal Quality and Safety Report, noting achievement of the Maternity Incentive Scheme for this year.
	  ○ Saving Babies Lives
	  ○ Maternity Insight Visit
	• Senior Leadership Walkaround report
	• Learning from Deaths Report Q2 incl. update on progress with Morecombe Bay
	• Safe Staffing Report, noting the balance between providing quality care and financial stability.
	• End of Life Strategy Presentation
	• Tissue Viability Quality Improvement Plan Update
	• Independent Clinical Governance and Maternity Review Closing Reports, acknowledging the hard work that went in to these reviews and that the work was now embedded as business as usual.
	• Medicines Management Annual Report

	• The following Escalation Report was received, noting the improvement in the quality of reports, and the assurance this provided the committee: ○ Quality Governance Group, noting the work to shape the Quality Committee in Common. Escalation reports from below sub-groups of the Quality Governance Group were also received for assurance. • Medicines Committee • Mental Health Steering Group • Patient Experience and Public Engagement Committee • Research Steering Group
Decisions made at the meeting	•
Issues / actions referred to other committees / groups	•

Report to	Trust Board	
Date of Meeting	10 December 2024	
Report Title	Maternity and Neonatal Quality and Safety Report	
Prepared By	Jo Hartley Director of the Midwifery and Neonatal Service	
Approved by Accountable Executive	Dawn Dawson, Chief Nursing Officer	
Previously Considered By	Quality Committee, 26/11/2024	
Action Required	**Approval**	Yes
	Assurance	No
	Information	No

Alignment to Strategic Objectives	Does this paper contribute to our strategic objectives? *Delete as required*	
Care	Yes	
Colleagues	Yes	
Communities	Yes	
Sustainability	Yes	
Implications	Describe the implications of this paper for the areas below.	
Board Assurance Framework	SR1 – Safety and quality	
Financial	Achieving the Maternity Incentive Scheme (MIS) provides approx. £250k rebate to maternity services	
Statutory & Regulatory	Elements in this report relate directly to Maternity Incentive Scheme	
Equality, Diversity & Inclusion	Not specifically	
Co-production & Partnership	Nil	

Executive Summary

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

- Data relating to tobacco dependency fluctuates but within standard variation. The loss of the band 7 Public Health Lead Midwife post at the end of the financial year is a concern in relation to this workstream. The service will be overseen by a Matron.
- No 3rd or 4th degree tears
- For this MIS reporting period, there have been no qualifying MNSI cases/Early Notification Incidents
- Babies admitted to the neonatal unit >37 weeks gestation 6.6%. This is above the target of 5%. All cases are reviewed by the ATAIN (avoiding term admissions into the neonatal service) multi-professional team to identify learning.
- Post partum haemorrhage (PPH) rate over 1500mls above the average but this within standard variation limits. The MOH Group continues to review all cases and identify and embed improvements as a consequence of any learning.
- Decrease in percentage of babies receiving breastmilk as their first feed. Currently, a reason for this hasn't been identified but may be related to workload on the postnatal ward. First feed takes place on Labour Ward where the woman would still be receiving 1:1 care. Work is underway to determine causative factors.
- Total number of incidents reported 89. Of note, a new digital incident in relation to a possible memory leak within BadgerNet. A dedicated Incident Oversight Group was established and is managing the response.

- There were a significant number of staffing flags across both units. There were also four periods of escalation to OPEL 3 or 4.
- There were three reported incidents of the homebirth service being suspended. This relates to sickness. One woman was unable to have her planned homebirth.
- Risk register updated.
  The neonatal nursing staffing remains high risk in relation to BAPM standards. The business case has been completed and a MIS requirement is Board level review and support. Awaiting the response to the business case – high, 15
- Charitable funding agreed for three resuscitaires – moderate, 9. The risk will be archived once the equipment is in place.
- There has been no progress to date in relation to replacing the SCBU ventilators – moderate, 9
- Midwifery staffing remains high risk. BR plus draft report received and being reviewed. Most shifts not fully staffed due to short term and long-term sickness and in line with sub-optimal headroom thresholds. Manager on call routinely called in to cover rota gaps. A small number of services have reduced capacity due to permanent reallocation of staff. However, the rota covering Christmas has no gaps currently.
- The one complaint in October, is related to the complaint in September and has been answered as a single response.
- Workforce data showed an increasing sickness rate - Midwives: 6.85%, Maternity Support Workers: 6.88%, Special Care Baby Unit: 11.35%. 23% midwifery shifts not covered. 8% MSW shifts not covered. All women received 1:1 care in labour and all shifts had a supernumerary coordinator
- Minutes from combined Quadrumvirate and Maternity Safety Champions meeting note:
- Audit of consultant attendance – Trust position is 99% compliance with RCOG guidance. 2 incidents of non-compliance which have been followed up.
- CQC Picker Survey action plan
- Compliance with mandatory training
- Actions from SCORE survey
- Training data improving with MIS compliance achieved. Acknowledged that next year specialist services will be expected to take responsibility for their attendance. Midwifery will not follow up individual doctors on the day if they fail to attend. MIS co-ordination and movement to the Nursing and Quality Directorate will support a Trustwide approach.

Recommendation

Members are requested to:

- **Approve the document**

NHS
Dorset County Hospital
NHS Foundation Trust

Maternity & Neonatal Quality and Safety report

November 2024

Submitted by Jo Hartley, Director of Midwifery & Neonatal Services

Executive sponsor: Dawn Dawson CNO

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Executive Summary

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    2. Charitable funding agreed for three resuscitaires – moderate, 9. The risk will be archived once the equipment is in place.
    3. There has been no progress to date in relation to replacing the SCBU ventilators – moderate, 9

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- Actions from SCORE survey

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Activity

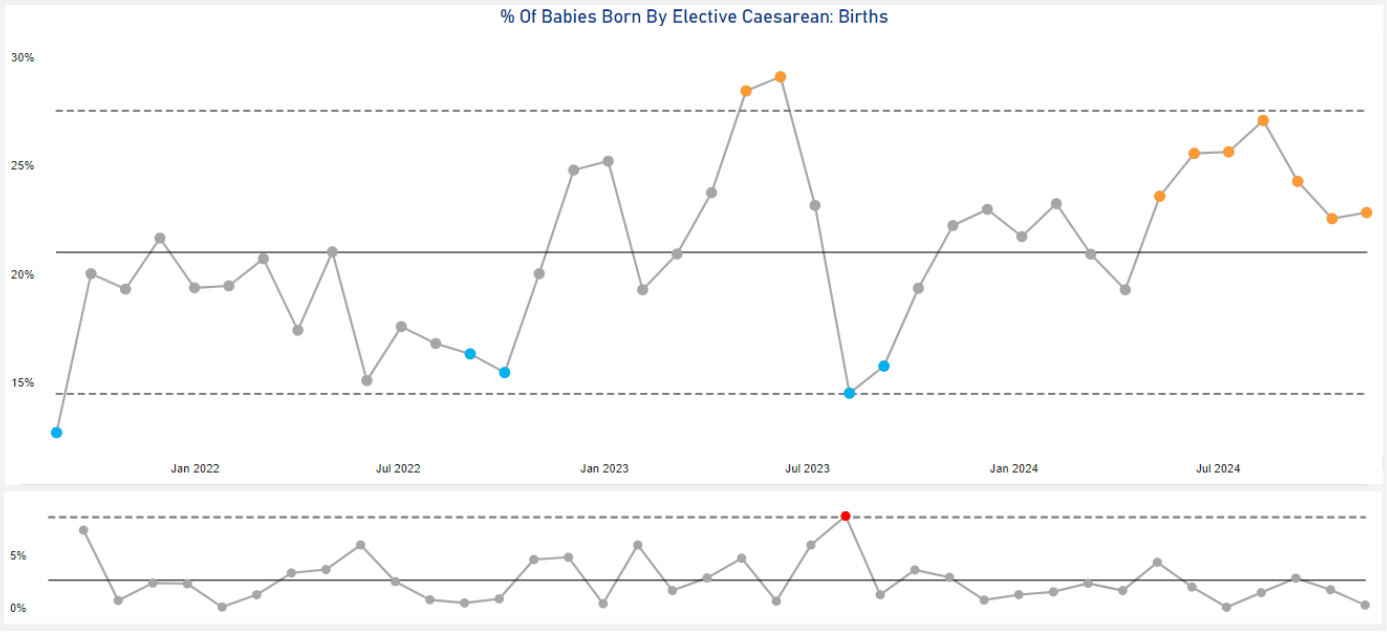
Exception report for SPC charts (NTI – no target identified)

Metric	Target	Current position and mitigation/actions
% babies born by elective caesarean	NTI	22.8%
% babies born by emergency caesarean	NTI	21.5%
% women on a continuity of care pathway by 28 weeks	NTI	20%
% women smoking at time of delivery	6%	7.6%
% CO recorded at booking	95%	90.9%
% CO record at 36 weeks	95%	95.8%
Number of stillbirths		0
Number of neonatal deaths		1
% babies >37 weeks admitted to SCBU	5%	6.6%
Rates per 1000 of PPH >1500mls (current 3 months)	30	52.8
Rates per 1000 of 3rd/4th degree tears (current 3 months)	25	18.9
% live births <37 weeks gestation	6%	7.5%
Babies transferred to a level 2 or 3 Neonatal unit	NTI	2
Hypoxic Ischemic Encephalopathy incidents		Nil
Percentage of babies with 1st feed maternal	NTI	68.1%

MetricName

% Of Babies Born By Elective Caesarean

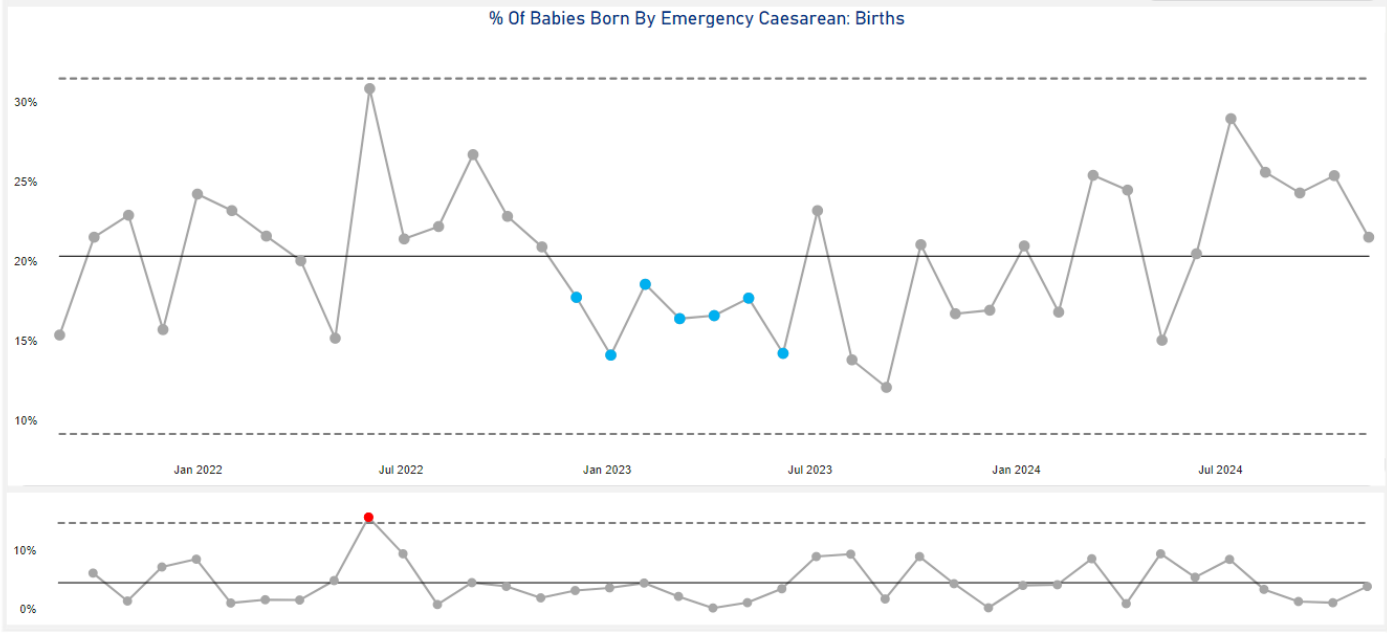
31/10/24 Latest Date	**14.46%** -3σ	**23** Metric ID	Variation	Assurance
22.8% Value	**20.99%** Mean	**Month** Horizontal Axis		
Target	**27.51%** +3σ	**% Meeting Standard** Vertical Axis		

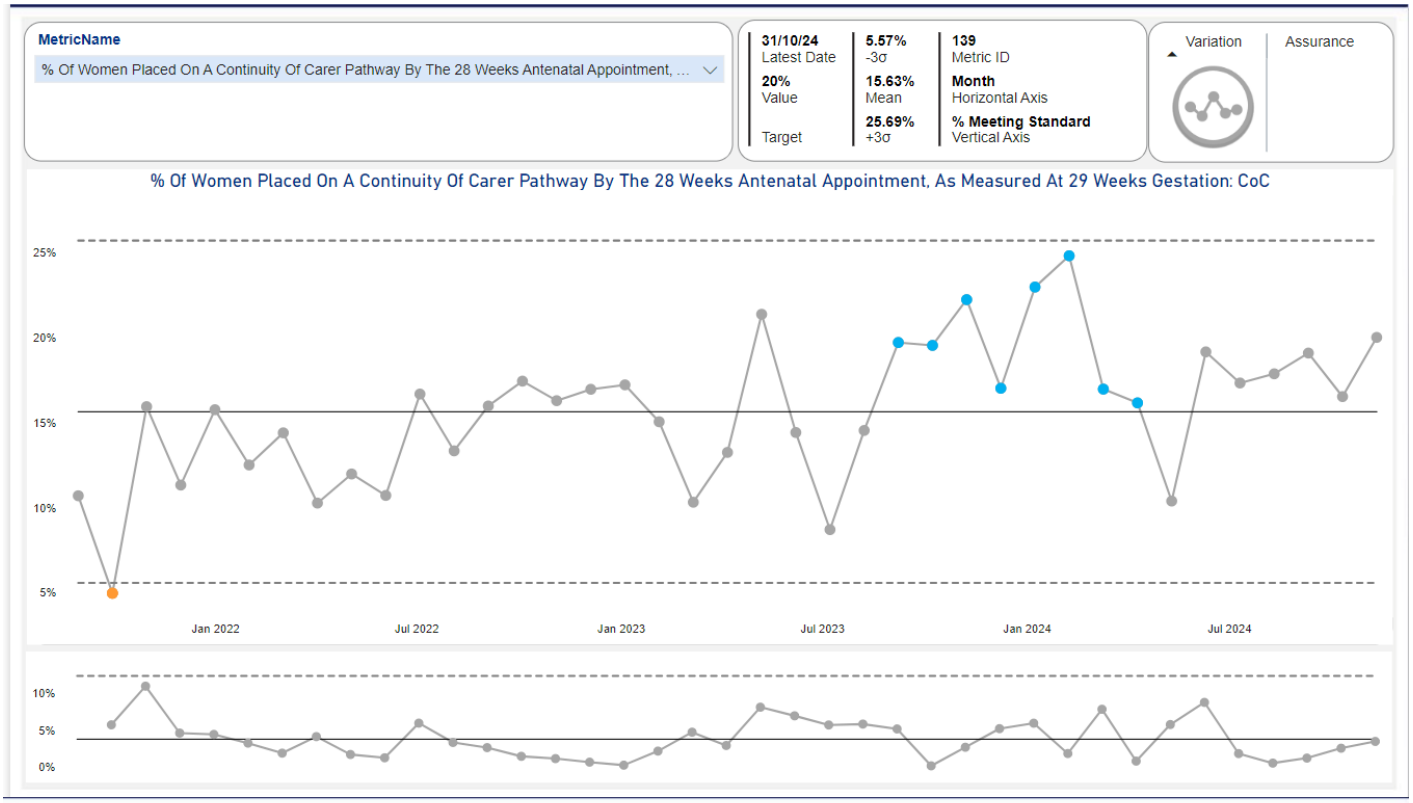


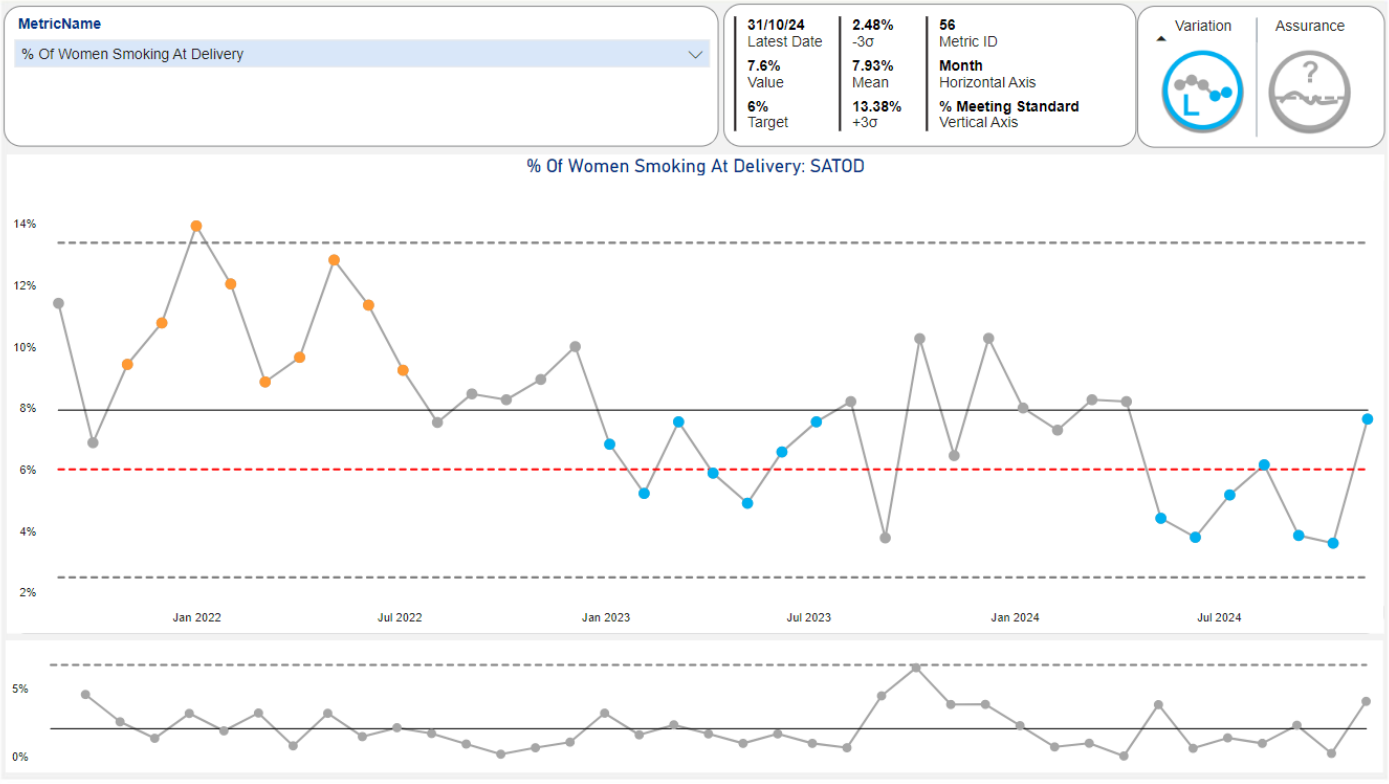
MetricName

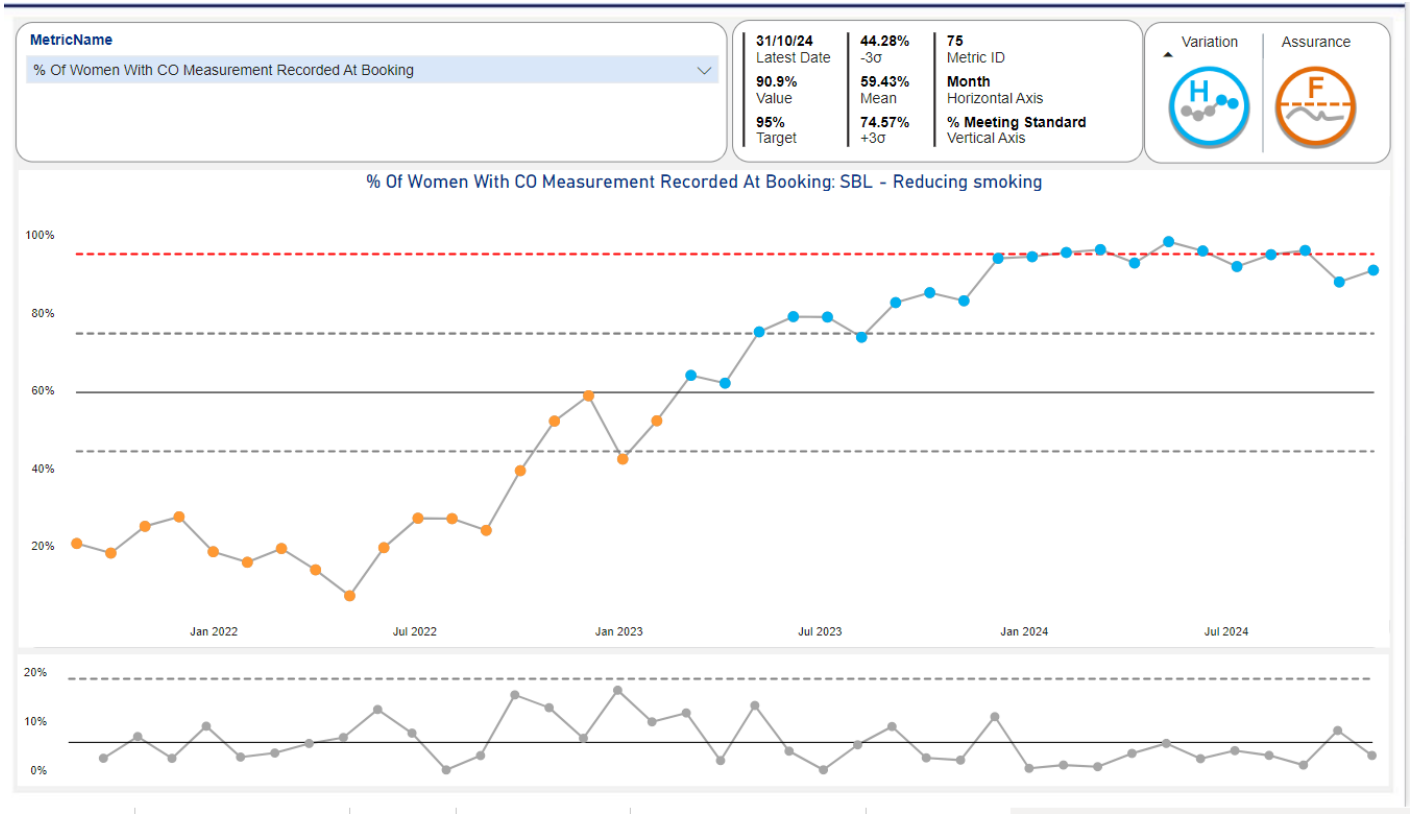
% Of Babies Born By Emergency Caesarean

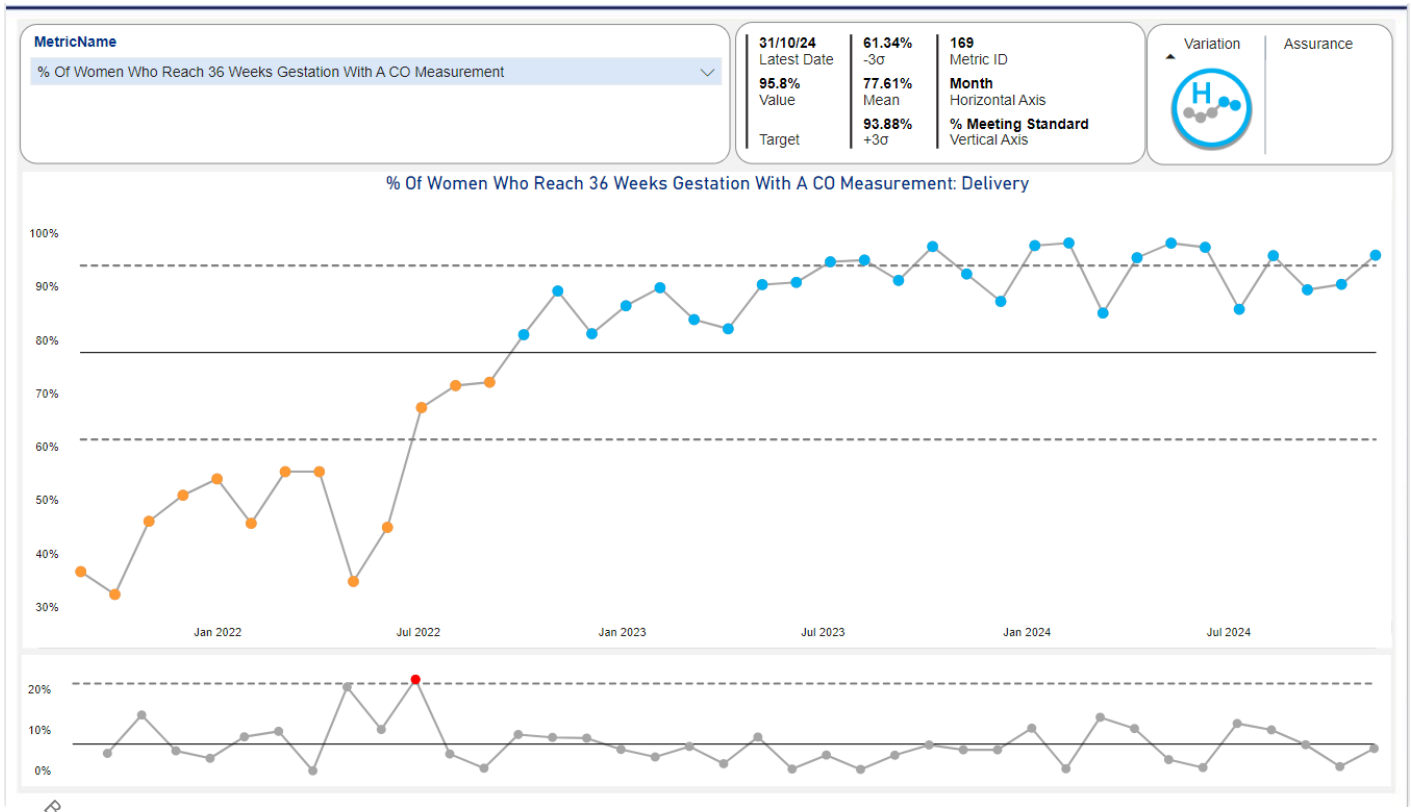
31/10/24 Latest Date	**9.12%** -3σ	**24** Metric ID	Variation	Assurance
21.5% Value	**20.29%** Mean	**Month** Horizontal Axis		
Target	**31.45%** +3σ	**% Meeting Standard** Vertical Axis		







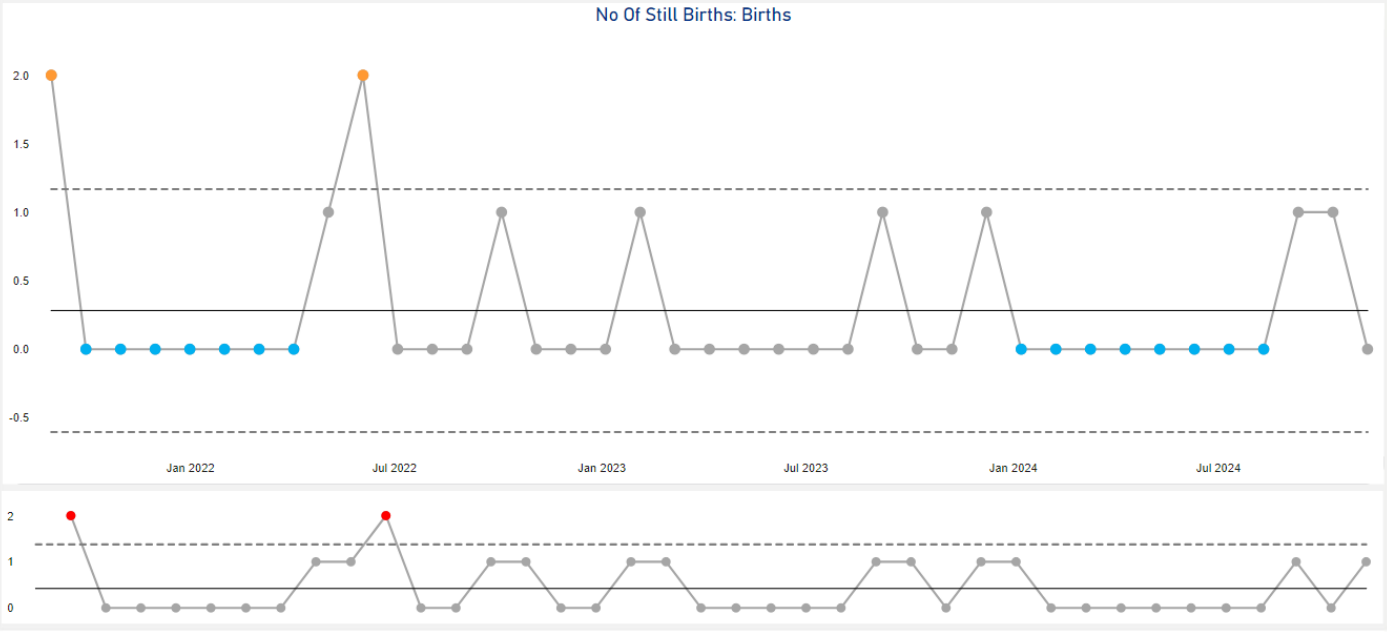




MetricName

No Of Still Births

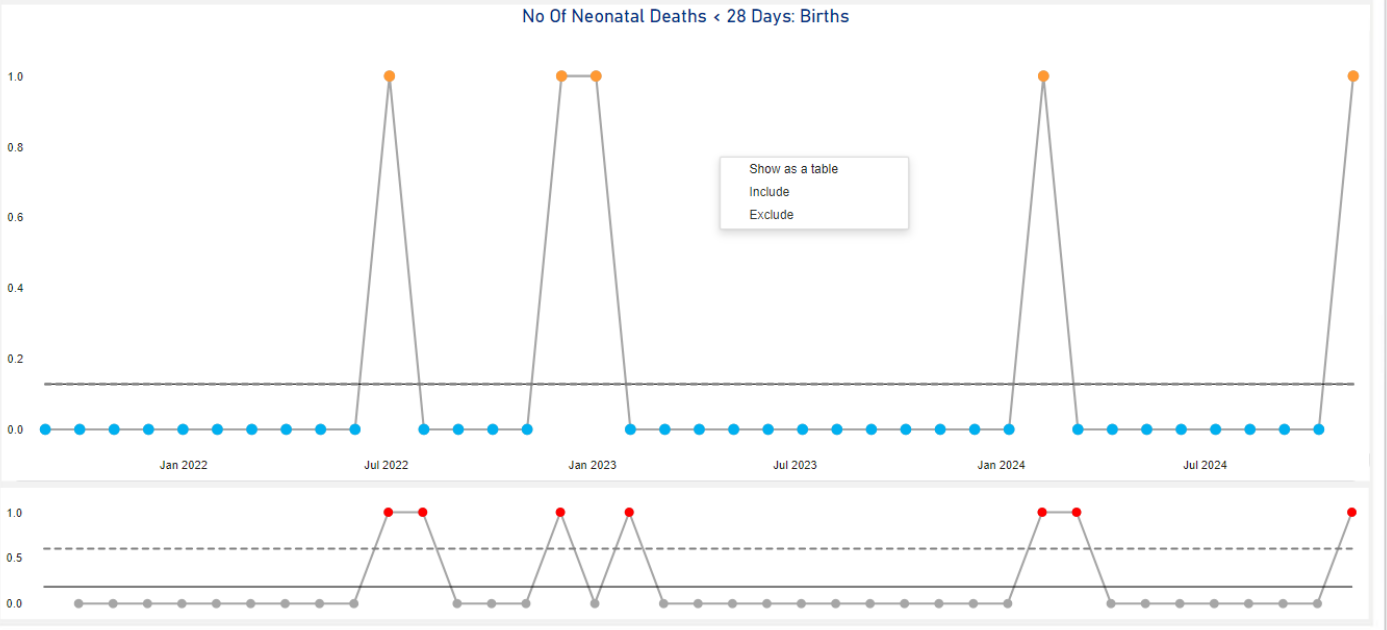
31/10/24 Latest Date	**-0.6** -3σ	**11** Metric ID	Variation	Assurance
0 Value	**0.28** Mean	**Month** Horizontal Axis		
Target	**1.17** +3σ	**Number Of Births** Vertical Axis		



MetricName

No Of Neonatal Deaths < 28 Days

31/10/24 Latest Date	**0.13** -3σ	**13** Metric ID	Variation	Assurance
1 Value	**0.13** Mean	**Month** Horizontal Axis		
Target	**0.13** +3σ	**Number Of Births** Vertical Axis		



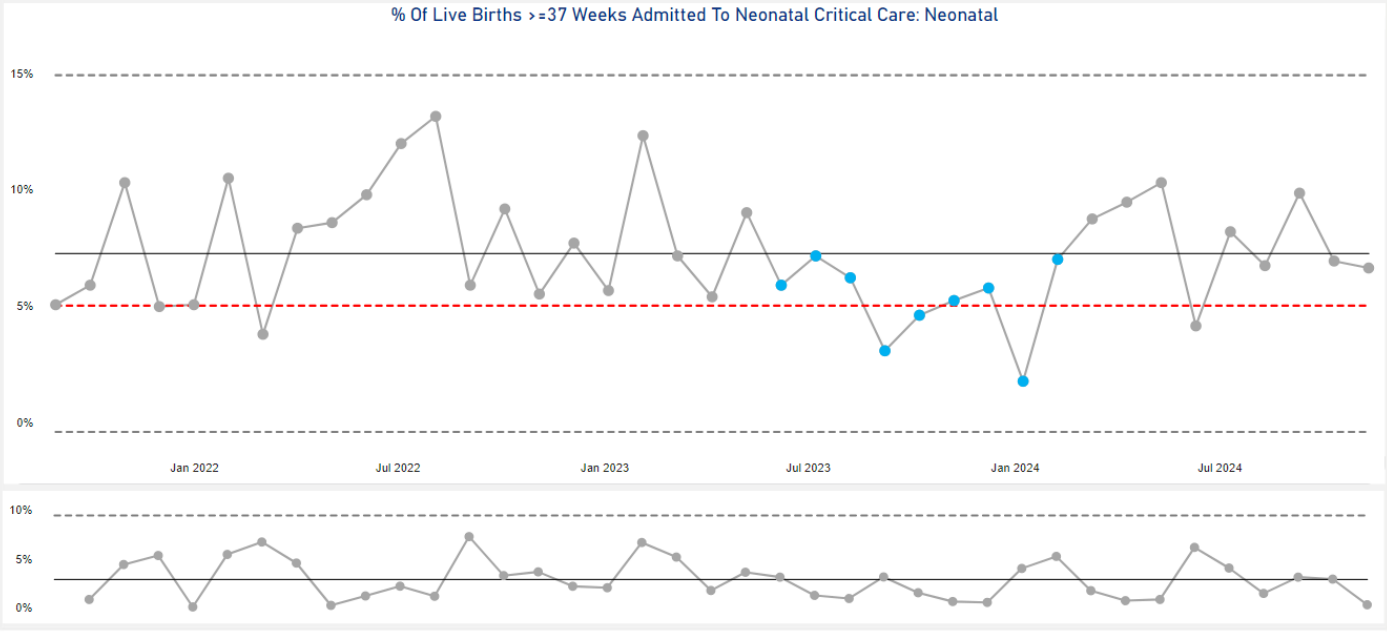
Baker,Abi
09/12/2024 13:00:34

MetricName

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

31/10/24 Latest Date	**-0.43%** -3σ	**101** Metric ID
6.6% Value	**7.24%** Mean	**Month** Horizontal Axis
5% Target	**14.91%** +3σ	**% Meeting Standard** Vertical Axis

Variation Assurance

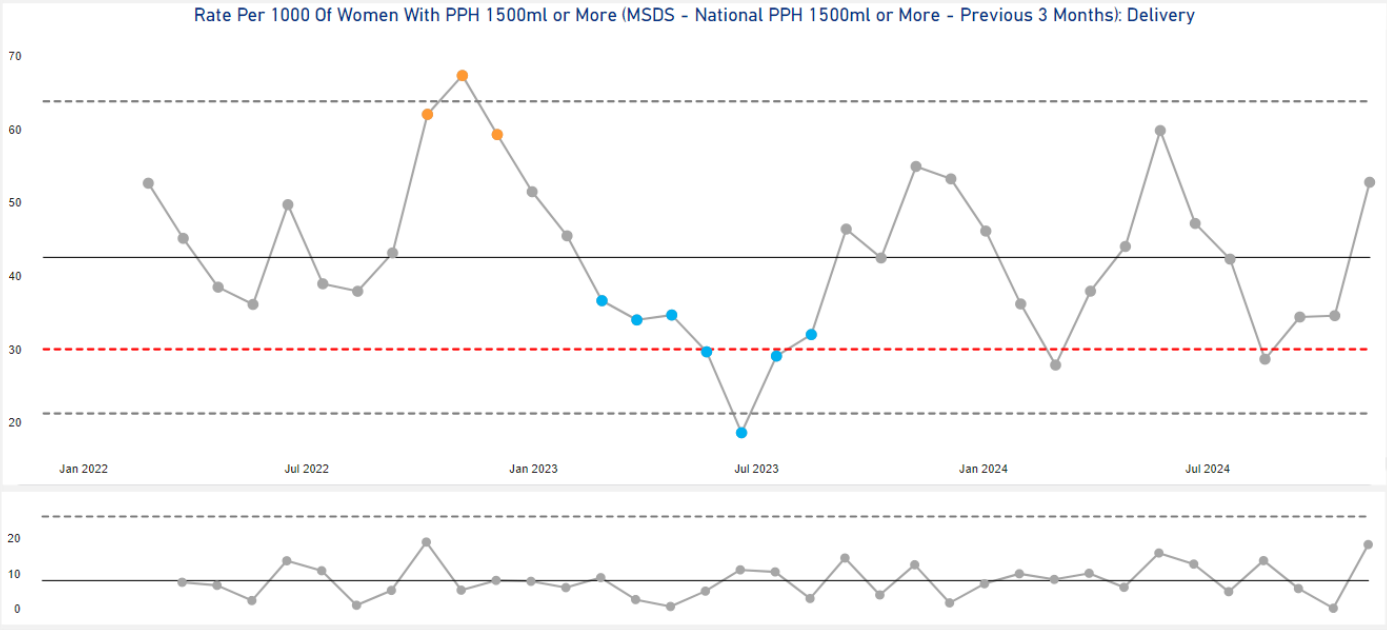


MetricName

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

31/10/24 Latest Date	**21.25** -3σ	**178** Metric ID
52.8 Value	**42.52** Mean	**Month** Horizontal Axis
30 Target	**63.79** +3σ	**Rate Per 1000** Vertical Axis

Variation Assurance



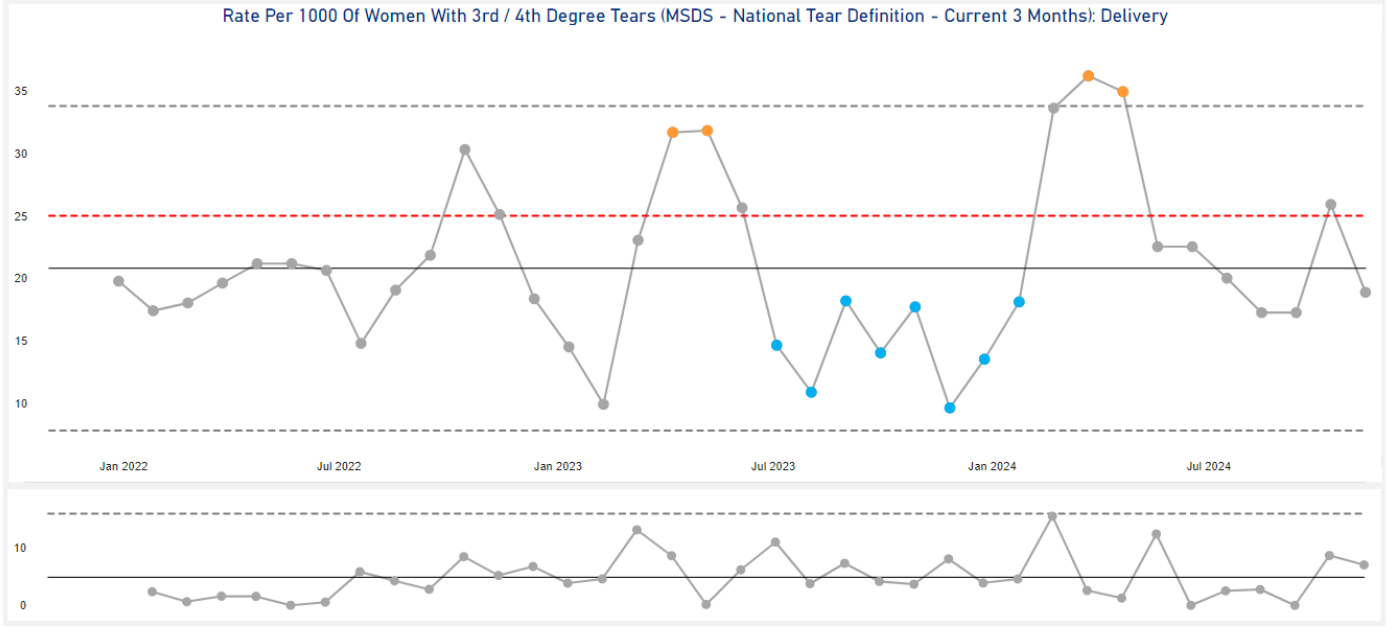
Baker,Abi
09/12/2024 13:00:34

MetricName

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

31/10/24 Latest Date	**7.8** -3σ	**182** Metric ID
18.9 Value	**20.79** Mean	**Month** Horizontal Axis
25 Target	**33.78** +3σ	**Rate Per 1000** Vertical Axis

Variation | Assurance

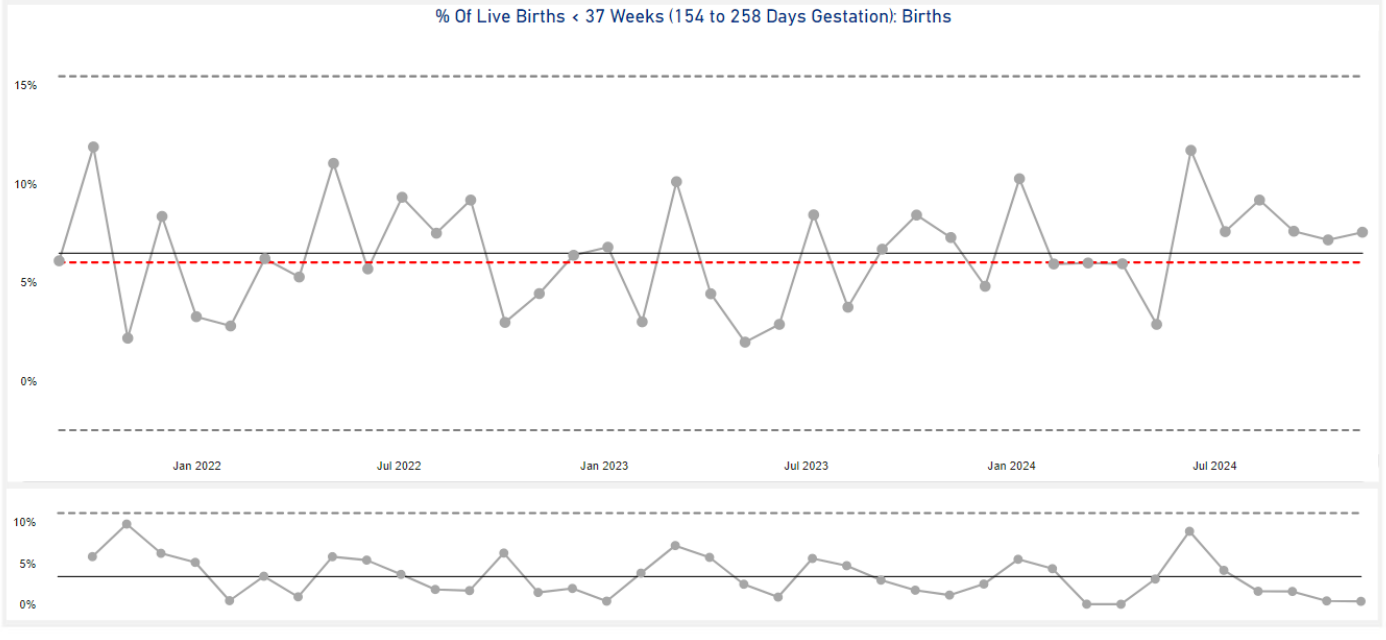


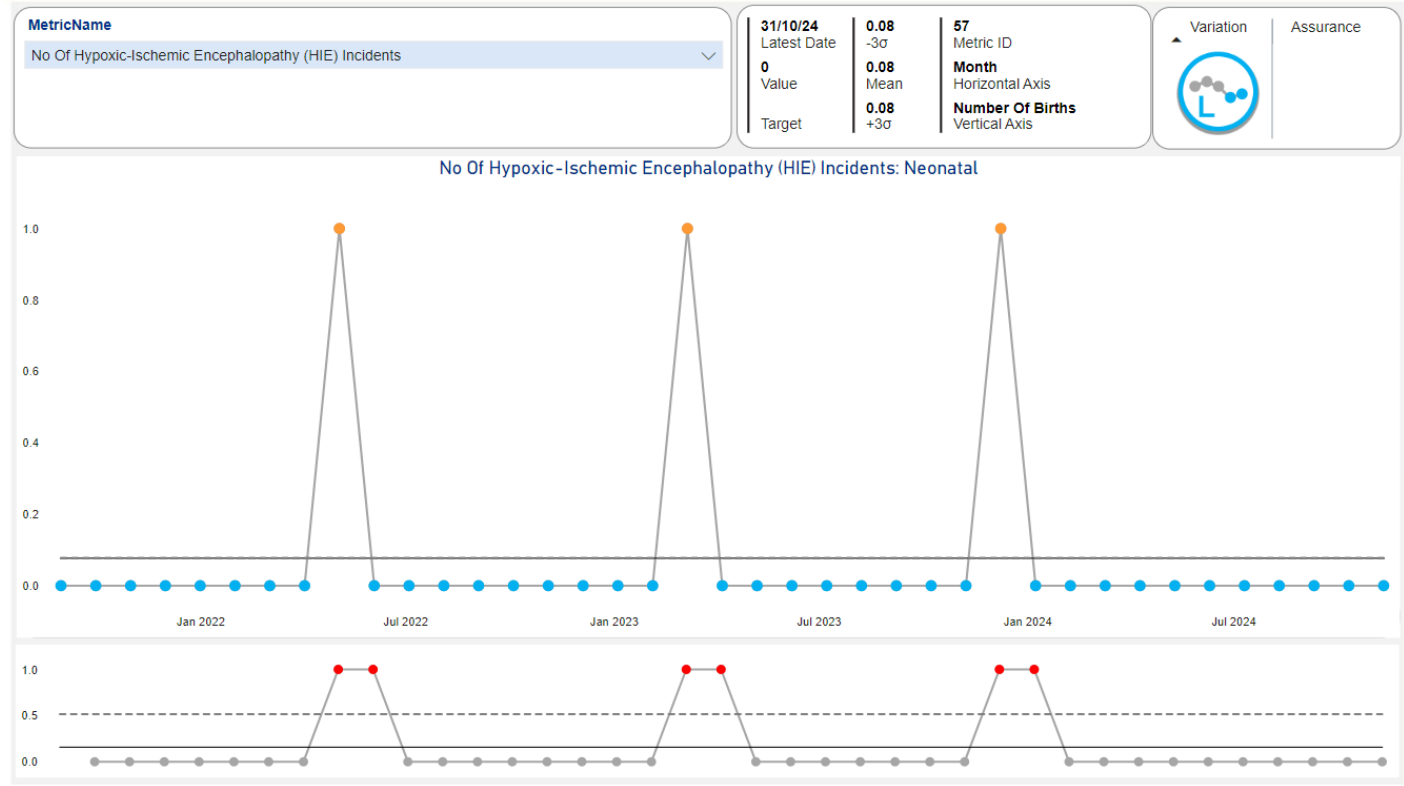
MetricName

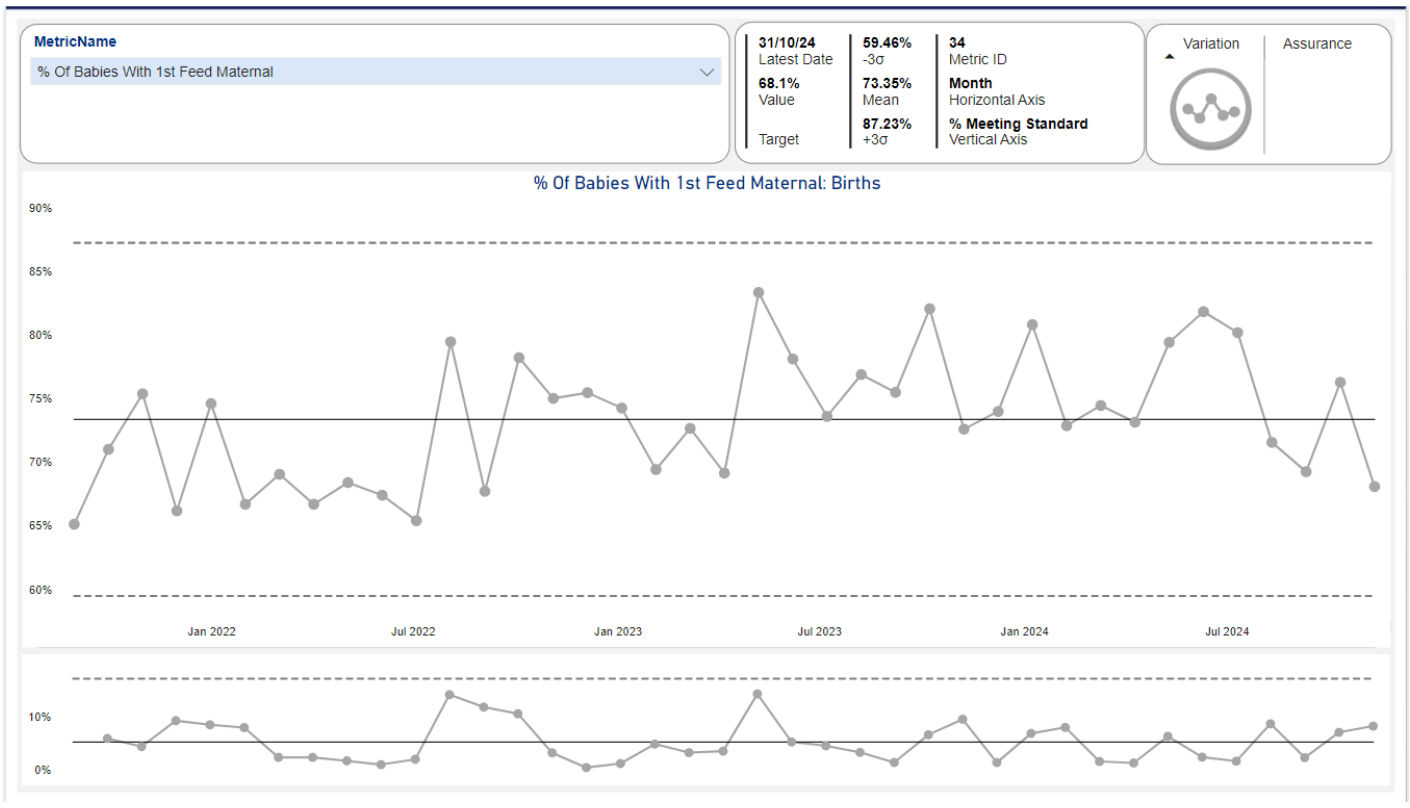
% Of Live Births < 37 Weeks (154 to 258 Days Gestation)

31/10/24 Latest Date	**-2.5%** -3σ	**106** Metric ID
7.5% Value	**6.47%** Mean	**Month** Horizontal Axis
6% Target	**15.43%** +3σ	**% Meeting Standard** Vertical Axis

Variation | Assurance







Total Number of Incidents submitted for October 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 September
RF1	Escalation to divert of maternity services & poor staffing numbers, including medical staffing and SCBU	17 for maternity, 5 for SCBU, 1 for maternity reception
RF2	Missed medication	0
RF3	Delay in providing or reviewing an epidural in labour	0
RF5	Full examination not carried out when presenting in labour	0
RF6	Delay of ≥2 hours between admission for induction of labour & starting process	5 delayed IOLs, 3 delayed caesareans
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	2 due to sickness
RF10	Delay of time critical activity	0

In-utero transfers – UHD is default level 2 NICU for DCH pregnancy <32 weeks	
UHD	3 (but 4 datix submitted)

Incidents graded as moderate harm or above and incidents of interest for October

Reference	Risk	incident	Action
DCH99900		Advisory Notice received from SystemC (BadgerNet Maternity & Neonatal System supplier) about a Memory Leak affecting iPads (see attached emails) and subsequent phone call 24/10/24 to advise us an app fix was being deployed to the app store. Originally thought this was to resolve longstanding issue where a smart booking form crashes the app and the information is lost. However, it was realised there's an anomaly happening on the iPads where an app user could be in Woman P's record and open a form to complete for her but when the form loads, it actually has information for Woman J, who the user documented on earlier that day.	Contacted DTI to expedite iPad fix update Plan: Alerted Maternity Safety Team and Senior Management to issue Communication and mitigation sent out to all BadgerNet iPad users via email and private social media channels Maternity Safety Pin issued SystemC contacted for further clarification of issue Incident Oversight Group stood up for Monday 28/10/24 SBAR for incident to be created. Immediate actions to mitigate ongoign risk and work to undertake retrospective review for any safety concerns.

		This means you could be making a clinical decision on information held for Woman J instead of Woman P. Your entries may also be saved in the wrong record. Unaware of how many records this is happening with but SystemC have said it's occurring on a small scale.	
DCH100048	**1959**	This lady was due elective CS. She was delayed until 18:10 due to lack of availability of theatres. Highlights need for second maternity theatres. Prolonged starvation causes dehydration,reduced patient comfort, increased catabolic response to surgery, ketoacidosis and metabolic acidosis. Immediate Action Taken: apologised to patients for long wait due to lack of availability of theatres for elective sections.	ongoing work for a separate ELCS pathway away from maternity with completely separate team to reduce any impact for either ELCS or emergency work in maternity. this work is dependant on theatre provision within DCH and additional staff with appropriate speciality in obstetrics anaesthetics. This work should ensure timely provision of care for ELCS and IOL on maternity

3rd & 4th degree tears October

Parity	Ethnicity	BMI	Baby's position	Grade of tear	Mode of birth	Birthweight	hands	OASI	Position of woman	Blood loss	Referral made
None reported											

Risk Register

ID	Title	Risk Statement	Open	Risk	responsibility
1959	IT systems allowing manual input of pathology results by clinical teams	It has been recently brought to the attention of Serious Hazards of Transfusion (SHOT) that the UK maternity patient data management system as supplied by Badgernet allows clinical staff to manually input patient pathology and other test results into the system. This may impact decisions related to patient care including blood group, red cell antibody screen and identification results. Other clinical systems that use pathology data may be similarly impacted. A preliminary national review of cases submitted to SHOT in the last 3 years revealed at least 12 incidents where the cause of the preventable error was a manual transcription error in the maternity IT system. **Mitigation** The process of transcribing has not changed since the use of paper notes, however, the care pathways and treatment is generated by the maternity BadgerNet system by the manual input of results. Staff are prompted on the system to double check when inputting results. The digital team and laboratory management team are working together to identified a suitable and safe solution.	06/09/2024 Chloe Mackenzie, Digital Lead Midwife, quarterly review	Moderate 8	Care group

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 additional nursing wte 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** Awaiting response to the business case	01/05/2024 Debora Coalwood-Horta, Maternity Matron, monthly review	High 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. No further update expected due to funding restrictions	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 manufacturing in May 2015 and the 7year period of maintenance support has now passed. Currently the devices only have a standard 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** Scoping of cost to replace ventilators underway. No further update	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** The charitable request has been agreed and funding confirmed	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 **Update** Risk assessment required in relation to the SOP for management of a second theatre in an emergency. To review choice of theatre location, equipment provision, allocation of a resuscitaire, transport of neonate, care of partner	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** Recruitment of 10th consultant underway	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** Training actively underway to ensure all staff who answer the phone out of hours are able to use the BSOTS triage pathway	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** Currently in the final stage of testing the new system. Once this is completed, it will be active	02/09/2022 Managed by Paul Daniell, Estates. quarterly review	moderate -9	divisional
876	Maternity Staffing	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. **Update** BR plus draft report received and being reviewed. Most shifts not fully staffed due to short term and long term sickness primarily. Manager oncall routinely called in to cover rota gaps. A small number of services have reduced capacity due to permanent reallocation of staff – the Perinatal Mental Health Service, the Safety Team, the Frenulotomy Service (tongue tie), Teenage Parents Team and we have stopped providing antenatal education. However, the rota covering Christmas has no gaps currently	21/09/2021 Managed by Jo Hartley, Director of Midwifery, Monthly reviews	High 15	corporate

Complaints for maternity and SCBU

Total informal and formal

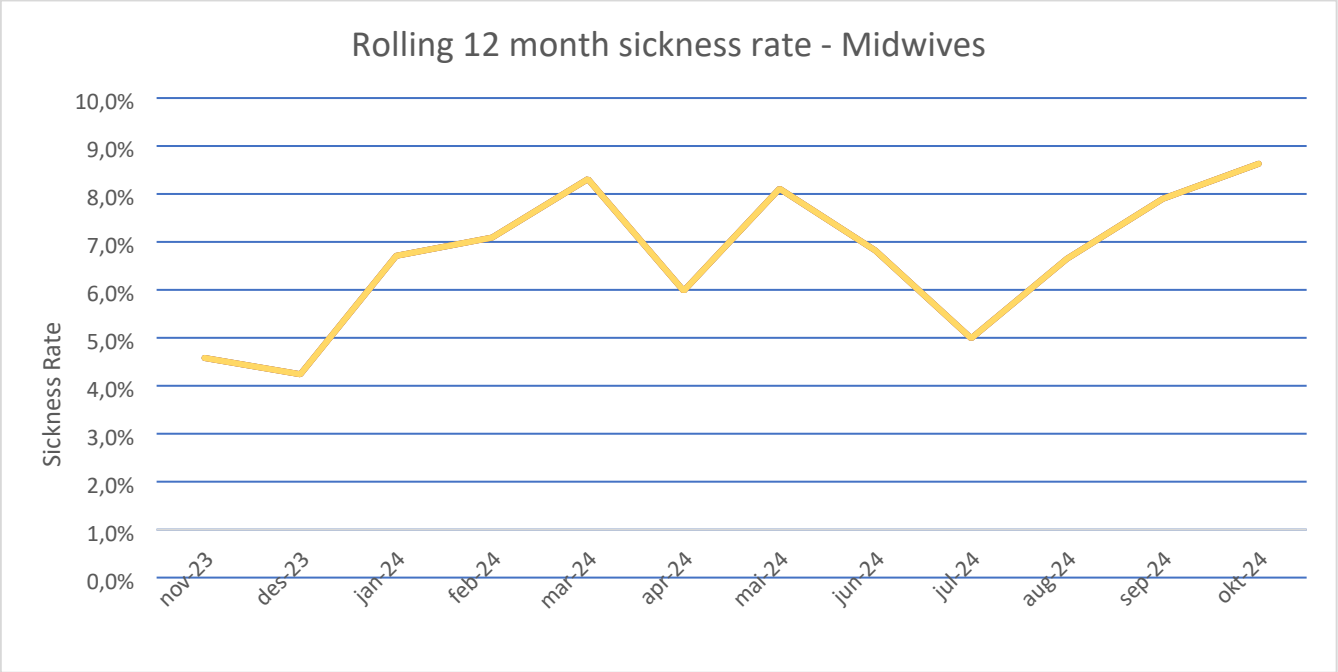
Month	Nov	Dec	Jan	Feb	Mar	April	May	June	July	Aug	Sep	Oct
total	3	2	1	2	2	6	3	2	1	1	1	1

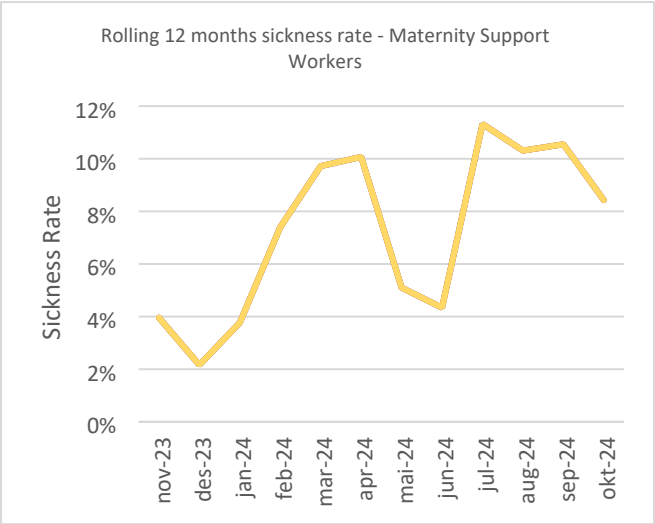
Action identified	Action taken
No new actions this month	

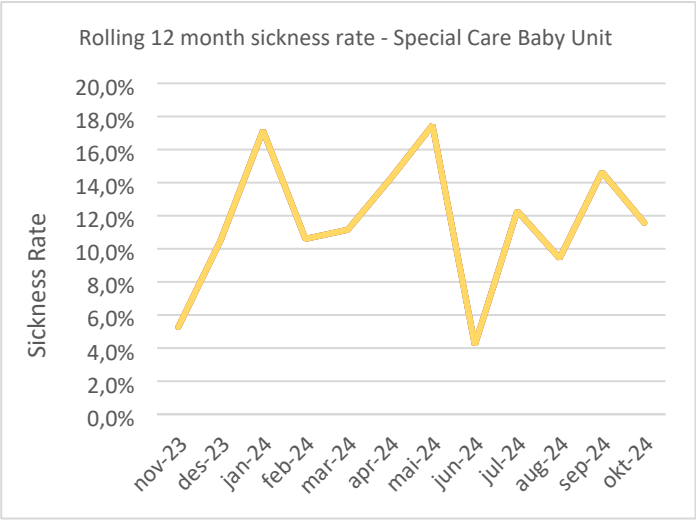
Neonatal transfer out data for October

Not available

Workforce data – October



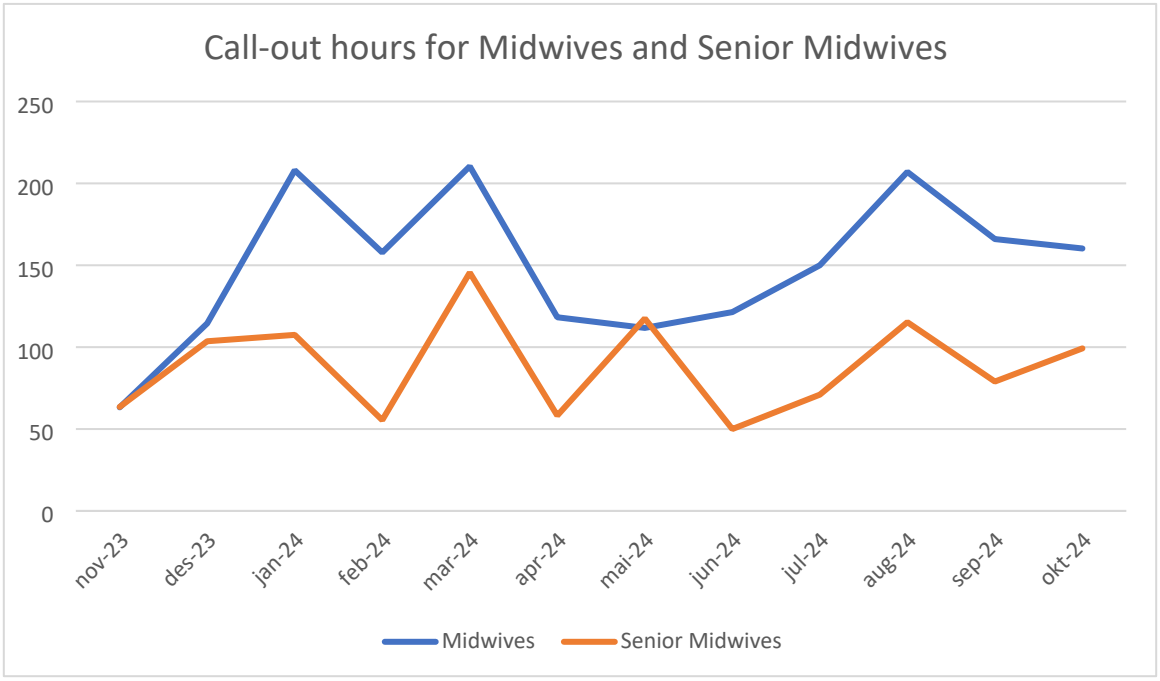




Overall sickness rates from 1st October 2023 – 30th September 2024
Midwives – 6.85%
Maternity Support Workers – 6.88%
Special Care Baby Unit – 11.35%

October Call-Out Hours

Midwife call-out for the unit – **160.25 hours.**
Senior Midwives call-out – **99.25 hours**



Bank and Excess hours

	Maternity Unit/ DAU	MSW's / DAU	SCBU Band 5/6	SCBU Band 3
Bank	129 hrs / 89 hrs	45.5/ 55.25 hrs	273 hrs	12 hrs
Excess/Overtime	479 hrs	50.5 hrs	290 hrs	

Shifts not covered by substantive or bank staff

Maternity Unit – based on 6 midwives per shift		**Special Care Baby Unit**	
Day Shift	21.6%	Band 5/6	2 shifts not covered
Night Shift	24.4%	Band 2	13 shifts not covered
Maternity Support Workers			
Day Shift	10.4%		
Night Shift	6.4%		

Combined Maternity safety Champions & Quadrumvirate Meeting

Minutes of the Meeting of 13th November 2024
In person and online

Present:

Jo Hartley, Director of Midwifery
Aglaia Salvari, Consultant Anaesthetist
Jennie Townsend, Consultant Anaesthetist
Beena Dandawate, Consultant Obstetrician
Lindsey Burningham, Head of Midwifery
James Male – Service Manager
Eiri Jones – NED Safety Champion
Débora Pascoal-Horta – Neonatal Matron

Matters arising

- **Presentation of Audit of Obstetric Consultant Attendance Q1 and Q2 –** 83 occasions reviewed. Benchmarked against RCOG document Roles and Responsibilities of the Consultant providing Acute Care in Obstetrics and Gynaecology. Overall good results with 99% compliance. Two incidents where the consultant didn't attend. Both incidents addressed by the CD. This audit will be shared at The Clinical Governance Meeting, Consultant Meeting and with the LMNS. This led to a discussion about understanding any harm caused and this being recorded in the audit. Currently, no harm caused.

- **CQC Picker Survey Action Plan –** results of the survey discussed, focusing on the free text. Specific themes identified
    1. Support for the partner when the woman must go to theatre after the birth for MRoP, repair of a tear etc.
    2. Support with infant feeding
    3. Really listening to women telling midwives they think they are in labour
    4. Communication about epidural availability. This prompted a discussion about anaesthetic availability and the process for contacting a second anaesthetist when required for an epidural
    5. Ensuring women aren't left in dirty sheets etc. and receive care after giving birth – this led to a discussion about care and compassion and how this can be communicated in a few minutes. It's not necessarily task-focused
    6.
- **Training requirements for the MIS –** discussion centred on the challenges of ensuring anaesthetic colleagues attending the mandatory training.
- **Consideration of culture including SCORE survey**
    - **Discussed the importance of breaks and possibility of a tea trolley for staff**. **Action:** A weekly tea-trolley has been established, provided by a volunteer. This relatively small intervention is proving really popular
    - **The importance of positive feedback**. Ideally by email so it can be saved and used as required. Action: staff encouraged to provide feedback. **Action:** Evidence of an increase in positive feedback by email and professional WhatApp group
    - **Importance of taking breaks**. **Action:** all coordinators to prioritise staff taking breaks in a timely manner. Specialist midwives and managers may be asked to work on the ward to relieve staff working clinically. Staff genuinely unable to take a break to be paid but careful management of those staff who are reluctant to take a break
    - **Perceptions of burnout** – there is a lot of discussion amongst midwives and MSWs about burnout, work-related stress, the relentless pressure of being a midwife in the current national climate. **Action:** individual and group support provided by the PMAs, management

team and line managers. Flexible working arrangements prioritised whenever possible (very rarely refused). Actions suggested by staff always reviewed, reported on and where possible, actioned. Regular staffing meetings with the DoM

Training data for November

Rolling 12-month period ending November 2024 with MIS position and work required for November deadline MIS Year 6.

Key	
≥90% compliance	
<90% compliance	
Lower compliance accepted	
Not reportable MIS Yr 6	

Training	Role	Compliance (percentage)	Non-compliance (number)	Narrative
Practical Obstetric Emergency Procedure Training (PROMPT)	8.10: 90% of obstetric anaesthetic consultants and autonomously practising obstetric anaesthetic doctors	92%	1	
	8.11: 90% of all other obstetric anaesthetic doctors commencing prior to 1 July 2024	100%	0	90% of all other obstetric anaesthetic doctors (commencing with the organisation prior to 1 July 2024) including anaesthetists in training, SAS and LED doctors **who contribute to the obstetric anaesthetic on-call rota**. This updated requirement is supported by the RCoA and OAA.
	8.12 Rotational Anaes staff starting on/after 1st July 2024	100%	0	
	70% of non-obstetric anaesthetic doctors (including anaesthetists in training, SAS and LED doctors) who contribute to the obstetric	89%	2	***Currently excluded from MIS Year 6 Reporting*** Emma Wyatt has 2025 dates and will roster staff to attend, based on expected compliance target 90% MIS Year 7. 4 already booked to attend before Dec 2024. This updated requirement is supported by the RCoA and OAA*

	anaesthetic on-call rota in any capacity.			
	Consultant Obstetrician	100%	0	
	Registrars	90%	1	
	SHOs ST1/F2/GP Trainees	100%	0	
	Midwives	99%	1	BAU
	MSW	95%	2	BAU
Newborn life support (NLS) Yearly 24th sept 24	Midwives	92%	11	BAU. 7 new preceptors started, all booked to attend in November as October date not possible due to Trust Induction dates.
	Paediatric SHO's rotational	100%	0	BAU
	Paediatric SHOs non-rotational	100%	0	BAU
	MSW's Band 3 in PN Care	100%	0	***Currently excluded from MIS Year 6 reporting*** New data for September 2024, not reportable for MIS but can be included in NLS training as per local training plan.
	HCAs	60%	2	***Currently excluded from MIS Year 6 reporting*** New data for September 2024, not reportable for MIS but can be included in NLS training as per local training plan. 2 staff to be captured in October.
	Neonatal nurses	100%	0	**MET for MIS Year 6**
	Paediatric Consultants	100%	0	**MET for MIS Year 6**
	Paediatric Registrars	100%	0	**MET for MIS Year 6**
	ANNP	100%	0	**MET for MIS Year 6**
NLS 4 Yearly	Senior & Cygnet Midwives	100%	0	**MET for MIS Year 6**
	Neonatal nurses	100%	0	**MET for MIS Year 6**
	Paediatric Consultants	100%	0	**MET for MIS Year 6**
	Paediatric Registrars	100%	0	**MET for MIS Year 6**
Saving Babies	Midwives	92%	11	BAU

Lives study day	Consultants	89%	1	1 planned to attend in November however has completed the online eLFH Saving Babies Lives update for version 3, reflected in Element 1.9 stats below.
	Registrars	90%		BAU
	SHOs	100%		BAU
SBLv3 Element 1	Intervention 1.8 – CO monitoring Midwives and MSWs giving AN care	95%		BAU
	Intervention 1.9 – VBA all staff – m/w's, obstetricians and MSWs	95%	10	BAU
	E2.11 Practical SFH Assessment	95%	7	BAU
K2 CTG & IA	Consultants	100%	0	BAU
	Registrars	100%	0	BAU
	Midwives	91%	11	Managed by Fetal Monitoring Lead. 11 midwives out of date. 4 expire in November – will be given extra notice to complete before Nov deadline.

Report to	Board of Directors, part 1	
Date of Meeting	10 December 2024	
Report Title	Learning from Deaths Q2 2024/25	
Prepared By	Dr Julie Doherty / Prof Alastair Hutchison	
Approved by Accountable Executive	Prof Alastair Hutchison, Chief Medical Officer	
Previously Considered By	Hospital Mortality Group, 13 Nov 2024 Quality Committee 26 Nov 2024	
Action Required	**Approval**	Y
	Assurance	-
	Information	-

Alignment to Strategic Objectives	Does this paper contribute to our strategic objectives? *Delete as required*	
Care	Yes	
Colleagues		No
Communities		No
Sustainability		No
Implications	Describe the implications of this paper for the areas below.	
Board Assurance Framework	SR1 Safety and Quality	
Financial	Potential implication if coding needs additional resources (to improve staff recruitment & retention)	
Statutory & Regulatory	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. 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.	
Equality, Diversity & Inclusion	Please complete all boxes in this section. If there is no implication, please state 'no implication'.	
Co-production & Partnership	Potential implication if further joint working with DHC to support coders.	

Executive Summary

The purpose of the report is 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.

- The latest published SHMI data (5 months in arrears) for DCH was 1.1023 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. There has been a recent decrease in depth of coding which is concerning.
- There is an increasing backlog of SJRs awaiting completion in Division A. A plan is being drawn up to mitigate risk & to try to address the issue.

Recommendation
Members are requested to: • **Approve** publication of the report.

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 2 2024/25 Report

Structured Judgement Review Results:

The Family Services & Surgery Division had 45 deaths in quarter 2, of which 40 that require SJR's to be completed. Within quarter 2 39 SJR's have been completed from this quarter and previous months.

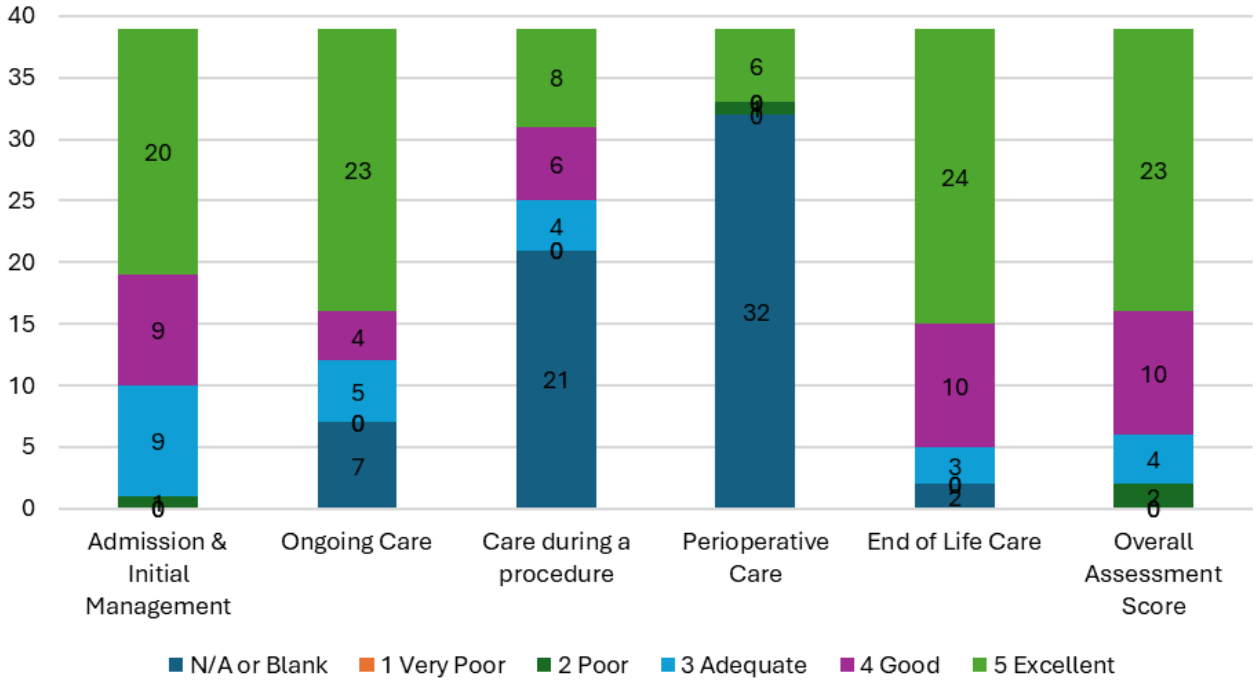
Outstanding SJR's:

The Division have completed a number of SJR's from previous quarters. The backlog of outstanding SJR's (over 2 months) for the Division as at 31/10/2024 is 24:

May	June	July	August
3	6	7	8

Feedback from SJR's Completed in Quarter 2:

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	7	21	32	2	0
1 Very Poor	0	0	0	0	0	0
2 Poor	1	0	0	1	0	2
3 Adequate	9	5	4	0	3	4
4 Good	9	4	6	0	10	10
5 Excellent	20	23	8	6	24	23



Overall Quality of Patient Record:

Blank	Score 1 Very poor	Score 2 Poor	Score 3 Adequate	Score 4 Good	Score 5 Excellent
0	0	0	8	13	18

- Difficult to navigate the care provided in ED due to the Agyle system used there, otherwise record of events, treatments provided, MDT involvement, family conversations all documented clearly and concisely.

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	1	0	2	36

Action Required:

Following completion of the 39 SJR's, 8 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.

Other actions:

- 1 was for review and discussion at Specialty M&M/Clinical Governance meetings.

- 3 requested second SJR from specific specialty.
- 1 was for discussion at Quality Assurance meeting.

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.

Learning from Division

1. Earlier NGT if patients can't swallow
2. Benefits of early chlordiazepoxide in alcohol withdrawal
3. If paraplegic and unwell with PUO – consider early CT
4. Need to document functional status on admission

Emerging Themes:

1. Excellent family communication
2. Long ED stays for severely unwell patients -Trustwide awareness and risk mitigation in progress
3. Difficulties in accessing Hospice Care – raising awareness of availability of palliative care team and palliative care suites in Community hospitals.
4. Continued instances of poor surgical clerking - repeat audit conducted and action plan in place
5. Increased use of bedside echo in ICU to guide treatment

1.2 Division of Urgent & Integrated Care – Quarter 2 Report 2024 / 25

In quarter 2 there were 262 deaths (**80% rise to Q1**), 54 SJR's were requested **(69% rise to Q1)** from these deaths, and 12 SJR's were completed during this period (completed SJR's not necessarily from this quarter).

	Q2			Q3			Q4			Q1			Q2		
	Jul	Aug	Sep	Oct	Nov	Dec	Jan-24	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
Deaths	65	58	60	49	41	63	65	59	69	48	52	45	75	105	82
Deaths requiring SJR'S from Month	15	14	18	11	14	13	15	16	12	9	8	15	6	22	26
*Completed SJR'S	2	14	17	20	12	3	7	11	2	6	10	9	1	9	2

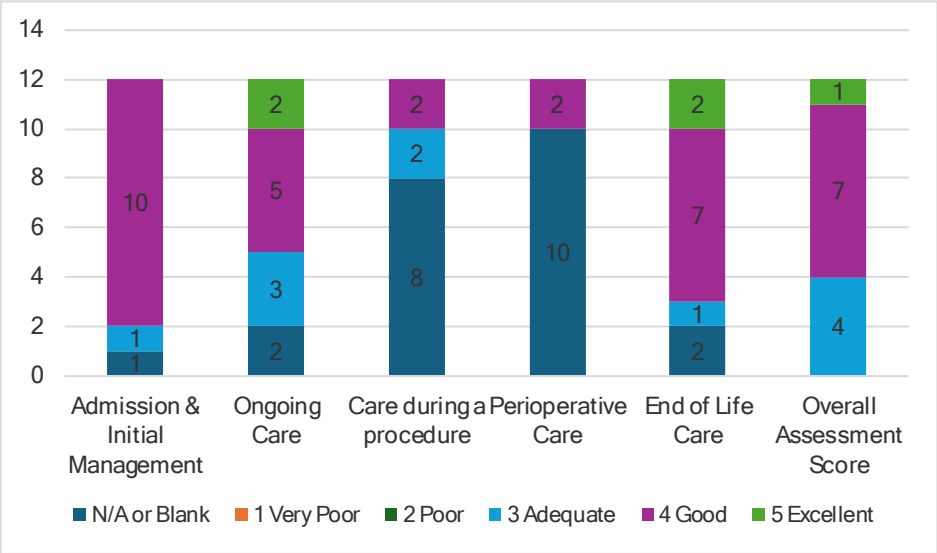
* Completed SJR'S not necessarily from that month's deaths

Outstanding SJRs for the Division as at 12/11/2024 is 119 including outstanding nosocomial reviews:

Jul	Sept	Oct	Nov	Dec	Jan-24	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
1	5	7	4	6	7	15	8	7	8	0	5	20	26

Phase score from 12 completed SJR's in quarter 2:

Phase Score	Admission & Initial Management	Ongoing Care	Care during a procedure	Perioperative Care	End of Life Care	Overall Assessment Score
N/A or Blank	1	2	8	10	2	0
1 Very Poor	0	0	0	0	0	0
2 Poor	0	0	0	0	0	0
3 Adequate	1	3	2	0	1	4
4 Good	10	5	2	2	7	7
5 Excellent	0	2	0	0	2	1



Overall Quality of Patient Record:

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

- Noted that some records are difficult to read and not in time order

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	1	11

Action Required:

Following completion of the 12 SJR's, 0 required further actions:

SJR Key themes from Areas of Good Practice:
- Early Involvement and recognition of palliative care and discussions with family
- Good and prompt review by MDT

SJR Key theme of Areas for Improvement:
- On-site face to face palliative care team representation at a weekend – may be gaps in provision
- More prompt initial consultant assessment on admission
- Completion of nursing documentation
- Sepsis diagnosis earlier identified and documented
- Complete documentation of DNACPR

Areas for escalation

Number of SJRs being received is increasing and current process does not facilitate capacity to complete all of these and tackle the backlog the division currently hold (95). There is currently no identified formal training for staff members keen to start completing SJR's. System that facilitates completion of reviews is not user friendly.

Process for identifying & sharing learning from M&M requires improvement.

Initial plans to mitigate risk:
- Review triggers for SJR (original target set nationally was for ~20% of deaths to be reviewed via SJR; DCH numbers consistently above this)
- Formal training required to widen the pool of who can complete SJR's. RJ looking into provision.
- Process for sharing learning under review by divisional directors.

For further LfD and QIP see section 4.

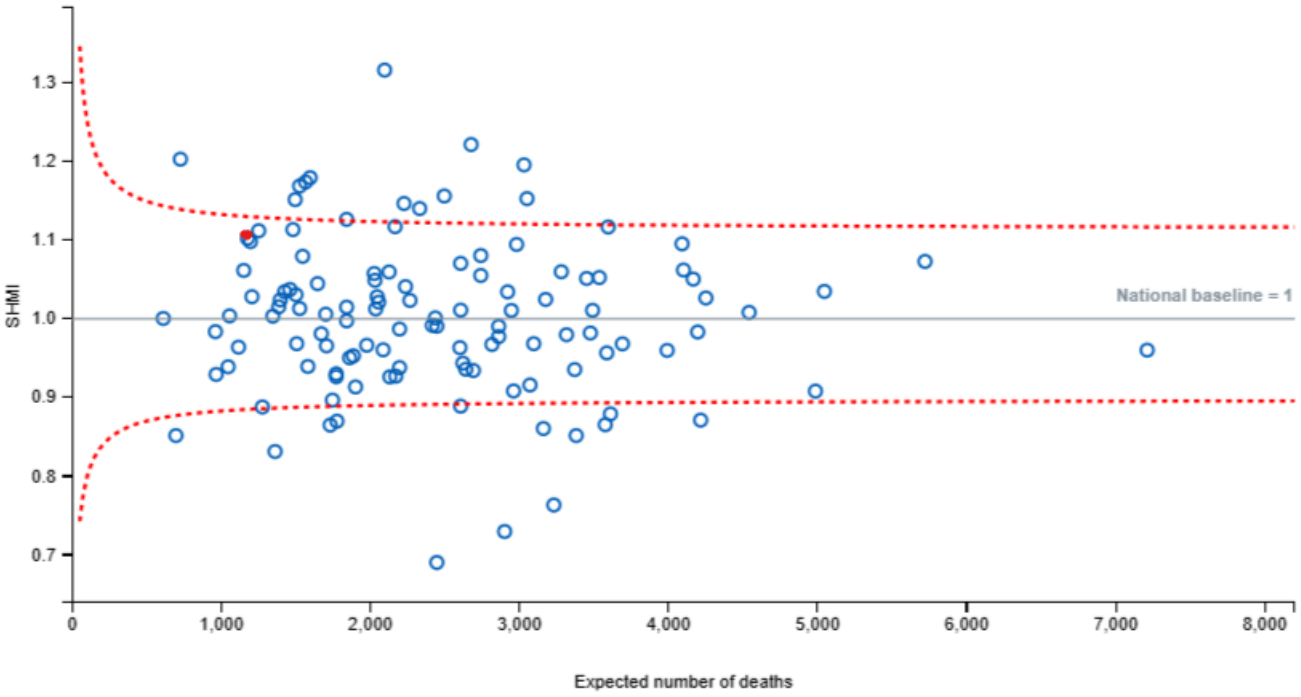
2.0 NATIONAL MORTALITY METRICS AND CODING ISSUES

2.1 Summary Hospital-level Mortality Indicator (SHMI)

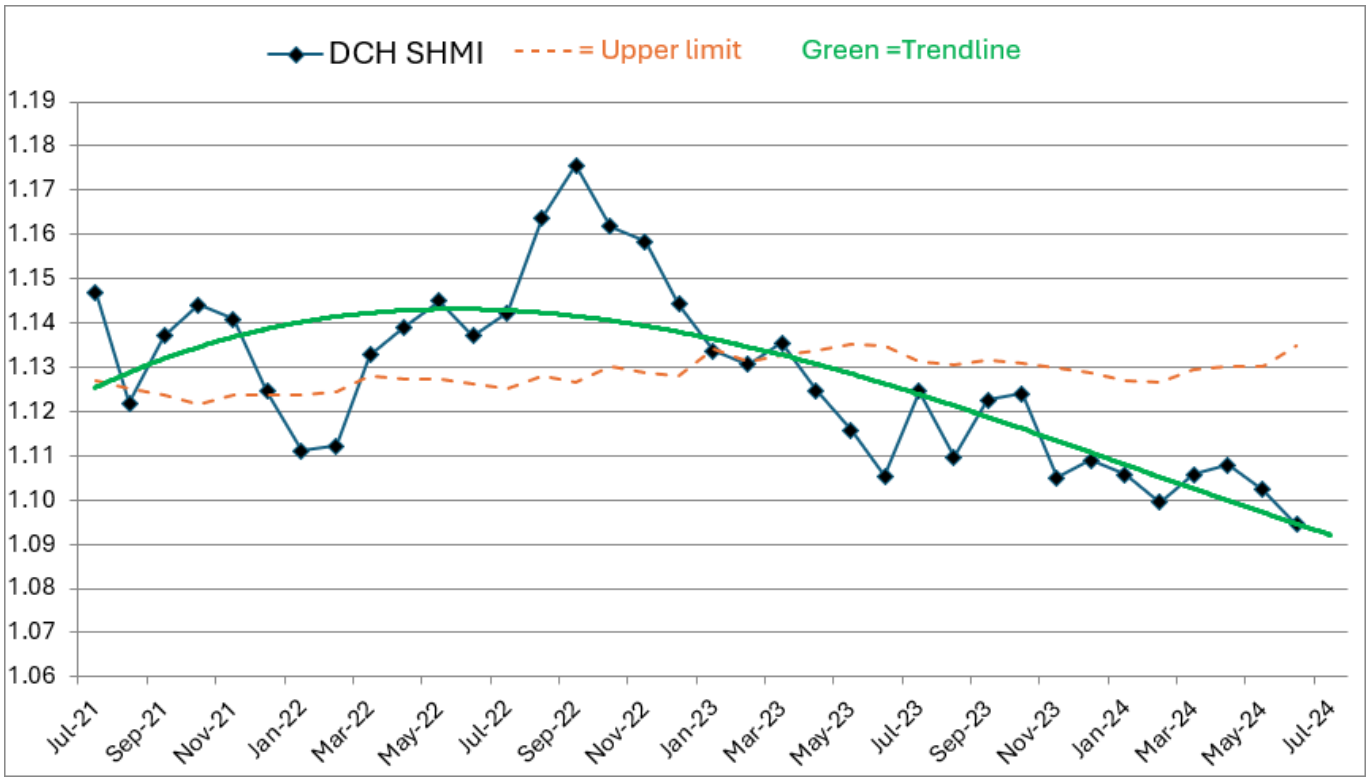
SHMI is published by NHS Digital for a 12-month rolling period, and 5 months in arrears. It takes into account all diagnostic groups, in-hospital deaths, and deaths occurring within 30 days of discharge. It is calculated by comparing the number of observed (actual) deaths in a rolling 12-month period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

The latest SHMI publication from NHS England is for the period June 23- May 24. **The Trust's figure is 1.1023. which is within the expected range** using NHS England's control limits.

DCH =red dot



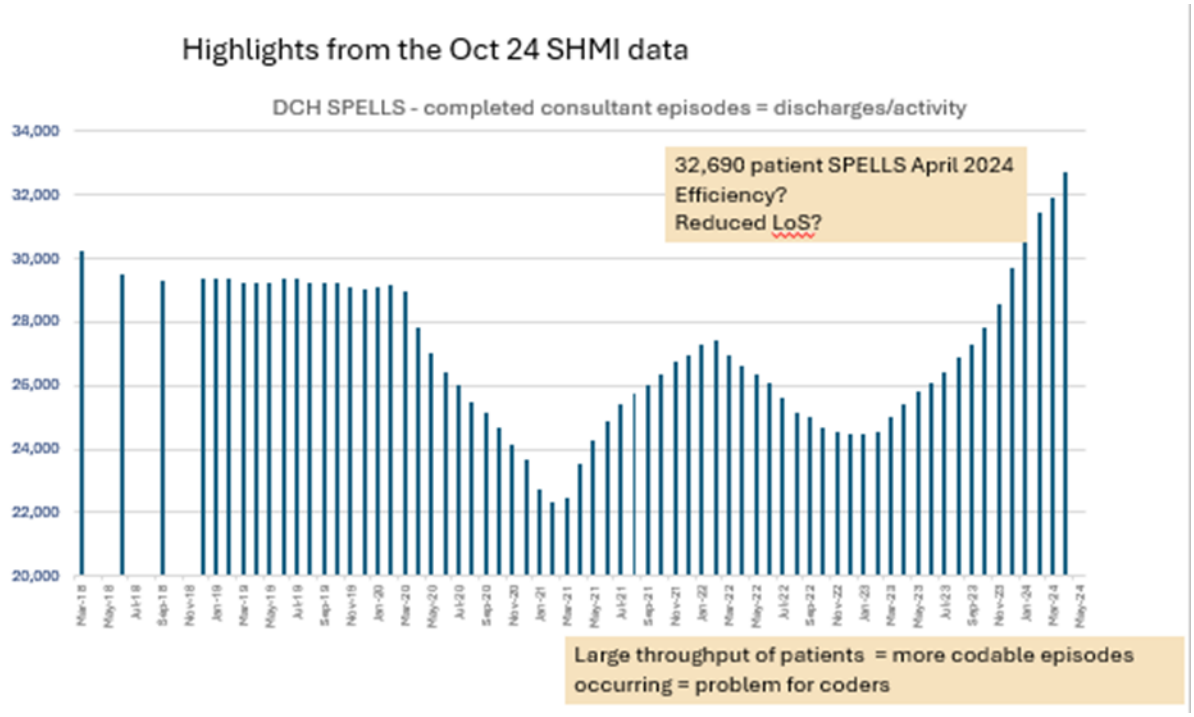
We are aware that our data is influenced by staffing levels in the Coding Department (though mitigations in place), and a possible under-reporting of 'sepsis' in the medical record.
Septicaemia is a recurring alert and further exploration of this is being undertaken (with support from the Deteriorating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

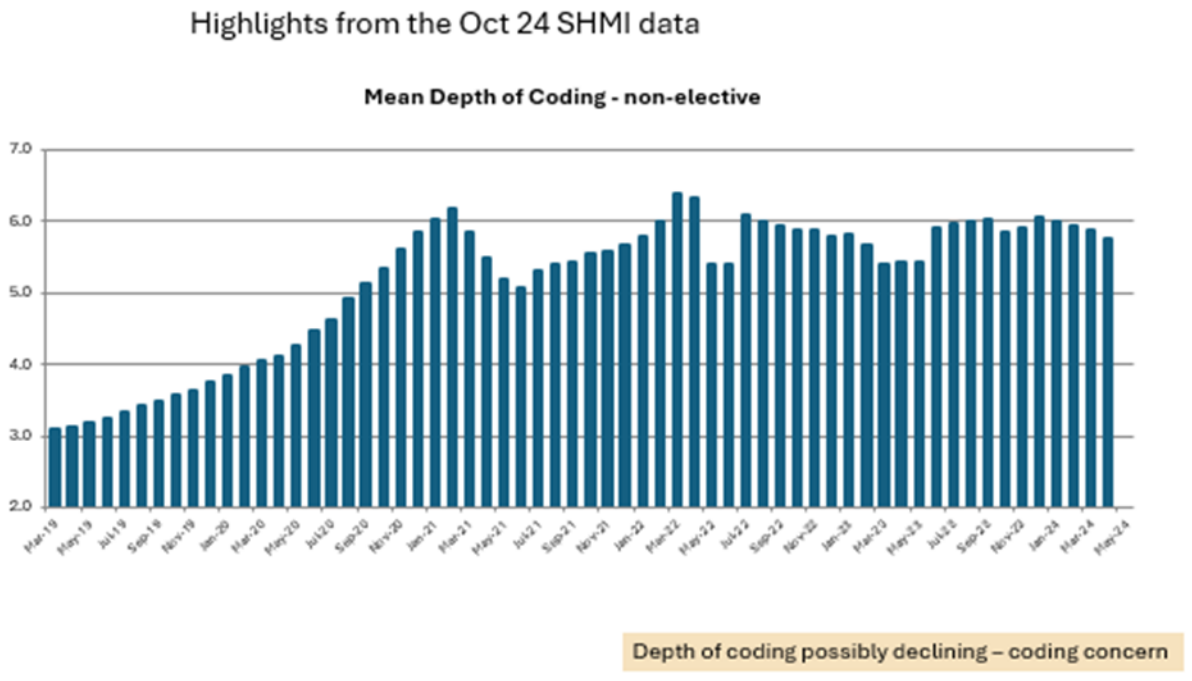


2.2 Depth of coding: NHS Digital states "*As well as information on the main condition the patient is in hospital for (the primary diagnosis), the SHMI data contain up to 19 secondary diagnosis codes for other conditions the patient is suffering from. This information is used to calculate the expected 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 stabilised at around 6.0 – in line with the national average (5.9) for non-elective admissions, somewhat concerningly however it has reduced again to just below this figure at 5.8. Dorset Healthcare have been able to provide an additional 20 hours/week of coding time which helps significantly but there remain concerns regarding lack of resources available to coding. DCHFT mean depth of coding for elective admissions is now further below the England Average at 5.2(compared to 6.1).

DCH % of provider spells with a primary diagnosis which is a symptom or sign is 15.7 (England average 13.8).

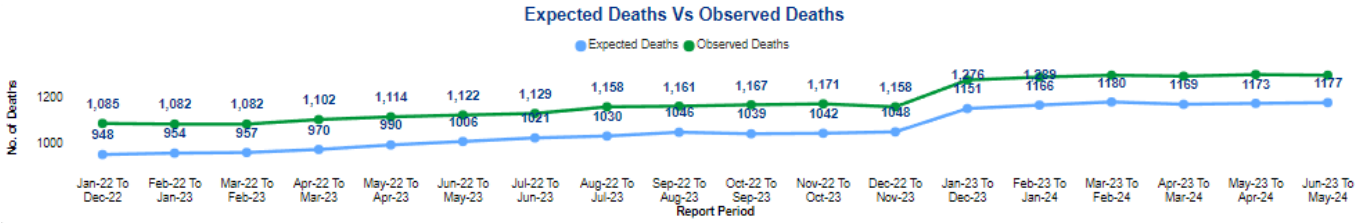


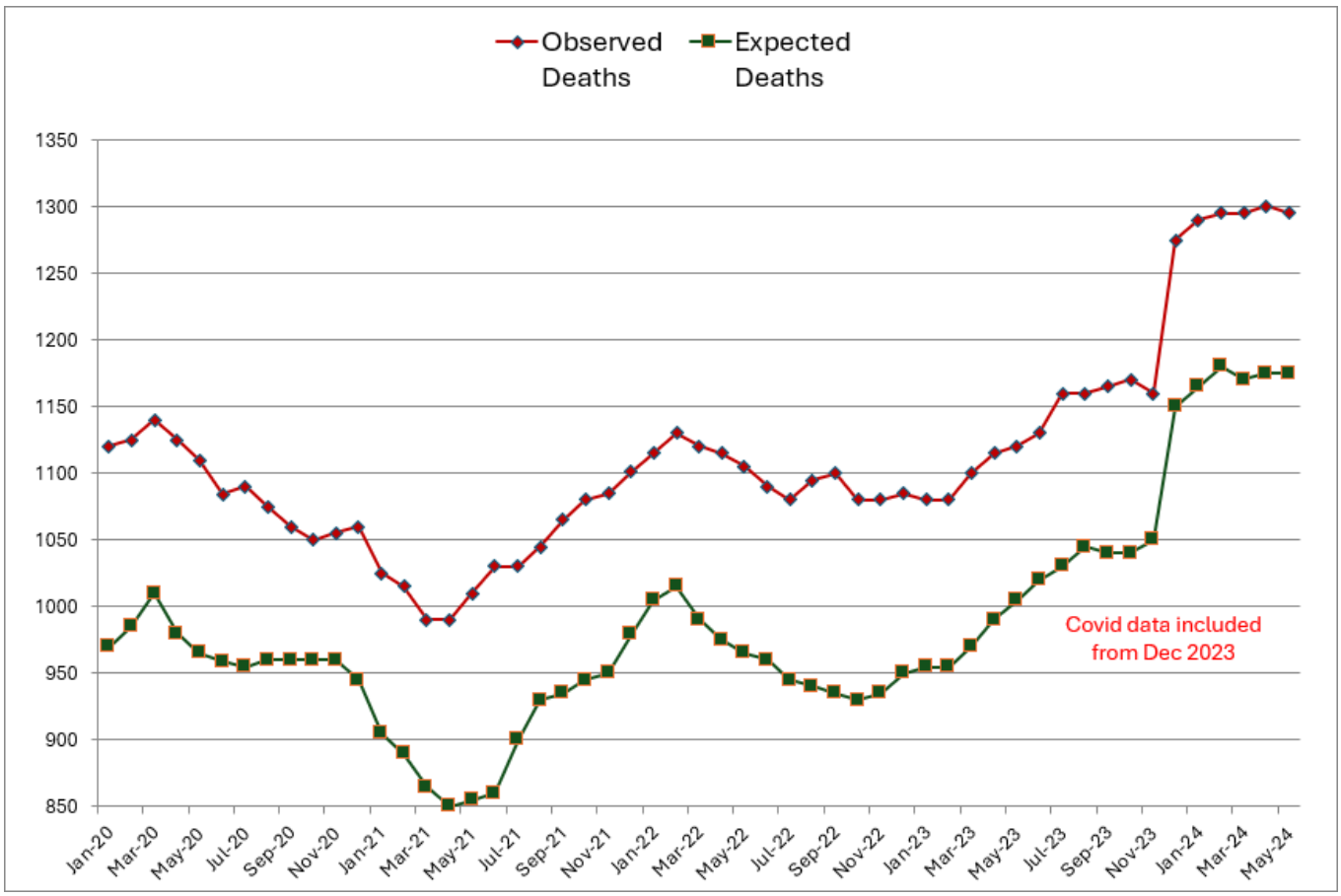


2.3 Expected Deaths (based on diagnoses across all admissions (except covid) per rolling 12 months):

The chart below shows observed (actual) and expected (calculated by NHS Digital) deaths, 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 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.

The observed deaths for this quarter are 1295 with expected deaths at 1175 from 32690 provider spells.





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.

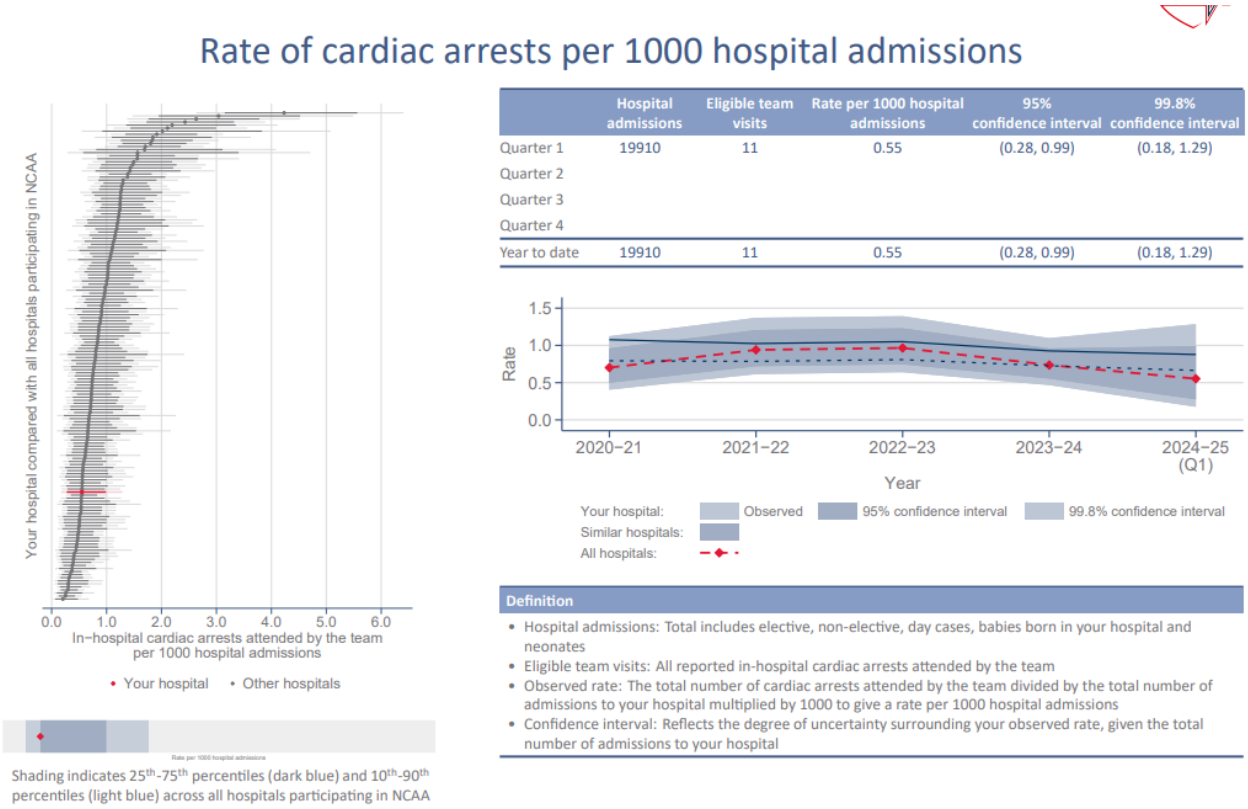
For other metrics of care including complaints responses, sepsis data, AKI, patient deterioration and DNACPR data and VTE assessment data please see the Quality Report presented on a monthly basis to Quality Committee by the Chief Nursing Officer.

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

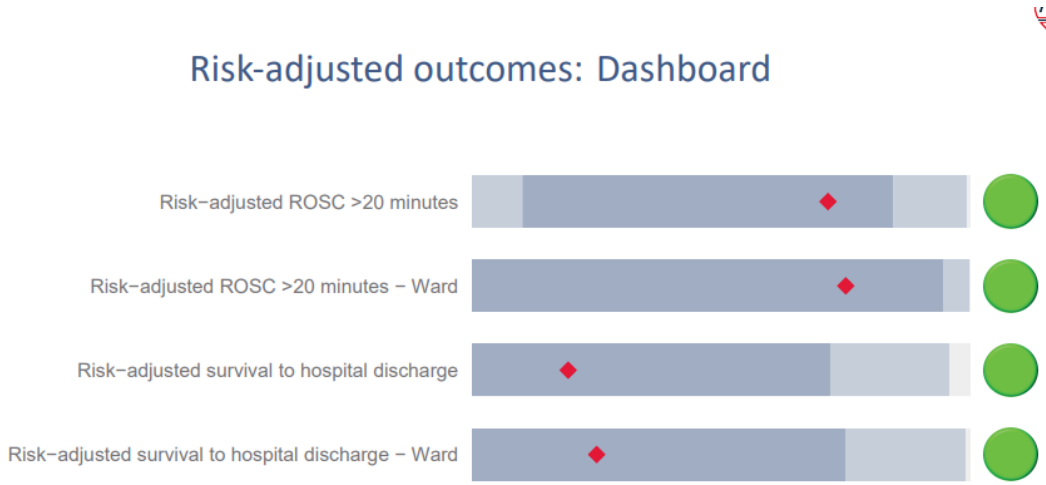
The latest national Cardiac Arrest audit for DCH includes data from 1 April 2024 to 30 June 2024 & was published on 04/11/24. Frequent cardiac arrest calls suggest unanticipated deteriorations in a patient's condition, whereas fewer calls suggest higher standards of ward care, although this is unproven.

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:

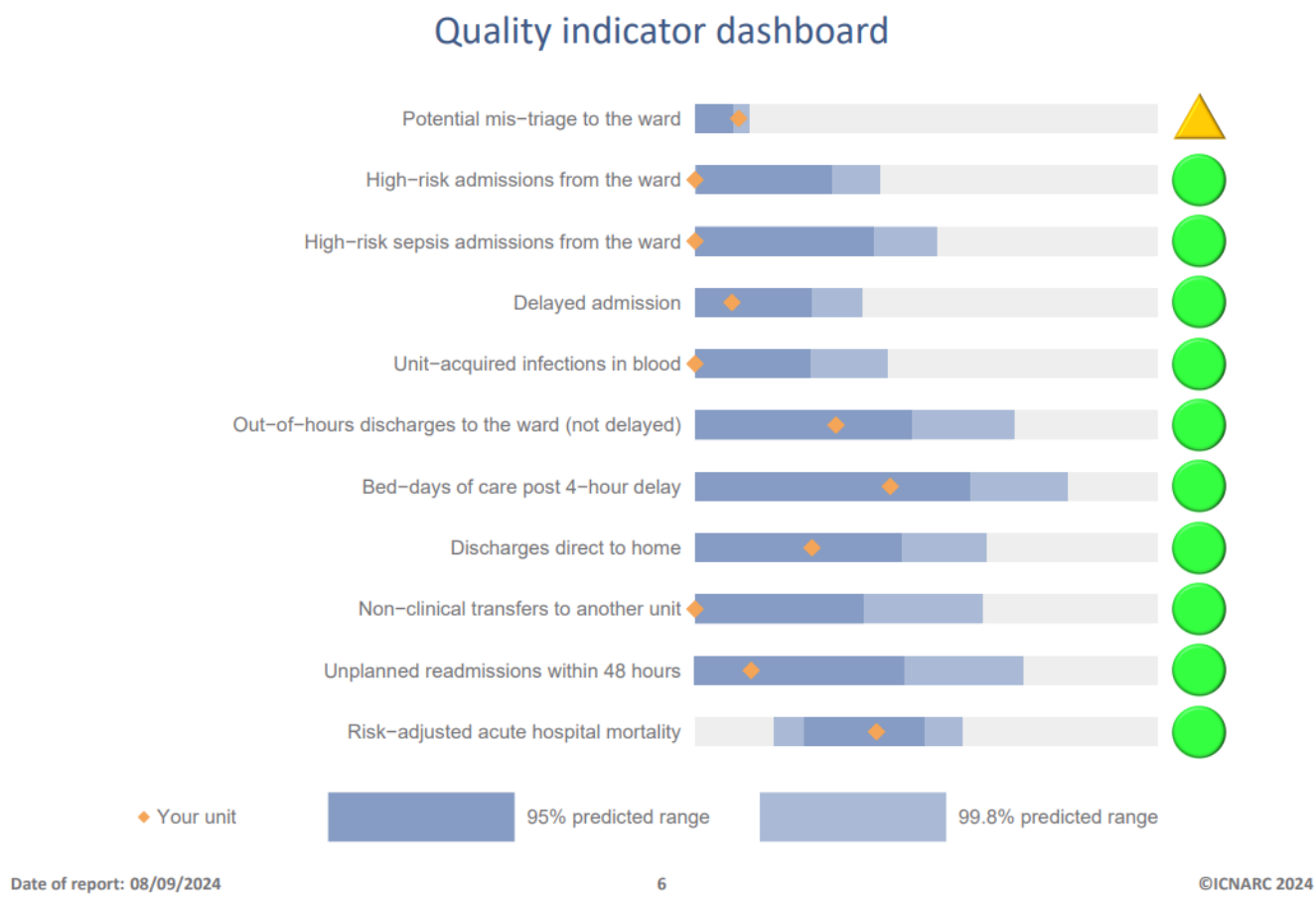
a) Time to 'Return of Spontaneous Circulation' (a measure of resuscitation effectiveness) and
b) Survival to Discharge.
These and all other measures in the report get a 'green' indicator.



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 Q1 dates 1 April 24 - 30 June 24 published Sept 2024 and based on 175 admissions of 168 patients.

All but 1 of the indicators remain in the GREEN area. Potential mis-triage to ward has previously been 'green', thus awaiting results for next quarterly publication.

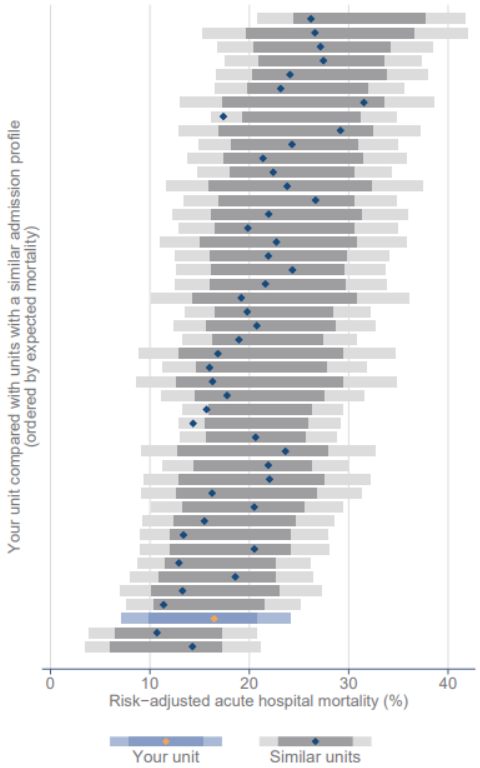


The charts below show the “risk-adjusted acute hospital mortality” following admission to the DCH Critical Care Unit. They compare observed and expected death rates in a similar fashion to SHMI.

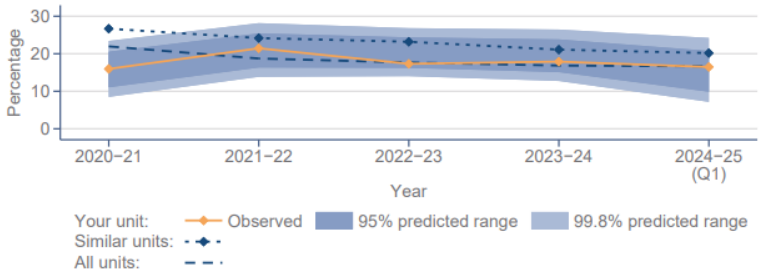
These results are well within the expected range.

case mix programme

Risk-adjusted acute hospital mortality



	Eligible n	Complete n (%)		Observed n (%)	Expected %	95% predicted range	99.8% predicted range	
Quarter 1	170	170 (100.0)	●	28 (16.5)	15.4	(9.9, 20.7)	(7.2, 24.2)	●
Quarter 2								
Quarter 3								
Quarter 4								
Year to date	170	170 (100.0)	●	28 (16.5)	15.4	(9.9, 20.7)	(7.2, 24.2)	●

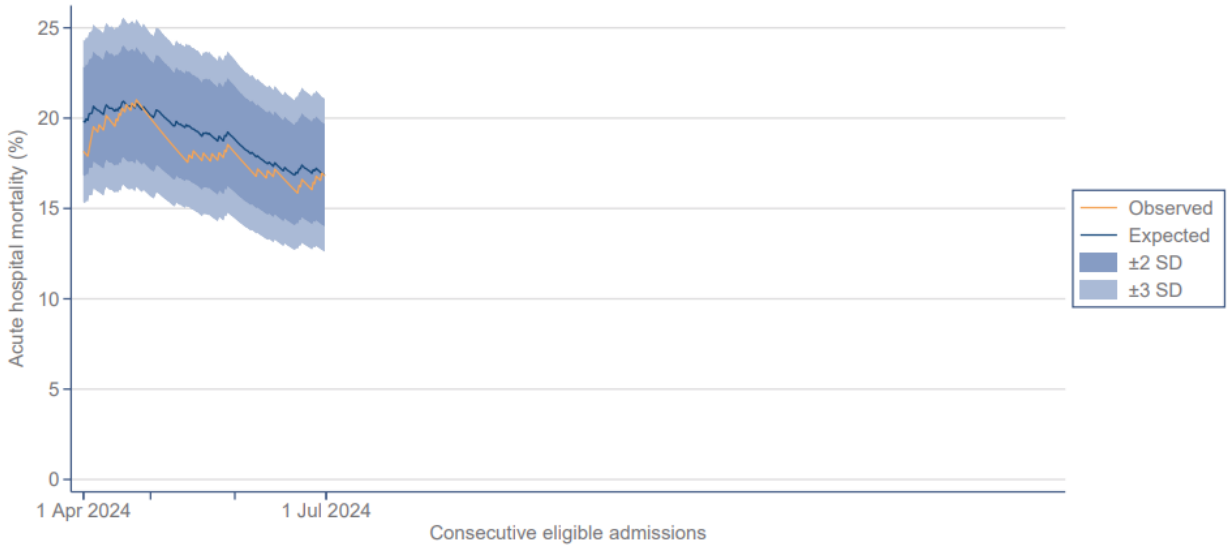


Your unit: Observed 95% predicted range 99.8% predicted range
Similar units:
All units:

Definition

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

Risk-adjusted acute hospital mortality (EWMA plot)

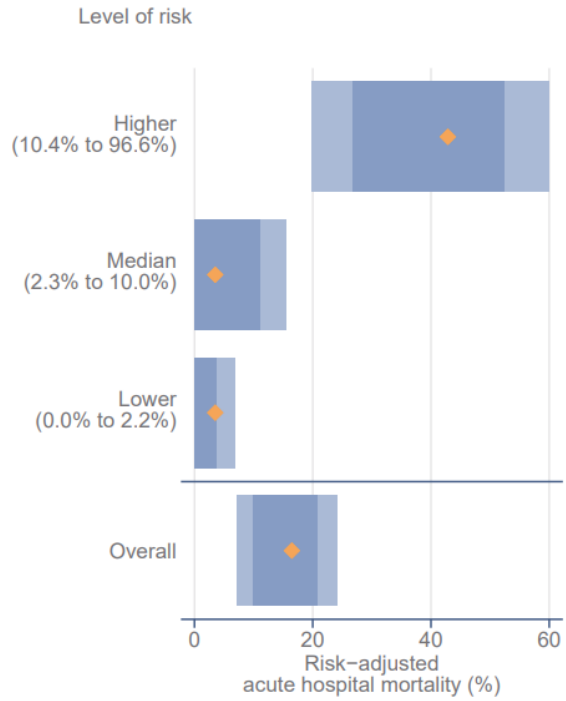


Explanation

- 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)

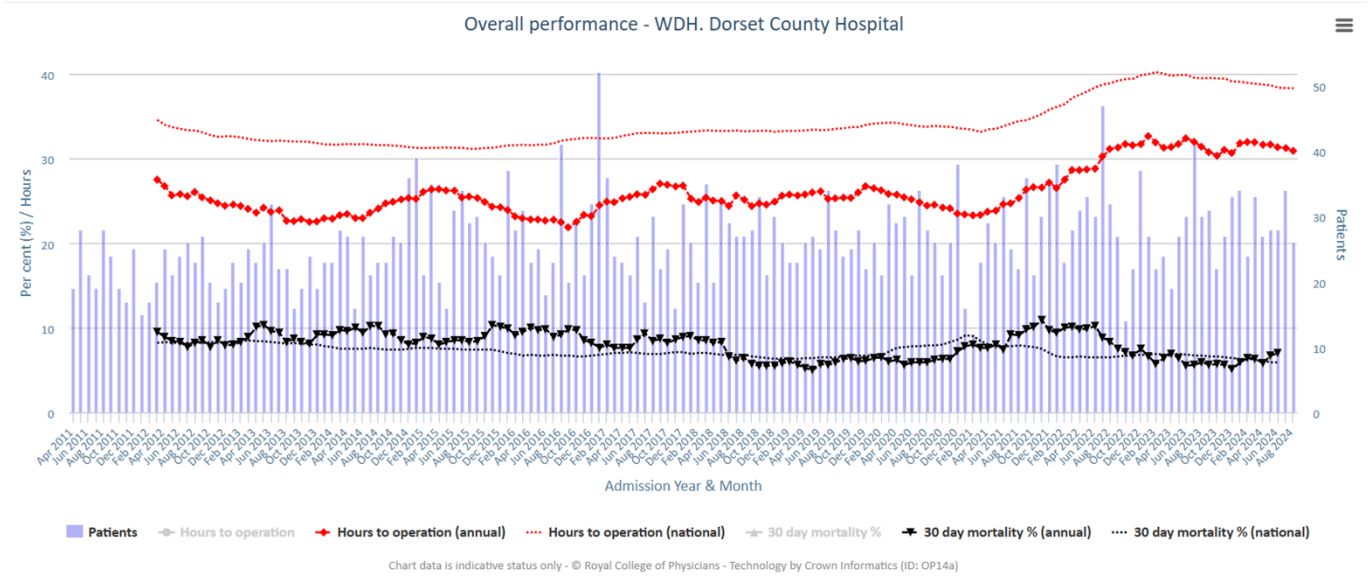


Level of risk	N	Observed n (%)	Expected %	95% predicted range	99.8% predicted range	
Higher	56	24 (42.9)	40.2	(26.7, 52.4)	(19.8, 60.0)	
Median	57	2 (3.5)	5.3	(0.0, 11.0)	(0.0, 15.6)	
Lower	57	2 (3.5)	1.1	(0.0, 3.7)	(0.0, 6.8)	
Overall	170	28 (16.5)	15.4	(9.9, 20.7)	(7.2, 24.2)	

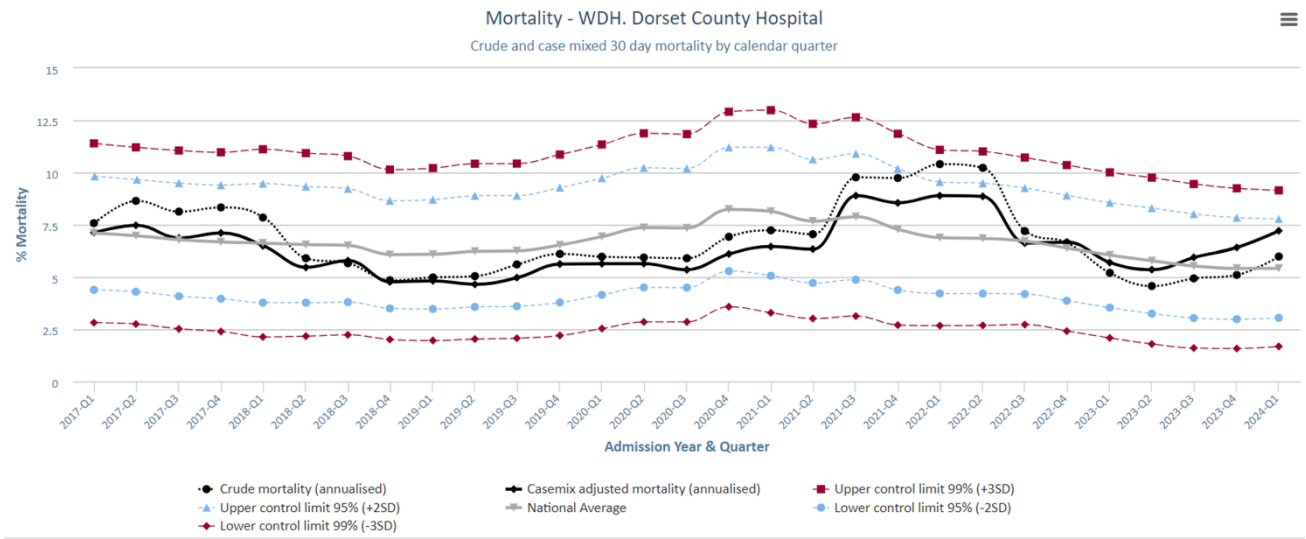
Explanation

- 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



'Hours to operation' remains significantly better than the national average with 30 day mortality in line with the national average. The trauma lead and trauma coordinators are looking into the mortality data which is now plotting just above the national average. Data quality was an issue the last time this occurred but we are obviously keen to understand the trend better.



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.

3.6 Getting it Right First Time

Since the last LfD report, the following reviews have been conducted via GIRFT / external organisations:

07/08/2024	Acute Oncology Service Review	Wessex Cancer Alliance	cancer services
09/08/2024	Pharmacy Aseptic Unit Audit	Regional Quality Assurance South West	Pharmacy
Sep			
02/09/2024	Histopathology ISO 15189:2022 transition (project 317497)	UKAS	Histopathology and NG cytology
17/09/2024	General Surgery Gateway Review - Dorset ICS	GIRFT	Gen Surg
27/09/24	Endocrinology (Medicine & Surgery) Gateway Review SW Region	GIRFT	Endocrinology

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.

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)

No new releases Q2.

Paediatric Mortality for Q2:

There have been 2 child deaths in Q2; 1 expected and 1 unexpected.

The notification pathway following an unexpected child death has been updated to ensure practice consistency and timely information sharing.

Pan Dorset & Somerset CDOP continues to review cases and share learning as appropriate. CDOP is planning a learning event in March 2025 for professionals from all agencies.

3.10 MBRRACE data:

MBRRACE-UK: Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK | MBRRACE-UK | NPEU

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/

No new reports / data for Q2

3.11 National Perinatal Mortality Review tool

Reports | PMRT | NPEU

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

There has been a total of 4 perinatal deaths occurring at DCH reported via the PMRT in Quarter 2. None of the cases met the threshold for referral to Maternity and Newborn Safety Investigations (MNSI).

No concerns have been raised with the notification and surveillance submissions and the current reporting process is to continue.

To improve local learning all perinatal deaths reported by other tertiary centres, involving mothers who receive their antenatal care pathway with DCH as primary care givers will be included.

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. Management of backlog of SJR in Division A
2. Mortality Review policy update complete

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:

Orthopaedic

1. Infection left THR
   - Early aspiration and aggressive debridement
   - Good MDT liaison
   - Infection resolved

2. Wound infection left long gamma nail
   - Early senior review and debridement
   - Infection resolved and fracture union without removal of nail

3. Failure of ankle ORIF metalwork
   - Failure to recognise latent malleolus displacement
   - Registrar supervision in clinic

4. Patient transferred from medics to ortho without notification
   - Admitted under medics with intracranial bleed, considered to be potentially traumatic
   - Transferred to ortho ward without senior notification
   - Deterioration clinically soon after transfer
   - Agreed in future to remain under medics if medical issues outweigh ortho issues

Paediatrics

Learning & actions:

- Discussions around risk to self vs patient care: At what point does risk to staff override treating patient? Actions to be taken / considered if a staff member refuses to be involved in a situation due to concerns about their own safety?
- Support for junior staff to contact the most senior people on call if they have patient and/or staff safety concerns?
- Recognition of when post-ictal becomes unconscious / reduced GCS not caused by the seizure?
- Excellent ITU support & good escalation of care within teams (PIMS – TS)

Anaesthetics

1. Checking & documentation of important family history in pre-assessment. A separate elective section list and greater anaesthetic staffing e.g. in the afternoon in obstetrics may take the pressure off the busy environment and reduce missing important clinical information.
2. Patients should not leave recovery area in pain – appropriate drug rescue should be prescribed and given if needed in recovery.
3. Premedication issues: staffing issues + checking whether the premed has been given so intra-op medications can be adjusted if necessary.
4. RIH repair listed as LIH – appropriately marked and consented. Learning: WHO check picked this up appropriately prior to anaesthesia – good use of checklist.

5. Standard practice in dental surgery is to remove cannula before patient leaves – some of anaesthetic team not aware of this, risk put in as anaesthetist asked for a cannula to remain in a patient – unclear whether appropriate or not but note guidelines are such and can be deviated from when appropriate.
6. Out of date drugs – boxes of muscle relaxants found to be out of date so ensure drug ampoules always checked.
7. Latex allergy noted at sign in – not discussed in team brief so delayed the list but good use of WHO check list picking this up. Ensure allergies discussed in team brief, consider latex free hospital.
8. Transfusion traceability tag for platelet unit not returned. All anaesthetists should do blood transfusion training. Ensure tags returned.
9. Awareness of hazard's next to theatre table.

General and Colorectal Surgery

1. Good care of patient with sepsis.
2. Complex surgical history & elective surgery for colon cancer. Post op sepsis, not drainable with IR. Complex case with a long post op stay. Abdo collections effectively managed with open drainage.

Elderly Care & Stroke

- Setting up refresher education session and feedback for SpRs
- Monthly update email to be set up
- SpR document being created around stroke on calls to support building confidence

6.0 LEARNING FROM CORONER'S INQUESTS Q2

During the period 01.07.2024 to 30.09.2024, 22 inquests were opened. A total of 11 Inquests Hearing were held in this period.

For these 11 cases, 16 statements were obtained from clinicians involved in the patient's care.

Of the 16 statements provided, only 3 clinicians were called to give live evidence..

No Inquests have progressed to a claim in this period as yet.

52 open inquests.

No legal representation was required to support the Inquest process through this period and 1 Pre-Inquest Review (PIR) was conducted. This PIR will result in a Jury inquest next year.

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

Learning Identified:

- Lack of Care Plan from Care Home, should have been requested on admission to DCH
- Delay in hydration on admission

7.0 LEARNING FROM CLAIMS Q2

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 2 FY 24/25.

New potential claims	14
Disclosed patient records	15
Formal claims	4 clinical negligence 1 employee claim
Settled claims	0
Closed - no damages	12 (limitation expired)

8.0 SUMMARY

The latest SHMI publication from NHS England is for the period 1 May 2023 – 30 June 2024. The Trust's figure is 1.1023, 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.

Work planned to agree an action plan to support completion of SJR within division A.

MORECOMBE BAY PROGRESS UPDATE- OCTOBER 2024

- Review frequency of RO reporting to Board – complete and for further consideration with appointment of Interim CMO
- Consider developing an 'Employer Relations Report'
  - Analysis of no / type grievances & disciplinaries via care group
  - No of clinical performance improvement plans
  - +/- bullying / harassment; whistleblowing and FTSUG report
- Establish Decision Making Group (DMG)- Draft Terms of Reference created and first meeting planned. Aim to make this Multi-disciplinary across Medical, Nursing and AHPs.
- Audit of Case investigation & management with regard equality & diversity– undertaken previously for Nursing; underway for Medical.
- Strengthening clinical audit– link to claims / complaints - Deputy Director of Nursing 'Heads of' meeting established to triangulate; Quality Surveillance Group to be re-established

  Triangulating the learning from and handling of complaints, incidents and claims
- Strengthening mortality reviews and Board reporting – included in Clinical Governance review; Neonatal, Paediatric and LeDeR data to be included in Hospital Mortality Group and Learning from Deaths Report.

Dorset County Hospital
NHS Foundation Trust

Report to	Board of Directors, Part 1	
Date of Meeting	10 December 2024	
Report Title	Senior Leadership Walkaround report – April – September 2024	
Prepared By	Alison Male, Head of Quality Governance	
Approved by Accountable Executive	Dawn Dawson, Chief Nursing Officer	
Previously Considered By	Quality Committee, 26 November 2024	
Action Required	**Approval**	-
	Assurance	Y
	Information	-

Alignment to Strategic Objectives	Does this paper contribute to our strategic objectives? *Delete as required*	
Care	Yes	
Colleagues		No
Communities		No
Sustainability		No
Implications	Describe the implications of this paper for the areas below.	
Board Assurance Framework	SR1 Quality and Safety	
Financial	No implication	
Statutory & Regulatory	Performance against a number of local and national metrics and KPIs and linked to legal and regulatory requirements Integral to CQC quality standards	
Equality, Diversity & Inclusion	No implication	
Co-production & Partnership	Patient experience and confidence of local community in services provided. Improving the health of the local community and opportunities for wider engagement	

Executive Summary

Senior Leadership Walkrounds - 6 months review:

Between April 2024 – September 2024 there were 18 Walkrounds undertaken by Directors, Non-Executive Directors, Governors and Senior Management Staff, covering 7 Out-patient areas, 9 In-patient areas and 2 non-patient areas.

Templates were devised for each area based on the 15 Step Challenge principles and the Institute of Healthcare Improvement Patient Safety walkaround toolkit which look at first impressions and the safety and improvement culture within the team.

The Trust currently uses the JISC system for recording the walkrounds and updated templates were added to the system in July. We plan to further update the questions and move the walkaround templates to Microsoft forms (MS forms) in the coming weeks, this will provide more flexibility in the completion and sharing of information and outcomes from the walkarounds.

Themes Identified from Walkrounds 2024/25

First Impressions: -

- Staff in reception area were friendly and helpful
- Good signage indicating door locked for safety reasons.
- Staff engaged and welcoming to visitors.
- Staff in the booking area/reception were welcoming, patients in the admission waiting area appeared relaxed

Safe:

- Dept was accessible for my colleague (NED) who was using a scooter. Evidence of a good flow through the dept that reflects the pathway
- All patients spoken to were complimentary of the service and staff.
- Discussed feedback from Datix submissions is regular. Signs of QI but some HCSW unaware they were taking part in QI but did feel their ideas were listened to.
- A clean, tidy department

Caring and Involving:

- All patients and carers looked relaxed. Saw positive interactions between staff and patients.
- Excellent team spirit - helping each other to manage peaks of work

Well organised and calm:

- Cleaning was observed on the visit which was unannounced, use of gloves, hand washing and use of alcohol gel was in place. Prompt cleaning and a cleaning kit was available should there be an MRSA patient attend the department. Fire doors were not blocked, medicine trolleys in the corridor does restrict some space.
- Entry door locked for security, security guard attending patients presenting risk for staff and patients
- Clean and tidy, Receptionist helpful
- Helpful porter/patient interaction
- Good signage about patient transport and returning equipment

Well-led:

- All staff knew the Matron by sight and name, they were aware of plans to move the booking team back from South Walks House and co-locate.
- I was informed that all staff had a regular daily meeting together and were encouraged to raise any areas of concern.
- Positively focused on the unit and its contribution to support patient flow.
- Patients appeared comfortable Staff appeared to know their roles and the rhythm of the unit

Recommendations and Actions:

- Library upgrade - Capital Estates Plan - noted.
- Reminder regarding safe use of fire doors - days room & kitchen. An audit is underway with the Fire Safety Officer.
- Publication of cleaning schedules – these have now been signed off and are in being installed.
- EFM to consider ceiling hung signs for toilets.
- Staff informed us that bed spaces lacked enough electrical sockets for the equipment used in care of patients with respiratory conditions.

Large improvement projects:

- Signage – The Trust has undertaken a Trustwide refresh of the 'way finder' signage around streets and departments – Estates & Facilities Management is currently developing a strategy to address signage and wayfinding.
- Damers Restaurant – a refurbishment of the restaurant, including a dedicated staff area, has competed. This forms part of a wider programme of improvement to nutrition and hydration for patients and staff.

- Review of visiting times and standardisation of public facing information and access – New Visiting policy published with the introduction of open visiting.

Assurance of actions completed:

Actions are monitored by the CQC Compliance Group with feedback reports, including recommendations shared with Wards and Departments. Feedback is used as part of the evidence for Ward Accreditation. Feedback direct to areas ensures that local changes are reviewed and monitored by Ward Managers, Matrons and Heads of Nursing.

Recommendation

Members are requested to:

- Receive the report for **assurance**

Report to	Board of Directors	
Date of Meeting	10th December 2024	
Report Title	Safe Staffing Annual review	
Prepared By	Louisa Way, Interim Deputy Director of Nursing (Acute Care) Trudy Goode, Lead Nurse Workforce and Safer Staffing	
Approved by Accountable Executive	Dawn Dawson, Joint Executive Chief Nursing Officer	
Previously Considered By	Quality Committee, 26th November 2024	
Action Required	**Approval**	Yes
	Assurance	Yes
	Information	

Alignment to Strategic Objectives	Does this paper contribute to our strategic objectives? *Delete as required*	
Care	Yes	
Colleagues	Yes	
Communities		No
Sustainability		No
Implications	Describe the implications of this paper for the areas below.	
Board Assurance Framework	SR1 Quality and Safety	
Financial	Direct impact on agency and temporary staffing spend	
Statutory & Regulatory	Performance against a number of local and national metrics and KPIs and linked to legal and regulatory requirements Integral to CQC quality standards	
Equality, Diversity & Inclusion	No implication	
Co-production & Partnership	Patient experience and confidence of local community in services provided. Improving the health of the local community and opportunities for wider engagement	

Executive Summary

The papers outline the process and governance to ensure that Dorset County Hospital can meet national workforce requirements for safe staffing within inpatient wards and the Maternity Service. A bi-annual establishment review follows the National Quality Board (2016) requirements and the Developing Workforce Safeguards (2018) guidance and provides a comprehensive account which concludes with a series of recommendations to ensure safe staffing and enhance care provision in our inpatient wards.

This report is the Annual Report of Safe Staffing to the Board, with a 6 monthly audit and report submitted previously. In addition to the use of the formal Safer Nursing Care Tool (SCNT), staffing levels, patient acuity and dependency, and effective utilisation of resources is discussed twice daily at the internal bed/operational flow meetings and at twice daily strategic staffing reviews. Staff are requested to move area of work to ensure safe and effective care of our patients. This review is undertaken in conjunction with the Ward Sisters, Matrons and Heads of Nursing responsible for their respective areas.

Since the Annual Safe Staffing Report (2023) the Allocate Safe Care module has been implemented, in line with recommendations from the previous report. The project commenced April 2024 with 4 wards starting initially before Trust wide roll out. Acuity census is required 3 times daily using the Safe Nursing Care Tool (SNCT 2023). A further 4 wards commenced utilisation of the module in September 2024 with remaining areas going live before the end of December. Further consideration is being given to this tool being utilised in Maternity Services. This would be as an addendum to the Professional Judgement framework and to supplement the completion of BirthRate Plus every 3 years.

Alternative roles in the clinical area also been explored and a pilot project for Ward Housekeepers is being undertaken on 2 wards. Early indications are that this has been successful with improvement demonstrated during a PLACE assessment during the project. This has particularly been evident with bed area preparation, management of allergens, improved hydration and nutritional intake and the support given to patients to remain on their wards and de-escalate anxiety. Food service and food safety is now a priority with food being seen as medicine (NHS 2023 National Standards for Healthcare Food and Drink) which support delivery of quality indicators such pressure ulcer management and patient experience. It is anticipated that a review of Domestic Housekeeper provision will be considered and role redesign, to incorporate both cleaning and hostess duties, the likely outcome. This will require input from Hotel Services, Finances and HR to ensure appropriate transition arrangements are in place. Additionally, a Ward Clerk project to review core competencies is being undertaken to both improve the bank administration offers across the Trust with an aim to improve compliance with Trust standards. Improved ward clerk provision is expected to improve Electronic Discharge Summary (EDS) completion, appointments made, response times to answering ward telephones as well as meet and greet on the wards. The Trust does not have consistent Ward Clerk provision across all relevant areas, or 7 days a week. It is anticipated that a business case would be required to extend this provision.
Both roles are expected to release nursing staff time to care.

Summary
The Trust has reviewed the SNCT audits results for the Inpatient wards and Maternity Services and has identified the need for additional staff in specific areas. The Trust also remains within the expected limits of the Model Hospital data in relation to nursing and midwifery staffing.

The 2023/2024 Annual Report actions completed include:

- Invest in a Safe Staffing Clinical Lead role to develop and support the 'Safe Staffing Strategy' - Actioned and in place for 12 months and has successfully completed the Interrater Reliability Assessment for SNCT.
- Embed 'Safe Care' assessment daily utilising current digital software to support and evidence movement of staff around the Trust to support areas of greatest need based on acuity and dependency alongside care hours per patient day. In progress.
- The requirement to manage safe staffing via allocate and the rosters – full governance and rostering review of inpatient areas has been completed.
- Encourage Safe Staffing Fellowship access by senior nurses – Deputy Chief Nurse (EH) successfully completed her Fellowship training. Applications from Maternity had been submitted.

The Lead Nurse for Workforce and Safe Staffing has attended a two-day national workshop.

Recommendation

Members are requested to:

- Receive the report for **assurance**
- **Approve** the recommendations in this report

The recommendation of this report is to:

- Support the alignment of headroom allocations to identified areas to meet minimum national standards (27% for Emergency Department, 25% for Critical Care, Special Care Baby Unit and Maternity and 22.2% for general wards), noting a targeted approach to areas of specific need.
- Note the findings of the Annual Review (completed Summer 2024) and note the next planned biannual review Spring 2025)
- To note and support the uplift in staffing levels in accordance with audit findings.

QUALITY COMMITTEE

Annual Safe Staffing Review 2024/2025

Inpatient Wards

Executive Summary

This report provides assurance in relation to Safer Staffing for acute ward-based nursing following the acuity and dependency audit completed September 2024 for a period of 30 days. The last audit was completed in June 2024 and that report was presented to Trust Board in July 2024. It is acknowledged that the audit should be twice yearly which is the planned audit programme going forwards.

Maternity staffing was subject to review using professional judgement and review of activity and complexity in Quarter 3 2023/24 and the Birthrateplus© 3 yearly staffing review was undertaken in the second half of the financial year as agreed with the Director of Nursing. The results and recommendations will be included in the Bi- annual Safe Staffing report 2025.

This report outlines recommendations for consideration in order to meet the patient care and safety needs identified and in accordance with national guidance (Developing Workforce Safeguards, NHS England, 2018). This will be reviewed again in line with NICE requirements in Spring 2025.

1. Introduction

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

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

risk to safety, quality, finance, performance, and staff experience must be clearly described in these risk assessments.

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

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

This review has included all inpatient wards at Dorset County Hospital.

Critical Care, Special Care Baby Unit (SCBU), Emergency Department have not been included in this report. A separate review of Critical Care staffing and Emergency Department staffing is being conducted in recognition of the New Hospitals Build and remains in progress. Maternity Safe Staffing Report is covered by a separate paper and is reported concurrently with this report.

2. Methodology

The methodology for determining safer staffing has previously been approved by the Trust Board. This incorporates the use of an acuity and dependency evidence-based tool (Safer Nursing Care Tool (SNCT), The Shelford Group 2023), alongside any relevant benchmarking (such as Model Hospital or Royal College of Nursing recommendations), and professional judgement.

Safer staffing reviews are expected as part of the regulatory framework to ensure the organisation is meeting the needs of the patients that use our services. Lesson learnt from national reviews underpinned the need for staffing levels, and the outputs of regular safe staffing reviews, are overseen by Trust Boards (Francis Report (2013) and Keogh Review (2013)).

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

The Royal College of Nursing has set out detailed expectations for employers, national organisations, and regulators to support patient safety and enable the UK's nursing workforce to deliver safe and effective care. The 14 workforce standards, launched by the college in May 2021 are intended to bring the entire nursing community in the UK, under one set of standards for the benefit of staff and patient safety. The RCN have recently announced a review of guidance and consideration of best methodologies and benchmarking including nurse to patient ratios and Care Hours per Patient Day. The outputs

of this review are outstanding but will form a revision of approaches at Dorset County Hospital to ensure audit against best evidence-based practice.

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

The Trust financial team have been involved from the onset and throughout recommendation process. Work is underway, following previous board level approval, for a targeted investment approach to areas identified in this report.

All inpatient wards were required to collect data using the SNCT during the same period, to ensure consistency and allow benchmarking across the Trust. The audit took place in June 2024.

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

- Patient Acuity and Dependency
- Professional Judgement
- Quality Indicators

Nurse to Patient ratios was also applied considering the ambition to achieve a higher staff to patient ratio. The ratio of 1:8 has broadly been applied and some areas, with recognised higher acuity, are demonstrating a ratio of 1:5/6.

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

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

Currently the headroom for general wards is held at 20%. The national recommendation for ward establishments is 22.2% headroom (for training, annual leave etc), of which 2% is kept centrally for sickness absence cover using temporary staffing. It should be noted that Safe Staffing toolkits (including SNCT) are unable to accurately calculate below 22.2% uplift. The current uplift for the Critical Care Unit is 25% and Emergency Departments is 27% (Royal College of Emergency Recommendations) and to recruit to 25%. The recommendations are to align budgeted establishments with the national recommendations (see below).

Theatres and Day Surgery Unit (DSU) also have their national recommendations for headroom and this is set at 25%.

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

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

Business planning 2023/2024 included a business case to request investment to align to national recommendations and thereby significantly reduce reliance on short-term agency use to cover planned leave and absences.

Since the bi-annual review in February 2024, alternative roles in the clinical area have been explored and a pilot project for Ward Housekeepers is being undertaken on 2 wards. Early indications are that this has been successful with improvement demonstrated during a PLACE assessment during the project. This has particularly been evident with bed area preparation, management of allergens, improved dietary selection, hydration and nutritional intake and the support given to patients to remain on their wards and de-escalate anxiety. Food service and food safety is now a priority with food being seen as medicine (NHS 2023 National Standards for Healthcare Food and Drink) which support delivery of quality indicators such pressure ulcer management and patient experience. It is likely this will be a phased roll out recommendation with a report to be submitted September 2024.

Additionally, a Ward Clerk project to review core competencies is being undertaken to both improve the bank administration offer across the Trust with an aim to improve compliance with Trust standards. Improved ward clerk provision is expected to improve Electronic Discharge Summary (EDS) completion, patient and family contacts and communication, appointments made, response times to answering ward telephones as well as meet and greet on the wards. There is a requirement to improve filing of patient notes, scanning and compliance with NHS Record keeping standards, which are currently a risk on the risk register.

Both roles are expected to release nursing staff to time to care.

3. Additional In-Extremis Beds

Over 2024/2025 additional in-extremis beds were opened by exception to support additional admission demand. This has been fluctuating but presents an ongoing pressure to staff the wards to ensure patient safety. The February 2024 acuity and dependency audit reflected all these beds being open and the below chart reflects the requirement to support this pressure. Action is taken to de-escalate the in-extremis beds as soon as possible. Currently the areas

below remained open during the acuity audit of Summer 2024 with the exception of the Mary Anning Unit and Purbeck beds being closed.

Ward	Extremis Beds	Additional Staff Required
Moreton Ward	3	1RN & 1 HCSW LD & ND 7/7
Fortuneswell Ward	3	1HCSW LD&1 RN ND 7/7

With effect from beginning of November 2024 the extra beds (Moreton and Fortuneswell) have been included into the hospital bed base but without the additional staffing being embedded as part of the ward establishments.

Purbeck extra capacity was closed August 2024.

4. Results

Several areas were identified as under established. This was identified following completion of the SNCT and professional judgement review with Divisional leads. It is noted that the ability to recruit into current vacancies and subsequently reduce the need for temporary staffing remains the highest challenge in current management of safer staffing.

Ward	Current WTE Establishment (Excluding Band 7 and Admin Roles)	SNCT Results with 22.2% uplift	Current Vacancies (WTE) **as at 30.6.24**	Recommendations
Abbotsbury Ward (29 Beds)	40.43 (+4 RNDA)	40.96	No vacancies	No change to current establishment but it is recommended that to improve the nurse-to-patient ratio there needs a roster template change to achieve 4RN's both day and night. The implementation of 22.2% headroom and targeted investment to increase RN cover at night will achieve this.
Lulworth Ward (31 beds)	42.95 (+1RNDA)	37.50	No vacancies	For the period of the SNCT audit the acuity was not reflective of critical care stepdown patients. It should be noted that the ward takes CRCU stepdown patients – 33% of CRCU discharges go to Lulworth. Recommend targeted investment to improve night RN by 1 for cover in recognition of CRCU discharges to ward and improve nurse to patient ratios from 1:11 to 1:8. The establishment needs to improve by 2.05 WTE to manage this.

Ward	Current WTE Establishment (Excluding Band 7 and Admin Roles)	SNCT Results with 22.2% uplift	Current Vacancies (WTE)	Recommendations
Purbeck Ward (27 beds) +additional 2 beds open for the duration of the audit	39.81	48.61	3.88 RN offset by 2 NQN commencing September 2024	Close the in-extremis beds and configure the space to eliminate future use, completed August 2024. This will form part of a wider bed configuration exercise across the Trust. Recommend targeted investment to ensure safe staffing for patients requiring to enhanced care(e.g. spinal injuries requiring 5 to log roll) and ensure night RN patient ratio cover is improved. Require 5.4 WTE.
Portesham 14 beds (temporary ward during refurbishment of Ridgeway ward. Substantive staff currently re-deployed to other areas and vacancies held) Ridgeway 15 beds + 4 chairs on return	28.49	19.64 on 14 beds	No vacancies	No change to current establishment Unable to recommend as tool recordings were based on 14 beds during a refurbishment of Ridgeway ward. When the ward becomes 24 beds, based on the SNCT submissions there should be no change but will remain under review. Recommend review and wait
Kingfisher Ward (14 beds + PAU)	27.33	19.64 using SNCT specific tool for paediatric	No vacancies	Smaller unit principles applied. No change - incentives for band 6 cover due to skill mix currently. Recommend 22.2% headroom uplift

Ward	Current WTE Establishment (Excluding Band 7 and Admin Roles)	SNCT Results with 22.5% uplift	Current Vacancies (WTE)	Recommendations
Fortuneswell Ward (17 beds) + 3 additional beds open for the duration of the audit	26.86	33.39 on 20 beds	1.5 RN 2.7 HCSW	Recommended increase to establishment of 2 RN's and 3 HCA's if beds are to remain open If at 17 beds, staff would need to be redeployed from other areas. Recommend application of 22.2% headroom accepting that 3 extra beds are open in a sustained way plus require 5.4WTE or await review as to MDT solution geographically may reduce staffing needs.
Moreton Ward 23 beds + additional beds open for the duration of the audit and historically since Covid-19 pandemic began.	38.29	41.31	2.50 HCSW	If 3 extra beds remain open, an additional 3 RN's and 3 HCA's are required to manage the geographical spread of the ward, the acuity of patients and to meet the nurse to patient ratio. Beds will be reviewed as part of bed reconfiguration plans. It should also be noted that the ward takes step down patients from CRCU – 17% of all discharges go to the ward from CRCU. Recommend fund the 3 extra beds and apply 22.2 & headroom to increase the establishment and reduce the agency expenditure as one of the highest users of agency staff. Require an extra RN LD & ND and HCA LD. Ead

Ward	Current WTE Establishment (Excluding Band 7 and Admin Roles)	SNCT Results with 22.5% uplift	Current Vacancies (WTE)	Recommendations
Evershot Ward (14 beds)	30.40	22.82	No vacancies 1.0 wte TNA gapping HCA vacancy	Current ratio is 1:46 with 3 RN's and SV Sister–small ward principles applied however area is demonstrated via nurse ratios and SNCT as being over established. Divisional HoN to plan redeployment to support other areas and as a review of bed configuration. No changes further recommended than above, review model of care.
Cardiac Care Ward (18 beds)	33.23	28.38	1.5 vacancies HCA (1.0 wte TNA against vacancy)	No change to current establishment – smaller unit principles applied area functions as ward and CCU. Add 22.2.% but hold HCA recruitment as RNDA's return to base ward = 4.8 wte
Ilchester Ward (33 beds)	53.78	54.40	No vacancies	No changes to establishment required nurse: patient ratio currently 1:5 and not functioning as a high turnover ward.
Mary Anning Unit 38 beds audit completed on 38 beds	68.78	65.18	No vacancies	Maintain reduced the bed base. Recommend pause and review establishment add 22.2% compare A&D results January 2025.

Ward	Current WTE Establishment (Excluding Band 7 and Admin Roles)	SNCT Results with 22.5% uplift	Current Vacancies (WTE)	Recommendations
Maud Alexander Ward (10 beds)	19.26	11.63	No vacancies	No recommendations for change and small ward principles applied. No changes required, nil headroom recommended, ward has amended establishment to reduce HCA LD 7/7 by 1.
Stroke Unit (24 beds)	48.23 + ACP 9-5 Mon-Fri, Outreach B6 08:00-20:00 Daily Nurse Consultant M-F	41.54	5.43 HCSW Vacancies with 2 wte RNDA's to off set	Unit is in process of developing HASU model and to meet national stroke standards. Ward establishment will be adjusted accordingly, and any shortfalls identified. The Somerset developments will further inform staffing recommendations. Recommend 22.2% headroom = .55wte RN
Prince of Wales Ward (13 beds)	30.81	16.97	No vacancies with 1 wte TNA	No change to current establishment – smaller unit principles applied and noting regional emergency dialysis unit status. Pause for establishment review & review of rosters - COE required by HoN, 22.2% only

Summary of Recommendations:

- Targeted investment, subsequent to approved business case May 2024, required to increase budget uplift, increase substantive posts with direct offset of agency use to manage planned and predicted absence (Annual leave and Mandatory training)
- Review of redeployment opportunities to right size bed and staffing capacity and in line with planned bed reconfigurations
- Ongoing review and investment of Stroke staffing considering planned increased in HASU and Acute Stroke capacity, and in line with national Stroke Standards as measured by SSNAP Sentinel audit
- Review of e-roster to ensure nighttime staffing levels are strengthened
- Completion of reviews for Critical Care and ED for assurance and noting the investment requirements for the New Hospitals Programme.
- SDEC – nil recommended
- Bournemouth Dialysis & DCH dialysis – nil recommended
- Medical Day Unit – nil recommended
- Acute Hospital at Home – nil recommended
- Hospital at Night – nil recommended
- SCBU – require a supervisor on every shift as BAPM (British Association of Perinatal Medicine) standard – 25% headroom to be added to budget = .39 RN & .18 HCA, await quarterly audit from Matron –**transitional care is not currently included in the National audit but from 2025, this will be included to cover SCBU nurses providing such care for babies on the Maternity Unit**
- ED – RCEM (Royal College of Emergency Medicine) recommends 27%, recommend recruit to 25% - currently at 20.5% and have a high agency expenditure due to “corridor care”. Cover required = 3.89 wte RN to recruit to **(awaiting audit results from June)**
- CRCU – uses 11% of agency expenditure (largely TNS) recommend 25% headroom uplift recommended = 1.54 RN & 0.11 HCA wte
- DSU & Theatres 25% headroom to be added = 1.06 RN for DSU & 2.97 RN for Theatres plus 0.80 HCA theatres
- Maternity – await results of Birthrateplus© audit due September

Conclusion

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

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

In addition to the formal review, staffing levels, patient acuity and dependency, and effective utilisation of resources is discussed and mitigated twice daily at the internal bed/operational flow meetings. Twice daily Safe Staffing meetings are in place to support the Divisions with immediate staffing requirements. Staff are requested to move area of work to ensure safe and effective care of our patients. This review is undertaken in conjunction with the Ward Sister, Matron and Divisional Head of Nursing and Quality responsible for that area.

It should be noted that during the reporting period there have been no red flag shifts.

The Trust has reviewed the acuity and dependency audits results for the inpatient ward areas and the recommendations are as below in Section 5. The Trust also remains within the expected limits of the Model Hospital data in relation to nursing and midwifery staffing.

The 2024/2025 scheme to embed safe staffing methodology was as follows:

- Invest in a Safe Staffing Clinical Lead role to develop and support the Safe Staffing agenda – member of staff appointed as a secondment October 2023 for 18 months.
- Embed Allocate ‘Safe Care’ to complete twice daily acuity and dependency utilising digital software to support and evidence movement of staff around the Trust and to support areas of greatest need, alongside care hours per patient day. Safe Staffing Lead has commenced the implementation of the Safe Care project with 4 wards commenced on the project initially; a further 4 wards are due to be enrolled on the project September 2024, before further roll out trust wide.
- To manage safe staffing via allocate and scrutiny of rosters through monthly roster clinics.
- Encourage Safe Staffing Fellowship access by senior nurses – Deputy Chief Nurse completed.
- Lead Nurse for Workforce and Safe Staffing attended both RCN Conferences on Nurse-to-Patient ratios as well as attending the Shelford Group (NHS England) Introduction to Safer Staffing module in June 2024.

5. Recommendations

To acknowledge and accept the outcome of the Annual Safe Staffing Review 2024/25.

To acknowledge the uplift business case in headroom from **20.5 % to 22.2%** in inpatient areas where recommended and those with high agency expenditure, 27% for ED with 25% for the Critical Care Unit, Theatres and SCBU.

To consider the Trust Safe Staffing Lead position as a substantive role as the position currently will end 31 March 2025.

Trudy Goode, Safe Staffing Lead and Emma Hoyle, Deputy Chief Nursing Officer, August 2024

Further reviewed Trudy Goode, Safe Staffing Lead and Louisa Way, Interim Deputy Director of Nursing, November 2024

MIDWIFERY AND MATERNITY STAFFING REPORT FOR QUARTER 2

Presented by Jo Hartley. Director of the Midwifery & Neonatal Service

October 2024

Background

It is a requirement that as NHS providers we continue to have the right people with the right skills in the right place at the right time to achieve safer nursing and midwifery staffing in line with the National Quality Board (NQB) requirements.

Organisational requirements for safe midwifery staffing for maternity settings (NICE 2015) states that Trusts develop procedures to ensure that a systematic process is used to set the midwifery staffing establishment to maintain continuity of maternity services and to provide safe care at all times to women and babies in all settings.

Previously midwifery staffing data has been included in the nurse staffing paper. However, to provide evidence for NHS Resolutions Maternity CNST Incentive Scheme, a separate paper is now provided which also includes staffing data on other key groups ; obstetricians and anaesthetics.

Executive Summary

This report gives a summary of all measures in place to ensure safe midwifery staffing; including workforce planning, planned versus actual midwifery staffing levels, the midwife to birth ratio, specialist hours, compliance with supernumerary labour ward coordinator, one to one care in labour and red flag incidents. It also gives a summary of key workforce measures for obstetricians and anaesthetics to provide evidence for the maternity incentive scheme.

Birthrate Plus Workforce Planning

NICE (2015) recommend that an assessment is carried out every three years.

A formal Birth Rate Plus assessment is currently underway and will report in November 2024

The results are based on 3-4 months' casemix from January 2024 with 1515 births annually

Headroom of 22% and 24% are being calculated

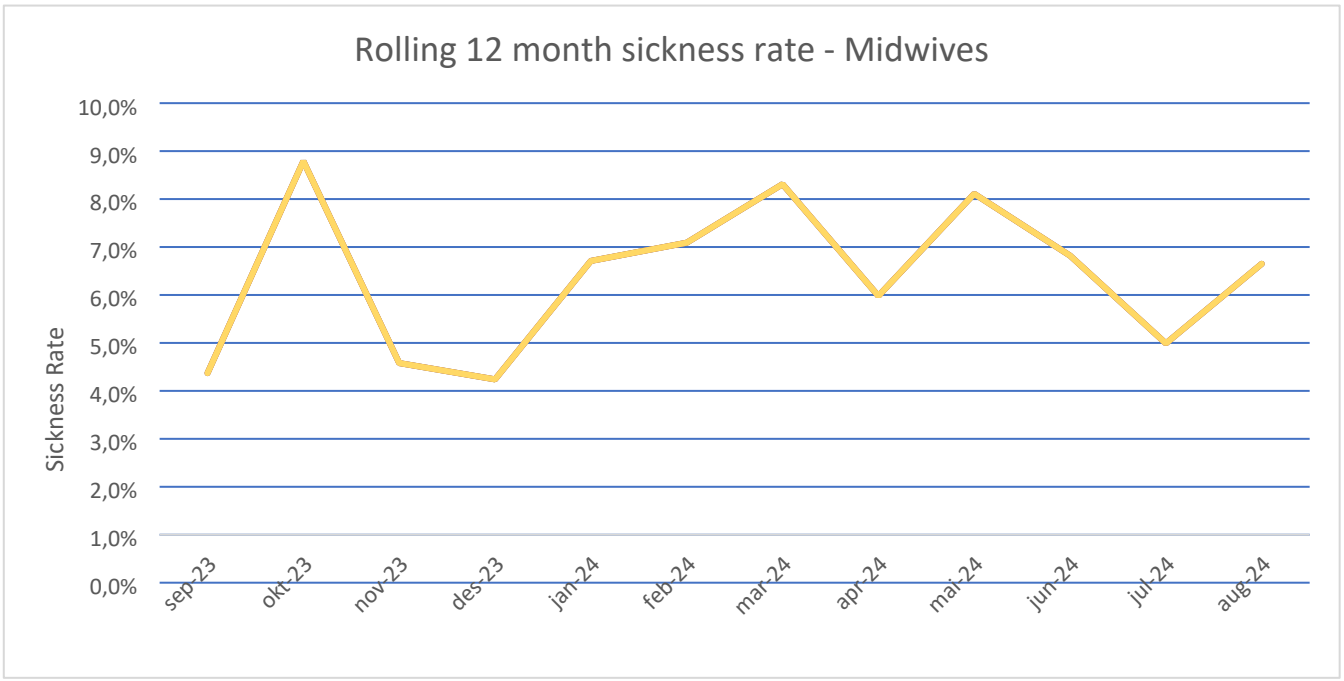
There has been an increased proportion of women in the higher casemix categories of IV and V from 61.3% in the previous study to 67.9% in this study, a trend seen in most maternity services reflecting increasing acuity. Birthrate Plus staffing is based on the activity and methodology rather than on where women may be seen &/or which midwives provide the care. Time is included for Band 7 Coordinators, Ward and Department Managers and Team Leaders to cover the day-to-day management and coordination in all areas.

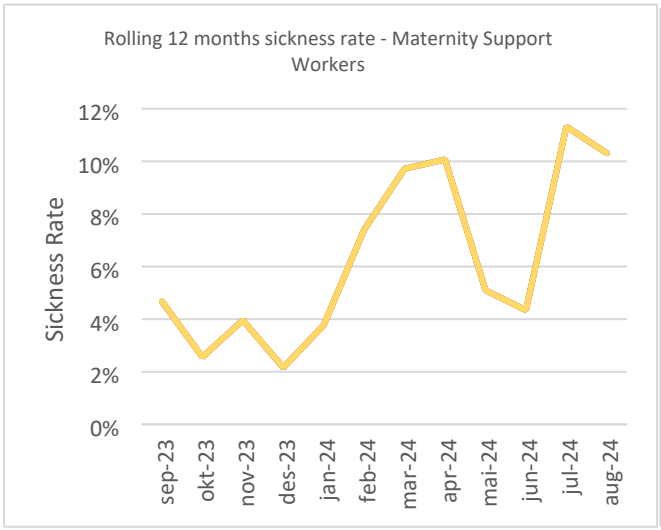
Risk register

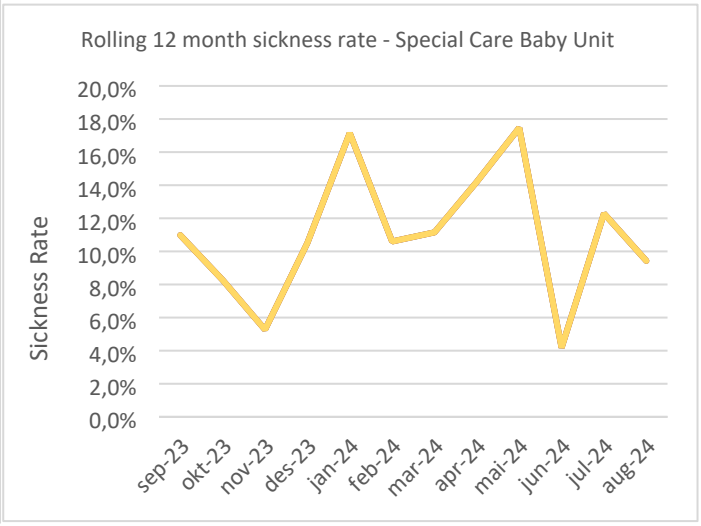
Currently Maternity Staffing remains on the risk register rated as high, 15. Whilst additional funding was agreed through business planning, there are still multiple shifts which are not fully staffed. Long term and short term sickness, alongside a significant mandatory training requirement and some additional roles required to meet national KPIs put sustained pressure on the workforce. Oncall staff are relied upon regularly to fill gaps, leaving further vacancies the next day and specialist midwives are frequently reallocated to work

on the ward, impacting the work they are required to complete. The oncall manager is regularly required to come in out of hours to fill rota gaps.

Work force data - rolling 12 months and snapshot







Overall sickness rates from 1st August 2023 – 31st July 2024

Midwives – 6.36%

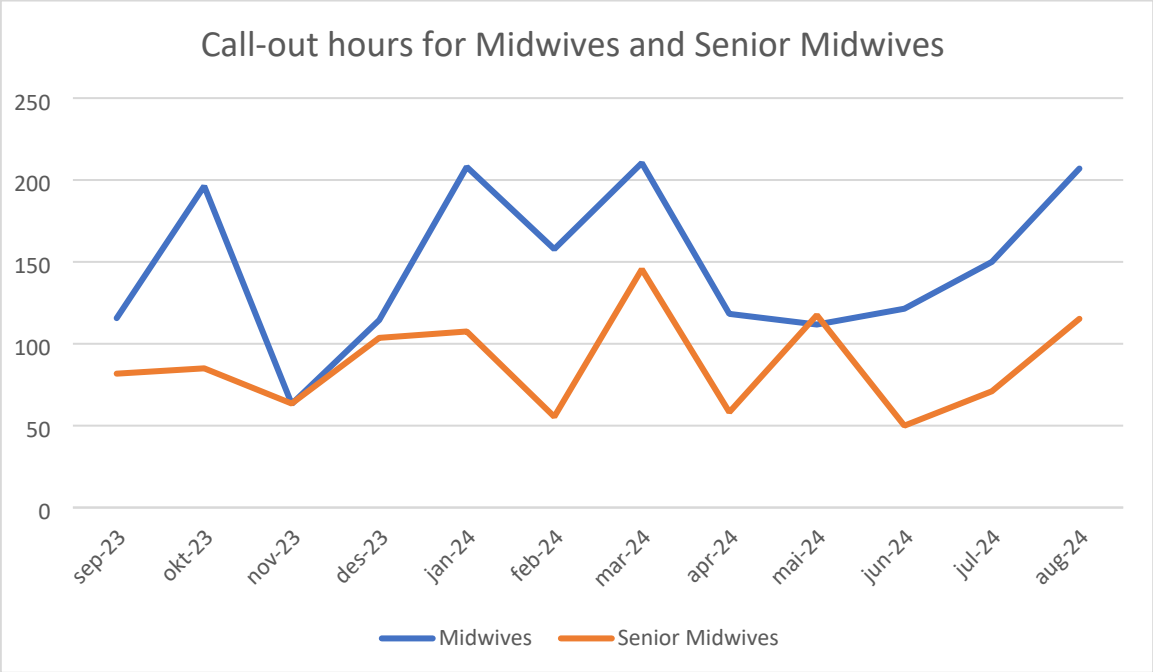
Maternity Support Workers – 6.03%

Special Care Baby Unit – 11.16%

Call-out hours for August

Midwife call-out for the unit – **207 hours.**

Senior Midwives call-out – **115.25 hours**



Bank and Excess hours August

	Maternity Unit/ DAU	MSW's / DAU	SCBU Band 5/6	SCBU Band 3
Bank	211 hrs / 89 hrs	231.5 / 137.25 hrs	285 hrs	
Incentives	22	5	6	0
Excess/Overtime	430.25 hrs	132 hrs	279 hrs	

Shifts not covered August

Maternity Unit – based on 6 midwives per shift		**Special Care Baby Unit**	
Day Shift	16.9 %	Band 5/6	2 shifts not covered
Night Shift	19.8 %	Band 2	4 shifts not covered
Total	17.9 %		
Maternity Support Workers			
Day Shift	25%		
Night Shift	11.3%		
Total	20.4 %		

Supernumerary Labour Ward Co-ordinator

Availability of a supernumerary labour ward co-ordinator is recommended as best practice to oversee safety on the labour ward. This is an experienced midwife available to provide advice, support and guidance to clinical staff and able to manage activity and workload through the labour ward. This is reported by exception via the datix system

The table outlines the compliance for quarter two

	Number of days per month	Number of shifts per month	Compliance
July	31	62	100%
Aug	31	62	100%
Sep	30	60	100%

Escalation

When staffing is less than optimum, the following measures are taken in line with the escalation policy:

Request midwifery staff undertaking specialist roles to work clinically

Elective workload prioritised to maximise available staffing

Specialist midwives reallocated to clinical work

Relocate staffing to ensure one to one care in labour and dedicated supernumerary labour ward co-ordinator roles are maintained

Activate the on-call midwives from the community to support labour ward

Request additional support from the on-call midwifery manager

All the above actions are designed to maximise staffing into critical functions to maintain safe care for the women and their babies

Management team

Director of the Midwifery and Neonatal Service

Head of the Midwifery and Neonatal Service

Intrapartum and Antenatal Matron

Neonatal Matron

Community and Postnatal Matron

Specialist roles

Governance Lead

PMA (professional midwifery advocate)

Tobacco Dependency Midwife

Safety (Risk) Lead

Practice Educator

Digital Lead

Safeguarding Lead

UNICEF Baby Friendly Lead

Continuity Lead

Preterm Lead

Public Health Lead

Fetal Monitoring Lead

Perinatal Mental Health Lead

Retention and Recruitment Lead

Student Link Midwife

One to One Care in Established Labour

Women in established labour are required to have one to one care and support from an assigned midwife. One to one care will increase the likelihood of the woman having a positive birth experience and will contribute to reducing both the length of labour and the number of operative deliveries. Care will not necessarily be given by the same midwife for the whole labour.

If there is an occasion where one to one care cannot be achieved then this will prompt the labour ward co-ordinator to follow the course of actions within the Policy for Safe Staffing and Escalation to Divert. These may be clinical or management actions taken.

The following table outlines compliance for quarter two

	July	Aug	Sep
Labour Ward	100%	100%	100%

Birth Rate Plus Live Acuity Tool

DCH has been unable to utilise the BR Plus Acuity Tool due to the integrated nature of our workforce and the fluidity of allocation of staff across inpatient areas that changes in real time as acuity and workload demands. Consequently, DCHFT monitors red flags using datix. A midwifery red flag event is a warning sign that something may be wrong with midwifery staffing (NICE 2015). Whilst this doesn't work as a predictive/prospective tool, it does provide some data about the impact of poor staffing on activity and therefore on safety and service user experience. It is reported via the monthly Maternity Quality and Safety Report.

Currently, the team are considering the feasibility of using the Safe Staffing functionality in Healthroster instead of a second attempt to successfully procure the BR Acuity Tool.

The Maternity Coordinator works closely with the Policy for Safe Staffing and Escalation to Divert http://sharepointapps/clinguide/CG%20docs1/1578-safe-staffing.pdf to guide her decisions related to safe staffing numbers. The Maternity Coordinator also works closely with the Maternity Manager Oncall to assess and respond to staffing concerns.

Obstetric staffing

The obstetric consultant team and maternity senior management team have committed to incorporating the principles outlined in the RCOG workforce document: 'Roles and responsibilities of the consultant providing acute care in obstetrics and gynaecology' into their service. Roles and responsibilities of the consultant workforce report (May 2022 update) (rcog.org.uk)This includes obstetric staffing on the labour ward and any rota gaps. Consultant attendance for the clinical situations listed in the RCOG document when a consultant is required to attend in person are now containing within a SoP. Episodes where attendance has not been possible are reported via datix and reviewed at unit level as an opportunity for departmental learning with agreed strategies and action plans implemented to prevent further non-attendance. Trusts' positions with the requirement are shared with the Trust board, the board-level safety champions as well as LMNS.

There was one incident where the consultant failed to attend when requested

A complex obstetric case presented on labour ward. The obstetric registrar required the consultant to attend out of hours as she was unsure of her ultrasound findings although there were other complexities about the case. The consultant initially declined to attend, saying that registrar should be able to perform an ultrasound. The midwife caring for the woman, then rang the Manager on call asked her to intervene. The DoM phoned the consultant explaining his attendance was required to provide support and advice. He immediately attended and remained until the babies were born by caesarean	The CD discussed this incident with the consultant. the consultant confirmed his willingness to attend but initially, what was described to him by the obstetric registrar, was a problem with scanning the patient accurately. Initially, he described to the CD, not agreeing that this was a reason for a consultant to be called in out of hours. he was not made aware at that point of the significant complexity of the patient and the challenges around her care. When the manager oncall rang him and asked him to attend as his expertise was required urgently to assist with managing this patient, he immediately attended. The consultant has reflected on this incident and acknowledged his responsibility to attend out of hours in accordance with the RCOG guidance. The wider learning in relation to requesting attendance out of hours is that the information is provided to the consultant clearly and succinctly, using an SBAR as required. Ideally it would be the maternity coordinator who contacted the consultant out of hours to request their attendance	**Learning & actions** Consultants to discuss and reaffirm their commitment to RCOG guidance The use of SBAR when requesting a consultant attend out of hours Coordinators to prioritise being the professional who contacts a consultant out of hours to attend

Anaesthetic staffing

For safety action 4 of the maternity incentive scheme evidence has to be provided to demonstrate that a duty anaesthetist is immediately available for the obstetric unit 24 hours a day and should have clear lines of communication to the supervising anaesthetic consultant at all times. Where the duty anaesthetist has other responsibilities, they should be able to delegate care of their non-obstetric patients in order to be able to attend immediately to obstetric patients. (ACSA standard 1.7.2.1). There was a small number of reported incidents where the wait for an epidural was >30 minutes. There were no incidents in the reporting period of an anaesthetist not being available promptly when required for an emergency procedure

	July	Aug	Sep
Incidents reported where anaesthetic attendance was delayed for an emergency procedure	0	0	0

Locum use in obstetrics and gynaecology

The RCOG has developed and published guidance around the engagement of locum doctors. This guidance outlines the roles and responsibilities for healthcare providers and individual doctors when undertaking locum positions in the NHS.

The Maternity Incentive Scheme requires Trusts should establish whether any short term (2 weeks or less) tier 2/3 locums have been undertaken between February and August 2024. Medical Human Resources (HR) or equivalent should confirm that all such locums met the required criteria.

Evidence has been received from the Service Manager that nine locums were employed by the Trust to cover vacant shifts. Eight of the doctors are either currently employed by the Trust on substantive contracts or have been up until recently. One doctor was employed on a locum basis only. All had met the standards laid out in the RCOG document.

Dorset County Hospital
NHS Foundation Trust

Finance and Performance Committee in Common Assurance Report for the meeting held on Monday 25 November 2024

Chair:	Executive Lead:	Date of Next Meeting:
Dave Underwood	Chris Hearn Anita Thomas	Monday 27 January 2025
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	• DCH Board Assurance Framework strategic risk 6 (finance) sits at 16. Given the level of financial challenge the committee agreed to raise the risk likelihood score to 5, bringing the total to 20. • Health and Safety (incl. Fire and Water) Compliance Report. Board Assurance Framework score for strategic risk 5 (estates) increased to 16, pending the completion of fire safety work. • Risk to delivering the financial plan.

Key issues / matters discussed at the meeting	The committee received, discussed and noted the following reports:
	• Performance Report (DCH) noting:
	  ○ The Trust has been put in to Tier 2 by NHS England due to performance with 65 week-wait times, which has stalled due to a number of factors. A plan, supported by NHS Dorset, was in place to reach the zero 65 week-wait target by the end of the year.
	  ○ Good performance in region in cancer in relation to cancer performance
	  ○ A workshop with NEDs and Chief Operating Officers was suggested to thoroughly review performance reporting.
	• Finance Report (DCH) noting:
	  ○ There was a risk to delivering the system position. The system had not been formally put in to the investigation and intervention (I&I) regime due to the interventions in place across the system. A formal, extraordinary ICB Board meeting was scheduled to discuss the financial outlook for the remainder of the year.
	  ○ For DCH, cash flow remains a high-risk area but continued to be monitored on a daily basis. Confirmation of ERF funding for December which will help cash position.
	  ○ Continued focus on the cost improvement plan (CIP) with progress against delivery slowing in month. A renewed focus is

	required in order to recover the pace seen in the initial months of the year. ○ Board Assurance Framework score for strategic risk 6 (finance) increased to 20. • 2025/26 Capital Plan. Committee members noted that it would be helpful to see greater detail on the level of risk of non-prioritised schemes. • Health and Safety (incl. Fire and Water) Compliance Report. Board Assurance Framework score for strategic risk 5 (estates) increased to 16, pending the completion of fire safety work. • Estates Compliance Report (DCH) 60% compliance, noting that when issues with compliance were identified action plans were put in place to rectify. • New Hospital Programme Associate Schemes Capital Spend (incl. generator) noting the links to the capital prioritisations earlier in the agenda and that elements of the NHP programme will need to be funded by the Trust. Approval of process and ring fencing of monies for generators. • Assurance reports from the below sub-groups ○ DCH SubCo Assurance and performance reports ○ Capital Planning and Space Utilisation Group • DCH SubCo Annual Report and Accounts • Internal Audit Reports on Nursing Agency Costs
Decisions made at the meeting	• Approval DCH Loan Repayment Plan • Approval of the Proposal for Commissioning of the new CAMHS High Intensity Environment Unit noting that the benefits outweighing shorter-term risks • Approval of the Modern Slavery and Trafficking Statements • Approval of the New Hospital Programme Associate Schemes Capital Spend (incl. generator) and ring fencing of monies for generators.
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	Y		
Dave Underwood	Y	Y		
Chris Hearn	Y	Y		
Alastair Hutchison	Apols	Y		

Nick Johnson	Y	Y		
Stephen Tilton	Y	Y		
Anita Thomas	Y	Y		
Frances West	Y	Y		

Report to	Board of Directors	
Date of Meeting	10th December 2024	
Report Title	Balanced Scorecard- An integrated report for the reporting month of October 2024	
Prepared By	Adam Savin, Director of Operational Planning and Performance	
Accountable Executive	Anita Thomas, Chief Operating Officer	
Previously Considered By	Anita Thomas, Chief Operating Officer Claire Abraham, Deputy Chief Finance Officer Emma Hallett, Deputy Chief People Officer Jo Howarth, Director of Nursing (Acute Care)	
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	Safety and Quality, capacity and demand and strategic risks	
Financial	ERF	
Statutory & Regulatory	Reporting against, constitutional and contractual standards	
Equality, Diversity & Inclusion	N/A	
Co-production & Partnership	N/A	

Executive Summary

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

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

Key areas to highlight:

Quality

- Emergency readmissions within 30 days of discharge has reduced slightly to 9.5% from 9.9% and is below the 13% target
- Electronic Discharge Summary sent within 24h of discharge remains below target at 74.46%. This is a decrease since last reporting.
- SHMI has remained within the expected range further improved

Performance

- UEC performance has remained steady, with the national planning guidance target being achieved.
- Cancer performance is being impacted by increasing demand, but a return to achievement of 28 day to diagnosis and the 62d treatment standard has been achieved
- Patients waiting the longest for elective treatment have reduced, but the total waiting list size continues to increase
- Diagnostic performance has improved

People

- Essential skills rate reduced to 88%, 2% below target
- Appraisal rate increased to 77%, remaining below target
- Vacancy rate increased to 4.56% but remains better than the target
- Turnover increased to 9.52% but remains better than target
- Sickness rate increased to 4.59%, above the target

Finance

- Adjusted financial plan showing as a confirmed overspend.
- Agency spend reducing and with improved medical and nursing agency spend.
- Capital expenditure is slightly behind plan, due to timings of spend.

Recommendation

The Board are asked to note this report.

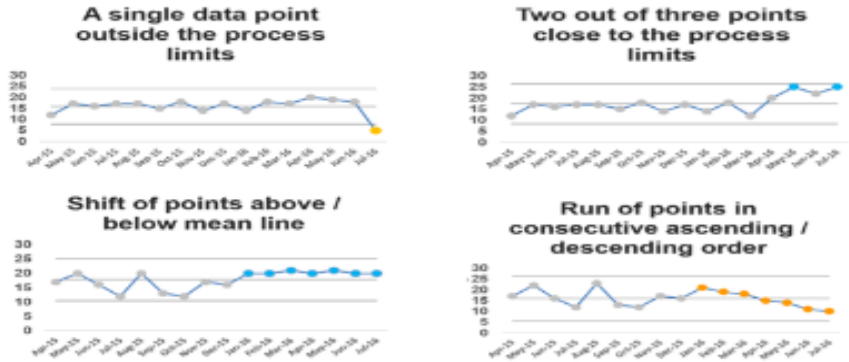
1) Understanding Statical Control Charts (SPC)

Is Performance Changing?

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

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

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



What are Summary Icons showing?

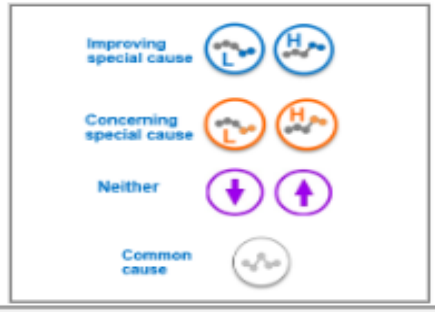
Blue icons indicate significant improvement or low pressure.

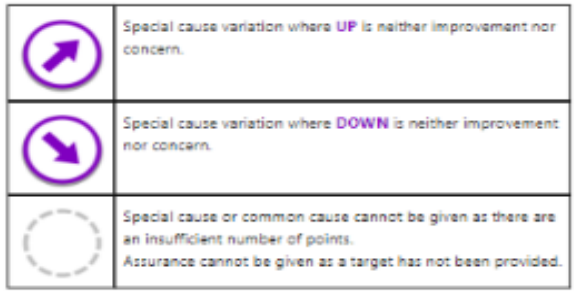
Orange icons indicate significant concern or high pressure.

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

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

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





What is a Moving Range Chart showing?

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

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

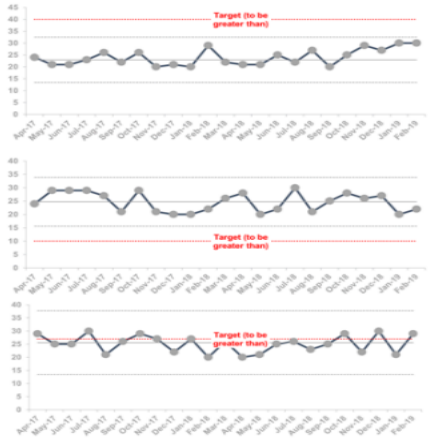
The centre line is the average value of all moving ranges.

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

The moving range chart will display below all SPC visualisations.

Assurance icon

Up is good (need to be greater than the target



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

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

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

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

2) Executive Summary

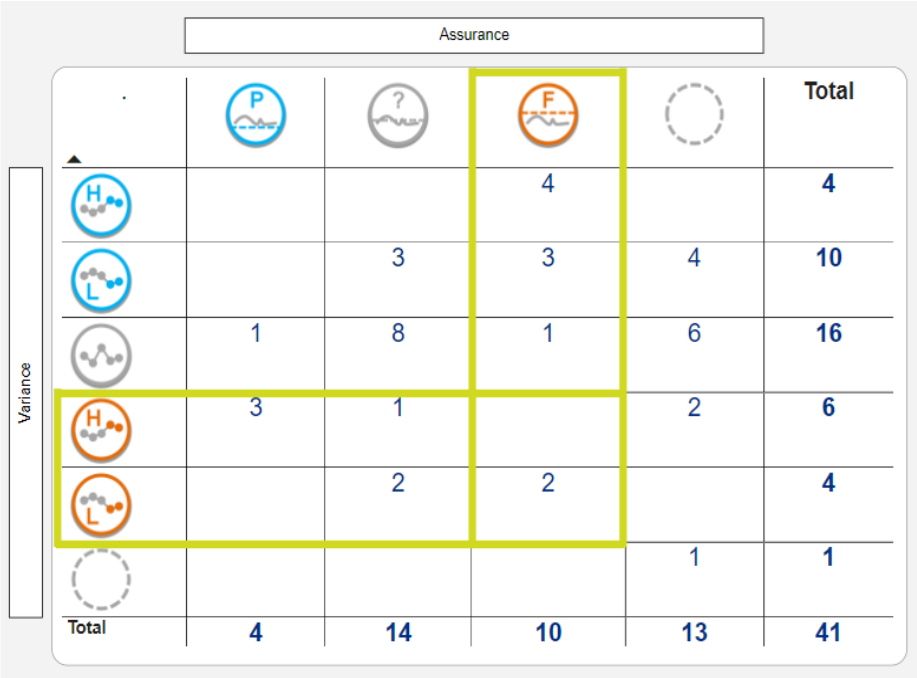
For the reporting month of October 2024, there are 8 indicators that are failing the target or are unstable (hit or miss) and showing as special cause for concern, this compares to 16 in the reporting month of August 2024.

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

For the people dashboard, 1 metric has a variance of special cause variation of a worsening nature, all others are improving or common cause variation. For finance, 2 have a variance of special cause variance of a declining nature, two of an improving nature and the rest common cause variation. For performance, 4 metrics are of a worsening nature, 8 improving and 2 common cause variation. For quality and safety, 4 metrics are a declining nature, 4 an improving and 5 common cause variation.

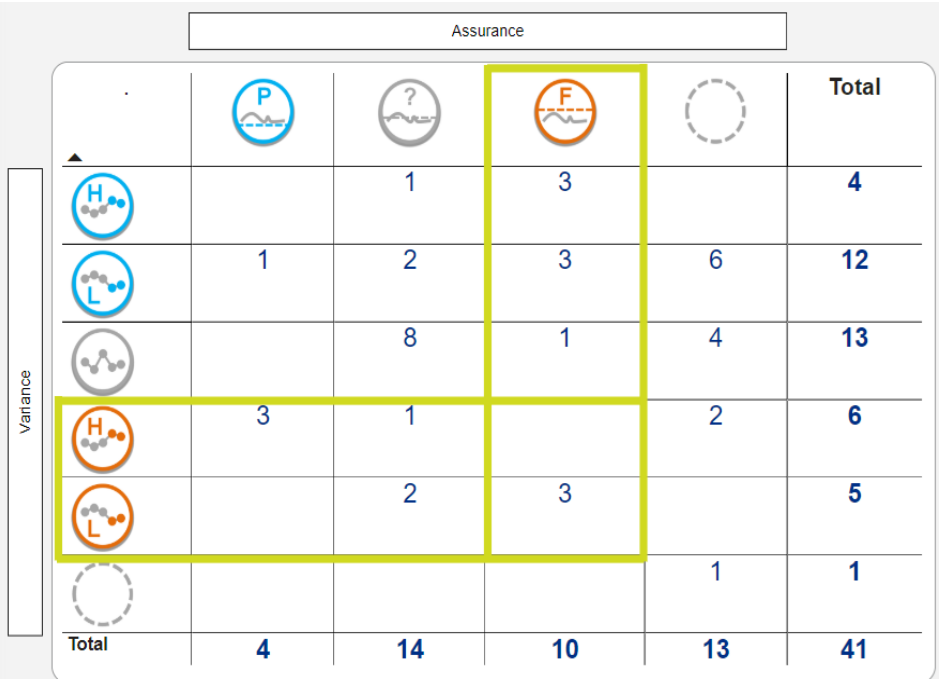
There are 12 indicators, across all dashboards (therefore the balanced scorecard) that have not got a target, therefore assurance cannot be given either way, this remains the same as the last reporting round.

August 2024 data



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

November 2024 data



Variance \ Assurance	P	?	F		Total
H		1	3		4
L	1	2	3	6	12
		8	1	4	13
H	3	1		2	6
L		2	3		5
				1	1
Total	4	14	10	13	41

The matrix summaries the number of metrics (at Trust level) under each variance and assurance category. The Trust is aiming for the top left of the grid (special of improving nature, passing the target). Items for escalation based on indicators which are failing target or unstable (hit and miss) and showing special cause for concern are highlighted in yellow.

3) Quality and Safety dashboard

Metric Group	Metric	Group	Latest Month	Value	Target	Variance to Target	Mean	PY - Month Value	YTD Value	Variation	Assurance
Effectiveness	Inpatient - EDS % Available < 24 Hours of Discharge	0 - Total	Oct-24	75.73%	90%	-14.27%	77.28%	77.96%	75.73%		
Effectiveness	Inpatient - EDS % Available < 7 Days of Discharge	0 - Total	Oct-24	84.04%	100%	-15.96%	87.56%	85.9%	84.04%		
Effectiveness	Inpatient - Emergency Re-Admissions % (1 month in arrears)	0 - Total	Sep-24	10.1%	13%	-2.90%	8.33%	9.09%	10.1%		
Experience	Complaints - Formal Complaints Received	0 - Total	Oct-24	34			26.7	17	174		
Experience	Friends and Family - Overall % Recommendation Rate	0 - Total	Oct-24	95.48%	94%	1.48%	91.81%	93.22%	95.48%		
Safety	Incidents - Confirmed Never Events	0 - Total	Oct-24	0	0.02	-0.02	0.07	0	1		
Safety	Incidents - Falls Resulting in Severe Harm or Death by Reported Date	0 - Total	Oct-24	0			0.18	0	0		
Safety	Incidents - Medication Incidents by Reported Date	0 - Total	Oct-24	84			62.49	115	615		
Safety	Incidents - Pressure Ulcers Reportable Confirmed Avoidable and Hospital A...	0 - Total	Oct-24	0			0.64	1	3		
Safety	Incidents - Serious Incidents Investigated and Confirmed Avoidable by Pan...	0 - Total	Oct-24	0	0	0.00	0.42	0	1		
Safety	Infection Control - C-Diff Hospital Onset Healthcare Associated Cases	0 - Total	Oct-24	5	3	2.00	2.63	3	19		
Safety	Infection Control - Gram Negative Blood Stream Hospital Onset Infections	0 - Total	Oct-24	4	5	-1.00	2.94	7	16		
Safety	Inpatient - SHMI Value	0 - Total	May-24	1.1			1.14	1.12	1.1		

Medication incidents- Demonstrates improved reporting of no and low-level harm events over the last 18 months, with October seeing a total of 84 incidents, down from the previous 2 months. Work is ongoing to reset the SPCs to reflect the improving trend.

Electronic Discharge Summaries:

- The EDS Task and Finish group has scoped the issues with the digital and clinical pathways. Action plan updated and agreed to develop a QI project for a group of Resident Doctors to review and improve the process of completing the EDS.
- There has been a slight improvement in the 24hr standard from 67.15 % in September to 75.69% in October although this is still not achieving target.
- Updates will be provided to the Quality Committee on an ongoing basis.

Emergency readmission rates- Readmission rates within 1 month remain below trajectory as a positive variance.

Electronic Discharge Summaries:

- The EDS Task and Finish group has scoped the issues with the digital and clinical pathways. Action plan updated and agreed to develop a QI project for a group of Resident Doctors to review and improve the process of completing the EDS.
- There has been a slight improvement in the 24hr standard from 67.15 % in September to 75.69% in October although this is still not achieving target.
- Updates will be provided to the Quality Committee on an ongoing basis.

**Narrative provided by Jo Howarth, Director of Nursing (Acute Care).*

4) Performance dashboard

Metric Group	Metric	Group	Latest Month	Value	Target	Variance to Target	Mean	PY - Month Value	YTD Value	Variation	Assurance
Cancer	Cancer - 28 Day Faster Diagnosis Standard Performance	0 - Total	Oct-24	79.05%	77%	2.05%	71.13%	74.87%	79.05%		
Cancer	Cancer - 31 Day Decision to Treatment Standard Performance	0 - Total	Oct-24	94.44%	96%	-1.56%	96.16%	95.45%	94.44%		
Cancer	Cancer - Patients Waiting 62+ Days from Referral to Treatment	0 - Total	Oct-24	78			79.37	80	520		
Elective	Theatres - Capped Utilisation	0 - Total	Oct-24	72.6%	85%	-12.40%	68.87%	71.76%	72.6%		
Elective	Theatres - Uncapped Utilisation	0 - Total	Oct-24	78.18%	85%	-6.82%	73.94%	77.28%	78.18%		
Outpatient	Diagnostic - Percentage Patients Waiting <6 Weeks Test	0 - Total	Oct-24	79.16%	95%	-15.84%	75.99%	79.87%	79.16%		
Outpatient	RTT - 65+ Week Waits	0 - Total	Oct-24	116			633.52	481	116		
Outpatient	RTT - 78+ Week Waits	0 - Total	Oct-24	0			280.24	8	0		
Outpatient	RTT - Waiting List Size	0 - Total	Oct-24	21959			19703.24	20991	21959		
UEC	ED - Ambulance Handovers Average (Minutes)	0 - Total	Oct-24	19.83	30	-10.17	14.03	22.32	19.83		
UEC	ED - DCH 4 Hour Performance %	0 - Total	Oct-24	60.38%	70%	-9.62%	69.48%	61.26%	60.38%		
UEC	ED - ED Attendances % Waiting 12+ Hours	0 - Total	Oct-24	8.22%	6.22%	2.00%	4.16%	7.22%	8.22%		
UEC	ED - Overall 4 Hour Performance %	0 - Total	Oct-24	79.02%	78%	1.02%	81.93%	78.55%	79.02%		
UEC	Inpatient - Adult General and Acute (G&A) % No Criteria to Reside Bed Occup...	0 - Total	Oct-24	20.06%			20.9%	21.24%	20.06%		
UEC	Inpatient - Average Number of No Criteria to Reside Patients	0 - Total	Oct-24	63	38	25.00	76.19	65	63		

For the reporting month of November 2024, 8 out of 15 metrics were special cause variation of an improving nature, 3 were common cause variation and 4 of a declining nature.

The 31-day cancer indicator did not achieve the target, however with a rating of common cause variation, with no significant changes. The assurance is hit or miss for the 31-day standard, which occurs when the target lies between the process limits. For October, the trust achieved 7the 62-day treatment standard and the 28 day to diagnosis standard.

The two theatre utilisation indicators have improved, both capped and uncapped theatre utilisation is special cause of an improving nature, but with an assurance rating of fail, with the process not capable and will continue to fail the target without process redesign. The level of improvement has not kept pace with regional or national comparators and thus, DCH is in the lowest quartile of performance. Weekly (previously by-monthly) continue with the COO, for the Theatre and Divisional Management team. The team are working through a report from NHS England, following their recent visit to theatres and subsequent suggested actions to improve the utilisation metric.

The percentage of patients waiting 6 weeks or less for a diagnostic procedure has improved and with consistent improvements for the last few months, it is showing as special cause of an improving nature but with assurance of fail. Cardiology remains the biggest area of concern with the largest backlog, progress is being made with the total backlog now reducing.

In terms of the elective waiting list, the number of patients waiting over 65 and 78 weeks is special cause variation of an improving nature as the cohort of patients that have been waiting the longest, continues to reduce. The total waiting list size shows special cause of a concerning nature but the growth of the total waiting list has stopped and is now close to trajectory.

Average ambulance handover times have increased since the last Board reporting, the indicator is special cause of a concerning nature however, and with an assurance of pass, the process is capable of consistently passing the target. Performance of the ED 4-hour standard all (including MIUs) is special cause variation of an improving nature, with no significant changes and the process will continuously hit or miss the target. Performance is achieving above the national planning guidance target of 78%, with 79% achieved in October.

Full details of this and all metrics within the performance dashboard, are covered in the Finance and Performance Committee.

**Narrative provided by Adam Savin, Director of Operational Planning and Performance.*

5) People dashboard

Metric Group	Metric	Group	Latest Month	Value	Target	Variance to Target	Mean	PY - Month Value	YTD Value	Variation	Assurance
Growing for our Future	Essential Skill Rate	0 - Total	Oct-24	87%	90%	-3.00%	88.85%	90%	87%		
Looking After our People	Appraisal rate	0 - Total	Oct-24	76.66%	90%	-13.34%	75.68%	74.8...	76.66%		
Looking After our People	Sickness Rate (1 month in arrears)	0 - Total	Sep-24	4.3%	3.75%	0.55%	4.02%	4.35%	4.3%		
Looking After our People	Staff Turnover Rate	0 - Total	Oct-24	9.43%	12%	-2.57%	9.69%	11.48%	9.43%		
Looking After our People	Vacancy Rate	0 - Total	Oct-24	4.56%	5%	-0.44%	7.88%	9.16%	4.56%		

- Essential skills rate remained at 87%, 3% below target
- Appraisal rate increased to 77%, remaining below target
- Vacancy rate increased to 4.56% but remains better than the target
- Turnover increased to 9.43% but remains better than target
- Sickness rate remained at 4.3%, above the target

Essential skills remained at 87%, 3% short of achieving the target. At present this is common cause variation with no significant change, although due to the fluctuating nature of this indicator, the assurance classification remains as fail, without process redesign. Targeted work is underway in the four training areas currently sitting below the 80% lower threshold. The appraisal rate indicator has recovered and has reached 77% but a present this remains common cause variation with no significant change. The assurance classification remains as fail, without process redesign. Wider work on the appraisal and talent management processes is underway as part of the People Promise Exemplar Programme. Both the turnover and vacancy rate saw small increases in month, but the indicator remains special cause of an improving nature, with processes capable of consistently passing the targets. Sickness absence (reported one month in arrears) decreased for the second month running but remains in special cause of a concerning nature. Long term absence is decreasing but the increase in short term absence matches the usual seasonal pattern of absence.

**Narrative provided by Emma Hallett, Deputy Chief People Officer.*

6) Finance dashboard

Metric Group	Metric	Group	Latest Month	Value	Target	Variance to Target	Mean	PY - Month Value	YTD Value	Variation	Assurance
Capital	Capital Expenditure	0 - Total	Oct-24	1532	2596	-1,064.00	1959.67	2091	11697		
Revenue	Adjusted Financial Position	0 - Total	Oct-24	-1424	322	-1,746.00	-292.99	-1721	-8624		
Sustainability	Local Supplier % of Catering Spend	0 - Total	Oct-24	19.98%			23.51%	22.89%	19.98%		
Sustainability	Local Supplier % of Total Spend	0 - Total	Oct-24	6.63%			7.08%	7.58%	6.63%		
Value Board	Agency Spend	0 - Total	Oct-24	754.09	807	-52.91	1033.37	1226	4514.09		
Value Board	Efficiency Delivery	0 - Total	Oct-24	376	1400	-1,024.00	222.16	431	3297		
Value Board	Off Framework Agency Spend	0 - Total	Oct-24	50	83	-33.00	95.11	100	197		

Adjusted Financial Position (against control total)- Overspend against planned deficit position linked to unachieved CIP, costs supporting Industrial Action, Insourcing above planned levels expected to recover, inflationary RPI costs above planned levels, pay award shortfall, 33% increase for drugs specifically Gastro, Derm and blood thinner drugs being patient specific, catering incl provisions, laundry and utilities/rates, redundancies incurred, offset by agency improvement against plan although slowing pace and medical cover for sickness.

Agency Spend- Worsen since last month (medical locum usage Ophthal, Anaest, Obs & gynae. Nursing challenging and cover for SCBU, ED and Stroke). Medical agency usage escalated to SRO CMO for enhanced oversight and action plans.

Off Framework Agency Spend- Increases in usage of Off Framework noting areas of essential usage reviewed and limited to Emergency Department, Critical Care, Kingfisher paediatric ward and Special Care Baby Unit (SCBU), aligned to national off framework removal expected from July 2024 - break glass protocol only in use.

Efficiency Delivery- KEY ACTION AREA. Behind plan due to security and income generation schemes delayed (Dir of E&F action plan focus) offset by Covid related cost savings in month and cost reduction linked to agency improved spend against plan. Deep dive report presented to October F&PC.

Cash- 23/24 ERF payment received along with pay award funding paid out and HEE income for January. National revenue support received in April totalling £1.5m with further request submitted for December, Board approved pending national outcome. Continued risk of cash shortfall expected Q4.

Capital Expenditure (total)- Behind plan due to NHP enabling works timing, offset by internally funded schemes ahead of plan (Ridgeway, East Wing and medical equipment purchases timing).

**Narrative provided by Claire Abraham, Deputy Chief Financial Officer.*

7) All metric glossary

MetricName	MetricDescription
Cancer - 28 Day Faster Diagnosis Standard Performance	Percentage of patients meeting the 28 day faster diagnosis cancer standard (from referral to point where given an all clear or confirmed diagnosis). Sourced from Somerset Cancer Register (SCR).
Cancer - 31 Day Decision to Treatment Standard Performance	Percentage of patients meeting the 31 day decision to treatment cancer standard (based Treatment for DCH treated patients). Sourced from Somerset Cancer Register (SCR).
Cancer - Patients Waiting 62+ Days from Referral to Treatment	Number of patients waiting longer than 62 days from cancer referral to treatment following a screening service referral. Sourced from the DCH Manual Data Collection Portal via the Cancer Team.
Complaints - Formal Complaints Received	Number of formal and complex complaints raised based on received date. Sourced from Datix.
Diagnostic - Patients % Waiting < 6 Weeks for Diagnostic Test	Percentage of Patients waiting less than 6 weeks for a diagnostic test in line with DM01 methodology. Sourced from DM01 Monthly Position.
ED - Ambulance Handovers Average (Minutes)	Average DCH ambulance handovers in Minutes against 30 Minute Average Target. Sourced from ED SWAST information.
ED - DCH 4 Hour Performance %	Percentage of patients with an unplanned DCH Emergency Department visits lasting longer than the 4 hour peformance standard. Sourced from ED Agyle/PAS.
ED - ED Attendances % Waiting 12+ Hours	Percentage of patients with an unplanned DCH Emergency Department visit lasting longer than 12 hours. Excludes patients marked as streamed. Sourced from ED Agyle/PAS information.
ED - Overall 4 Hour Performance %	Percentage of patients with an unplanned Emergency Department/MIU visits lasting longer than the 4 hour peformance standard. Sourced from ED Agyle/PAS and MIU information.
Finance - Adjusted Financial Position	Finance Spend (£000) Adjusted financial performance surplus or deficit. Sourced from Finance team.
Finance - Agency Spend	Agency Spend (£000). Sourced from Finance team.
Finance - Capital Expenditure	Capital Expenditure (£000). Sourced from Finance team.
Finance - Cost Position	Cash position of the Trust (£000) noting this is a key risk area for 2024/25. Sourced from the Finance Team.
Finance - Efficiency Delivery	Paid CIP (£000) for efficiency delivery. Sourced from Finance team.
Finance - Local Supplier % of Catering Spend	Percentage of catering spend with local suppliers. Sourced from the Procurement team.
Finance - Local Supplier % of Total Spend	Percentage of total spend with local suppliers. Sourced from the Procurement team.
Finance - Off Framework Agency Spend	Off Framework Agency Spend (£000). Sourced from Finance team.
Friends and Family - Overall % Recommendation Rate	Percentage of overall Friends and Family recommendation. Sourced from the Patient and Public Experience team.
Incidents - Confirmed Never Events	Number of occurances of confirmed Never Events based on updated date excluding any rejected or duplicated incidents. Sourced from Datix.
Incidents - Falls Resulting in Severe Harm or Death by Reported Date	Number of occurances of falls catagorised as severe or death severity of harm caused, based on reported date excluding any rejected or duplicated incidents. Sourced from Datix.
Incidents - Medication Incidents by Reported Date	Number of occurances of medicine incidents based on reported date excluding any rejected or duplicated incidents. Sourced from Datix.
Incidents - Pressure Ulcers Reportable Confirmed Avoidable and Hospital Acquired (Category 3) by Reported Date	Number of occurances of hospital acquired (confirmed) category 3 pressure ulcers by panel date excluding any rejected or duplicated incidents. Sourced from Datix.
Incidents - Serious Incidents Investigated and Confirmed Avoidable by Panel Date	Number of occurances of serious incidents investigated and confirmed avoidable by panel date excluding any rejected or duplicated incidents. Sourced from Datix.
Infection Control - C-Diff Hospital Onset Healthcare Associated Cases	Number of occurances of hospital onset healthcare associated Clostridium difficile (C. diff) incidents by specimen date. Sourced from HCAI data.
Infection Control - Gram Negative Blood Stream Hospital Onset Infections	Number of occurances of hospital onset gram negative blood stream infection incidents by specimen date. Sourced from HCAI data.
Inpatient - Adult General and Acute (G&A) % No Criteria to Reside Bed Occupancy	Percentage of total adult G&A beds occupied (as per reported in UEC Daily SitRep) by No Reason To Reside (NRTR) patients (as per reported in EPPR Daily Discharge SitRep). Original source PAS /
Inpatient - Average Number of No Criteria to Reside Patients	Number of total adult G&A beds occupied (as per reported in UEC Daily SitRep) by No Reason To Reside (NRTR) patients (as per reported in EPPR Daily Discharge SitRep). Original source PAS /
Inpatient - EDS % Available < 24 Hours of Discharge	Percentage of electronic discharge summaries (EDS) available for GPs to access within 24 hours of discharge from an inpatient spell. Sourced from EDS reporting, original source ICE / PAS.
Inpatient - EDS % Available < 7 Days of Discharge	Percentage of electronic discharge summaries (EDS) available for GPs to access within 7 days of discharge from an inpatient spell. Sourced from EDS reporting, original source ICE / PAS.
Inpatient - Emergency Re-Admissions % (1 month in arrears)	Percentage of emergency re-admissions to hospital within 30 days of previous admission. Excludes patients under the age of 16 on original admission. Sourced from Emergency Readmission
Inpatient - SHMI Value (5 months in arrears)	Ratio result of Summary Hospital-level Mortality Indicator (SHMI) which reports applicable deaths within hospital, or within 30 days post discharge against expected (does not include Covid related deaths). Results show the ratio between the actual number of patients who die following hospitalisation at the trust and the number that would be expected to die on the basis of
RTT - 65+ Week Waits	Number of referral to treatment (RTT) patients on an admitted or non-admitted pathway waiting to start treatment for 65 weeks or longer. Sourced from PAS.
RTT - 78+ Week Waits	Number of referral to treatment (RTT) patients on an admitted or non-admitted pathway waiting to start treatment for 78 weeks or longer. Sourced from PAS.
RTT - Waiting List Size	Number of referral to treatment (RTT) patients on an admitted or non-admitted pathway waiting to start treatment. Sourced from PAS.
Theatres - Capped Utilisation	Percentage of planned theatre sessions that were utilised, based on Capped methodology for theatres within a Day Surgery or Main Theatres location. Sourced from Theatre Reporting, original source PAS.
Theatres - Uncapped Utilisation	Percentage of planned theatre sessions that were utilised, based on Uncapped methodology for theatres within a Day Surgery or Main Theatres location. Sourced from Theatre Reporting, original source PAS.
Workforce - Appraisal rate	Percentage of applicable appraisals completed within time frame expected. Sourced from Workforce team.
Workforce - Essential Skill Rate	Percentage of applicable essential skills completed within time frame expected. Sourced from Workforce team.
Workforce - Sickness Rate (1 month in arrears)	Sickness Rate. Full Time Equivalent (FTE) sick / FTE Days Available. Source ESR.
Workforce - Staff Turnover Rate	Percentage showing staff turnover rate based on a 12 month rolling view. Sourced from Workforce team, original source ESR.
Workforce - Vacancy Rate	Percentage showing Trust vacancy rate (budgeted FTE minus staff in post). Excludes positions with a frozen or proposed Hiring Status, positions with Org Level 2 of Honorary, Widows & Widowers, Dump Posts, Volunteers or Nurse Bank, positions with a Cost Centre of Nursing Relief Pool RN or HCA, and positions noted as Registered Nursing Degree Apprentices. Sourced from ESR.

Report to	Trust Board	
Date of Meeting	10th December 2024	
Report Title	DCH Finance Report	
Prepared By	Claire Abraham, Deputy CFO DCH	
Accountable Executive	Chris Hearn, Chief Finance Officer	
Previously Considered By	FPCIC 25th November 2024 for information	
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	Identify risks and mitigations associated with plan delivery, financial sustainability	
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 seven delivered a deficit of £1.4 million after technical adjustments, being £1.7 million away from plan of £0.3 million surplus. The year to date position is £2.6 million away from the reported plan standing at an actual deficit of £8.6 million.

Shortfall in efficiency delivery against planned levels; Insourcing above planned phased levels and a worsening of medical agency usage due to sickness have driven the worsening of the position in month.

The risk adjusted forecast outturn by year end remains intact at circa £6 million noting the expected worsening of the position in line with highlighted risks and focus on identified mitigating actions.

Further factors driving the year to date overspend include costs 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 76 no criteria to reside (NCTR) patients being supported which were captured at the end of October (not average).

Whilst agency expenditure has continued at lower than budgeted levels, there has been a steady increase in expenditure with total month spend of £0.8 million largely due to medical agency cover for sickness and vacancies in Ophthalmology, Anesthetics and Obs & Gynae specialties. Nursing agency

has increased in month across ED and Stroke along with Special Care Baby Unit (SCBU) and Day surgery covering sickness. Break glass Off Framework expenditure has been steadily increasing each month, with £0.050 million incurred in month seven resulting in £0.2 million year to date, with NHS England expecting nil Off Framework spend from July 2025.

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 23% of the target being £3.3 million, however efficiency delivery remains a significant risk for the Trust in achieving the break even plan for the year, as detailed in the deep dive report presented to the Committee last month. Progress against planned delivery has slowed in month seven with a renewed focus required in order to recover the pace seen in the initial months of the year.

Capital expenditure for month seven is behind plan at £1.1 million due to timing of equipment purchases. Year to date spend is £11.7 million and behind plan by £3.3 million largely due to NHP enabling works offset by internal schemes being ahead of plan by £0.5 million, both due to timing.

The cash position to October amounts to £8 million ahead of expected forecast due to earlier payments of last years ERF funding and Health Education England funding for January 2025. Pay award funding has also been received to offset this month, however noting a shortfall is currently being validated of up to £0.4m.
Cash remains a high risk area for the Trust with modelling indicating further cash support will be required for December per the Board approved paper submitted during October. A national revenue support request has been submitted for December for £1.4 million of cash support and £1.5 million of working capital, with the Trust awaiting the outcome of this request at the time of writing. A verbal update will follow for the Committee.

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 and risk to delivery of this as outlined in the report. A weekly Executive led DCH Recovery Group is driving mitigating actions to tackle the risks to the position.

- 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 Executive led SRO and DCH Recovery Group meeting

- 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.

Recommendation

Trust Board is recommended to:

1) Receive the report for a**ssurance**, noting the month seven financial position for the financial year 2024/25 and associated risk to delivering the break even position with key recovery actions taking place.

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Financial Position Update 2024/25

October 2024 - Month 7

Chris Hearn
Chief Financial Officer

Financial Position Update - October 2024

Executive Summary

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

In October 2024, Dorset County Hospital NHS Foundation Trust (DCHFT) has delivered a month 7 deficit of £1.424 million after technical adjustments, an adverse performance of £1.746 million against the revised plan of £0.322 million surplus.

This overspend in month has been driven by; pressures on the delivery of the CIP Plan (£1.4 million in month), pressures on insourced activity and 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 and increased use of off framework agency. Escalated beds at the end of the month were 19 with circa 76 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 addition, 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 47% of high risk schemes. Delivery to date stands at £3.3 million this is c£3.0 million behind phased plan of delivery to month 7. In addtion to this delivery, contributing cost avoidance and cost reduction is now being detailed (£2.5 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 mainly due to the 2024/25 pay award including backdated payments for months 1-6, impact of this pay award has not been included in the plan figures. Others areas above plan include 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 progressing with the capital programme for 2024/25, month 7 YTD spend totalling £11.7 million, a net £3.3 million behind rephased plan due to underspends on externally funded projects. Externally funded projects are £3.2 million behind plan due to the changes in the spend profile of the New Hospital Programme (NHP) enabling works. Purchases of IFRS16 Leases are a further £0.8 million behind plan but 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 30 October was £3.7 million above plan due to agreed arrangements to delay NHS supplier payments and remaining pay award funding to cover NI and Pensions backpay elements (£2.7m). The Trust requested and was granted £1.5m of national revenue support received in April and has requested a further £2.9m of cash support in December as modelling indicates a cash shortfall by the end of the year.

Financial Position Update - October 2024

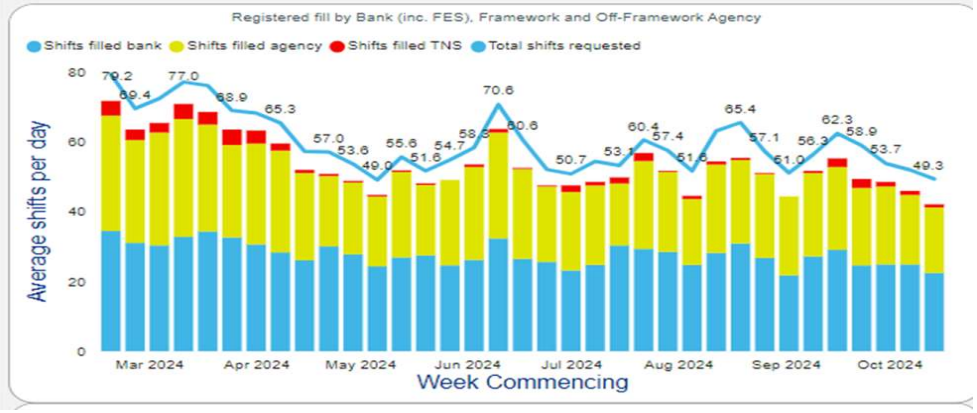
Key Risks

Red Risks:

The Trust has an efficiency delivery requirement of £14.4 million in order to reach the planned full year break even position. The target is now fully identified, however £6.8 million of the this is made up of High Risks schemes (47%) including workforce review and productivity stretch. 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 mandated all off framework agency spends to cease completely from July 2024. The trust has managed to largely achieve this, with the exception of Mental Health escalation requirements. This has resulted in the Trust exceeding it's FYE reduction of £1 million on spend, which currently stands at £1.2 million. The opening of Portisham Ward to support the extreme pressures seen in ED has also seen an impact on the usage of agency since month 5. Active plans in place as part of the internal High Cost Agency Reduction group, which is primarily focusing on nursing, are continuing to help prevent further deterioration of the position against plan and begin to work further on medical agency and locum spend. The table below shows registered nursing shift fill by bank, on framework agency and highest cost off framework agency. The Trust must increase bank usage and decrease agency usage whilst maintaining patient and staff safety and quality levels.



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

Financial Position Update - October 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 Q3 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

There is a risk to cash levels throughout the year due to deficits in the first 7 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, and a further request in progress of £2.9m submitted for December. 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 becoming urgent and unavoidable, resulting in over subscription against the internally funded capital programme. The Capital Planning and Space Utilisation Group (CPSUG) has collated a priortised and risk scored list from each area to actively oversee, identify and manage this risk.

Financial Position Update - October 2024

Key Risks

Amber Risk:

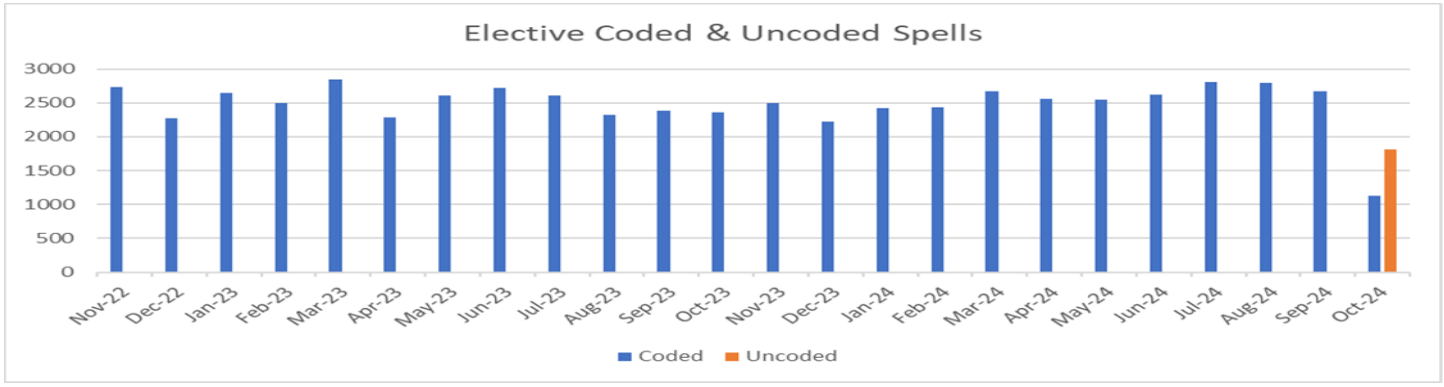
From 2023/24 NHS England introduced the Aligned Payment and Incentive (API) approach to all NHS standard contracts. This approach splits the payment mechanism for the majority of NHS contracts into two envelopes, Fixed and Variable.

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 October 2024 the Trust has 4,381 uncoded spells,1,826 are for Elective activity and 2,555 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 - October 2024

Recovery Plans

Weekly Executive Recovery Group meeting established with Targeted Service Areas and Recovery Plans
- Weekly Senior Leadership recovery meetings are taking place with specific focus areas
- 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. Current investments paused, while financial implications for 2024/25 are considered.

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.

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Financial Position Update - October 2024
Income & Expenditure

Income and Expenditure

The overall revenue position is a £1.424 million in month actual deficit, £1.746 million adverse to plan after technical adjustments. The YTD position is £2.669 million away from plan. Increase in agency costs, pressures on insourced activity and CIP underachievement have contributed to this overspend, along with continued inflationary pressures, and spike in COVID costs ahead of winter.

The Operating Income from patient care activities in month variance is due to; out of contract income, estimated month 1 - 7 Elective Services Recovery Fund (ESRF) income and high cost drugs income offset with expenditure.

Pay costs are over plan due to pay award including backdated payments, 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. October 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 a small peak again in September and again in October. The large pay variance is offset largely by income received for externally funded posts - an exercise is currently underway to transfer budget to the appropriate pay lines. The impact of the recent pay award is still being reviewed and discussed with Commissioners.

Non pay is over plan due to ongoing above plan inflationary pressures, in particular energy, catering supplies, blood products - specifically in Gastro (off patent drugs are expected to come into use towards the end of the year to start addressing this area of continued overspend) and maintenance contracts and laundry. Drugs expenditure is also high linked to activity and price increases, 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	21,265	26,358	5,093	148,863	163,566	14,702
Private Patients	87	94	7	606	624	18
Other clinical revenue	37	428	391	259	630	371
Other non-clinical revenue	2,006	4,504	2,499	13,967	18,876	4,909
Operating Income	**23,394**	**31,384**	**7,990**	**163,696**	**183,696**	**20,000**
Total Income	**23,394**	**31,384**	**7,990**	**163,696**	**183,696**	**20,000**
Raw materials and consumables used	(3,972)	(4,765)	(793)	(26,310)	(32,212)	(5,902)
Employee benefit expenses:						
Substantive	(13,216)	(20,111)	(6,894)	(94,269)	(109,538)	(15,270)
Bank	(826)	(1,213)	(387)	(5,972)	(7,466)	(1,494)
Agency	(833)	(754)	79	(5,895)	(4,534)	1,360
Other operating expenses (excl. depreciation)	(2,737)	(4,419)	(1,682)	(26,807)	(28,444)	(1,637)
Operating Expenses	**(21,585)**	**(31,263)**	**(9,678)**	**(159,252)**	**(182,193)**	**(22,941)**
Profit/(loss) from Operations (EBITDA)	**1,809**	**122**	**(1,688)**	**4,444**	**1,503**	**(2,941)**
Other Non-Operating income (asset disposals)	(15)	10	25	0	10	10
Total Depreciation and Amortisation	(1,035)	(1,035)	0	(7,246)	(7,245)	1
PDC Dividend expense	(408)	(408)	(0)	(2,857)	(2,857)	(0)
Total finance income	36	76	41	156	495	339
Total interest expense	(64)	(70)	(5)	(451)	(439)	12
Total other finance costs	(0)	(0)	(0)	(£0)	(£1)	(1)
SURPLUS/ (DEFICIT)	**322**	**(1,305)**	**(1,627)**	**(5,956)**	**(8,536)**	**(2,581)**
Technical Items Adjusted for:						
Donations Non-Cash Assets	(40)	(155)	(115)	(338)	(58)	(58)
Depreciation Donated Assets	40	36	(4)	250	(30)	(30)
SURPLUS/ (DEFICIT)	**322**	**(1,424)**	**(1,746)**	**(5,956)**	**(8,624)**	**(2,669)**

Financial Position Update -October 2024
Risk Adjusted Forecast Outturn

RAFOT Narrative
There is currently a risk to the delivery of the break even plan for financial year 2024/25. The year to date position is off plan by £2.7 million, there remains significant ongoing pressures in the latter part of the financial year specifically in relation to high risk efficiency scheme delivery (£6.8m), ongoing drugs growth, inflationary challenges and bed levels above those initially planned for. Costs supporting Industrial action have not been fully offset by the national funding allocation available leaving a shortfall which also contributes to the deficit position. A number of mitgations have been identified and are being closely monitored through the Trusts weekly Executive led DCH Recovery Group.

	Position to Month 7			Year End Position Risk @ M7		
Organisation	M7 YTD plan	M7 position	YTD Variance to plan	Year end plan (and reported FOT)	Year end risk adjusted (mitigated) forecast	Variance to Plan (RAFOT position)
DCHFT	(6.0)	(8.6)	(2.7)	0.0	(6.1)	**(6.1)**

Forecast Outturn 24/25 £m	DCHFT
Forecast deficit driven by:	
Impact of Industrial Action	(0.4)
ERF risk	(0.9)
Inflation not in plan	(1.7)
Drugs growth	(3.8)
Escalation beds/NCTR/Temporary workforce costs	(4.1)
Efficiency Shortfall	(6.8)
Total Forecast Deficit Excl mitigations (worst case):	**(17.7)**
Potential Mitigations (best case):	
Expected CIP delivery	5.5
IA partial funding	0.3
Income expediate	0.4
Pay - agency & locum improvements	1.0
Non Pay - in house security	0.6
Benchmarking opportunities	0.3
System opportunities/joint working initiatives	3.2
Partially mitigate ERF risk	0.5
2024/25 forecast, with mitigations	**(6.1)**
Planned Surplus/(Deficit)	**0.0**
Total 2024/25 forecast risk, with mitigations	**(6.1)**

Financial Position Update - October 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.

In M6 NHS England notified Trusts of their Industrial Action funding envelopes, Dorset County Hospital received £0.286m leaving an unfunded pressure of £0.123m.

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

	£'000
Industrial Action partial funding received	£286
Net cost & ERF income loss due to IA	£409
Industrial Action funding shortfall/cost pressure	**-£123**

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

Financial Position Update - October 2024
Trust Wide Performance: Agency

Pay Analysis - Agency

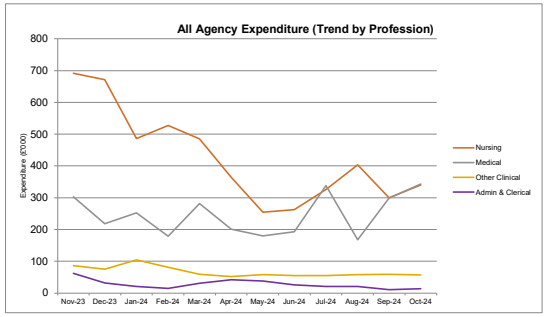
Agency costs equated to £0.754 million of actual expenditure in month against a plan of £0.833 million, showing a c£0.100 million increase on last month . This higher spend was largely due to continued Mental Health interventions and sickness and maternity cover in Ophthalmology.

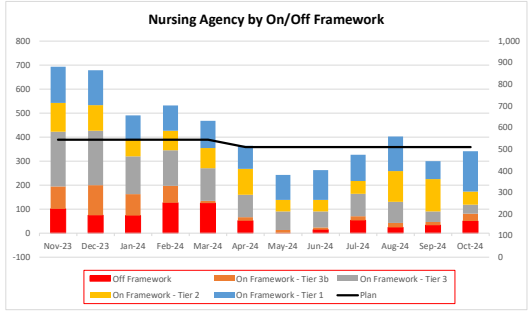
Agency expenditure remains over the 3.2% of total pay NHSE target set for 2024/25, to 4.4% of pay budgets - slightly increased from last month (4.1%), when adjusted for the pay award.

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)	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24
Nursing	692	672	487	527	485	364	254	263	326	403	300	340
Medical	303	218	253	179	281	201	180	193	338	167	299	343
Other Clinical	86	75	104	82	59	52	58	55	54	58	59	56
Admin & Clerical	62	32	20	15	31	42	38	26	21	21	10	14
Totals 2023/24 & 2024/25 YTD	**1,143**	**996**	**864**	**802**	**856**	**659**	**530**	**536**	**739**	**649**	**668**	**754**

YTD Actual	YTD Plan	Variance
2,250	3,348	1,098
1,720	1,622	-98
393	689	296
172	236	64
4,535	**5,895**	**1,359**

Nursing Agency Category	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24
Off Framework	102	74	73	126	125	51	-1	14	54	23	33	50
On Framework - Tier 3b	92	126	90	71	10	15	13	10	17	20	13	31
On Framework - Tier 3	229	227	157	148	136	94	77	66	93	87	44	37
On Framework - Tier 2	120	106	69	81	84	107	48	49	54	128	135	54
On Framework - Tier 1	151	145	102	105	113	96	104	123	109	145	74	169
Plan	543	543	543	543	543	509	509	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	**693**	**678**	**490**	**532**	**467**	**363**	**241**	**262**	**326**	**403**	**300**	**341**

Pay Metrics	In Month Actual	YTD Actual
Agency expenditure as % of total pay	4.4%	4.0%
Off framework expenditure as % of total agency	6.6%	5.9%

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

Area	On Framework	Off Framework	of which: RNMH	Total Nursing Agency	%
Emergency Dept Main Dept	398	35	19	433	19%
Day Surgery Unit	203	3		206	9%
Moreton Ward - Respiratory	203	2		204	9%
Abbotsbury Ward	137	17		154	7%
Purbeck Wd	150	0		150	7%
Stroke Unit	111	15	8	126	6%
Lulworth Ward	114	2		116	5%
Ilchester Integrated Assessmen	105	2		107	5%
CRCU	72	32		105	5%
Kingfisher Ward	45	53		98	4%
Fortuneswell Ward	94	1		96	4%
Ridgeway Wd	72	- 0		72	3%
The Mary Anning Unit	65	2		67	3%
DCH Dialysis	64	-		64	3%
SCBU	-	58		58	3%
Frailty SDEC	45	-		45	2%
Evershot Ward	40	- 1		39	2%
Prince Of Wales	36	1		37	2%
Theatre Suites	32	-		32	1%
Cardiology Care Ward	22	2		23	1%
Surge Area	7	-		7	0%
SDEC	6	- 1		5	0%
B'Mth Dialysis	3	-		3	0%
Discharge Team	1	-		1	0%
ENT Medical Staff/Sec	-	1		1	0%
Total Nursing Agency YTD	**2,026**	**224**		**2,250**	

*Adjusted for Pay Award in M7

Outstanding care for our patients in ways which matter to them

Financial Position Update - October 2024

Insourcing

Insourcing Narrative
The insourcing budget of £7 million is planned to; support the reopening of Weymouth Theatre, provide insourcing activity set via FPC at beginning of the year, fund substantive roles in ENT and Ophthalmology. All substantive posts are now recruited to including within theatres, however there is an additional Medimet team in place in Weymouth to assist with training of new recruits. This is however temporary and the team will be leave once training is complete. The current forecast of £7,382 million, (£0.382 million overspent) is based and costed on actual activity booked to March however, there are ongoing actions to bring back in line with plan and is expected to hit the planned £7 million target. The Trust was requirements to achieve 104% of activity against the 2019/20 baseline, current forecasts show a trajectory plan of 105% achievement.

	Actual Apr-24	Actual May-24	Actual Jun-24	Actual Jul-24	Actual Aug-24	Actual Sep-24	Actual Oct-24	Forecast Nov-24	Forecast Dec-24	Forecast Jan-25	Forecast Feb-25	Forecast Mar-25	Forecast Outturn
Budget:	**788**	**788**	**846**	**807**	**807**	**635**	**437**	**425**	**425**	**425**	**426**	**191**	**7,000**
Spend:													
Breast	(19)	(13)	(13)	(13)	(13)	(14)	0	0	(13)	0	0	0	**(98)**
Cardiology	(7)												**(7)**
Dermatology	(151)	(115)	(142)	(117)	(151)	(157)	(131)	(105)	(105)	(30)	(30)	(30)	**(1,264)**
Endoscopy/Gastro	(113)	(99)	(115)	(114)	(146)	(129)	(101)	(21)	(21)	(11)	(11)	(11)	**(894)**
ENT	(9)	(47)	(48)	(48)	(72)	(49)	(98)	(53)	(53)	0	0	0	**(479)**
General Surgery			(94)	(114)	(109)	(92)	(172)	(51)	(51)	(18)	(18)	(18)	**(737)**
Gynaecology	(95)	(99)	(83)	(78)	(129)	(83)	(76)	(54)	(54)	(20)	(20)	(20)	**(811)**
OMF	(152)	(174)	(120)	(33)	(114)	(110)	(119)	(50)	(74)	(29)	(29)	(48)	**(1,051)**
Ophthalmology	(26)	(44)	(31)	(90)	(35)	(35)	(18)	(9)	(9)	(15)	(15)	(15)	**(342)**
Orthopaedics	(52)	(83)	(62)	(52)	(88)	(78)	(43)	(94)	(59)	0	0	0	**(612)**
Urology			(2)	(32)	(48)	(16)	(13)						**(112)**
Vascular						(1)		1					**0**
Pre Assessment						(10)	(6)	15					**0**
Peads Surgery							(33)	33					
Theatre Staffing						(102)	(202)	(135)	(135)	(135)	(135)	(135)	**(980)**
Total spend	**(625)**	**(674)**	**(712)**	**(691)**	**(906)**	**(875)**	**(1,012)**	**(524)**	**373**	**(258)**	**(258)**	**(276)**	**(7,387)**
Surplus/(Deficit)	**163**	**114**	**134**	**116**	**(99)**	**(240)**	**(575)**	**(99)**	**798**	**167**	**168**	**(85)**	**(387)**

Financial Position Update - October 2024
COVID Expenditure

Covid Narrative
Covid spend jumped up in October to £0.550 million from £0.4 million in September. This was due to the purchase of bulk COVID test ahead of winter. £28k was still able to be released to CIP in month. Bringing the YTD total CIP from COVID to c£0.445 million. 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, however there was a spike in month due to challenging patients. 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	Sep-24	Oct-24	YTD
Plan:		**£2,287**	**£211**	**£211**	**£209**	**£208**	**£205**	**£203**	**£199**	**£1,446**
Expenditure:										
Pay	Substantive	£282	£1	£1	£14	£34	£9	£9	£11	£79
	Bank	£108	£0	£3	£7	£0	£0	£0	£0	£10
	Agency	£1	£0	£0	£0	£0	£0	£0	£0	£0
Total Pay		**£391**	**£1**	**£4**	**£21**	**£34**	**£9**	**£9**	**£11**	**£89**
Non-pay	Clinical Supplies and Services	£223	£32	£4	£22	£26	£52	£0	£91	£227
	General Supplies and Services	£0	£0	£0	£8	£5	£6	£4	£2	£25
	Establishment Expenditure	£6	£0	£0	£0	£0	£0	£0	£0	£0
	Other Non-Pay (security)	£472	£22	£21	£21	£23	£47	£15	£40	£189
	Premises and Fixed Plant	£162	£12	£12	£12	£3	-£12	£1	£0	£27
Total Non-pay		**£863**	**£65**	**£38**	**£62**	**£57**	**£93**	**£20**	**£133**	**£468**
Total Expenditure		**£1,254**	**£66**	**£41**	**£83**	**£91**	**£102**	**£29**	**£144**	**£557**
Total Surplus/(Deficit)		**£1,033**	**£145**	**£170**	**£126**	**£117**	**£103**	**£174**	**£55**	**£889**

Financial Position Update - October 2024
Sustainability & Efficiency

Efficiency & Sustainability Programme Update

The annual efficiency target for the Trust is circa 5% which equates to £14.4 million for the financial year.

In month delivery of c£0.3 million has been achieved, £0.070 million coming from agency cost reduction of Off Framework and the remainder largely from finance review savings (£0.175 million YTD savings) and pay slippage. YTD delivery stands at c£3.3 million (including £1.2 million of agency cost - for Off Framework reduction). This is c£3 million behind plan YTD. £2.5 million of cost avoidance schemes have also been achieved YTD (Reduction of agency usage against 2023/24 levels).

£7.1 million has been planned as fully identified schemes and in progress.
The remaining £6.8 million of schemes have now been identified as high risk (47%) and are yet to deliver any savings. Theses schemes have been identified and linked to workforce reviews, non recurrent delivery opportunities, pay sickness review and productivity.

Efficiencies identified so far include further Covid reduction against plan, procurement savings, corporate savings, 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.

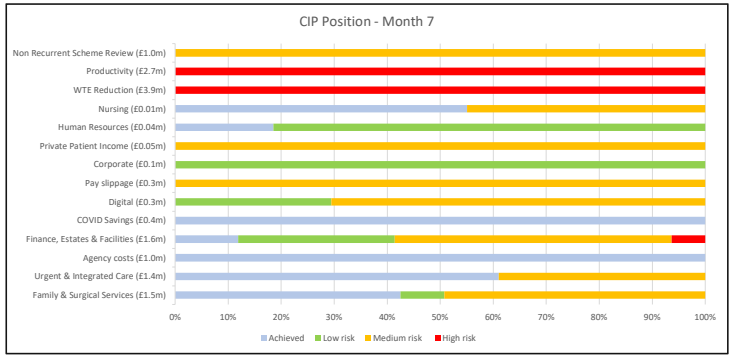
Efficiency by Division	Plan (excl Central Distribution)	Identified High Risk	Identified Medium Risk	Identified Low Risk	Total Identified
Family & Surgical Services	1,452		715	737	1,452
Urgent & Integrated Care	1,403		547	856	1,403
High Cost Agency & Off Framework Reduction	1,000			1,000	1,000
Finance, Estates & Facilities	1,581	100	826	655	1,581
COVID Savings	428			428	428
Digital	329		232	97	329
Pay slippage - Sickness Review TBC	318		318		318
Corporate	123			123	123
Private Patient Income	47		47		47
Human Resources	38			38	38
Nursing	9		9		9
WTE Reduction	3,918	3,918			3,918
Productivity - CANDo etc	2,800	2,800			2,800
Non Recurrent Scheme Review	923		923		923
Grand Total	**14,369**	**6,818**	**3,618**	**3,934**	**14,369**
Total as at October 2024	**14,369**	**6,818**	**3,618**	**3,934**	**14,369**

Plan YTD	Actual YTD	% Achieved (FY Plan)
693	617	42%
488	856	61%
442	1,214	121%
221	188	12%
702	445	104%
142		0%
141		-
55		-
20		-
19	7	0
7	5	55%
1,732		-
1,237	-	-
408	-	-
6,306	**3,332**	**23%**
6,306		

Scheme Status	Sustainable Workforce £'000	Productivity £'000	Variation £'000	Operational Efficiency £'000	Total £'000
Delivered	1,248		204	1,870	**3,322**
Identified - in progress	323		880	2,377	**3,580**
Identified - not started	7			643	**650**
Identified Stretch Targets (High Risk):					
Workforce WTE Review	3,918				**3,918**
Property leases Review				100	**100**
Productivity		2,800			**2,800**
Total CIP 5%	**5,496**	**2,800**	**1,084**	**4,990**	**14,370**

Cost Avoidance Schemes	Cost Avoidance YTD
Family & Surgical Services	**1,035**
Income - Non-Patient Care	-
Pay - Agency - reduce the reliance on agency	1,035
Pay - Establishment reviews	-
Urgent & Integrated Care	**1,474**
Income - Non-Patient Care	
Non-Pay - Procurement (excl drugs)	30
Pay - Agency - reduce the reliance on agency	1,422
Admissions Avoidance	22
Pay - Establishment reviews	-
Grand Total	**2,509**
Total as at September 2024	**2,509**

Efficiency Plan	£'000	%	No of Schemes
Recurrent			
Pay	5,205		17
Non Pay	1,972		22
Income	230		16
Total Recurrent	**7,406**	**52%**	**55**
Non Recurrent			
Pay	2,338		24
Non Pay	4,306		23
Income	319		10
Total Recurrent	**6,962**	**48%**	**57**
Grand Total	**14,369**		



Financial Position Update - October 2024

Cash

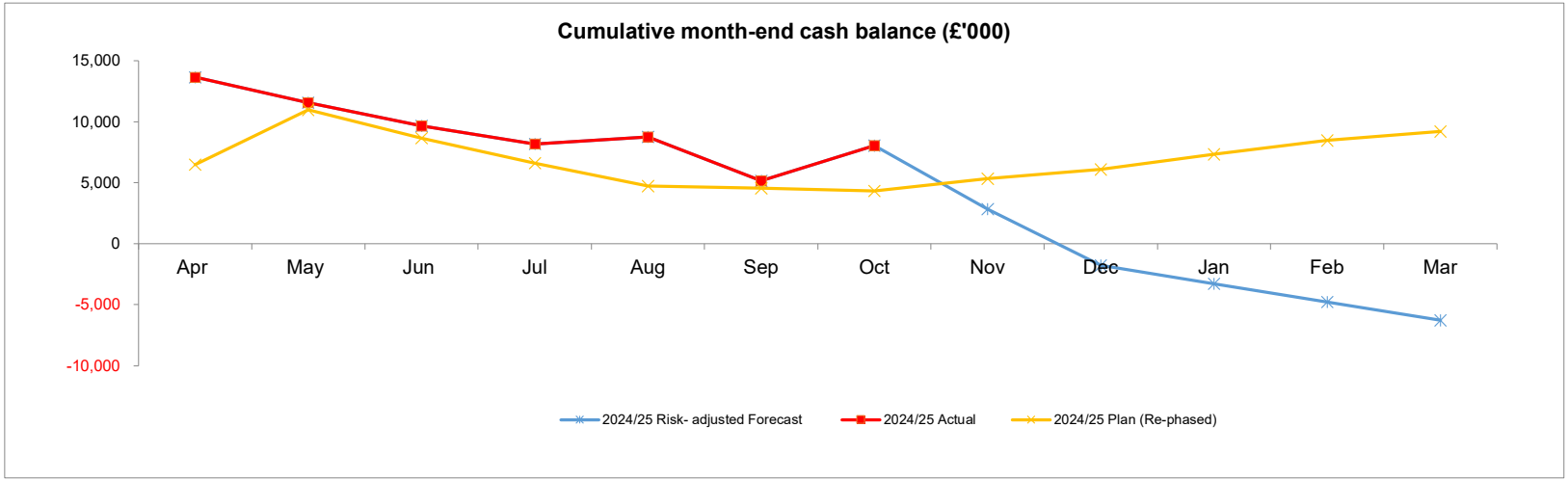
Cash Balance incl Forecast

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 £8.0 million at end of October, which is ahead of forecasted position of £4.3 million. During October, the Trust benefitted from receiving outstanding 2023/24 ERF income of £1.2 million, £1.0 million of income from HEE paid in advanced relating to January 2025. There was also a cash timing benefit on pay-award income of £2.7m relating to the October NI & Pension costs which will be paid in November.

The Plan assumed full delivery of the efficieny programme, due to ongoing slippages against these schemes the Risk-adjusted forecast highlights cash shortfalls if delivery of schemes is not achieved. The CFO is leading regular support meetings to deliver all efficiency schemes, in conjunction with ongoing system conversations regarding options for cash support.

The Trust received the first instalment of revenue support funding in April totalling £1.5m which supports the repayment of working capital, a second request has been made to NHSE for a further £2.9m cash support in December given the risk-adjusted forecast modelling a cash shortfall during this month, further drawdowns may be required in Q4.



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 Risk- adjusted Forecast								2,832	-1,779	-3,279	-4,779	-6,279
2024/25 Actual	13,650	11,566	9,660	8,164	8,752	5,158	8,037					

Financial Position Update - October 2024

Capital

Capital Programme Narrative

Capital expenditure year to date to the end of October was £11.7 million and behind plan by £3.3 million.

Internally Funded schemes and donated schemes are overall ahead of plan at the end of October by £0.7 million.

Digital and Medical Equipment Schemes were behind 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.

During September, the Trust received confirmation from NHS England of external capital funding for the Colposcopy Service totalling £0.6 million.

Externally Funded capital expenditure was £3.2m 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.

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	442	16	426	1,024	198	826	1,932	1,932	1,932	0
East Wing Theatre	0	(41)	41	450	1,413	(963)	1,527	1,527	0	(1,527)
Estates Schemes	**11**	163	(152)	**1,088**	1,902	(814)	1,802	1,802	1,650	(152)
Digital Services										
Digital Schemes	**220**	145	75	**1,414**	1,071	343	1,619	1,630	2,291	661
Equipment										
East Wing Theatre Equipping	0	45	(45)	295	100	195	319	319	295	(24)
Other Equipment	52	178	(126)	418	457	(39)	240	240	1,272	1,032
Sub-Total Internally Funded Expenditure	**725**	**505**	**220**	**4,689**	**5,140**	**(451)**	**7,439**	**7,450**	**7,440**	**(10)**
Donated										
Other Donations	0	0	0		21	(21)	21	21		(21)
Chemotherapy Unit Refurbishment	40	154	(114)	120	316	(196)	459	459	480	21
Sub-Total Planned Donated Expenditure	**40**	**154**	**(114)**	**120**	**337**	**(217)**	**480**	**480**	**480**	**0**
IFRS 16 Lease Additions										
Warehouse	0	0	0	480	546	(66)	546	546	480	(66)
MSCP Lease remeasurement	0	0	0	1,000	392	608	392	731	1,000	269
CEF Lease remeasurement	0	0	0	600	215	385	215	215	600	385
One Dorset Pathology	0	0	0	0		0		750	250	(500)
Accommodation & Vehicle Lease Additions	0	0	0	91	177	(86)	177	238	150	(88)
Sub-Total Planned IFRS 16 Expenditure	**0**	**0**	**0**	**2,171**	**1,330**	**841**	**1,330**	**2,480**	**2,480**	**0**
Total Internal & Leased Capital Expenditure	**765**	**659**	**106**	**6,980**	**6,807**	**173**	**9,249**	**10,410**	**10,400**	**(10)**
Additional funded schemes										
NHP Development	85	7	78	758	924	(166)	1,409	1,511	758	(753)
NHP Works	1,500	0	1,500	2,000	0	2,000	0	4,152	12,819	8,667
NHP Enabling	155	812	(657)	4,660	3,612	1,048	3,636	4,837	4,660	(177)
Digital EHR Funding	91	54	37	336	279	57	527	1,093	1,093	0
CDC Funding	0	0	0	16	15	1	16	16	16	0
Mental Health UEC Funding	0	0	0	257	0	257	0	0	257	257
Colposcopy	0	0	0	0	0	0	32	608	0	(608)
Inventory Management System (pending)	0	0	0	0	30	(30)	30	30	0	(30)
Total Externally Funded Capital Expenditure	**1,831**	**873**	**958**	**8,027**	**4,860**	**3,167**	**5,650**	**12,247**	**19,603**	**7,356**
Total Capital Expenditure	**2,596**	**1,532**	**1,064**	**15,007**	**11,668**	**3,339**	**14,899**	**22,657**	**30,003**	**7,346**
Expenditure as a % of Plan			59%			78%				76%

NHS
Dorset County Hospital
NHS Foundation Trust

Report to	Board of Directors, Part 1	
Date of Meeting	10 December 2024	
Report Title	Operational Resilience and Capacity Plan (Winter) 2024/25 including Dorset System Winter Plan	
Prepared By	Lesley Roberts, Head of Operations/NHS Dorset	
Accountable Executive	Anita Thomas, Chief Operating Officer	
Previously Considered By	Anita Thomas, Chief Operating Officer SLG 18 September 2024 (DCH plan only) Finance and Performance Committee in Common 23 September 2024 (DCH plan only)	
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	Referenced specifically under SR4 Capacity, Demand	
Financial	Intention 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. DCH plan forms part of the NHS Dorset Plan alongside all other System partners and associated workstreams	

Executive Summary

This DCH based surge plan has developed throughout Q1/Q2 informed by working with Better Care Fund Support Team and more recently Newton (System Strategic partner) 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. (delivering 13.5 additional 'beds')
- Improve SDEC capacity including direct referrals for 111 and SWAST. (delivering 7 additional 'beds')
- Introduce a Frailty SDEC as per national guidance on a mature SDEC offer (delivering 11.5 additional 'beds')
- 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. (Delivering 11.5 'beds')
- 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.

NHS Dorset Plan key features:

- Planning for Winter – including lessons from last winter
- Targeted improvements – links to DCH plan in terms of focus on SDEC, admission prevention, Transfer of Care Hubs operating on acute sites 7 days a week and the first phase of the work with Newton focussing on front door interventions to prevent admission or shorten length of stay.
- Management of risk – links to DCH EPRR plans
- Governance Arrangements – link to DCH plan OPEL levels, reporting and escalation of risk and concerns

Please note the system plan has not been updated with the latest bed modelling for the winter which indicates a bed deficit of 20 – 30 beds (depending on day of the week) at DCH. The actions outlined in the DCH plan aim to offset this deficit and go further to reduce bed occupancy below 100%. DCH will still rely on System partners delivering on shorter length of stay and an over all reduction in NRTR patients in order to consistently deliver 92% bed occupancy and good principles of hospital flow.

Recommendation

The Quality Committee is asked to:

- Review and approve the proposed document.

Dorset County Hospital
NHS Foundation Trust

Dorset County Hospital NHS Foundation Trust

OPERATIONAL RESILIENCE AND CAPACITY PLAN (WINTER) 2024/25

SEPTEMBER 2024

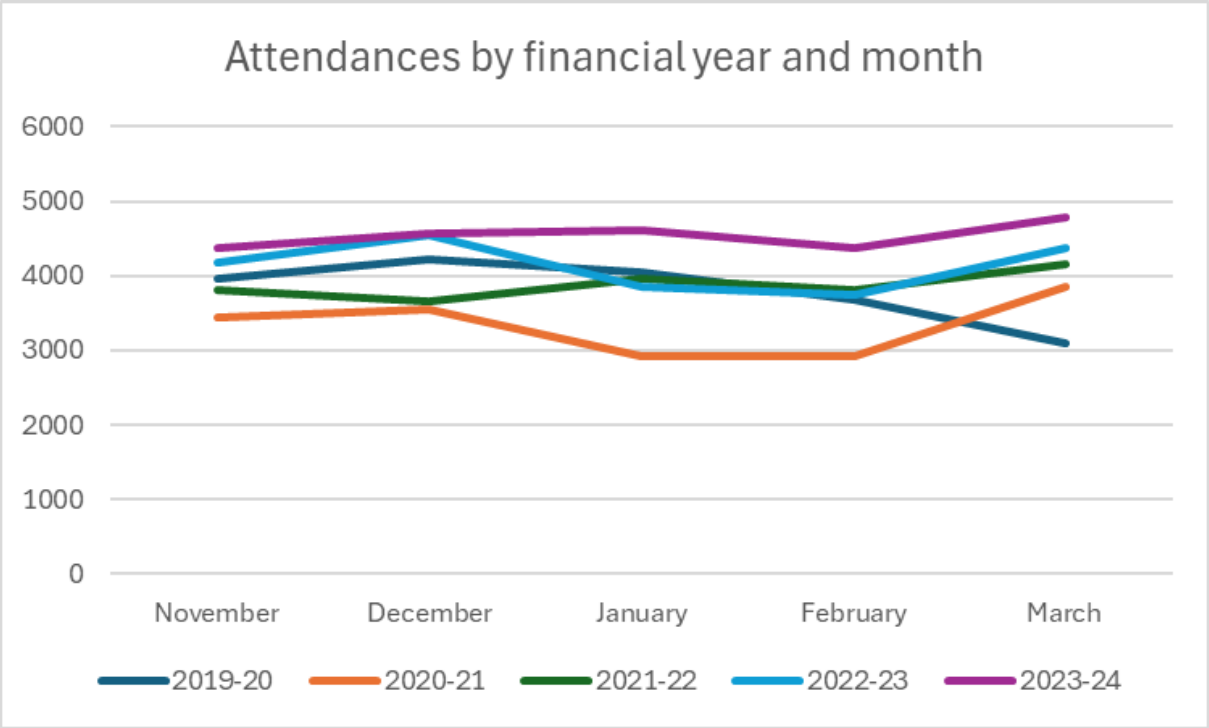
DORSET COUNTY HOSPITAL NHS FOUNDATION TRUST

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.
- 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.

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

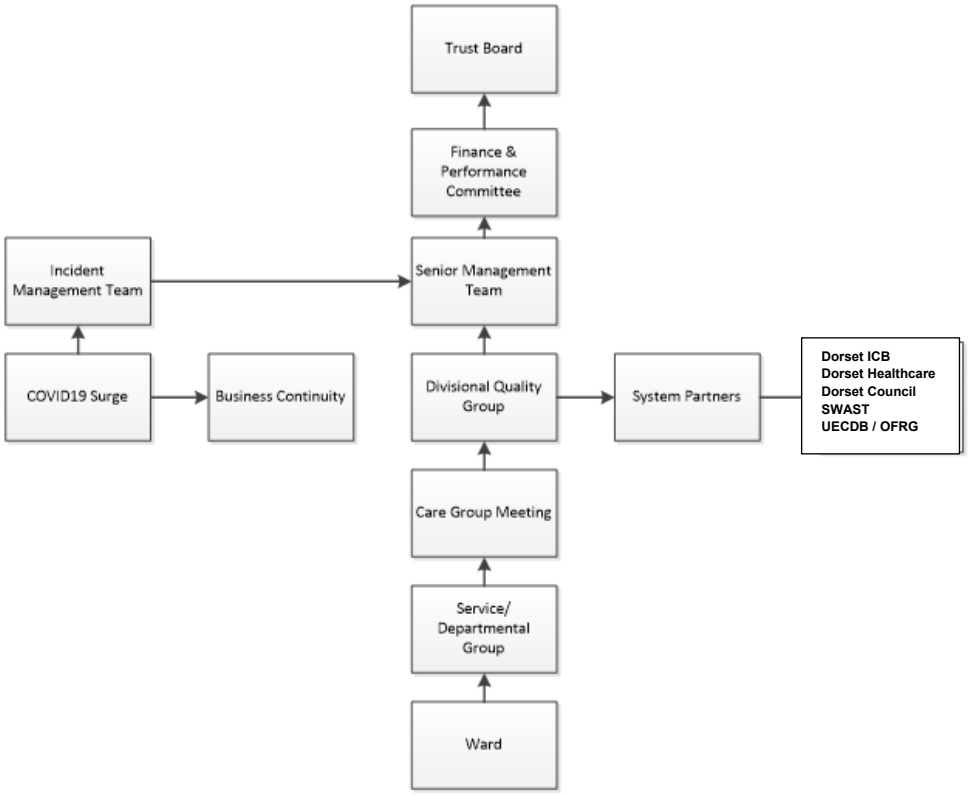
Action	Approach
1. Refreshed demand and capacity analysis	• Build on our BCF planning for intermediate care • Assessing surge capacity requirements in acute and community (health, social care and VCSE) • Impact of flow improvement (LOS reduction)
2. Targeted improvement in key areas *- Communication* *- 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 	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.

Dorset ICS Winter Plan 2024/25

Dorset ICS

Version: 01 Date: 00/00/00 Author: Name

Contents

Executive Summary

Overview

The Dorset ICS Winter Plan builds upon insights from last winter to establish system objectives, set targets, and map out performance trajectories. It seeks to proactively identify risks and mitigations. This plan is a result of close collaboration with teams across our hospitals, community and primary care providers, and local authorities.
We focus on:

- Admission and Attendance Avoidance
- 7-day system flow
- Intermediate care (D2A) flow
- Transfer Of Care Hubs
- Ability to flex capacity
- System OPEL 3 & 4 Actions
- Shared internal & external escalation processes
- Ability to share risk across partners
- NCTR Recovery Plan

2024/25 Workstreams

We will focus on delivering measurable improvement in three key areas:

1. **Reducing non-elective acute admissions** by focusing on:
   - Increasing access to same day emergency treatment and support and improving utilisation of community admission prevention offers.
   - Developing a care co-ordination hub with improved links from 111 to services that can support people in the community rather than in hospital.
   - Improving our response to mental health presentations at A&E departments so that people do not wait too long for the support they need.
   - Targeting interventions at those at risk of presenting to hospital most frequently and who could be supported at home.

2. **Reducing acute and community bed length of stay** by focusing on**:**
   - Earlier discharge planning in acute and community settings with effective escalation and response to areas of risk and delay.
   - Streamlined decision-making with reduced hand-offs and decision-points (linked to Transfer of Care hub redesign and scaling of trusted assessment).
   - Right-sizing of intermediate care and discharge to assess capacity in bedded and home care to meet acute and community demand (linked to intermediate care redesign).

3. **Increasing the volume of weekly discharge and improving flow over 7 days** by focusing on:
   - Increasing the number of people discharged in the mornings and at weekends to reduce delays in hospital.
   - Developing a consistent discharge pipeline that meets expected target activity levels and makes the best use of available community capacity.

Improving system flow across these areas will contribute to lower bed occupancy which in turn will enable better flow through ED (support delivery of the 4hr ED safety standard) and reduce the risk of ambulance handover delays.

We will seek to maintain our strong performance in Cat 2 ambulance response as part of plan delivery.

Our Dorset

What are our risks and challenges?

Demand
Unanticipated surges in demand across services.

Infection
Infection prevalence and its impact on capacity and workforce.

EPRR
Impact of industrial and/or collective action.
Winter weather and other incidents.

Finance
Financial sustainability is an informing factor in decision-making.

Surge Capacity
Over reliance on acutes escalation capacity; need to shift to out of hospital.

Ways of Working
Ability to change ways of working to optimise flow.

Actions
Creating headspace to facilitate decision making, focus on actions and balance risk.

Public
Ability to influence public behaviour to support prevention and attendance/admission avoidance.

Our Dorset

Risks & Mitigations 1 of 3

Risk Description	Organisation	Mitigation / Controls	Risk RAG	Potential impact
Reduction of NCTR is not meeting trajectory.	ICS	Increased focus via UEC Weekly Improvement Group with targeted actions outlined on slide 29.		Increase in the number of patients waiting in acute beds, not best suited to their needs. Potential to hinder flow across acutes.
Industrial Action (IA)/Collective Action	ICS	IA planning process is well established and has been extended to cover Collective Action (CA) in Primary Care		Action taken in one part of ICS can have wider impact on the delivery of healthcare across the system. Further information on IA & CA is included within the EPRR slides (41-44).
Lack of workforce over peak periods due to holidays and sickness.	All providers	Each organisation is responsible for mitigating their workforce issues, Assurance has been given that bank/agency and overtime will be utilised if required. Each organisation has recruitment plans or campaigns in place for staff vacancies		Potential to reduce organisational workforce and impact delivery of services. Negatively impact on staff morale and physical and mental wellbeing.
Handover delays causing pressure on SWAST availability to respond.	Acutes and SWAST	'Updated handover SOP' across all 3 acutes in production. SWAST Escalation plan, Dorset Surge & Escalation plan, SCC Ambulance escalation SOP, Acute action cards.		Potential to reduce SWAST resources available for response. Increased response times and ability to achieve Cat2 response target. Greater risk being held in the community.
Reliance on SWAST to provide cohorting/corridor care.	Acutes and SWAST	UHD are rreviewing corridor process in place with regards to reflecting corridor care and impact on ambulance crews in escalation processes. Action plan being drafted to support by Snr Matron ED.		Increased pressure on SWAST/ED staffing levels. Reduced numbers of SWAST crews available to respond to 999 calls increasing risk held in the community. Increased response times and ability to achieve Cat2 response target.

Risks & Mitigations 2 of 3

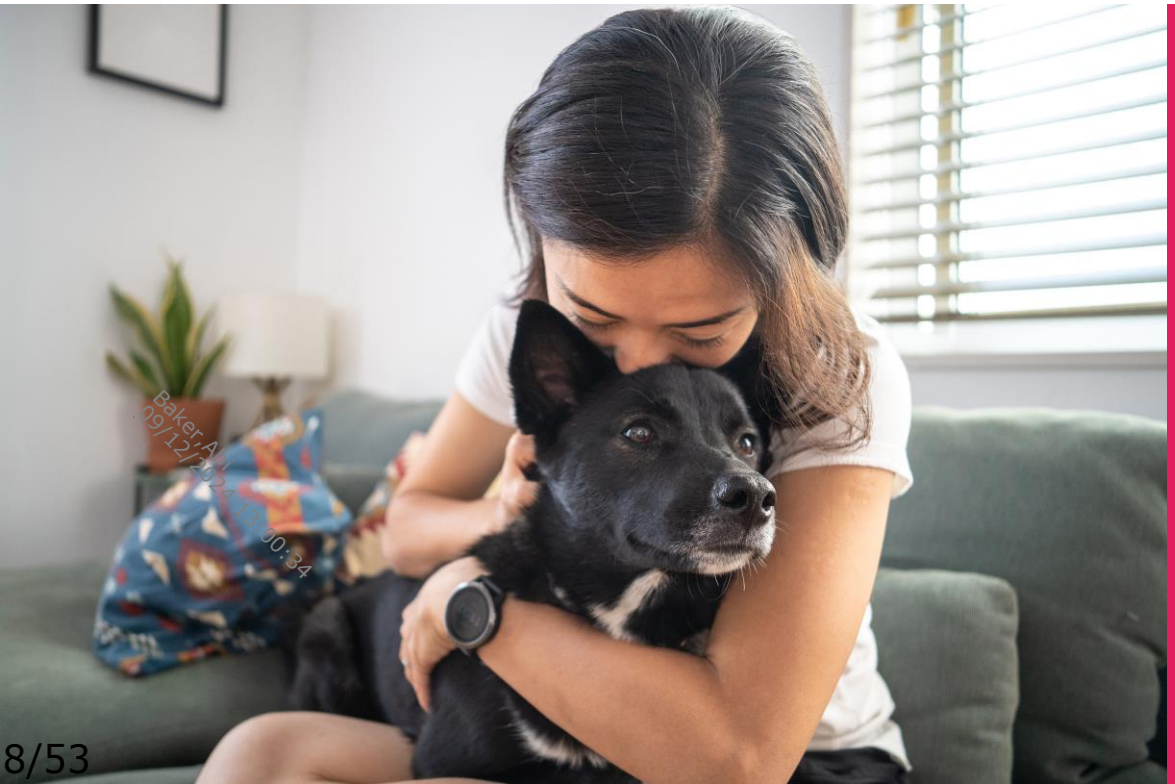
Risk Description	Organisation	Mitigation / Controls	Risk RAG	Potential impact
SWAST under establishment going into the winter period and under resourced particularly over weekends	SWAST	Working towards increasing establishment for Lead Clinicians and Non-Lead Clinicians. Trust recruitment and retention plan now in progress.		Potential to reduce SWAST resources available for response. Increased response times. Greater risk being held in the community.
SWAST escalating to REAP Black (or implement EOC 58 Level 3).	SWAST	Localised mitigation/control is limited as escalation is linked to South West region ambulance pressures.		Risk of impact to other services as SWAST redirect Cat 3 and Cat 4 calls. Potential to increase activity at other front door services including (ED/UTCs/111/Primary Care).
Insufficient number of beds to meet demand within acute trusts	Acutes	Operating virtual wards at 90% utilisation (currently 73%) Reducing NCTR to agreed operating plan levels Increasing utilisation to 95% occupancy (increases risk of handover delays)		If acute services are under pressure for occupancy, they may bed into SDEC which impacts ability for SDEC Activity to operate effectively.
Surge in attendances to ED	Acutes	Themes in clinical presentation to be identified at TRG to inform appropriate communications. Staffing assurance has been provided from acutes.		Potential to increase operational pressures in ED to such an extent that the 4hour safety standard performance deteriorates.
Acute core bed capacity reached/exceeded.	Acutes	UHD - escalation of capacity into beds allocated for elective activity. Ensure increased utilisation of Virtual ward capacity.		Reduction in beds allocated for elective activity will have a significant operational impact.

Risks & Mitigations 3 of 3

Risk Description	Organisation	Mitigation / Controls	Risk RAG	Potential impact
Ongoing GP CA redirecting demand to other services	General Practice	PCNs are following guidelines issued by BMA regarding number of patients seen. ICB Primary Care monitoring levels of CA being taken.		Potential to increase presentations at other front door services.
Workforce: Recruitment & training needs ongoing within IUCS.	DHC	The service will continuously monitor performance and where operationally practical adjust capacity requirements within the agreed funded establishment. The service continues to review escalation processes. The service continues to recruit into vacancies with courses planned to ensure service operates at establishment levels. Risks regarding staffing will be mitigated through advertising vacancies to bank, overtime and consideration of agency support.		Potential to reduce performance and increase call abandonment levels due to insufficient staffing. Potential to increase SWAST referrals if staff are unable to validate due to capacity.
Mental Health acute bed capacity consistently over 98%	DHC	Assessment of acuity levels will control the movement of staff to appropriate wards/areas.		Reduced flow into MH beds will increase the numbers of patients and the time waiting in acute beds inappropriately.

Approach to Winter

Section 1



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Approach to Winter 24/25

Assessment → **Prioritisation** → **Delivery**

- Review last winter.
- Progress to date.
- Forward look – what are we anticipating?

- Joint approach with partners.
- Gap analysis - identification of risks & opportunities.
- Targeted investment of resources.

- Oversight of whole system.
- Early and effective escalation.
- Shared approach to managing risk.

Our Dorset

Operational Plan 24/25 Summary

System Position

As we move forward into 2024/25 we will continue to recover services in a way which seeks to address the unmet need and backlogs in an equitable way; through embedding health inequalities and improving outcomes within all of our work programmes. We will do this whilst ensuring we focus on financial sustainability.

We will continue to work to deliver:

- The agreed financial plan deficit of £20m.

Key Challenges

We have a number of challenges that we will work together during 2024/25 to resolve these include:

- Striking the balance between system resilience, service recovery, versus people recovery. We continue to see high and complex demand, workforce challenges and ongoing industrial action
- Improvements in our financial position both in 2024/25 and future years will require an increased focus on transformation and productivity. We recognise that we may have to make some difficult decision during the year to ensure services continue to be value for money for our population.
- We will continue to review our progress, understanding what we can do to improve our capacity to support recovery, minimising risks for patients whilst maintaining parity between any services, be it primary, community, or secondary care.

Our Dorset

Key System Objectives

To keep our population safe and well at home over winter

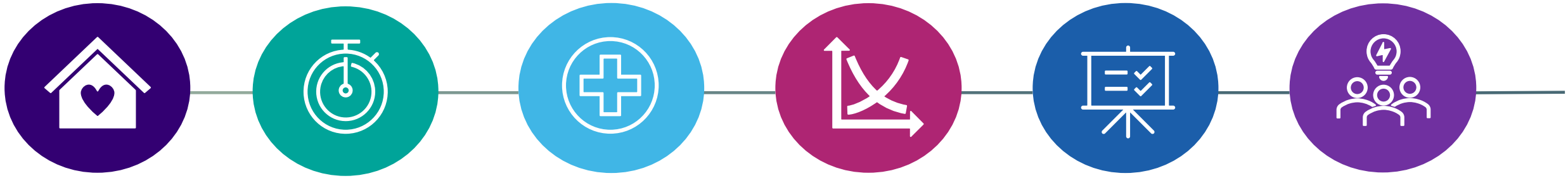
To maintain timely access to care and support when it is needed

To protect the health and wellbeing of our teams

To utilise resilience plans at times of peak demand and escalating pressures

To enable progression of our UEC and elective recovery objectives

Dorset ICS to manage and share risk more effectively as a system



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System focus to achieve objectives

Areas of Focus

- Admission and Attendance Avoidance
- 7-day system flow
- Intermediate care (D2A) flow
- Transfer Of Care Hubs
- Ability to flex capacity
- System OPEL 3 & 4 Actions
- Shared internal & external escalation processes
- Ability to share risk across partners
- NCTR Recovery Plan

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APPROACH DEVELOPED BY THE SEASONAL PLANNING & DELIVERY GROUP WITH PARTICIPATION FROM ALL KEY PARTNERS AND FUNCTIONS

Our Dorset

Our ICS Approach

The Dorset ICS winter plan should be read in conjunction with the provider plans outlined on the final page of this document

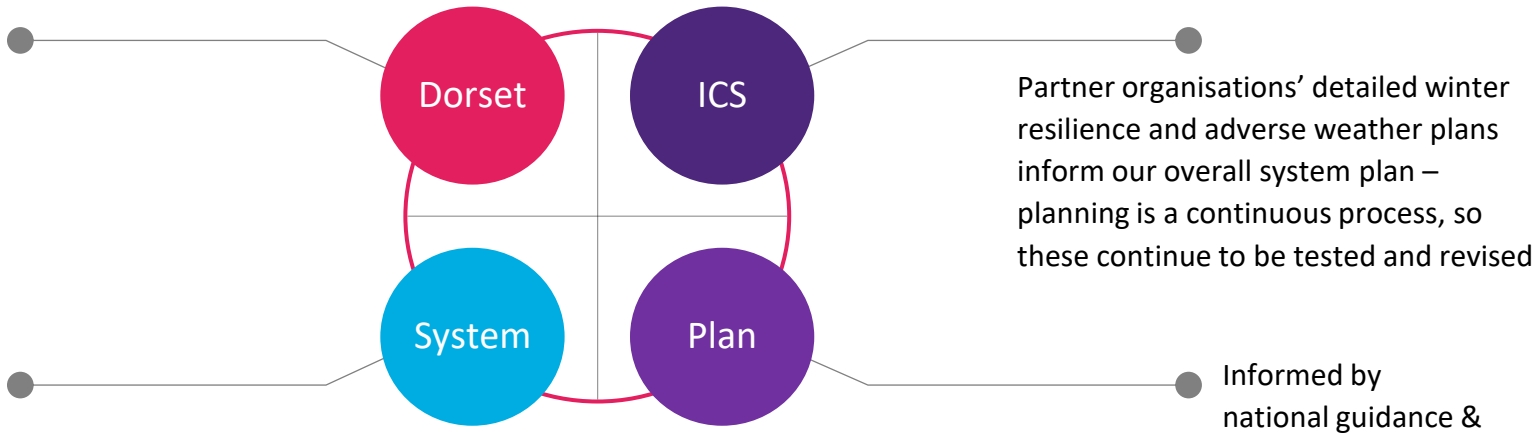
Winter Operating Model

Dorset Seasonal Planning & Delivery Group (SPDG)

- Named operational leads (virtual team) from each partner agency
- Seasonal planning & Delivery Group meets fortnightly

Local Escalation Plans (& close liaison with NHSE regional team).

- Dorset ICS Surge & Escalation Plan and Action Cards
- Dorset OPEL Framework (metrics and actions)



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National UEC Recovery Plan Targets & Trajectories

Metric	Target (Mar'25)	Baseline Aug 2024	Trajectory (Q3) (Nov)
Emergency Department 4hr Standard (System)	>78%	78.1%	76.1%
Maintain Category 2 Ambulance Response Times (Av. Minutes)	31.7	28.7	32.2
Ambulance Handover Delays (Av. Minutes)	17 mins	28mins 18 sec	20 Mins
Virtual Ward Capacity (number of beds)	250	247	250
Virtual Ward Occupancy %	80%	80%	80%
UCR Response Times (% responded to within 2 hours)	1,500	1,500	1,500
UCR Referrals (number received)	70%	70%	70%
NCTR (number, System)	138	197	159
Bed Occupancy % (System)	94%	92%	93%
21-day LOS (number)	229	245	222
SDEC activity (number)	2223	2219	2446
Community bed occupancy %	91.79%	89.86%	89.86%

Our Dorset

Key OKRs

OKR stands for Objectives and Key Results, a goal-setting framework used to define and track objectives and their outcomes.

In addition to the recovery plan targets outlined on slide 11, the NHS Dorset UEC have OKRs in the following:

Key result	Target Date	Metric/ Measurement	Position at 30/09/2024	Target for end Q3	Position at 11/11/2024
Maintain zero tolerance to opening unfunded acute escalation beds	31/12/2024	Number of unfunded acute escalation beds opened in last 7 days	35	0	**16**
Reduce the number of delays in exiting community beds to below 50	31/12/2024	Number of delays in community beds	87	<50	**83**
Increase volume of acute discharges on a Sunday across all pathways to 100 / week	31/12/2024	Total number of discharges from each acute trust (all pathways)	Ave for Q2 = 48	100	**91**
Increasing proportion of P1 and P2 discharged within 5 days to more than 60%	31/12/2024	% of discharges from all sites discharged within 5 days	Ave for Q2 = 51%	60%	**53%**
Increase utilisation of virtual wards to at least 90%	31/12/2024	% utilisation of 207 virtual wards	73%	90%	**75%**
Increase proportion of 111 calls given the top service selection returned by the Directory of Services to at least 80%.	31/12/2024	% of callers given the top service selection	71%	80%	**TBC (DHC data feed error to be resolved)**

Our Dorset

UEC Approach

01

Refreshed demand and capacity analysis

- Build on BCF planning for intermediate care.
- Incorporate outcomes from the Newton Diagnostic.
- Further develop TOC hubs.
- Assess surge capacity/requirements in acutes and community (health, social care and VCSE) including impact of flow improvement (LOS reduction).

02

Targeted improvement in key areas

- Mental Health flow.
- Attendance and admission prevention.
- Primary Care.
- High Impact priority areas (SDEC, UCR, Virtual Wards).
- Acute and intermediate care flow (early discharge planning and streamlined transfer of care).
- NCTR

03

Strengthened system resilience response

- Enhanced System Co-ordination Centre response.
- Improved localised OPEL actions.
- Refreshed escalation processes.
- Co-ordination with EPRR including for GP Collective Action
- IPC

04

Planning ahead for next year

- Integrated neighbourhood teams (NAPC).
- Integrated place-based intermediate care (Home First).
- UTC/MIU Review.

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Section 2

Learning from last winter

Identifying the successes, barriers, what the data reflected, and the feedback was from those involved at an operational level via winter debriefing.

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Appraising last winter: The Headlines

- Highest ED and 111 demand seen in December.
- 8,431 Hours lost to ambulance handover delays.
- Acute bed occupancy was consistently above 92% ambition, highest occupancy level (99.15%) reached in December.
- Adult inpatient mental health bed occupancy was continuously high, averaging more than 99%.
- 84% of discharges were P0 (8% P1, 5% P2, 3% P3) against a 90% target.
- Primary care appointments peaked in early November 2023.
- All three acutes showed continued reduced pressure in the lead up to Christmas.
- System OPEL score averaged 3 (Nov-Feb).
- Poole had most days at OPEL 4.

Indicator	Average (Nov-Feb)	Peak
111 Performance	91%	92.6% (Nov 2023)
Cat 2 response time	28.2mins	71.4mins (Dec 2023)
ED type 1 demand	17,361 per month	18,000 (Jan 2024)
Escalation beds open	86	122 (Jan 2024)
% Beds NCTR	21% (System)	33.6% (Poole Nov 2023)

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Appraising last winter: Our Learning

1

What worked well?

- Virtual Wards
- Onsite presence of VCSE
- HALO provision
- System communications
- Positive system engagement
- Improvement in focus at TRG on operations and discharge & flow
- Commissioning of double up rapid response service supporting people on D2A from hospital.
- Development of TOC hubs.

2

What was challenging?

- Lack of impactful OPEL actions
- Impact of elective cancellations
- Reliance on ambulance cohorting
- Ambulance handover delays
- Industrial Action
- Mental Health pressures
- ED Demand
- Use of escalation beds
- Bed occupancy
- NCTR numbers

Our Dorset

Appraising last winter: The Recommendations

17 recommendations based around 4 themes:

Data

Recommendations set the future trajectory of the TOC hubs and inform discharge processes

Planning

Recommendations will deliver a suite of targeted actions/surge plans across all providers to inform TRG (and SRG) actions and escalations for Winter 24/25. They will improve the integration of wider ICS partners into seasonal planning

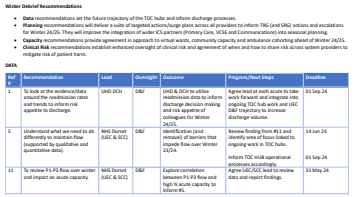
Capacity

Recommendations provide agreement in approach to virtual wards, community capacity and ambulance cohorting ahead of Winter 24/25

Clinical Risk

Recommendations establish enhanced oversight of clinical risk and agreement of when and how to share risk across system providers to mitigate risk of patient harm

Winter Debrief Recommendations



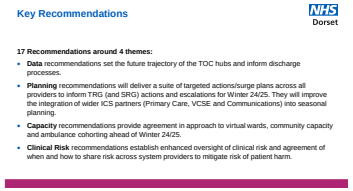
Winter Debrief Recommendations

- **Data** recommendations set the future trajectory of the TOC hubs and inform discharge processes.
- **Planning** recommendations will deliver a suite of targeted actions/surge plans across all providers to inform TRG (and SRG) actions and escalations for Winter 24/25. They will improve the integration of wider ICS partners (Primary Care, VCSE and Communications) into seasonal planning.
- **Capacity** recommendations provide agreement in approach to virtual wards, community capacity and ambulance cohorting ahead of Winter 24/25.
- **Clinical Risk** recommendations establish enhanced oversight of clinical risk and agreement of when and how to share risk across system providers to mitigate risk of patient harm.

Data

Ref #	Recommendation	Lead	Oversight	Outcome	Progress/Next Steps	Deadline
1	To look at the evidence/data around the readmission rates and trends to inform risk appetite to discharge.	UHD DCH	D&F	UHD & DCH to utilise readmission data to inform discharge decision making and risk appetite of colleagues for Winter 24/25.	Agree lead at each acute to take work forward and integrate into ongoing TOC hub work and UEC D&F trajectory to increase discharge volume.	01 Sep 24
5	Understand what we need to do differently to maintain flow (supported by qualitative and quantitative data).	NHS Dorset (UEC & SCC)	D&F	Identification (and removal) of barriers that impede flow over Winter 23/24.	Review finding from #11 and identify area of focus linked to ongoing work in TOC hubs. Inform TOC HUB operational processes accordingly.	14 Jun 24 01 Sep 24
11	To review P1-P3 flow over winter and impact on acute capacity.	NHS Dorset (UEC & SCC)	D&F	Explore correlation between P1-P3 flow and high % acute capacity to inform #5.	Agree UEC/SCC lead to review data and report findings.	31 May 24

Debrief Recommendations updates



Key Recommendations

NHS Dorset

17 Recommendations around 4 themes:

- **Data** recommendations set the future trajectory of the TOC hubs and inform discharge processes.
- **Planning** recommendations will deliver a suite of targeted actions/surge plans across all providers to inform TRG (and SRG) actions and escalations for Winter 24/25. They will improve the integration of wider ICS partners (Primary Care, VCSE and Communications) into seasonal planning.
- **Capacity** recommendations provide agreement in approach to virtual wards, community capacity and ambulance cohorting ahead of Winter 24/25.
- **Clinical Risk** recommendations establish enhanced oversight of clinical risk and agreement of when and how to share risk across system providers to mitigate risk of patient harm.

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Section 3

Current Performance Against Operational and Local Plans

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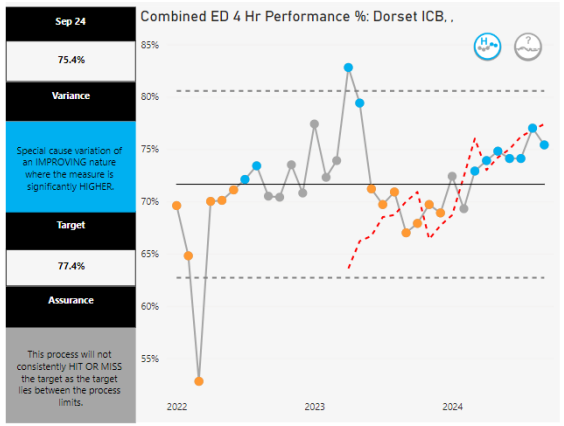
System Performance against Trajectory/Target

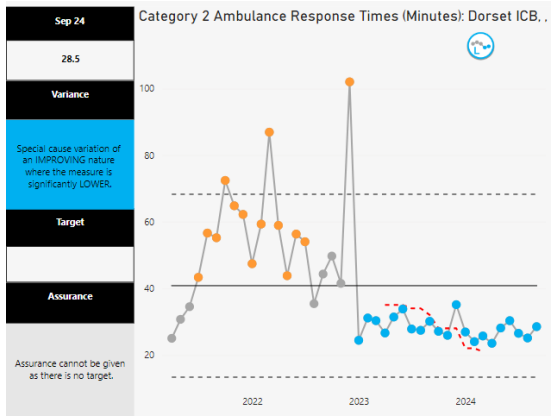
Target March 25: >78% of patients waiting less than 4 hours to be seen

Performance against trajectory: The system performance averages 75.4% and is currently 2% below trajectory.



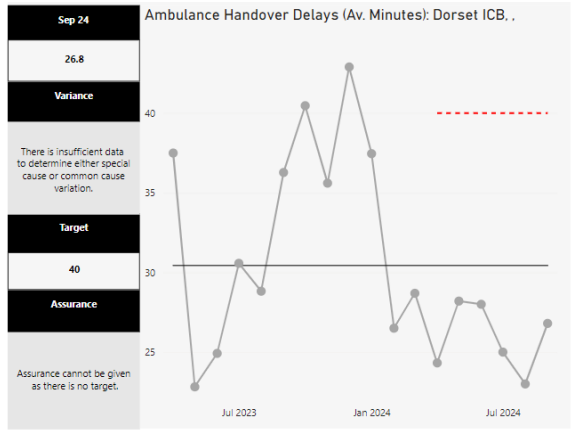
Target March 25 : Category 2 ambulance calls for SWAST <31.7mins

Performance: The system performance averages 28.5 mins. This is within the target for year end by 3.2 minutes.



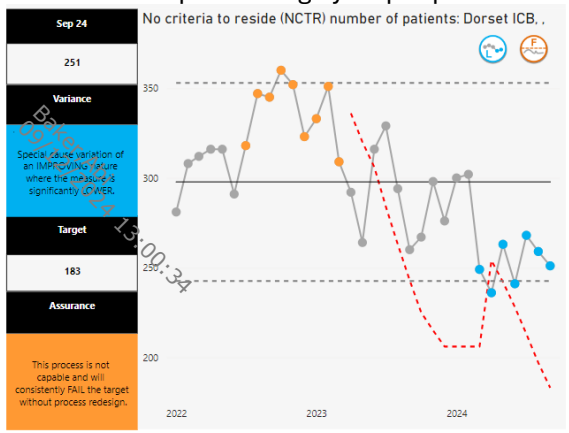
Target March 25 : Reduce average handover time to below 17 minutes

Performance: The system performance in Sep averages 26.8 minutes. This is 9.8 mins above the March 25 target.



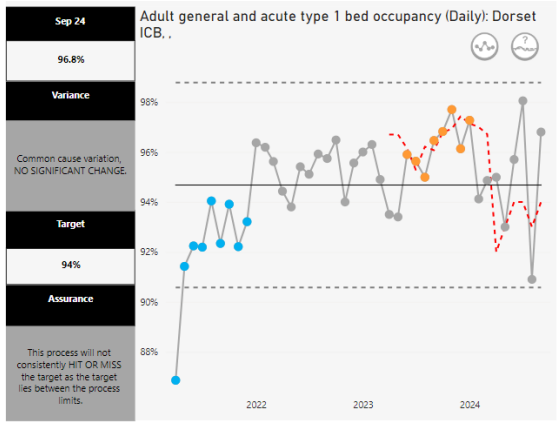
Reduce the number of patients with no criteria to reside to less than 138 across the system

Performance against trajectory: The system is currently underperforming by 68 people.



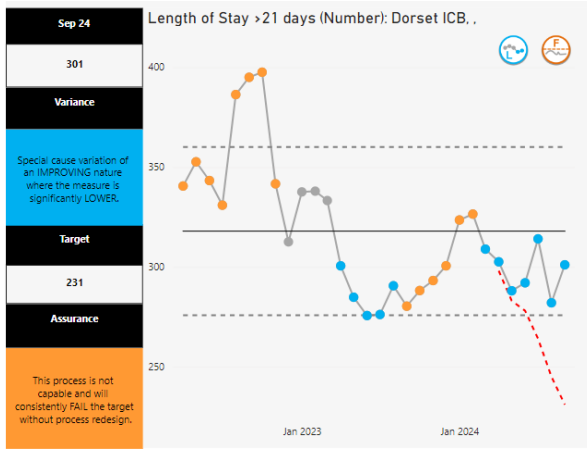
Reduce the percentage of general and acute bed occupancy to below 94%

Performance against trajectory: The system performance for September was 96.8%. 2.8% above the target.



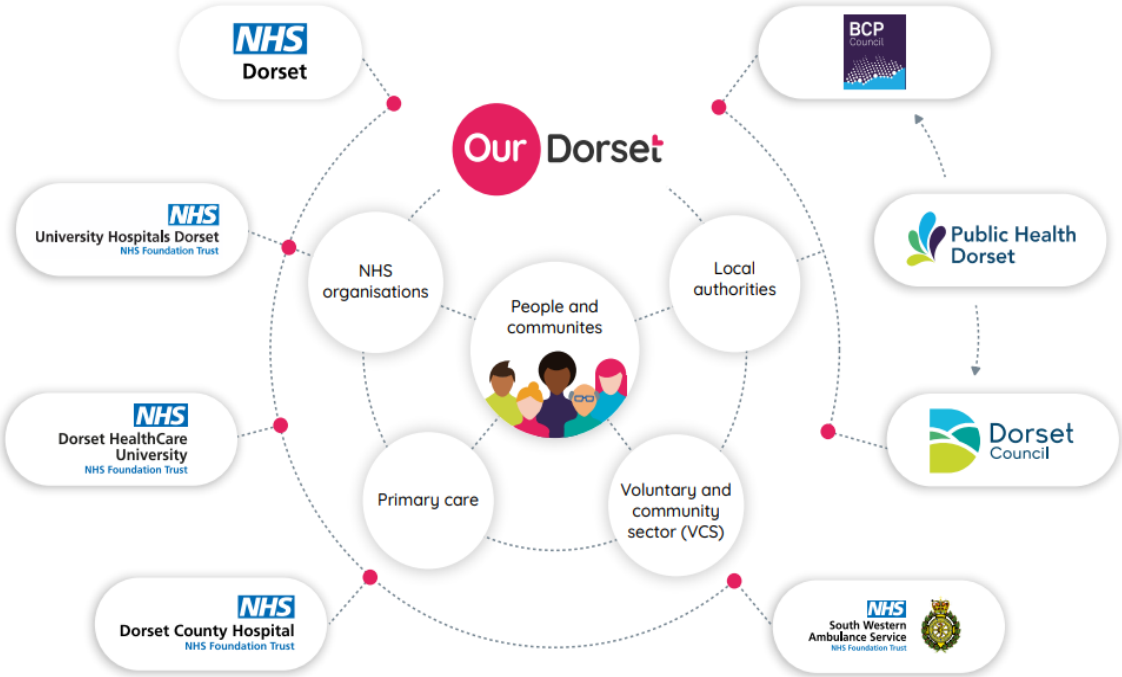
Reduce number of stays longer than 21 days

Performance against trajectory: The system is currently 70 stays below the trajectory.



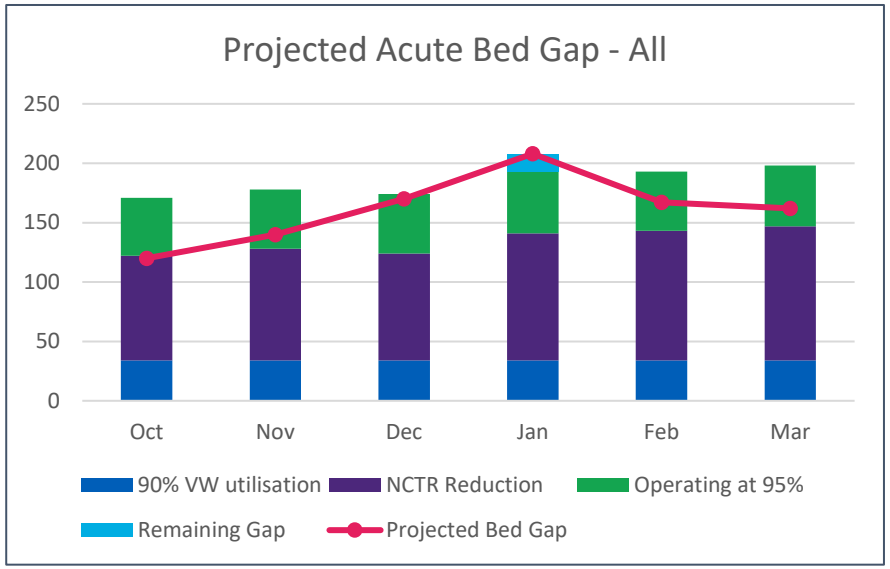
Dorset ICS Financial Position

- Dorset ICS has a £20m deficit plan for 2024/25 with substantial financial risks to achieving that position at year end. As at the end of July the system is £11.2m off plan and although it is forecast to recover this there are significant cost pressures to address through the remainder of the financial year. The system plans reflected likely winter pressures, and we have allocated all available funding, meaning there is no further flexibility for investment over winter.
- National and regional messaging remains consistent – systems should not expect further funding for winter pressures.

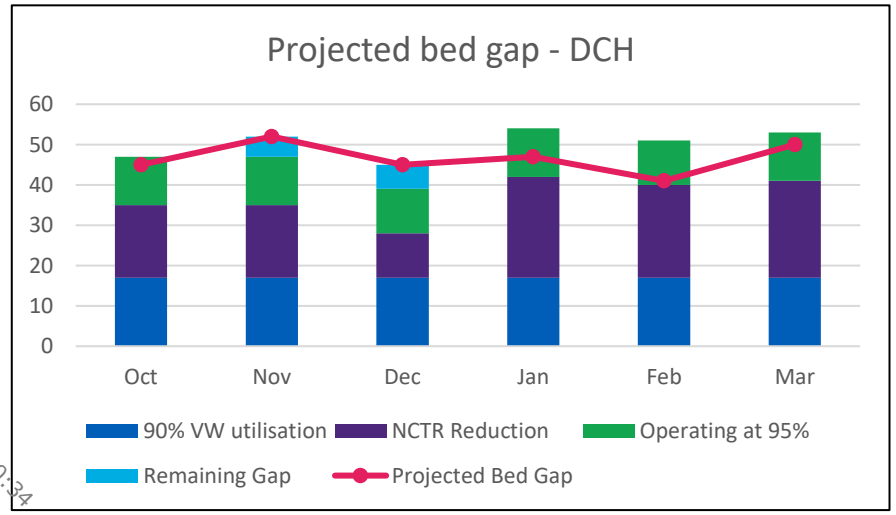


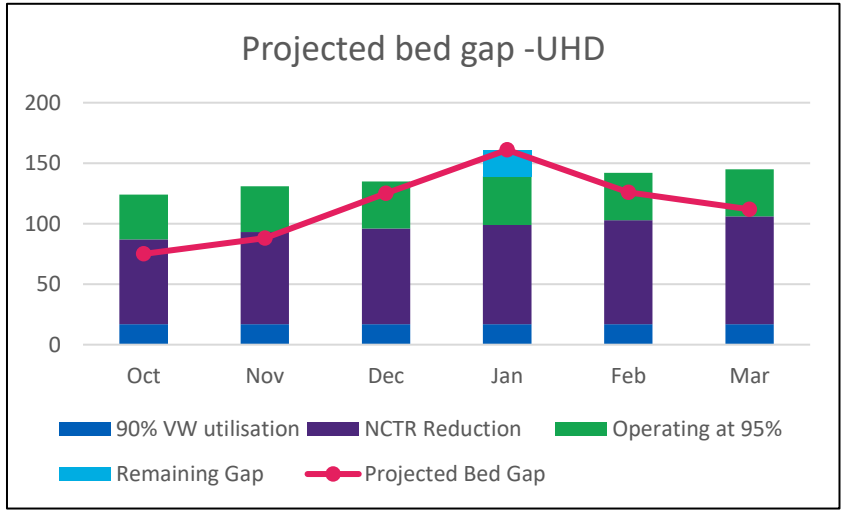
ICS Capacity

Acute Bed Gap Modelling



- Opening bed gap based on 92% occupancy and continuation of current rates of UEC and elective activity
- Peak system bed gap in January 2024 (208 beds)
- 3 key areas of mitigation
  1. Operating virtual wards at 90% utilisation (currently 73%)
  2. Reducing NCTR to agreed operating plan levels
  3. Increasing utilisation to 95% occupancy (increases risk of handover delays)
- There is a remaining gap of 5 beds in January 2025
  - UHD have a remaining gap of 22 beds in January 2025
  - DCH have a remaining gaps of 5 and 6 beds in Nov and Dec 2024
- Mitigations do not current include any additional internal actions being taken by acute trusts nor broader system interventions to increase admission avoidance





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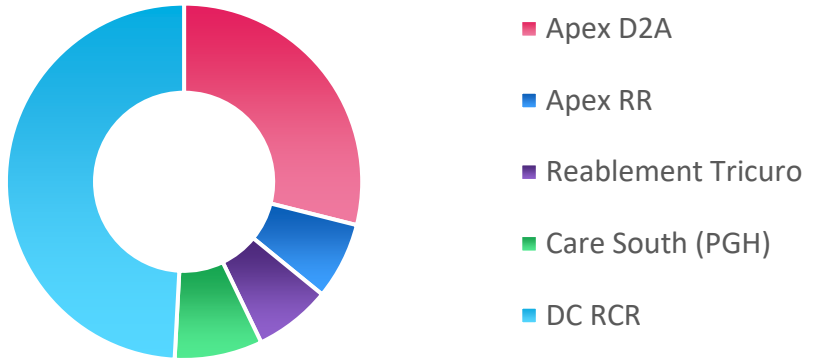
Core Intermediate Care Capacity

Pathway 1 Capacity	Hours
Apex D2A	1450
Apex RR	350
Reablement Tricuro	350
Care South (PGH)	400
DC RCR	2465
Reablement Care Dorset	1865
Interim	340 (approx)

This pathway applies to patients who are medically fit to leave the hospital and can return to their own home but require some level of additional support to continue their recovery. Support could include short-term reablement services, domiciliary care (such as personal care and help with daily living activities), community nursing, or therapy services.

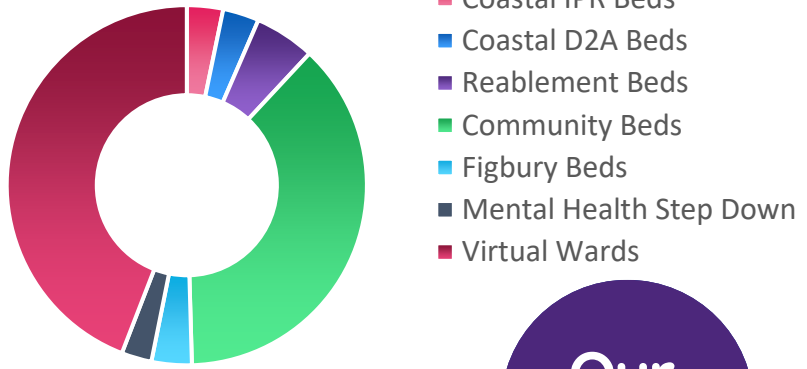
Pathway 1 Capacity



Pathway 2 Capacity	Hours
Virtual Wards/Remote monitoring	244
Mental Health Step down	15
Coastal IPR	18
Coastal D2A beds	18
Reablement beds	30
Community Hospitals (8 sites)	208
Figbury Beds (Step-up/down)	20

This pathway is for patients who are unable to return directly to their own home due to more complex care needs that require short-term rehabilitation or recovery in a 24-hour bed-based setting. Such settings could include community hospitals, step-down care units, or residential care facilities that provide the necessary support until the patient is well enough to return home.

Pathway 2 Capacity



Our Dorset

BCF Demand and Capacity Modelling – awaiting confirmation

	BCP	DC	Response
Pathway 0	• Demand and capacity largely aligned • 79% activity (141 referrals per month) focused on step-up response	• Demand and capacity largely aligned • 70% activity (358 referrals per month) focused on step-up response	• To grow and evolve offer with VCSE partners as alternative to or in conjunction with P1 support
Pathway 1	• More capacity than demand but fragmented offers means that people can be seen by more than one service	• Overall P1 capacity largely aligned but disparity between reablement and rehabilitation offer • Compounded by geographic disparities	• Development of integrated operating model intermediate care that brings P1 services together at place level
Pathway 2	• More capacity than demand but reflective of creating headroom needed for D2A roll-out and management of backlog	• More capacity than demand but reflective of creating headroom needed for D2A roll-out and management of backlog	• Retain capacity in 2023/24 in order to embed D2A approach and integrate P1 offer • Use capacity in more agile and recovery-focused way • Seek to reduce commitment in 2024/2025
Pathway 3	• 4% of total intermediate care demand • All brokered care – longer wait time	• 4% of total intermediate care demand • All brokered care – longer wait time	• Expand core intermediate care offer to be able to support more complex needs

Whilst there is broad alignment in our current demand and capacity profiles, the reality is that we continue to hold a large backlog of people waiting for step-down intermediate care. This is indicative of improvement that we need to make to our process and arrangements for managing capacity that enables us to optimise our utilisation and flow through these spaces.

This has been a key area of focus in our 2024/25 operating plan delivery and where we are seeking to continue to build momentum and improvement over the winter period

Our Dorset

Wider system capacity to support same day needs

Capacity	Availability Weekday	Availability Weekend
General Practice		
Dorset General Practise (86)	09:00 – 20:00	09:00-17:00 (Saturday)
MIU		
Bridport	09:00-18:00	09:00-18:00
Swanage	09:00-18:00	09:00-18:00
Westminster Shaftesbury	09:00-18:00	10:00-16:00
Yeatman Sherborne	09:00-18:00 (Closed Friday)	10:00-16:00 (Closed Saturday)
Victoria Wimborne	08:00-20:00	08:00-20:00
Blandford	09:00-17:00 (Mon & Wed ONLY)	Closed
UTC		
Weymouth	08:00-20:00	08:00-20:00
Poole	08:00-20:00	08:00-20:00
Bournemouth	08:00-20:00	08:00-20:00
SDEC *As stated on DoS		
Dorset County Hospital (Acute Medical)	08:00-20:00	Open
UHD Bournemouth (Acute Medical)	08:00-20:00	Open
UHD Poole (Acute Medical)	08:00-20:00	Open
Pharmacy		
Dorset Pharmacies (142)	Varying times (08.30-23.00)	Varying times (08.30-23.00)

Section 4

Targeted Improvements for Winter

Health, care & wellbeing

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Winter Plan Deliverables

Key to NCTR reduction

1. Preventing ill-health and proactive care	2. Same day urgent response and ED flow	3. Transfers of care: Acute inpatient flow and discharges	4. Intermediate Care capacity and flow	5. Mental health capacity and flow	6. Managing risk – escalation and response
a. Vaccination Programme b. Targeted work with high-risk groups c. Communication and public messaging	a. SDEC capacity and utilisation b. Virtual ward capacity and utilisation c. Increase pathways from Care Co d. Improved 111 signposting and access e. SWAST winter response f. New mental health front door model g. Maximise Pharmacy First h. Maximise use of Immedicare support in care homes	a. Implementing on-site TOC over 7 days b. Streamlined decision-making on core discharges c. EDDs and early discharge planning (complex discharge focus) d. Increase P0 discharges over 7 days e. VCSE input in supporting discharge f. Targeted focus on delays, discharges and LOS reduction	a. Early discharge planning b. Targeted focus on delays, discharges and LOS reduction c. Proactive capacity management a. Pathway 1 b. Pathway 2 c. Mental health and OOA beds d. Agree approach to management of non-core and hard-to-place discharges e. Processes around joint assessments for long-term care		a. Discharge escalation process b. System resilience process (via SCC) c. Agreed process for managing surge d. Dynamic risk assessment

Our Dorset

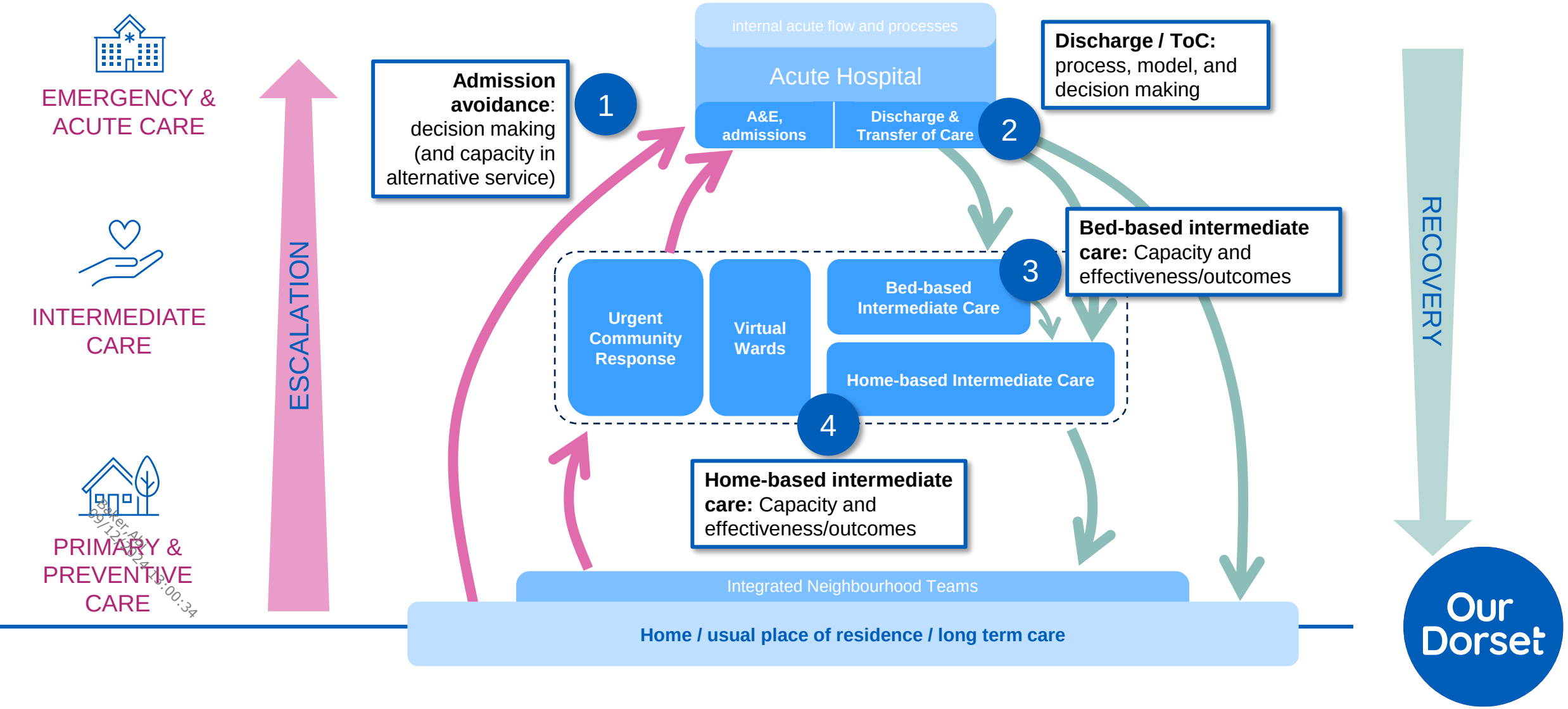
High impact interventions

Submitted to NHSE 16th September 2024

Intervention	Summary	Self-assessment score
Same Day Emergency Care.	Reducing variation in SDEC provision by operating a variety of SDEC services for at least 12 hours per day, 7 days per week.	5
Frailty	Reducing variation in acute frailty service provision. Improving recognition of cases that could benefit from specific frailty services and ensuring referrals to avoid admission.	7
Inpatient flow and length of stay (acute):	Reducing variation in inpatient care and length of stay for key pathways/conditions/cohorts by implementing in-hospital efficiencies and bringing forward discharge processes for pathway 0 patients.	DCH 6 UHD 0
Community bed productivity and flow:	Reducing variation in inpatient care and length of stay, including mental health, by implementing in-hospital efficiencies and bringing forward discharge processes.	3
Care Transfer Hubs:	Implementing a standard operating procedure and minimum standards for care transfer hubs to reduce variation and maximise access to community rehabilitation and prevent re-admission to a hospital bed.	6
Intermediate care demand and capacity	Supporting the operationalisation of ongoing demand and capacity planning, including through improved use of data to improve access to and quality of intermediate care including community rehab	6
Virtual wards	Standardising and improving care across all virtual ward services to improve the level of care to prevent admission to hospital and improve discharge.	6
Urgent Community Response	Increasing volume and consistency of referrals to improve patient care, ease pressure on ambulance services, and avoid admission.	5
Single point of access	Driving standardisation of urgent integrated care coordination which will facilitate whole system management of patients into the right care setting, with the right clinician or team, at the right time.	5
Acute Respiratory Infection Hubs:	Support consistent roll out of services, prioritising acute respiratory infection, to provide same day urgent assessment with the benefit of releasing capacity in ED and general practice to support system pressures.	0

Our Dorset

Newton - UEC Transformation Programme Scope – Focus Areas



Priority 1: Reducing non-elective acute admissions

Areas of impact: More people supported at home or in non-acute settings; Reduced pressure on EDs and primary care

	Objective	Key actions	Baseline	Target
1	**Increasing access to same day emergency treatment and support and improving how well our community admission prevention offers are used**	• Deliver consistent 7-day SDEC offer in all acute sites • A system level plan is in place to develop joined up working to enable a standardised approach to the Dorset wide SDEC services to enable the application of the National SDEC criteria		NEL admissions: UHD: Reduce by 45 per month (1% reduction) DCH: Reduce by 60 per month (3% reduction)
2	**Developing a care co-ordination hub with improved links from 111 to services that can support people in the community rather than in hospital**	• Reduction in people requiring conveyance to hospital through more direct and faster access to appropriate community support. Initial scoping meeting completed with SWAST and DHC.		Operational care co-ordination hub.
3	**Improving our response to mental health presentations at A&E departments so that people do not wait too long for the support they need**	• Pilot of band 6 MH practitioners to triage in emergency departments		Reduce TCIs to 2 or less with a wait for bed <6hrs.Reduce DToCs to 10 or less.
4	**Targeting interventions at those at risk of presenting to hospital most frequently and who could be supported at home**	• Targeted work to provide alternatives for high presenting ACS conditions		
5	**Redesign of urgent care 'front-end offer' to include IUCS service redesign, expansion of booking options for 111, and progressing UTC/MIU reconfiguration**	• Focus on standardising and implementing changes to UTCs aligned to the CSR and NHP. • Review the MIU model as part of the Integrated Neighborhood Team Programme.		

Priority 1: Reducing non-elective acute admissions

Areas of impact: More people supported at home or in non-acute settings; Reduced pressure on EDs and primary care

	Objective	Key actions	Baseline	Target
6	**To maximise uptake of COVID and flu vaccination programme. To include RSV and MMR for eligible cohorts**	• Improve uptake in underserved communities is being developed based on learning from previous communities. • Maintaining/increasing staff uptake of COVID-19 and Flu vaccinations; • Improve uptake in eligible cohorts who have learning disabilities and/or serious mental illness. Focus on initiatives to enhance messaging and vaccine confidence through healthcare colleagues who are seeing these patients as part of routine healthcare. • RSV to be offered to 75 and over, pregnant who are at least 28 weeks pregnant • MMR uptake – to reduce the difference between the highest and lowest performing practice.	65% New offer	Staff vaccination uptake level a minimum of 60%. Unserved community uptake level 60% Eligible cohorts 65% 70% increase overall uptake of complete doses by 1%
7	**To increase utilisation and impact of VCSE prevention offers**	• Refresher training will be given to all CoHo discharge co-ordinators in September/October to remind them of the services available and the importance of involving VCSE early in a patients stay. • An increase in VCSE uptake within emergency departments • Single point of access for VCSE /Primary Care. • Regular VCSE Communications- aligned within providers.		
8	**To increase/optimise access to primary care (general practice, pharmacy, dental) over winter months**	• Improving Internal Comms - Understand daily pressures within Primary Care and streamline requests for support. • Single Point of Access for VCSE - Help for people attending General Practice (de-escalating, mitigating risk and reducing risk of re-attendance).		

Priority 2: Reducing acute and community bed length of stay

	Objective	Key actions	Baseline	Target
1	**Earlier discharge planning in acute and community settings with effective escalation and response to areas of risk and delay**	• Use escalation process as means to reduce long delays and in line with our pathway standards • Better conversations with patients and families (linked to earlier discharge planning) • Role clarification of discharge coordinator/Key patient worker, discharge nurses and ward staff in discharge process • D2A form before medically fit		Reduction in over 50-day delays (50% reduction) Number of patients with EDD within 72 hours
2	**Streamlined decision-making with reduced hand-offs and decision-points (linked to Transfer of Care hub redesign and scaling of trusted assessment)**	• Functioning East/West TOC hub • The creation of one team, working in an integrated way, sharing information and collaborative delivering complex discharge plans • Provide a single point of referral supported by clear referral processes for complex discharges • Screen and triage referrals from medical, nursing and specialist teams to agreed KPI within operational hours • Pathway process mapping for P1, P2 and P3 from triage to discharge simplified including referral form from Ward		Increase the proportion of people discharged on P1-P3 within 5 days to more than 60% (acute and community) Reduce NCTR to 138 (March 25)
3	**Right-sizing of intermediate care and discharge to assess capacity in bedded and home care to meet acute and community demand (linked to intermediate care redesign)**	• Adopt D2A model for all patients placed in intermediate care • TOC hub support offer • Engagement with Newton to share outputs of Leadership workshops to date • Process map ideal discharge route from intermediate care to community resources/package • Review P1 commissioned services and criteria to enable best discharge decision • Reduce Hand offs in P1 services between Interim, AGIN Care, APEX, Reablement		Reduction in delays in community beds (50% reduction)

Priority 3: Increasing the volume of weekly discharge and improving flow over 7 days

Areas of impact: More people supported at home or in non-acute settings; Reduced pressure on EDs and primary care

	Objective	Key actions	Baseline	Target
1	**Increasing the number of people discharged before 11am and at weekends to reduce delays in hospital**	• Building a 7-day pipeline for discharges. • Targeted approach to drive up weekend discharges		Increase in weekly discharges to 200 per week on P1-P3 Increase weekend discharges to 25 per day
2	**Developing a consistent discharge pipeline that meets expected target activity levels and makes the best use of available community capacity**	• Increase in weekly discharges to 200 per week on P1-P3 • Increase the proportion of people being discharged on P1-P3 within 5 days to more than 60% (Acute & community)		PGH - 70 P1 to P3 - 60% need to be P1 RBH - 60 P1 to P3 - 70% need to be P1
3	**Increase rate of P1 flow in the East to match demand**	• Accelerate work to take out hand-offs and process steps to access P1 offers and stop multiple moves for patients • Targeted PTL approach to P1 exit planning to ensure there is capacity available (daily review and escalation) • Prioritise the utilisation of P1 capacity to reduce acute waits		Increase P1 East discharges to 80+per week
4	**Increase uptake of supported discharge offers with VCSE partners**	• Involvement with weekly "ward huddles" at DCH to identify patients who would benefit from support after discharge. • On-site support from VCS in the Discharge Lounges • Pre-discharge Support worker based in RBH, PGH, also Alderney and Coastal lodge, connected with the discharge coordinators, discharge Key Workers and TOC.		

Priority 3: Increasing the volume of weekly discharge and improving flow over 7 days

Areas of impact: More people supported at home or in non-acute settings; Reduced pressure on EDs and primary care

	Objective	Key actions	Baseline	Target
4	**Intensive work to reduce delays in community beds**	• Targeted PTL approach to community bed delays (daily review and escalation) • Review of all patients in all beds to ensure discharge plan and EDD in place and monitored • Prioritise social work input to COHO delays to reduce time for CAA		Reduce community bed delays to below 50 people Reduce LoS in community hospital to below 40 days
5	**Implement solution for non-core P2 discharges**	• Test new process from Sept 1 on East and West to enable non-core referrals to be supported at home under virtual ward • Implement 'safety net' approach with ICSD telephone support available to care providers • Work with acute providers to improve accuracy of information captured for this non-core group to support better discharges		Reduce P2 non-core delays to below 30 per week
6	**Redesign of intermediate care offer in partnership with local authorities to include full demand and capacity analysis, BCF supported D2A pathway review and agreement on risk share framework**	• Timely assessments for ongoing care to exit P1 intermediate services and increase capacity (trusted assessors?)		Increase capacity in P1 to 80+ discharges per week Reduce LoS in P1

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Communications Winter 2024/25 Campaign

'If you are ill, Know where to go'

Key Messages:

- Go to www.staywelldorset.nhs.uk
- The full 111 offer – it's not just a helpline
- Get well sooner - don't leave it until you need intervention
- Self Care messaging
- Promoting Pharmacy First
- There are lots of ways to access your General Practice
- Make use of digital tools

Campaign Channels and Tools:

Staywelldorset.nhs.uk - to be updated and used as central point for the campaign

Leaflet for all providers to use with simple messages/QR code which links to staywelldorset site

Website button for partners to use for link to staywelldorset site

Targeted comms based on 'top five' reasons for presentation

Explore possible videos using 'real people'

Internal campaign for discharge

Sept 24
Stay well leaflet available to partners

2nd Sept
New Staywell Website launched

2nd Dec
Self Care/ Repeat prescription reminder

30th Dec
New Year 'Choose Well'

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Staywell campaign launch
2nd Sept

School Holiday stay well reminder
21st Oct

Be prepared in advance of the festive period
16th Dec

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Section 5

Management of risk

Health, care & wellbeing

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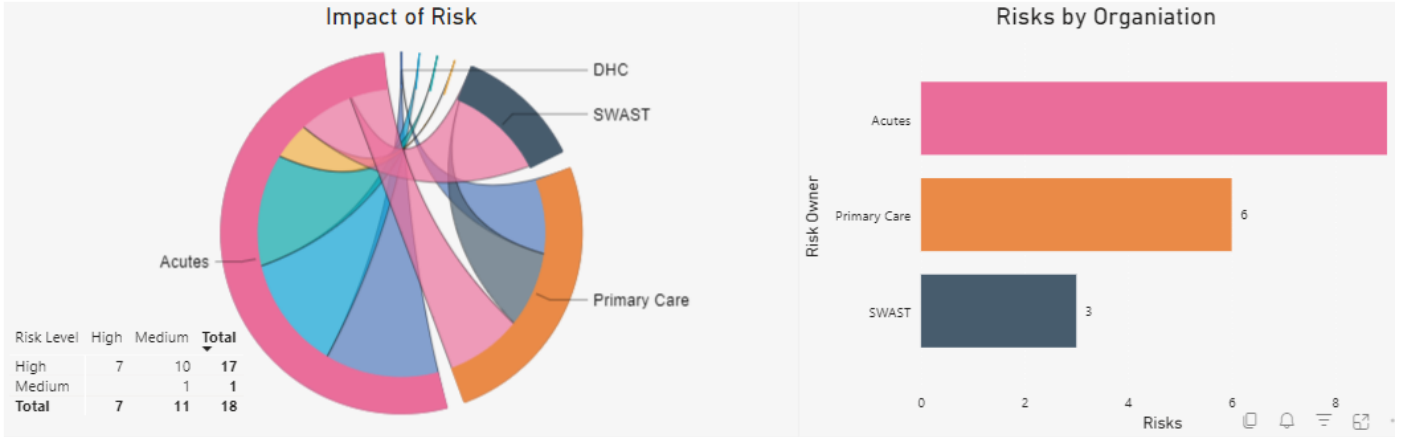
Key Risks to Winter Plan 24/25

This winter, it is proposed to test an enhanced risk share approach that is intended to support partners in agreeing how operational risk can be better balanced across partner at times of peak pressure and/or where there is a forecast increase in pressure.

There are seven overarching ICS risks that challenge delivery:

1. NCTR
2. Handover Delays
3. Ambulance Cohorting
4. Collective Action – Appointments
5. Collective Action – Shared Care
6. Escalation Beds
7. Acute Bed Capacity



Risk Name	Primary Partner(s)	Count of Implicated Partner(s)	Control Measure	Further mitigations available.
Acute Bed Capacity	Acutes	4	Mitigate	Utilisation of VW at the front door to reduce admissions. Improved utilisation of SDECs to turn patients around within a day. Improved utilisation of Immedicare to help avoid SWAST being called to Care Homes and to reduce conveyance.
Acute unfunded escalation beds	Acutes	2	Mitigate	Consistent complex discharges over 7 days. Surge P0 discharges with support of VCSE when occupancy is challenged. A&AA pathways (including VW and SDEC) maximised when occupancy is challenged. Review internal approval/escalation processes for opening beds.
Collective Action - 25 Patient contacts per day.	Primary Care	3	Accept	
Collective Action - Shared Care Hand Back	Primary Care	3	Mitigate	DHC - have some MH and ADHD provision.
Handover Delays	SWAST	2	Mitigate	Finalisation of updated handover SOP' across all 3 acutes. Improved utilisation of Immedicare to help avoid SWAST being called to Care Homes and to reduce conveyance.
NCTR off trajectory	Acutes	3	Mitigate	Identify and increase pre noon discharges.

System Surge & Escalation Plan

Surge and escalation

- Experience over last 2 years is that system can become rapidly stressed, developing effectively unmitigated risks
- Clearly it would be preferable to be acting proactively to reduce risks and we should push the work around ambulance handover delays and discharge pathways
- Severe workforce challenges – evidence that even core services are struggling – potential for staff to move, thereby moving the issue rather than providing a solution
- To ensure that an action in one part of the system does not impact adversely on another part of the system – system solutions vs individual solutions
- Assurance that all patients are in receipt of some level of care, and prioritised by available support to the individual, at that time

- Dorset ICS surge and escalation plan (Primary care included in appendix)
- Dorset County Hospital surge and escalation plan
- University Hospitals Dorset surge and escalation plan
- Dorset Healthcare surge and escalation plan
- Dorset Council surge and escalation plan
- BCP Council surge and escalation plan

Our Dorset

Emergency Preparedness Resilience & Response

Our Dorset

Potential risks with EPRR focus

- All of the below are national risk register items and addressed by the Dorset Local Resilience Forum (LRF) and specific partners as appropriate.
- In the event of the below incidents occurring, Operation Link will be used to coordinate a multi-agency response **except for NHS industrial action.**

Risk	Mitigation
NHS Industrial & GP Collective Action	Dorset ICS have well established processes in place to communicate, manage and respond to any notifications of industrial action accordingly. This risk is also noted in slide 40.
Cyber attacks	Dorset Police have developed a Cyber Crime Prevention Toolkit.
Disruption to fuel supplies	There is a Dorset LRF Fuel Sharing Protocol as well as the National Emergency Plan for Fuel (NEP-F).
Severe weather	Severe Weather Response Guide please use this guide as management guidance for an episode of severe weather. Please see slide 61 for further guidance.
National/Regional Power outages	Exercise Mighty Oak took place in March 2023 and recommendations and learning were taken from this. An action card to manage this type of incident can be found in the on-call pack.
Emerging infectious diseases (human & animal)	We have several plans and pathways depending on the type of outbreak. These are all listed in the on-call pack and on-call scheme members are aware. A Dorset ICS communicable disease plan is also in development to support the response to this kind of event.

GP Collective Action

Collective Action may be taken by General Practices from 01 August 2024, at their discretion. We are working closely with Primary Care colleagues to bolster relationships and support the continuation of collaborative system working.

NHS Dorset have established a command-and-control structure to coordinate and respond to any incidents which could occur as a result, as well as a clear escalation route for Dorset ICS partners.

A Collective Action Plan has been developed to ensure the focus on the continuation of essential services, maintaining system performance, and the delivery of equitable safe patient care are achieved.

Our Dorset

Weather

This Winter, there are several online resources which can be accessed using the below quick links:

- Keeping warm and well: staying safe in cold weather
- Top tips for keeping warm and well this winter

In addition to this specific action cards relating to severe weather events have been developed and can be found in the on-call pack.

UK Health Security Agency

Keeping warm and well: staying safe in cold weather

Plan ahead

- Check the weather forecast and the news
- Make sure you have sufficient food and medicine
- Take simple measures to reduce draughts at home

Keep yourself warm

- Heat rooms you spend most time in to 18°C if you can
- Keep bedroom windows closed
- Wear multiple layers of thinner clothing

Prepare your home

- Check what financial support may be available for you
- Use energy saving tips to save money on heating
- Make sure appliances are safe and working well

Look after yourself and others

- If you're eligible, get vaccinated against flu and COVID-19
- Check on others who may be vulnerable
- Get help if needed. Call NHS 111 or in an emergency 999

For more information go to:

Top tips for keeping warm and well this winter - www.GOV.UK

Our Dorset

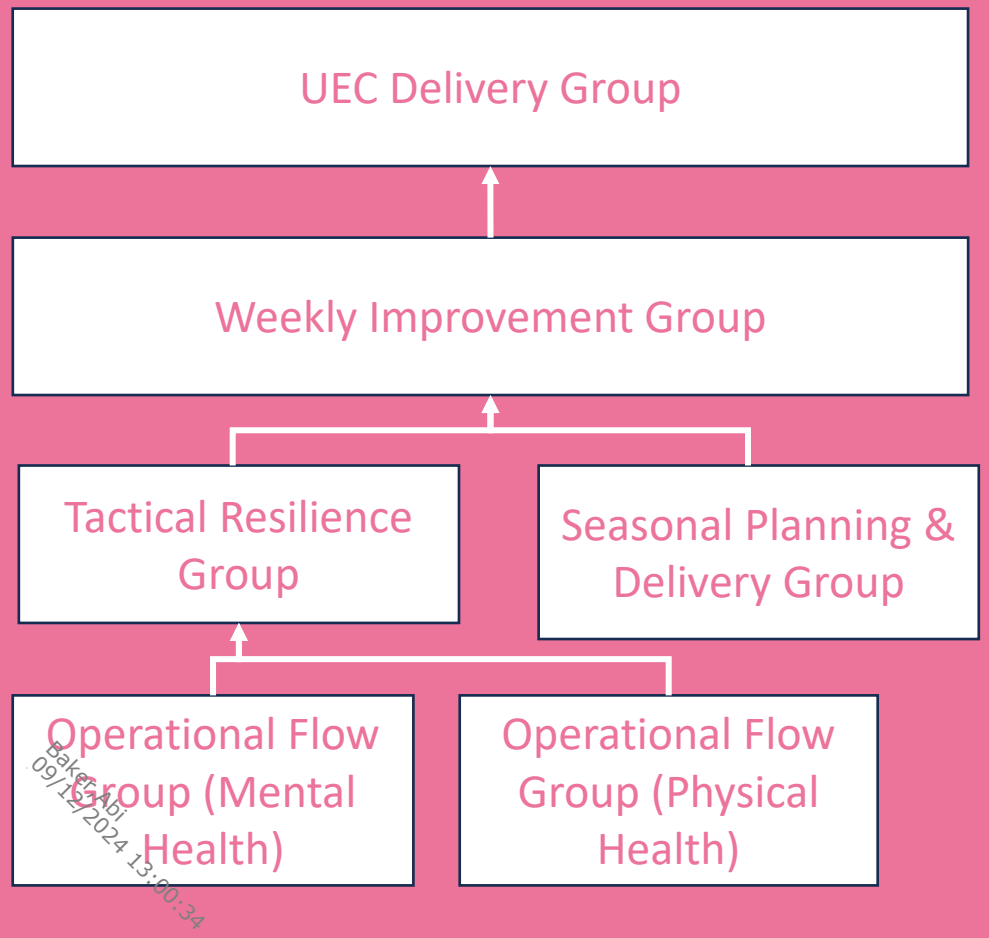
Section 6

Governance

Health, care & wellbeing

www.ourdorset.org.uk

Oversight of Delivery



Escalation

Our Dorset

Meeting Governance

Meeting	Purpose
Executive Resilience Group	To provide executive leadership and oversight to inform planning and delivery of services during times of extremist escalation. that are unable to be resolved at the strategic level.
Strategic Resilience Group	To agree additional mitigating actions in response to an escalation of operational issues and/or system pressures that are unable to be resolved at the tactical level or outside of SRG. Ensure the required response from each partner is implemented to maintain safe services across the Integrated Care System (ICS) for its population.
Tactical Resilience Group	The group will assess and manage system performance on a day-to-day basis. TRG will take actions at the tactical level to mitigate against operation pressures, incidents, and barriers to discharges and flow.
UEC Delivery Group	To support the delivery of the Integrated Care Strategy, NHS Joint Forward Plan and NHS Operational Plan through guiding and overseeing the operational and clinical workstreams within the Delivery Group
Weekly Improvement Group	To bring together senior leadership from across the ICS on a weekly basis to review the system position in relation to Urgent and Emergency Care and Discharge and Flow across the ICS. The group will identify, establish and oversee workstreams to address system performance issues.
Seasonal Planning & Delivery Group	The group will improve ICS planning and delivery on a seasonal basis and pursue recommendations for development in planning and operational delivery, ensuring a collective approach across all system partners. It will take a “Forward Look” approach to predict and manage the demands over periods of seasonal pressure.
Operational Flow Group (Mental Health)	Proactively improve operational flow, dealing with operational barriers and addressing arising trends, using data to support and inform.
Operational Flow Group (Physical Health)	Proactively improve operational flow, dealing with operational barriers and addressing arising trends, using data to support and inform.

Our Dorset

System Resilience and Escalation calls

To ensure that we have a structured approach to de-escalation, the system must achieve the de-escalated OPEL score for a sustained period of 48 hours as of 8am.

System OPEL	Weekday cadence	Weekend cadence
OPEL 1	TRG takes place Thursday at 11:15, with SCC Senior Manager/SCC Manager as Chair. Providers can request TRG calls on Tue, Wed, Thu, Sat, Sun by contacting SCC.	No weekend meetings
OPEL 2	TRG takes place at 11:15 on Monday and Thursday with SCC Senior Manager/SCC Manager as Chair.	SCC to seek assurance on OPEL actions via email/phone call with acutes. If not assured SCC to escalate to Manager On-Call with view to standing up a TRG at 09:30. If TRG stood up Manager On-Call will Chair and SCC Room Lead will facilitate and support. Providers can request TRG calls on Sat and Sun by contacting SCC.
OPEL 3	TRG takes place at 11:15 daily. SCC Senior Manager/SCC Manager as Chair with nominated Director to attend as ICB representative.	TRG takes place at 09:30. Manager On-Call to Chair with SCC Room Lead to facilitate and support. If post 1800 call cadence is requested, Manager On-Call and Director On-Call to facilitate and chair.
OPEL 4	TRG takes place at 11:15 daily with SCC Senior Manager/SCC Manager as Chair. ICB EPRR Manager/Officer to attend. Decision made at 1115 TRG as to whether a second TRG at 15:15 is beneficial. If 1515 TRG agreed SCC Senior Manager/SCC Manager as Chair. If post 1800 call cadence is requested, Manager On-Call and Director On-Call to facilitate and chair. SRG takes place at a time to be agreed with nominated Director as Chair. Director On-Call to attend. NHSE SW to be invited. SCC operating hours: 0800-1800. SCC will extend operating hours to 2000 if requested by SW ROC to reflect their extended operating hours. SCC staff will support NHSE Regional team calls as required.	TRG takes place at 09:30. Manager On-Call as Chair with SCC Room Lead to facilitate and support. SRG takes place at 1230. Director On-Call as Chair with SCC Room Lead to facilitate and support. Manager On-Call to attend. SCC operating hours: 0800-1800. SCC will extend operating hours to 2000 if requested by SW ROC to reflect their extended operating hours. SCC staff will support NHSE Regional team calls as required

In addition to the system OPEL status escalation calls will be stood up should any of the following metrics be met. This is to ensure that the response is dynamic to any emerging system risks:

- Escalation beds open (above numbers funded/agreed for 24/25).
- Community Hospital NCTR above 45.
- Number of patients in UHD and DCH on the TCI exceeds 8.
- Number of Mental Health patients in OOA beds exceeds 8.
- Incident Declared (BCI/CI/MI)
- Red Flag Report submitted by ICS provider to region.
- SWAST cohorting at any Dorset acute.
- 48 hours of low P1-P3 discharges (below 20 per day).

Our Dorset

SCC Role and Responsibility

The SCC exists to be a central co-ordination service to providers of care across the ICS footprint, with the aim to support patient access to the safest and best quality of care possible.
The SCC will provide 7-day cover between 0800 hrs and 1800 hrs.

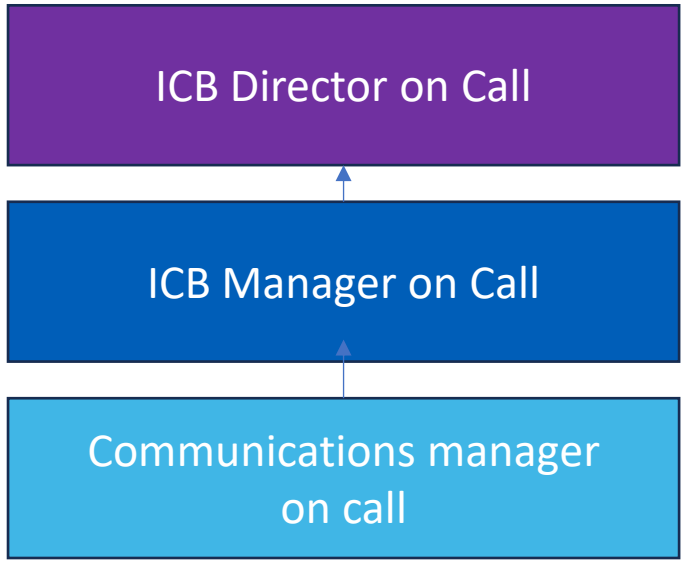
Improved visibility of operational pressures	Real-time co-ordination of capacity and action	Improved clinical outcomes

The SCC will proactively co-ordinate the system response to operational pressures and risks utilising interventions outlined in the Operating Pressure Escalation Level (OPEL) Framework and System Surge & Escalation Plan (and Action Cards).
The SCC works closely with the EPRR team to ensure Dorset ICS is a resilient healthcare system; prepared to respond to incidents and maintain business continuity.
The SCC utilises available information and intelligence to assess and validate local assurance submissions with regards to planning for events that impact on UEC and wider system pathways that require specified operational planning, including:

- Half term planning and assurance (October/Feb).
- Christmas/New Year Bank Holiday planning and assurance.

ICB On-call Scheme

- The purpose of the on-call scheme is to provide a single point of contact for provider, other health and care systems and multi-agency partners to access senior NHS leadership in response to incidents which require wider coordination of the NHSE response



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- Further to the on-call scheme arrangements, NHS Dorset must remain prepared to mobilise additional support to sustain response to an incident both in and out of hours. There are three clear instances where this may be the case:
  - To staff an Incident Coordination Centre (ICC)
  - To mobilise subject matter experts to support the response of an Incident Management Team
  - To provide senior clinical decision making, support and advice during an incident

Our Dorset

Supporting Documents

- Provider Surge and Escalation Plan
- Winter SWAST Plan
- BCF Plans
- Provider Winter Plans
- Transient Risk Assessment
- UEC Recovery Plan
- Business Assurance Framework
- Winter KLOEs
- Communications Plan
- Operational Plan 24/25/24
- LRF Severe Weather Plan
- System OPEL Framework
- SCC Framework

Our Dorset

Dorset County Hospital
NHS Foundation Trust

People and Culture Committee in Common Assurance Report for the meeting held on 25 November 2024

Chair:	Executive Lead:	Date of Next Meeting:
Frances West	Nicola Plumb	Monday 27 January 2025
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

- Benefits of joint working across organisations
- Sustainability of the work in regards to the People Promise, when the dedicated support team's contract comes to an end in April 2025.
- **DCH**
  - Reduction in sickness levels
  - Ahead of plan for agency reduction, but below our plan for agency spend.
  - Whole-time equivalent reduction programme, reduced in month 7 but we remain behind plan.
  - Essential skills training compliance rates have dropped, recorded at 87% in September and remained at that level in October. Recovery plans are place for the areas that have fallen below the 80% threshold.
  - Overspend on Occupational Health service but increased quality of service. Costs causing overspend were one-off costs.
  - Noted increase of 156% across DCH in regard to FTSU queries being raised.
  - GMC report was positive overall and would provide positive assurance to the Board.
- **Both organisations**
  - National review of mandatory and statutory training is underway.
  - FTSU e-learning has been mandated in both Trusts.

Key issues / matters discussed at the meeting

The committee received, discussed and noted the following reports:

- **Board Assurance Framework**
  Staff Networks risk updated, and Equality, Diversity and Inclusion is being monitored via the BAF.
- **Informal Committee meetings**
  Discussion around how the Committee would like to record informal meetings. Decision was to raise any actions or concerns at the time, and for these to progress via usual management routes, with feedback

to the Committee. Committee felt that recording informal meetings would make them formal.

- **Joint Workforce Wellbeing Plan**
  The Trusts are developing a joint People Plan which will come to Committee in January 2025. The Plan will take a well-being approach and is aligned with the national plan.

  We are looking at how we benchmark, and where there may be gaps within the organisations of 'take up' of the service. There are a lot of networking events taking place, so the teams get to know what is happening across the country. Locally, the team is looking at Trusts within the Dorset system and the psychological support available. And baselining where all the Trusts are at.

  The work is being based around the NHS Wellbeing Framework, which is a culture change tool. The People Promise is clear on what is required. Information is triangulated with the staff survey, with staff well-being being reviewed throughout the year, along with sickness absence rates.

  Dignity and Respect work is also now running, which now includes sexual safety at work.

- **People Promise Update Report**
  Key areas discussed were:
  - Effective appraisals
  - Managers and compassionate leadership
  - Flexible working
  - Awareness and accessibility of opportunities and offers
  - Local inductions
  - Understanding leavers within the first 2 years of service. 30% of leavers not unknown or other as their reason for leaving.

  Project work undertaken by two leads, which has moved this work forward. Without this specific support, the traction on these workstreams would not have been there. The challenge is that we now embed the work that has been started.

- **Workforce Key Performance Indicator Dashboard**
  DCH:
  - Reduction in sickness in months 5 and 6 and a positive decrease in long term absence.
  - Active engagement with Live Well Dorset around blood pressure, we have undertaken events for World Mental Health Day, Worl Menopause Day and commenced the staff flu and Covid vaccination campaigns which has had really good take up.

- Vacancy and turnover rates have both stabilised and both remain within tolerance level
- Current focus is on the whole-time equivalent reduction programme, which did reduce in month 7, but we remain behind plan.
- A review of fixed term contracts has also been undertaken.
- Preparations for a MARS scheme has happened and been discussed at Board, and there is executive oversight of the whole-time equivalent work remains in place and is discussed via a weekly recovery group meeting.
- We remain ahead of plan for agency reduction, but below our plan for agency spend.
- Declining pattern of essential skills has been reported and it was recorded at 87% in September and remained at that level in October. We do have recovery plans in place for the four areas that have fallen below the 80% threshold.
- Staff survey remained open until the end of November, currently at 39% and are on track to exceed our 41% achievement in the last financial year.

- **Review of Occupational Health Services**
  DHC colleagues in attendance declared a potential interest in this item as the service is provided to DCH by DH under an SLA.

  It was noted that this is a critical staff service and the DCH team were impressed by the level of service received in comparison to the previous service provider. Quality of service was evidenced in the KPIs'.

  It was noted that the cost had been greater than expected, (£61k overspent) however the cost should fall over the coming months. This was not a concern as the costs were a one off. However, if the costs continue to be as they are, DCH will have to retender at the end of year 2.

  From a quality and safety view, service we are getting is gold standard, and it became clear that the previous provider was not providing services as contracted, but that they had also undercharged.

  OH Service, DCH and DHC were looking at the DNA rates, to see if that could be lowered, as DNAs have cost implications. OH services is offering clinics and South Walks which is easier for staff to get to.

- **Guardian of Safe Working Report**
  DCH
  Noted this was a mechanism for ensuring that staff are not working over their hours. Report detailed the exception reports received over the last quarter. Nothing had changed from previous reports and there were no areas of concern.

It was noted that the only areas where we were seeing reporting I sin Orthopaedics, which we are already aware of, and it has been problematic over a period of time, and additional resource has been put in over the last two tears. We are keeping an eye on this and if necessary, it can be increased again.

We are going to be taking on more foundation doctors and the Government is expanding medical places and we are now accepting foundation year doctors from across the world provided they meet the appropriate criteria.

- **Freedom to Speak Up Report**
  Noted both Trusts had combined their information, It was note that there was an increase in contacts at DCH, but that was explained as the FTSUG had started undertaking workarounds and undertaking some targeted listening events.

  Numbers for anonymous reporting was lower than the national picture on the benchmarking data, which was positive in that staff felt able to raise their concerns directly.

  Registered nurses and midwives are the highest percentage raising concerns across both organisations, but they are the largest workforce. Admin and clerical are the second highest reporters and again they are the second highest employed staff group. This mirrors the national picture.

  Both FTSUGs will be targeting the quieter reporting areas.

  Across both Trusts the themes are the impact on worker safety and wellbeing is a prominent theme, with poor communication being second.

  DHC currently have associate guardians which are not there in DCH, DCH has a network of champions which DHC don't have, so looking at aligning.

  FTSU e-learning/training has been mandated in each organisation.

- **GMC Survey Action Plan – DCH specific.**
  Noted that the survey related to a single point in time and that the survey only collates feedback from the training posts. DCH has 160 training posts. Response rates had increased from 65% in 2023 to 78.7% this year. Survey was undertaken in April. At this time the rota for Surgery had been rewritten

  There was a lot of positive information in the report, but some areas were scored red. Recent feedback shows an improved position.

	Paediatrics provided and action plan that has been fed back to the medical education group as an exemplar.
	
	Trainer feedback has also improved.
	
	• **Assurance reports from sub-groups**
	  • **DCH Partnership Forum**
	  Issues noted about staff feeling unsettled about not knowing when the reintroduction of parking fees would happen. Referred to SLG or FPC.
	  • **DCH Equality, Diversity, Inclusion and Belonging Steering Group**
	  Noted

Decisions made at the meeting	• Informal Committee meetings not to be minuted. • Approval to establish a ROAG at DHC.
Issues / actions referred to other committees / groups	• Appraisal compliance KPIs to go to SLG • Re-introduction of car parking fees at DCH to go to SLG or FPC • Safeguarding compliance to go via Quality Committee

Report to	Board of Directors, Part 1	
Date of Meeting	10 December 2024	
Report Title	**Quarterly Guardian Report of Safe Working report: Doctors in Training (July 2024 – Sept 2024)**	
Prepared By	Dr Jill McCormick, Guardian of Safe Working	
Accountable Executive	Alastair Hutchison, Chief Medical Officer, DCH	
Previously Considered By	Submission to People and Culture Committee approved by Alastair Hutchison	
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	Relates to Board Assurance Framework: SR1: Safety and Quality SR2: Culture SR3: Workforce Capacity 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.	
Financial		
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 is also an annual report.

- The is the Q2 Report submitted to the Trust Board by the Guardian of Safe Working, dates from 01/07/2024 – 30/09/2024.
- There is continued support from educational supervisors towards supporting the Exception Reporting system, when clinical need has demanded Resident Doctors work outside of their contractual role.
- Nationally adopted that Junior Doctors are now called Resident Doctors; reflecting the fact the former name was demeaning and misleading, implying that doctors were students or apprentices, instead the new term reflects that these Doctors are fully qualified and responsible for a large portion of patient care. We have fully taken this on board at DCH.
- During this period of time there were 82 reports received, 7 were Immediate Safety Concerns (ISC). The majority were related to hours of working (66 in total), 2 regarding educational opportunities and 6 related to service support available.
- The Immediate Safety Concern (ISC) were only 7 during this period, down from 13 in the previous Q1.

- Trauma & Orthopaedics continue to have the greatest Exception Reporting (ER) numbers, with 32 in total, mostly related to hours worked beyond 5pm due to work load.
- WTE has improved in this Q2, with new Resident Doctor's in August 2024 from an average of 24.3 (Q2) from 36.3 (Q1).

Recommendation

The Board is requested to:

- Receive the report for **assurance**

APPENDICES

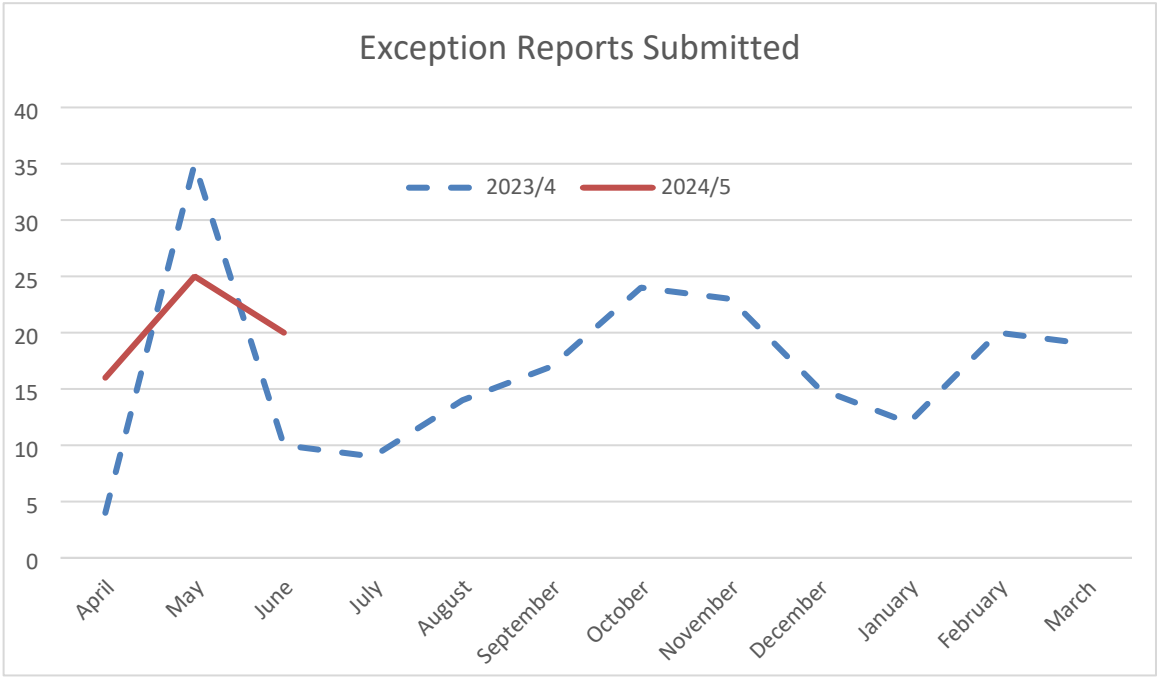
QUARTERLY GUARDIAN REPORT ON SAFE WORKING HOURS: DOCTORS IN TRAINING

JULY 24 – SEPTEMBER 24

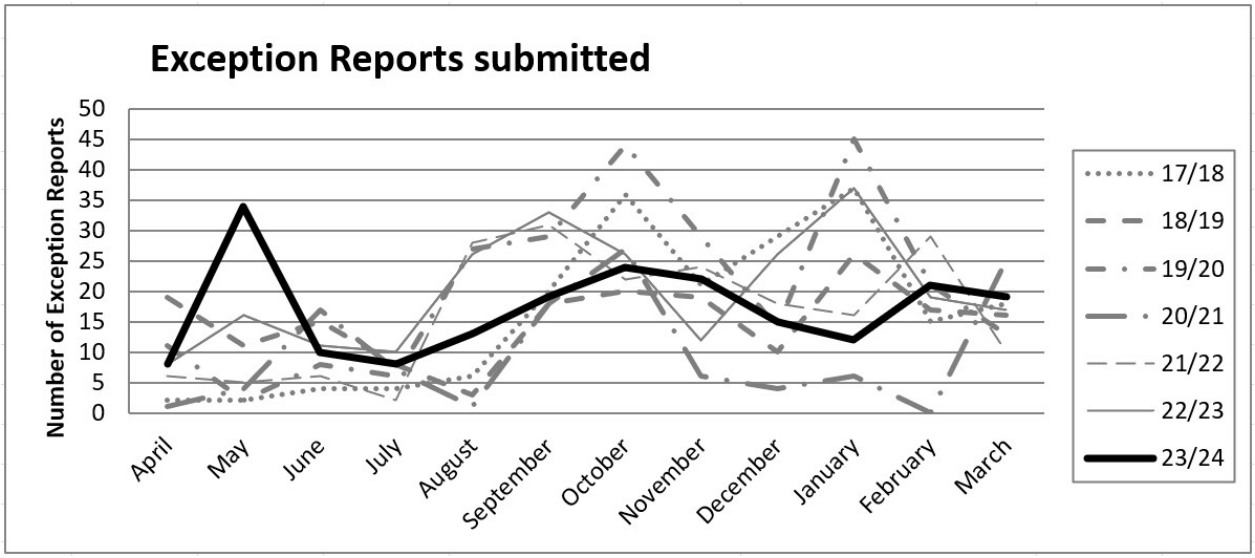
Appendix 1 – Trainee Vacancies within the Trust

Department	Grade	Rotation Dates	Jul 24	Aug 24	Sep 24	Average Q2
Paediatrics	ST3	Sept	0	0	0.2	0.1
Paediatrics	ST4+	Sept	0.7	0.7	1	0.8
O&G	ST1	Oct	0	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	0.1
Surgery	CT1	Aug	0	0	0	0.0
Surgery	CT2	Aug	1	0	0	0.3
Surgery	ST3+	Oct	0	0	0	0.0
Orthopaedics	ST3+	Sept	1	1	1	1.0
Anaesthetics	CT1/2	Aug	1.2	1.4	1.4	1.3
Anaesthetics	ST3+	Aug and Feb	0.2	0.2	1	0.5
Clinical Radiology	ST1/2	Aug and Feb	0	0	0	0.0
Medicine	CT1/2	Aug	5.5	4.1	4.1	4.6
Medicine COE	ST3+	March	0.2	1.2	1.2	0.9
Medicine Diab/Endo	ST3+	Aug	1	1	1	1.0
Medicine Gastro	ST3+	Sept	0	0	0	0.0
Medicine Resp	ST3+	Aug	0	0	0	0.0
Medicine Cardio	ST3+	Feb	0.2	0.2	0.2	0.2
Medicine Acute Internal	ST3+	Sept	N/A	N/A	0	0.0
Medicine Renal	ST3+	Aug	0	2	2	1.3
Haematology	ST3+	Sept	0.4	0.4	1	0.6
Med/Surg	FY1	Aug	4	2	2	2.7
Med/Surg	FY2	Aug	0.6	1.9	1.9	1.5
GPST	ST1	Aug & Feb	14	0.4	0.4	4.9
GPST	ST2	Aug & Feb	0.6	0	0	0.2
GPST	ST3	Aug & Feb	2.5	0	0	0.8
Orthodontics	ST3+	March	1	1	0	0.7
Ophthalmology	ST3	Aug	0	0	0	0.0
Total			35.1	18.5	19.2	24.3

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



Dorset County Hospital
NHS Foundation Trust

Report to	Trust Board	
Date of Meeting	10th December 2024	
Report Title	Freedom to Speak Up Q1 & Q2	
Prepared By	Lynn Paterson – Freedom to Speak Up Guardian (FTSUG)	
Approved by Accountable Executive	Nicola Plumb – Chief People Officer	
Previously Considered By	N/A	
Action Required	**Approval**	N
	Assurance	Y
	Information	Y

Alignment to Strategic Objectives	Does this paper contribute to our strategic objectives? *Delete as required*	
Care	Yes	
Colleagues	Yes	
Communities	Yes	
Sustainability	Yes	
Implications	Describe the implications of this paper for the areas below.	
Board Assurance Framework	SR2 Culture – The FTSU policy forms part of the controls with assurance sourced through monthly dashboard data and bi-annual reports.	
Financial	Within existing budgets.	
Statutory & Regulatory	NHS England » The guide for the NHS on freedom to speak up	
Equality, Diversity & Inclusion	The report includes staff data relating to protected characteristics where known.	
Co-production & Partnership	The report includes data provided by the Organisational Development (OD) team and benchmarking against Devon Partnership NHS Foundation Trust.	

Executive Summary

This bi-annual report provides a summary of the activities of the Freedom to Speak Up (FTSU) contacts between April 2024 and September 2024 (Q1 and Q2). **There were 256 cases reported to the guardian during this period, compared with 100 during the same period last year. 108 cases were reported in Q1 and 148 in Q2.** The guardian is temporarily working full-time to respond to this increase.

We welcome concerns raised as part of our commitment to a culture of speaking up safely. The number of concerns raised through the FTSU process during this period was significantly higher than the previous two quarters. The increase in activity is in part due to targeted listening events and increased visibility of the guardian on regular weekly walkabouts.

Concerns involving elements that indicate a risk of impact to worker safety/wellbeing was again the most prominent theme, mainly in relation to poor communication.

Over 95% of concerns raised were acknowledged within 72 hours and actions for resolution agreed within 3 weeks.

Development opportunities such as the Trust's Dignity and Respect at Work (DRW) workshops, Inclusive Leadership and Management Matters Programmes raise awareness about acceptable and unacceptable behaviour. The monthly Supporting Our People bulletin from OD is used regularly to reiterate messaging around speaking up, culture and signposting to training opportunities. Additionally Speak Up e-learning modules are now being mandated which will raise awareness further.

Next steps include continued collaboration in shared workstreams with DHC, update intranet site and improve on how learning is shared throughout the organisation.

Recommendation

Members are requested to:

- Receive the report for Approval.

Bi-annual Freedom to Speak Up Report

1.0 Introduction

1.1 It is a contractual requirement for all NHS provider Trusts to have a FTSUG. The guardian's key role is to support the creation of a positive, open learning culture where our people feel listened to, and feedback is welcomed, and acted on. 'Every Voice Counts' is one of the principles outlined in the People Plan/Promise (2020/21) which advocates for all staff to feel safe and confident to speak up with an expectation to be listened to and for appropriate action to be taken.

1.2 The FTSUG provides bi-annual updates to the Trust Board, as recommended by the National Guardian Office (NGO).

1.3 The FTSUG is supported by a network of FTSU Champions, which continue to increase in numbers most recently from 34 to 39. Champions work to ensure colleagues understand and can access routes to speaking up and provide a confidential source of signposting, in addition to raising awareness. This model follows the recommendations of the NGO and Care Quality Commission.

1.4 The relevant policy to follow for those wishing to make a formal whistleblowing disclosure is the Freedom to Speak Up (Raising Concerns/Whistleblowing) policy (EM63). The policy signposts individuals to those who can support them to raise informal and formal concerns.

2.0 Speaking Up Cases

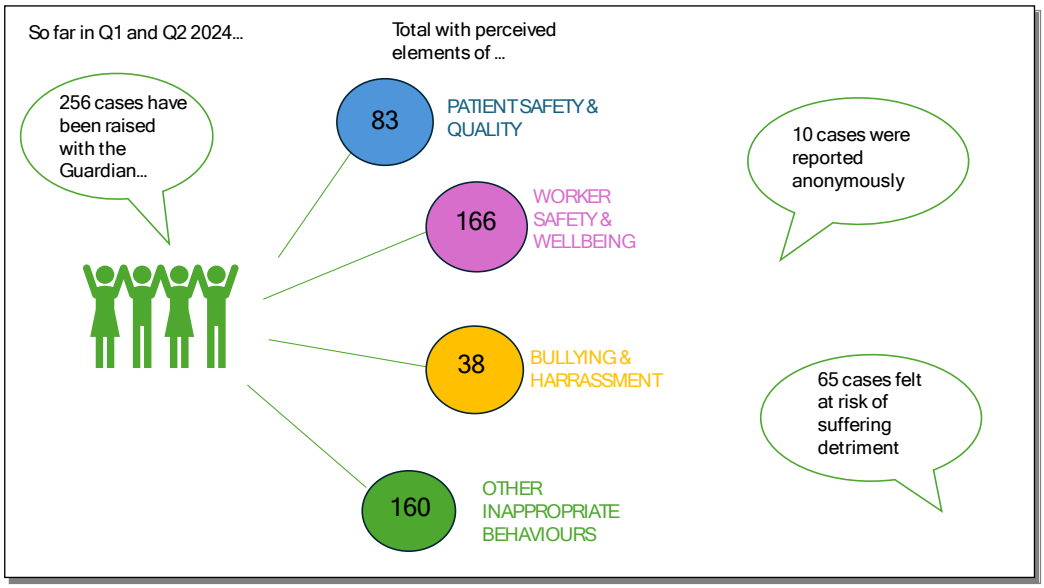
2.1 The FTSUG submits quarterly speaking up data online via the NGO Portal. This is published nationally by the NGO alongside all other NHS Trusts' data submissions.

2.2 Q1 and Q2 saw a 27% increase in cases from the previous reporting period (187 to 256). This positive trend is likely attributed to increased visibility of the guardian on regular walkabout Wednesdays in addition to several targeted listening events including Radiology and Housekeeping.

2.3 Targeted listening events are often held at the request of the local manager due to lack of engagement from staff or when an area is reporting concerns anonymously indicating staff feeling psychologically unsafe in their work environment. Much learning and improvement takes place as a result of speaking up. Recent examples include staff reporting that managers were not visible on the shop floor, in response, the managers moved their office to be based by the staff room and now rotate the weekly staff meeting Chair to provide visibility and interaction with the team. One department has changed the working pattern for the operational leads to provide consistent cover where there were gaps previously, solely based on staff raising concerns at a listening event.

2.4 Benchmarking against a similar size Trust who employ approximately 3,600 staff, our case numbers of 108 for Q1 are over double the 53 cases they reported. At this time, their Q2 numbers have not been submitted so a comparison cannot be made.

2.5 FTSU data for Q1 and Q2:



2.6 In many cases, concerns are attributed more than one element of perceived risk, for example, a member of staff worried about staffing levels might assign both patient safety and worker safety/wellbeing to the concern.

2.7 The guardian approaches each case individually in discussion with the member of staff to reach a resolution. Most cases needed escalation to facilitate a resolution, with manager behaviour and colleague behaviour attributing to many of the concerns raised. The majority of contacts were met with face to face.

2.8 The staff role for reporting the highest number of concerns is Registered Nurses, accounting for 28% of cases. This mirrors the national picture due to nursing being the largest workforce. Administrative and Clerical roles accounted for 18% of the cases. Healthcare Scientists/Additional Scientists and Technicians are the lowest reporting roles, accounting for just 2% of cases.

2.9 Any colleague raising a patient safety concern is advised to complete a Datix and guided on anonymous Datix reporting where appropriate.

2.10 Q1 and Q2 shows a decrease in concerns raised anonymously, (10 in Q1 and Q2 compared to 17 in the previous two quarters) primarily raised via the FTSU postbox during targeted listening events. Staff are encouraged to raise a concern by any means they feel most comfortable.

2.11 Of the 65 members of staff reporting a risk of suffering detriment when speaking up, from the feedback surveys, only 1 indicated suffering detriment 'indirectly' as a result.

2.12 From the 256 contacts, 46 members of staff were from a protected characteristic group that the guardian was aware of (18%).

2.13 Over 95% of concerns raised were acknowledged within 72 hours and actions for resolution agreed within 3 weeks.

3.0 Emerging Themes

3.1 Elements that indicate a risk of adverse impact of worker safety and wellbeing has consistently been the most prominent theme. These cases are primarily in relation to incivility towards staff and poor behaviour. Staff are signposted to our wellbeing offers in these cases, and the Trust's DRW workshop recommended so staff feel empowered to be upstanders and challenge poor behaviour. The FTSUG continues to collaborate with OD colleagues to support facilitation of the DRW workshop.

3.2 Incidents including poor communication and staff not being provided with feedback feature as a recurrent theme. Managers need to provide clarity for their staff and close the communication gap which can create an environment of instability and insecurity, adding to their unease in the current economic climate.

This echoes the importance of the ongoing engagement and development activities such as the Trust's DRW Programme, Inclusive Leadership, Management Matters, induction talks and promotion of the agenda through comms and Supporting our People bulletins. The Education Committee has agreed to mandate the Speak Up modules via e-learning, to support education for all staff, with added modules for those with line managers responsibilities to highlight and improve communications and feedback to staff.

3.3 Robust triangulation of data continues, to help identify hotspots, particularly in relation to patient safety and staff turnover/retention. Weekly Patient Safety Huddles take place with attendance from FTSUG and relevant stakeholders, in addition to regular meetings with safeguarding. Monthly local intelligence meetings between HR, Workforce Business Partners (WBPs), Education, Recruitment and the OD Team have now been operational for almost 18 months. This collaboration is incredibly helpful in providing context around issues and then identifying how to support and who to progress matters to. The guardian attends national, regional and local meetings to ensure best practice is shared and where needed, adopted within the organisation.

3.4 Steps to improve to the FTSU culture and awareness include visiting teams face-to-face to present awareness sessions, holding listening events, providing regular updates at Ward Leaders monthly meetings, attendance at preceptorship cafes, social media posts, local induction sessions, meet and greets with the night staff and Wednesday walkabouts with the Practice Educator for International Nurses.

4.0 Next Steps

4.1 The FTSUG would like to have time to develop the more proactive aspects of the role particularly establishing routes within the organisation to share the learning that comes from the cases raised. A dedicated FTSU intranet page is in the makings and will help reiterate the FTSU message and include staff case studies which will contribute to shared learning.

4.2 The fear of 'detriment' as a result of speaking up still features as a theme, predominantly when staff are raising concerns about their manager. The need to reiterate the messages around 'zero tolerance' on detriment, as stated in the policy continues. However, the fear does not appear to match the reality when staff are asked via a feedback survey 6-8 weeks after their case is closed, whether they have suffered detriment.

4.3 The Champions Network is increasing with regular meetings and drop-in sessions to share ideas for promotional activities and raising awareness of speaking up. Promoting their role and how they can be accessed needs further exploration and will also be included within the intranet site.

4.4 The FTSUG continues to drive a stronger 'speaking up' culture and recognises the need to continue to identify and tackle barriers to speaking up and learning to achieve improvements. More contact needs to be established with our staff network groups. With such an emphasis nationally on nurturing a culture of openness and transparency, the newly mandated FTSU training will support this agenda and bi-annual meetings with the networks will be set up in the new year.

4.5 Collaborative working with the FTSUG at DHC is well established with regular face to face meetings providing peer supervision, sharing ideas and developing opportunities for future workstreams. Several areas have been identified where a joint approach will support our common agenda including aligning policy to include and a combined FTSU strategy.

4.6 The Board Reflective tool remains in progress, and it is hoped to be a live/working document in the new year.

4.7 FTSU training enrolment has increased, but currently only stands at a few hundred staff. Uptake will significantly improve now the Speak Up modules are being mandated.

5.0 Conclusion

5.1 The FTSU Guardian role supports the creation of a positive culture and environment for raising concerns. It helps protect patient safety and quality of care, improve staff experience and promote learning and development leading to continuous improvement.

5.2 As a system, we need to improve communications locally and be more visible in terms of messaging, living our values and upholding civility. Staff mainly appear to be employed in a role they enjoy; which provides reassurance, however, in some cases wellbeing is being impacted by incivility and poor communication. Managers should be positive role models and the flagship for our Trusts values.

5.3 Training programmes including DRW will give staff the confidence to challenge uncivil and unprofessional behaviour as it arises and the Management Matters Programme will reinforce skills such as conflict resolution, compassionate leadership and motivating and maintaining morale within their teams. The guardian's work will continue to support and promote staff to respectfully challenge where appropriate to create a culture of empowerment, engagement and civility.

6. Recommendation

The Board is recommended to receive this report for approval.

Lynn Paterson, FTSUG
December 2024

Dorset County Hospital
NHS Foundation Trust

Report to	DCH Board of Directors	
Date of Meeting	10th December 2024	
Report Title	Joint Workforce Wellbeing Plan 2024-27	
Prepared By	Kerry Pocock	
Approved by Accountable Executive	Nicola Plumb	
Previously Considered By	Nicola Plumb, Chief People Officer, DHC's Workforce Wellbeing Steering Group and DCH Health and Wellbeing Steering Group.	
Action Required	**Approval**	Yes
	Assurance	No
	Information	No

Alignment to Strategic Objectives	Does this paper contribute to our strategic objectives? *Delete as required*	
Care	Yes	
Colleagues	Yes	
Communities	Yes	
Sustainability	Yes	
Implications	Describe the implications of this paper for the areas below.	
Board Assurance Framework	The content of this paper and its action plan shows alignment to the requirements of our EDS2 report, staff survey, pulse survey results and workforce delivery framework, all of which are included in the BAF.	
Financial	No specific financial implication in relation to the approval required for this paper.	
Statutory & Regulatory	No specific statutory or regulatory implication in relation to the approval required for this paper.	
Equality, Diversity & Inclusion	This wellbeing plan will be delivered alongside the Joint Inclusion & Belonging strategy for both Trusts as there are many aspects of wellbeing that align to equality, diversity & inclusion.	
Co-production & Partnership	This wellbeing plan has been developed in partnership across both Trusts.	

Executive Summary

This documented Joint Wellbeing Plan provides both the rationale and roadmap of how we intend to progress an equitable culture of wellbeing across both Dorset County Hospital and Dorset HealthCare. This three-year plan details the projects and business as usual activity that will support our people to be healthy and promotes proactive prevention.

It is presented for approval to publish and to seek backing from the Committee to support the implementation of these actions. For Dorset HealthCare, this plan replaces the 'Staff Health and Wellbeing Framework' (2021) and Dorset County Hospital's draft Staff Health & Wellbeing strategy. The plan presents objectives and actions plans for both Trusts aligned to the new joint strategy and NHS England Wellbeing Framework elements.

As our two Trusts work more closely together, this joint plan will enable us to work more efficiently whilst remaining focused on the needs of the people within each organisation.

The Joint Wellbeing Plan was presented to the PCCiC on Monday 25th November 2024 and received approval.

Recommendation

Members are requested to:

- Approve this Workforce Wellbeing Plan for publication and support the implementation.

Dorset County Hospital and Dorset HealthCare

Workforce Wellbeing Plan

2024 - 2027

'Putting the health and wellbeing of NHS people first should be a fundamental part of the DNA of the Service, enabling our NHS people to put our patients first.'

Dame Carol Black
Expert Adviser to the Department of Health
NHS England, 2021

Healthier lives Empowered citizens Thriving communities

Author: Kerry Pocock, Workforce Wellbeing Lead

Contents

1. Introduction

Our personal wellbeing can be impacted by many factors: physical health, mental health, our finances, relationships, bereavement, changes in our social support networks, our living conditions and many more. How we feel about work and how we experience the workplace can also impact our wellbeing. We are all different, and a sense of wellbeing will be unique to each of us.

Foreword by Matthew Bryant

Joint Chief Executive of Dorset County Hospital and Dorset HealthCare

Wellbeing is not just the absence of ill health. It is how people feel about themselves and their lives. This plan is a written commitment to ensure our people feel supported, empowered to care for their wellbeing and have opportunities to flourish.

Evidence shows that the health and wellbeing of a workforce directly impacts clinical outcomes and patient experience.

At Dorset County Hospital (DCH) and Dorset HealthCare (DHC), we understand that the physical and psychological health and wellbeing of our people is paramount to deliver safe, high quality, compassionate care for our patients and the community. Alongside that, as a responsible employer, we have a duty of care to create the culture and conditions for everyone to thrive in our workplaces.

We have a collective responsibility to achieve the actions detailed in the plan by role-modelling healthy workplace behaviours and ensure that wellbeing is part of our day to day working experience. By fostering a culture of wellbeing, we will have a healthier workforce, an end in itself, and a health and care team who will be more able to continue providing the highest quality care to our patients and communities.

Working together, improving lives

Working together, improving lives is the new five-year joint strategy for the federation of Dorset County Hospital and Dorset HealthCare. The strategy's vision is 'Healthier lives, empowered citizens, thriving communities' with a mission of 'working in partnership to provide high quality, compassionate services and nurture an environment where people can be their best'.

The strategy has four core strategic aims:

- providing safe, high quality, compassionate care
- helping to grow strong and healthy communities
- creating an environment where our many diverse colleagues can thrive
- ensuring our services are sustainable – financially, environmentally and in terms of workforce

Healthier lives
Empowered citizens
Thriving communities

The health and wellbeing of our workforce is fundamental to achieving these aims.

Why have a Joint Workforce Wellbeing Plan?

'Good work means having not only a work environment that is safe, but also having a sense of security, autonomy, good line management and communication within an organisation.'

Health matters: health and work
Public Health England, 2019

This document provides the rationale and roadmap of how we intend to further develop a culture of wellbeing, which supports our people to be healthy and well and where proactively looking after ourselves and our colleagues is central to our daily work.

For Dorset HealthCare this plan replaces the 'Staff Health and Wellbeing Framework' (2021) and Dorset County Hospital's draft Staff Health & Wellbeing strategy to align with the new joint strategy and the NHS England Wellbeing Framework (2021).

As our two Trusts work more closely together, this joint plan will enable us to work more efficiently whilst remaining focused on the needs of the people within each organisation.

Who is this plan for?

It is for our people (the workforce of both DCH and DHC), to explain why wellbeing is important in the workplace and how we intend to support this.

The document is designed to be used by the Workforce Wellbeing / Health and Wellbeing Steering Group members and the Joint People and Culture in Common Committee members to monitor the delivery of this programme.

2 Context - Where are we now?

In 2023 NHS Providers published a report titled '*Providers Deliver: enabling wellbeing within trusts'* in the foreword the Chief Executive, Sir Julian Hartley stated

'Since 2010, the demands of working in the NHS have been compounded by rising staff vacancies, squeezed funding, increases in patient demand, an underfunded social care system, and a health system designed around treatment rather than prevention'

Because of this, workforce wellbeing is more important than ever. Since 2020 the topic of wellbeing has been more prominent in both the NHS and society as a whole. Within our organisations the appointment of Wellbeing Leads, the introduction of wellbeing plans and conversations for employees and the expansion of the voluntary Health and Wellbeing Champion and Coach roles all show the commitment and actions underway to support the wellbeing of staff, but there is still much to do.

The demographic of our workforce is an important consideration in tailoring the support we provide, making sure we are inclusive of all characteristics and backgrounds.

Dorset Health Inequalities

Health inequalities are unfair and avoidable differences in health across the population, and between different groups within society. Education, housing quality and employment directly and indirectly affect wellbeing and contribute to up to 85% of health status. Overall, Dorset has good health outcomes compared with much of England, but significant variations exist in parts of the county due to inequality.

Working-age population data for Dorset shows that people affected by health inequalities are more likely to smoke, and use alcohol in a harmful way, experience challenges keeping active and maintaining a healthy weight, and a lack of access to early mental health support in the community. It also highlights significant variation in outcomes for people with long-term conditions.

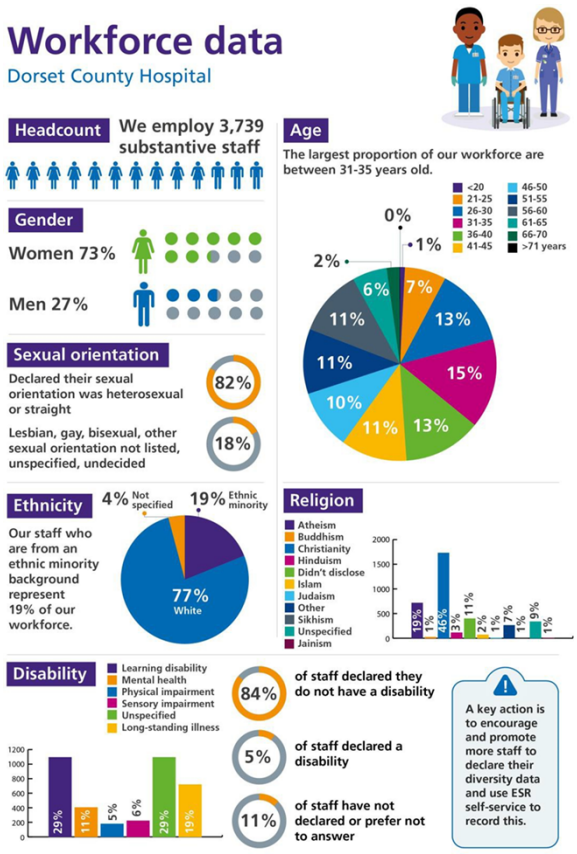
A significant proportion of our people are Dorset residents, however due to the protected factors of employment we do record information relating to health inequalities and our people.

It is also important to note that Dorset borders with five other counties and many of our staff are not Dorset residents; with the increase in remote working, we have staff members who live in other parts of the country.

2.1 Our People – Dorset County Hospital

The workforce data report (April/May 2024 –infographic) shows we employ around 3739 people. At that time 73% of our workforce were female, 27% male. The largest proportion of our people were in the 31-35 years old category, but 30% of staff overall are 51 years or older.19% of our workforce are from an ethnic minority background and 5% of staff have a declared disability.

A key ongoing action is to encourage and promote staff to declare their diversity data and use our self-service Electronic Staff Record (ESR) to record this.



DCH Sickness absence and staff retention

Between October 2022 and September 2024, the mean sickness absence rate for Dorset County Hospital was 4.28% (range of 3.5%-5.53%). The highest reasons for absence during that time were:

1. Anxiety/stress/depression/other psychiatric illnesses (23.29% mean)
2. Cough / Cold / Flu (11.03% mean)
3. Other Known Causes – not elsewhere classified (9.23% mean)

The cost of working days lost by DCH staff sickness absence in the last 12 months was £5.75million (Estimation by DCH business intelligence, October 2024.)

DCH Staff Survey results

In 2023, 41% of our people completed the annual NHS Staff Survey, (1421 questionnaires completed). Our trust is benchmarked against Acute and Acute & Community Trusts, where the median response rate was 45%. We are in the upper part of our benchmark group (between average & best scores in all the People Promise elements) and whilst we have seen many improvements there are areas requiring further work to improve staff survey scores. It is important to highlight that 41% of our staff who completed the survey felt they were suffering from work related stress, 30% suffered burnout, nearly 59% reported that they come to work while feeling unwell and over 34% noting emotional exhaustion.

DCH People Plan 2022-25

Our staff health and wellbeing commitment is outlined in People Principle 1. DCH Workforce availability and efficiency will be maximized by providing a healthy working environment and accessible resources to support wellbeing. We pledge to:

- Work across the ICS to maximise efficiencies for wellbeing and Occupational Health services.
- Build the foundations of a healthy workplace through the development of skills, systems and structures to support effective people management practices.
- Provide a stepped approach to a range of preventative and responsive wellbeing resources to ensure staff needs are met in the most timely and appropriate way.

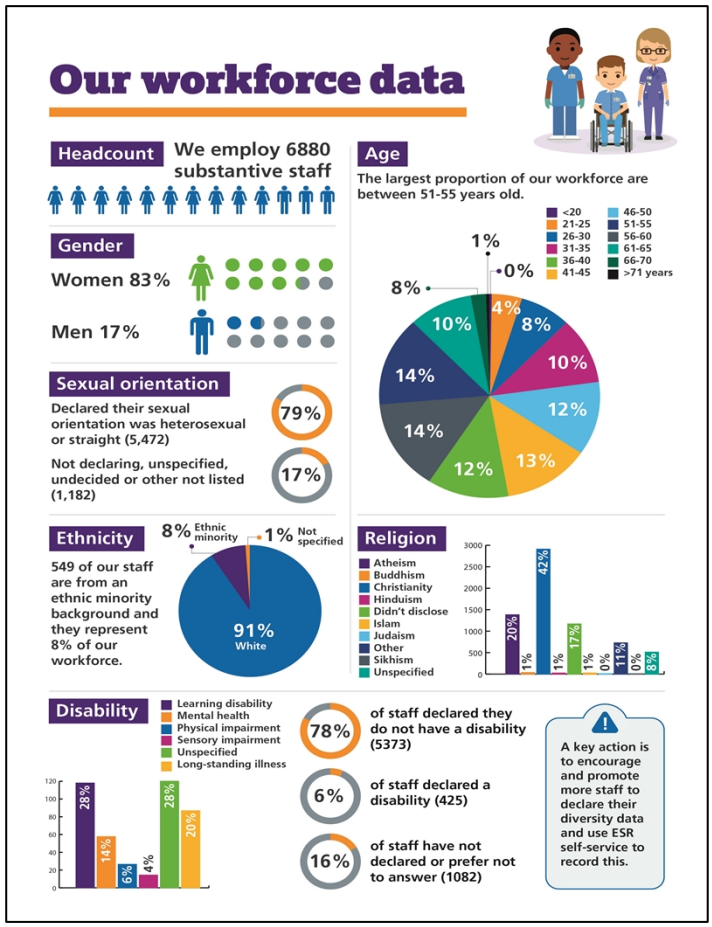
The People Plan focuses on reducing sickness absence rates, developing management skills in effectively managing sickness absence and taking proactive approaches in supporting staff health and wellbeing, including undertaking safe and effective wellbeing conversations. Our revised appraisal process also includes a focus on health and wellbeing.

Our network of Health & Wellbeing Coaches and Champions continues to grow as a community of practice. Our EAP provider agreed a tailored triage process to safely signpost staff to the most appropriate support, including access to on-site and telephone counselling. A new sickness absence policy and associated toolkit for managers is planned for early 2025.

2.2 Our People – Dorset HealthCare

The workforce data report (June 2023 - infographic) showed that the organisation employs around 6800 people. At that time 83% of our workforce were female, 17% male. The largest proportion of our people were 51-55 years old with 41% being 51 years or older. 7.8% of our workforce are from an ethnic minority background and 6% of people have declared a disability.
Our people work in many different roles and settings and in locations across the county.

This information is important as factors such as gender, age and background will impact the types of wellbeing support our staff require. Geographic location is also a consideration in access to the support.



DHC Sickness absence and staff retention

Between October 2023 and September 2024, the mean sickness absence rate for our Trust was 5.16% (range of 4.64%-5.16%). The highest reasons for absence during that time were:

1. Anxiety /stress/depression/other psychiatric illnesses (26.7 % mean)
2. Cold Cough Flu – Influenza (9.9% mean)
3. Other musculoskeletal problems (8% mean)

The cost of working days lost by DHC staff sickness absence in the last 12 months was £10.6million. (Estimation by DHC workforce data intelligence. Nov 2024.)

DHC Staff Survey results

In 2023, 50% of our people completed the annual NHS Staff Survey, (3407 questionnaires completed). Our Trust is benchmarked against Mental Health & Learning Disability and Mental Health, Learning Disability & Community Trusts, where the median response rate was 52%. We are in the upper part of our benchmark group (between average and best scores in all the People Promise elements bar we are always learning) and whilst we have seen many improvements there are areas requiring further work to improve staff survey scores. It is important to note that 37% of our staff who completed the survey felt they were suffering from work related stress, 23% stated they feel burnt out because of their work, 51% reported that they come to work while feeling unwell and over 31% noting they find their work emotionally exhausting.

DHC Workforce Delivery Framework

Health and Wellbeing is one of the six key work streams of the Trust's Workforce Delivery Framework with three key deliverable projects for health and wellbeing that are ongoing. The framework includes a focus on reducing sickness absence. A new policy and associated toolkit were launched in 2023 moving from a reactionary approach to absence management, to a more proactive approach. It is based on four key principles of prevention, early intervention, clear and consistent policy, and compassion. All of which are aligned with the wellbeing of our workforce.

The framework also focuses on the role of our Health and Wellbeing Champions and the desire to grow this network. The other aspect is in relation to continuing to develop our managers in how to hold supportive wellbeing conversations with their team members.

3 Strategic Alignment – how we fit together

The importance of staff wellbeing is reflected in national policy. The NHS People Plan (NHS England, 2020), Long Term Workforce Plan (NHS England, 2023) and Equality, Diversity and Inclusion Improvement Plan (NHS England, 2023), have a clear emphasis to improve staff experience of the workplace environment through compassionate and inclusive cultures.

All seven elements of the NHS People Promise impact the wellbeing of people.

External	
NHS England - Wellbeing Framework (2021)	Cocreated with organisations across the NHS this national level culture change toolkit provides a framework which shares best practice and details seven core elements of wellbeing in the NHS workplace.
Growing Occupational Health and Wellbeing Together Strategy (2023)	This five-year national strategy provides recommendations and best practice examples of proactive and preventative initiatives which improve workforce health and wellbeing and maximising value of interventions.
ICB Joint Forward Plan: 2023-28	This system wide plan has five areas of focus and five outcome health and wellbeing priorities.
Our Dorset People Plan (ICS)	Our people feel valued, included and psychologically safe to bring their whole self to work.
Internal	
Working together, improving lives (2024)	Dorset County Hospital and Dorset HealthCare joint strategy.
Joint Inclusion and Belonging strategy (2024)	Dorset County Hospital and Dorset HealthCare joint strategy for developing a culture of inclusion and belonging in the workplace.
DCH and DHC Joint People Plan (2025)	This new plan is under development and will be published in 2025 to detail delivery plans for working together and improving lives. Workforce wellbeing will be an integral element of this plan.

Our values

Our values are at the centre of what we do, guiding our actions and behaviours on both an organisational and individual level.

It is vital that these values are reflected and embedded when designing interventions that focus on workforce wellbeing at both Dorset County Hospital (Respect, Integrity, Teamwork and Excellence) and Dorset HealthCare (Working together for patients, Respect and dignity, Commitment to quality of care, Compassion, Improving lives, Everyone counts and Commitment to learning).

4 The Plan: where we want to be

This plan is about being proactive about prevention. Empowering and upskilling our people to live healthier lives. We want to be in a position where our people report, through the National Staff Survey and Quarterly Pulse survey and other metrics, that they feel supported and empowered and they are thriving in their teams. Where people feel this way, we will see a reduction in sickness absence, especially in our highest reason for sickness absence (Anxiety/stress/depression/other psychiatric illnesses) and increase in staff retention.

4.1 Our workforce wellbeing vision and mission

Our workforce wellbeing vision: We empower and support our people to live healthier lives, and our teams to thrive.

Our wellbeing mission is to: Work in partnership to provide wellbeing information, guidance and support to our people, helping them to be safe and healthy and their teams to thrive.

4.2 Workforce wellbeing objectives

To achieve this vision we have developed these seven objectives which align to the NHS England Wellbeing Framework elements:

1. **Improving personal health and wellbeing:** we will provide our people with information and appropriate time to proactively improve and maintain their personal health and wellbeing. Encouraging all employees to have their own personalised ‘My wellbeing at work plan’

2. **Relationships:** we will support and encourage compassionate working relationships through education and role modelling. Ensuring that wellbeing conversations are commonplace.

3. **Fulfilment at work:** we will foster a sense of fulfilment at work by promoting and prioritising inclusion, recognition, and work life balance.

4. **Managers and leaders:** we will provide managers and leaders with guidance and training on staff wellbeing and facilitating meaningful wellbeing conversations. Encourage managers to role model healthy working behaviours and consider the individual needs of their employees.

5. **Environmen**t: work together to promote ways to increase physically and psychologically safe, healthy, and inclusive work environments.

6. **Data Insights:** we will use workforce data, National Staff Survey and Pulse results to measure objective outcomes and plan for the future.

7. **Professional wellbeing support:** we will provide access to relevant and effective professional wellbeing support for people and ensure that when difficult or traumatic incidents happen at work people have rapid access to appropriate support.

4.3 Principles and enablers

Important principles about how we work in wellbeing:

- Using information, tools, and building personal skills to empower people in their own lives and be preventative in our approach
- Using data insights and monitoring systems to measure and evaluate the impact of our actions, and to identify areas for future improvement.
- Working together with our colleagues and system partners to support the wellbeing of our people and patients.

Four key areas will enable us to achieve these objectives:

1. Policy and guidance

A culture of wellbeing requires a foundation of clear documentation detailing what is expected and provided. This guidance will help to ensure equity for all staff across the Trusts. We will

- ✓ work with HR Teams and our Trade Union partnerships to ensure that all workforce related policies consider our people's wellbeing.
- ✓ ensure wellbeing plans and conversations are included in guidance as an expectation for all staff. Highlighting the use of the carers passport to support working carers.
- ✓ write and publish a guidance document that details clear expectations for workforce wellbeing. This guidance will reference and signpost to other people related policies.
- ✓ develop and implement wellbeing guidance documents for managers and health and wellbeing champions/coaches.

2. Communication & Engagement

The information our people receive shape their experience and how they talk about that experience creates the culture. We will:

- ✓ continue to review our health and wellbeing intranet pages to enable staff to access clear, up-to-date information.
- ✓ continue a rolling annual communications plan to promote awareness campaigns.
- ✓ organise and facilitate a variety of wellbeing events.
- ✓ strengthen senior leadership engagement through clear expectations and support to role-model healthy behaviours

3. Training

Supporting our workforce with high quality, effective training to help them to develop skills to support themselves and each other is pivotal to the success of this plan. We will:

- ✓ work with Learning and Development and Leadership development to review health and wellbeing related training offers and refresh as required.
- ✓ deliver team wellbeing and wellbeing conversation training for managers and leaders, equipping them with skills to confidently safeguard the wellbeing and psychological safety of their direct reports.
- ✓ continue to facilitate Health and Wellbeing Champion/Coach orientation and frequent CPD training.
- ✓ periodically deliver update training to our Human Resources Advisory Team and Occupational Health teams to ensure consistent information sharing and signposting.
- ✓ link with Health and Safety training and processes especially where HSE guidance is linked to is wellbeing such as work-related stress.

4. Interventions

Ensuring that we have safe, relevant and effective specialist support available to our staff if they should need it. We will:

- ✓ review the availability and effectiveness of the current therapeutic interventions for our people, including our Employee Assistance Programmes.
- ✓ create a business case to fund gaps in provision of necessary interventions.
- ✓ continue to promote and raise awareness of relevant services available to staff outside the Trust.
- ✓ Support our teams using TRiM processes when a traumatic incident occurs
- ✓ Support team development using the TED tool.

4.4 Collaboration and system working

Wellbeing is relevant wherever there are people. Wellbeing is everyone's business, and we will not deliver the objective in this plan unless we work together with organisation colleagues and wider ICB system partners.

Our particularly important alignments are:

- Occupational Health
- HR & Recruitment
- Equality, Diversity and Inclusion (including Staff Networks)
- Organisational Development
- Leadership Development
- Quality Improvement
- Freedom To Speak Up
- Estates and Facilities
- Sustainability
- Health & Safety teams
- Trade Union partnerships

5 Evaluation – how will we measure our progress?

Quarterly metrics reports will be put in place to ensure the actions detailed within this plan are fit for purpose and having the right impact. We will monitor and evaluate the following data to evidence the progress of this plan:

Metric theme	Metrics	Source of data	Frequency
Workforce physical and mental health	Sickness absence, whole time equivalent days sick, whole time equivalent days available and sickness absence rate: - all staff - staff group - ethnicity - gender - age band	Electronic staff record	Monthly
	NHS staff survey health, by staff group. For example: "in the last 12 months have you experienced musculoskeletal problems as a result of work activities?" "in the last three months have you ever come to work despite not feeling well enough to perform your duties?"	NHS staff survey	Annually
Workforce wellness	Life balance, by staff group. For example: - reason for leaving due to life balance - reason for leaving due to flexibility - reason for leaving due to health - NHS leavers rate - staff turnover rate - overall vacancy rate	Electronic staff record	Annually
	NHS staff survey wellness, by staff group. For example: "the opportunities for flexible working patterns" "adjustments to workplace"	NHS staff survey	Annually
	NHS staff survey leadership and management, by staff group. For example: "my immediate manager gives me clear feedback on my work" "my immediate manager takes a positive interest in my health and wellbeing" "my manager supported me to receive this training, learning or development"	NHS staff survey	Annually
Workforce safety	Freedom to speak up cases relating to bullying and harassment	Freedom to speak up guardians guardians	Quarterly
	NHS staff survey safety, by staff group. For example: "I receive the respect I deserve from my colleagues at work" "in the last 12 months how many times have you personally experienced harassment, bullying or abuse at work from...?"	NHS staff survey	Annually
	Sexual safety reporting		

A robust system for recording and reporting on wellbeing conversations to be offered and uptake is needed. The revision of the appraisals process may encapsulate this.

The number of wellbeing conversations offered, and number of Health and Wellbeing Champions should be included in the HR Monthly Dashboard reporting.

Additional data to support evaluation:

- Intranet analytics for Health and Wellbeing pages
- Volume and trends of access to EAP
- Number of wellbeing related events and training attended including the Our Mental Health training
- Number of line managers completing wellbeing conversation training
- New starters completing a wellbeing module as part of their induction and onboarding

6 Conclusion

This plan takes an action-oriented approach to embed wellbeing as part of our culture at Dorset HealthCare and Dorset County Hospital. It provides a baseline from which we can utilise our data to measure our progress. It is a collective responsibility to bring this plan to life. Together, we can create an environment where our workforce feels supported and empowered to live healthy, thriving lives. In turn this will help to improve our people's health and wellbeing and that of their friends and families, our patients, and the communities we care for.

The actions outlined have the potential to support the reduction of sickness absence, improve staff retention, reduce health inequalities, increase staff engagement, improve productivity, and enhance our ability to deliver quality care sustainably.

7 Ownership & Governance

This plan is one of the deliverables from our overarching workforce strategies and an action plan for each Trust has been included (Appendices 1a & 1b).

Progress on the development, implementation and impact of these action plans will be overseen by each Trust's Steering Group. These groups have clear terms of reference and report to the Joint People and Culture in Common Committee.

Each Trust has an appointed Wellbeing Guardian, a Non-Executive Director who acts as a critical friend and supports the development of a compassionate and inclusive wellbeing culture by independently challenging senior leaders, seeking assurance and recommending models, methods, and resources to support our people's wellbeing.

The Trust Board receive regular reports on key workforce metrics (retention, recruitment, sickness absence) as part of the integrated corporate dashboard which provide an indication of the impact of actions through trend analysis.

We recommend a Joint Workforce Wellbeing Report be presented to the Joint Trust Board annually and that Trust board members have specific and measurable wellbeing objectives to which they will be individually and collectively accountable by 2026.

Appendix 1a: DHC Workforce Delivery Action Plan

Our overarching workforce wellbeing action plan is a high-level overview of the actions we have committed to. It will be supplemented with a detailed plan that includes milestones and target dates to ensure we are continually held to account for delivery of this plan.

Actions	NHS England HWB Framework Element/ Joint Workforce Wellbeing Objective	EDS2 Domain	People Promise Element	EDI Imp Plan
Create and implement a DHC Workforce Wellbeing guidance/ policy and a Wellbeing Charter which clearly states responsibilities and expectations for the wellbeing of our workforce. Wellbeing Lead to link with policy review group regarding workforce policies.	1. Improving Personal HWB 2. Relationships 3. Fulfilment at Work 4. Managers & Leaders 5. Environment 7. Professional Wellbeing Support	2a, b, c & d	• We are healthy and safe • Compassionate & Inclusive • We work flexibly	
Review all HWB related training offers to ensure alignment with this plan and develop new courses where required including: • e-Hub courses • HWB Champion training • Wellbeing conversations • Modelling healthy behaviours • 'Our Mental Health' awareness training suicide prevention • Ensure cross reference with all Wellbeing related course such as sexual safety, and Leadership resilience and wellbeing and menopause awareness.	1. Improving Personal HWB 2. Relationships 3. Fulfilment at Work 4. Managers & Leaders 5. Environment 6. Data Insights 7. Professional Wellbeing Support	2a & d	• We are healthy and safe • Compassionate and Inclusive • We are always learning	
Complete the NHSE Health & Wellbeing framework diagnostic tool using our workforce data. Develop a clear reporting model to monitor progress on our action plan including National Staff Survey and Quarterly Pulse surveys data. Research the value of a Trust wide annual Health and Wellbeing survey.	6. Data Insights	2d	• We are healthy and safe • Compassionate and Inclusive • a voice that counts We are always learning	4a

Continued >

Actions	NHS England HWB Framework Element/ Joint Workforce Wellbeing Objective	EDS2 Domain	People Promise Element	EDI Imp Plan
Review and update our HWB intranet pages. Ensuring information remains easily accessible and accurate and current. Develop and implement an annual communications plan of awareness campaigns and events.	1. Improving Personal HWB 2. Relationships 3. Fulfilment at Work 4. Managers & Leaders 5. Environment 7. Professional Wellbeing Support	2a & c	• We are healthy and safe • Compassionate and Inclusive	
Work closely with our colleagues across the organisation and the wider system on projects and BAU that impacts our people's wellbeing. Including: Occupational Health, HR & Recruitment, EDI (including Staff Networks), OD & Leadership development, QI and FTSU, Estates & Facilities, Health & Safety and Trade Union representatives.	2. Relationships 3. Fulfilment at Work 4. Managers & Leaders 5. Environment	2a & d	• We are healthy and safe • Compassionate and Inclusive • Flexibly	
Review availability and effectiveness of the current HWB interventions available to our people. Create a business case to ensure we provide adequate and timely access to emotional trauma therapy and physical therapy interventions. Implement and monitor access to these interventions.	1. Relationships 4. Fulfilment at Work 5. Managers & Leaders 6. Data Insights 7. Professional Wellbeing Support	2a, b & d	• We are healthy and safe • Compassionate and Inclusive	

Continued …

Actions	NHS England HWB Framework Element/ Joint Workforce Wellbeing Objective	EDS2 Domain	People Promise Element	EDI Imp Plan
Maintain good coverage of active HWB Champions throughout the Trust.	1. Improving Personal HWB 2. Relationships 3. Fulfilment at Work 4. Managers and Leaders 5. Environment	2a & d	• We are healthy and safe • Compassionate and Inclusive • We area team • We are always learning • A voice that counts • Recognised and reward	
Ensure the offering of wellbeing conversations is regular managerial practice and promote the completion of the 'My Wellbeing at Work' plans by all staff and value of accepting wellbeing conversations offers from managers. Work with HR colleagues to develop wellbeing conversations as part of the appraisal refresh.	1. Improving Personal HWB 2. Relationships 3. Fulfilment at Work 4. Managers and Leaders 5. Environment 6. Data Insights 7. Professional Wellbeing Support	2a, b & d	• We are healthy and safe • Compassionate and Inclusive • We are always learning • A voice that counts	
Support and promote projects such as reducing violence and aggression, sexual safety and improving inclusion.	1. Improving Personal HWB 2. Relationships 4 Managers and Leaders 5 Environment		• We are healthy and safe • Compassionate and Inclusive • We are always learning • A voice that counts	
Promote smarter working to support wellbeing and encourage the use of technology to support this.	3 Fulfilment at Work 5 Environment		• We are healthy and safe • Compassionate and Inclusive • We are always learning	

Appendix 1b: DCH Workforce Delivery Action Plan

Our overarching workforce wellbeing action plan is a high-level overview of the actions we have committed to. It will be supplemented with a detailed plan that includes milestones and target dates to ensure we are continually held to account for delivery of this plan.

Actions	NHS England HWB Framework Element/ Joint Workforce Wellbeing Objective	EDS2 Domain	People Promise Element	EDI Imp Plan
Review all HWB related training offers to ensure alignment with this plan and develop new courses where required including: • HWB Champion/Coach training (induction and CPD) • PILOT PROJECT with Samaritans, based on their 'Listeners' training, tailored for use in hospital setting • Safe and Effective Wellbeing Conversations (part of Management Matters Programme) • Mental Health Awareness • Suicide First Aid • Personal Resilience • Dignity and Respect at Work • Sexual Safety at Work	1. Improving Personal HWB 2. Relationships 3. Fulfilment at Work 4. Managers and Leaders 5. Environment 7. Professional Wellbeing Support	2a & d	• We are healthy and safe • Compassionate and Inclusive • We are always learning	
Review and update our HWB intranet pages and HWB analog folders. Develop and implement an annual communications plan of awareness campaigns and events.	1. Improving Personal HWB 2. Relationships 3. Fulfilment at Work 4. Managers and Leaders 5. Environment 7. Professional Wellbeing Support	2a & c	• We are healthy and safe • Compassionate and Inclusive	

Continued …

Actions	NHS England HWB Framework Element/ Joint Workforce Wellbeing Objective	EDS2 Domain	People Promise Element	EDI Imp Plan
Work closely with our colleagues across the organisation and the wider system on projects and BAU that impacts employee wellbeing. Including: Occupational Health, HR & Recruitment. QI, FTSU, Estates & Facilities, Health & Safety, Risk & Governance, Trade Union representatives, Staff Networks. *HWB work embedded in wider OD Team: Leadership Development Lead, EDIB Lead, OD Projects Facilitator(s) and HR colleagues.*	2. Relationships 3. Fulfilment at Work 4. Managers and Leaders 5. Environment	2a & d	• We are healthy and safe • Compassionate and Inclusive • Flexibly	
Review availability and effectiveness of the current HWB interventions available to our people. Create a business case to ensure we provide adequate and timely access to emotional trauma therapy and physical therapy interventions. Implement and monitor access to these interventions.	1. Relationships 2. Fulfilment at Work 3. Managers and Leaders 4. Data Insights 5. Professional Wellbeing Support	2a, b & d	• We are healthy and safe • Compassionate and Inclusive	
Maintain good coverage and diversity of active HWB Champions/Coaches throughout the Trust.	1. Improving Personal HWB 2. Relationships 3. Fulfilment at Work 4. Managers and Leaders 5. Environment	2a & d	• We are healthy and safe • Compassionate and Inclusive • We are a team • We are always learning • A voice that counts • Recognised and rewarded	
Embed appraisal process across the Trust to ensure staff health and wellbeing conversations are happening regularly as a fundamental aspect of the revised appraisal process and supplemented by Safe and Effective Wellbeing Conversations (includes My Wellbeing at Work Plans).	1. Improving Personal HWB 2. Relationships 3. Fulfilment at Work 4. Managers and Leaders 5. Environment 6. Data Insights 7. Professional Wellbeing Support	2a, b & d	• We are healthy and safe • Compassionate and Inclusive • We are always learning • A voice that counts	

Continued …

Actions	NHS England HWB Framework Element/ Joint Workforce Wellbeing Objective	EDS2 Domain	People Promise Element	EDI Imp Plan
Improved menopause support for staff, includes introduction of Menopause Advocates, refresh of Menopause Forum, regular menopause training opportunities such as webinars, guest speakers and awareness activities.	1. Improving personal HWB 2. Relationships 3. Fulfilment at Work 4. Managers and Leaders 6. Data Insights 7. Professional Wellbeing Support	2a & c	• We are healthy and safe • Compassionate and Inclusive • We are always learning • A voice that counts	
Utilise the NHS HWB Framework as a culture change tool to explore priority areas of staff HWB to focus on and gather insights about. Complete the NHS England Health and Wellbeing framework diagnostic tool using our workforce data, data/evidence from National Staff Survey, Quarterly Pulse and tailored surveys and feedback from workshops/focus groups/other feedback mechanisms. Agree on a clear reporting model that will help us to monitor progress on our action plan and ensure that offers and interventions make a sustained and measurable difference.	6. Data Insights	2d	• We are healthy and safe • Compassionate and Inclusive • A voice that counts • We are always learning	4

NHS
Dorset County Hospital
NHS Foundation Trust

Report to	Board of Directors, part 1	
Date of Meeting	10 December 2024	
Report Title	2024 GMC National Training Survey	
Prepared By	Dr Paul Murray – Director of Medical Education	
Approved by Accountable Executive	Nicola Plumb – Joint Chief People Officer	
Previously Considered By	Medical Education Group – 26 September 2024	
Action Required	**Approval**	N
	Assurance	Y
	Information	Y

Alignment to Strategic Objectives	Does this paper contribute to our strategic objectives? *Delete as required*	
Care	Yes	
Colleagues	Yes	
Communities	Yes	
Sustainability	Yes	
Implications	Describe the implications of this paper for the areas below.	
Board Assurance Framework	The Trust aspires to provide high quality educational opportunities to all trainees. In the case of medical trainees, they are an important factor in both current and future workforce plans – linking to BAF risk 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*	
Financial	Poor survey outcomes may mean that training places and associated funding is withdrawn.	
Statutory & Regulatory	As above.	
Equality, Diversity & Inclusion	As above.	
Co-production & Partnership	NA	

Executive Summary

The purpose of this presentation is to provide the People and Culture Committee in Common with an overview of the most recent GMC National Training Survey results. The survey is undertaken in March to May each year. This report outlines the areas of excellence and those areas that were low outliers.

Both the DCH trainee (55%) and trainer (79%) response rates exceeded the Wessex and National average. Improved scores occurred in 14 of the 19 elements of the survey, with only one element (local teaching) scoring in the lower quartile with significance.

There were several individual areas of excellence, including areas in General Surgery, Gastroenterology, Paediatrics, Obstetrics and Gynaecology, GP posts, Anaesthetics and Geriatrics.

Areas identified as red (low outliners), alongside overall local teaching was the surgical F2 post, adequate experience, rota design in Paediatric Specialty posts, local teaching in all Paediatric posts and out of hours supervision and rota design in Geriatrics. Action plans for all red areas were submitted to the Medical Education Group in September.

Overall, DCH continues to score well in relation to the facilities provided to trainees. In relation to burnout, although both the DCH trainees and trainers report less than the national average, it has been identified that additional support should be provided to Emergency Medicine, where the risk of burnout is highest.

Recommendation
Members are requested to: • Receive the presentation for **information and assurance.**

Dorset County Hospital
NHS Foundation Trust

2024 GMC National Training Survey

Dr Paul Murray
Consultant Nephrologist
Director of Medical Education

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Key to Charts

Dorset County Hospital
NHS Foundation Trust

- Green are scores in the top quartile nationally and are significant
- Light green, top quartile but don't reach significance
- Red scores are lower quartile outliers and reach significance
- Pink are lower quartile but do not reach significance.
- 2024 change to reporting system

	Trust	Wessex	National
Trainee	78.74%	71.42%	76%
Trainer	55.37%*	40.04%*	38%

Trainee Survey

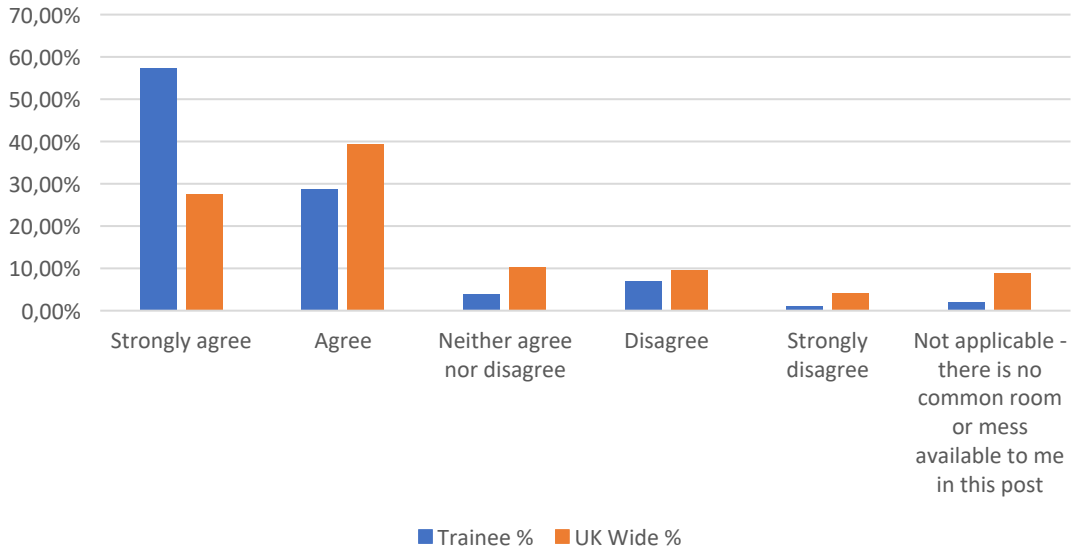
Overall Results for DCH

	2021	2022	2023	2024
Overall Satisfaction	78.29	73.31	78.45	79.31
Clinical Supervision	89.98	88.3	89.24	90.16
Clinical Supervision out of hours	86.24	83.42	84.99	85.82
Reporting Systems	77.1	71.38	75.14	73.54
Work Load	58.16	47.14	48.87	50.21
Teamwork	75	75.31	74.76	80.12
Handover	69.13	65.56	72.45	70.64
Supportive Environment	72.81	75.56	77.47	78.42
Induction	78.92	74.75	81.74	80.09
Adequate Experience	79.28	71.25	76.58	78.71
Curriculum Coverage	76.04			
Educational Governance	76.26	69.58	72.51	73.58
Educational Supervision	89.38	83.28	84.91	89.79
Feedback	76.39	64.96	70.66	77.11
Local Teaching	63.87	63.24	67.3	60.65
Regional Teaching	67.45	65.55	61.34	61.44
Study Leave	61.67	55.78	60.11	70.1
Rota Design	61.1	47.4	58.28	54.15
Facilities	72.64	75.06	75.31	75.47

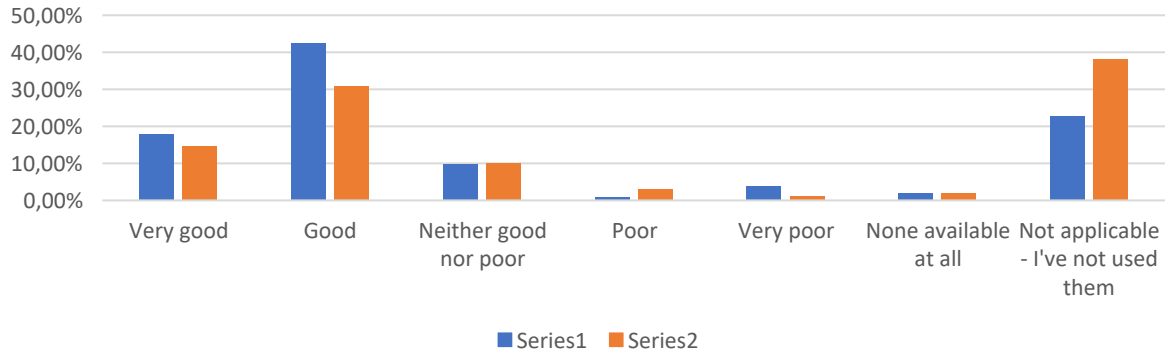
Facilities

Dorset County Hospital
NHS Foundation Trust

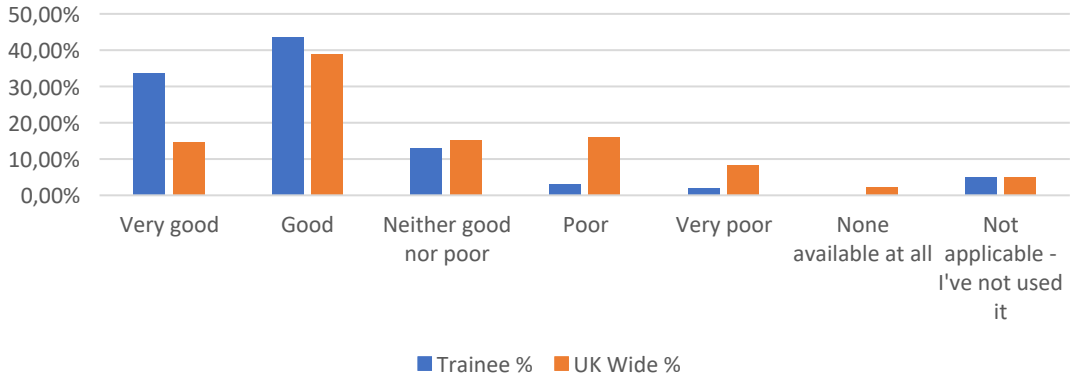
At the start of this post I got all the information I needed about how to access the common room or mess.



Please rate how good or poor the following are for your study needs in your current post: the collection of online resources offered by the library service 24/7 (databases, journals, e-books)



Please rate how good or poor the following are for your study needs in your current post: Wi-fi connectivity



Why Does DCH Score so Consistently well for Facilities?

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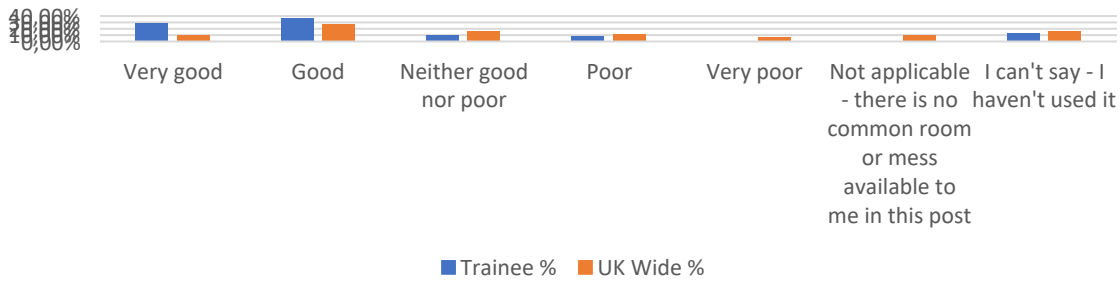
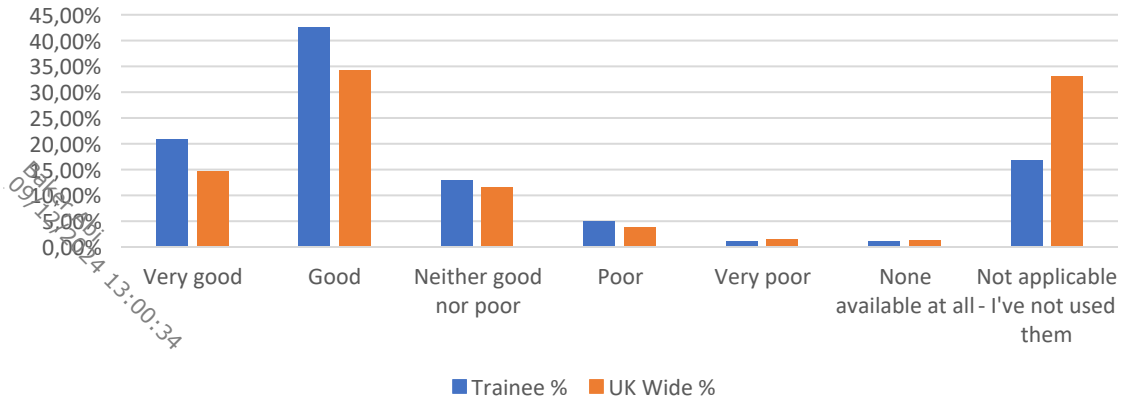
Facilites

Dorset County Hospital
NHS Foundation Trust

Please rate the quality of the common room or mess available to you in your current post. (Please consider the following: availability (24hrs, 7 days pw), accessibility, away from clinical areas, space for study, IT hardware available, showers, lockers, f



Please rate how good or poor the following are for your study needs in your current post: usability of online library resources (e.g. login support, NHS enabled, easy-to-use websites).



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How Does DCH Compare?

Dorset County Hospital
NHS Foundation Trust

Trust	Overall Satisfaction	Clinical Supervision	Clinical Supervision out of hours	Reporting Systems	Work Load	Teamwork	Handover	Supportive Environment	Induction	Adequate Experience	Educational Governance	Educational Supervision	Feedback	Local Teaching	Regional Teaching	Study Leave	Rota Design	Facilities
DCHFT	79.31	90.16	85.82	73.54	50.21	80.12	70.64	78.42	80.09	78.71	73.58	89.79	77.11	60.65	61.44	70.1	54.15	75.47
HHFT	73.9	86.78	83.44	70.12	43.92	73.63	69.82	71.61	75.55	73.9	69	84.18	73.23	62.71	65.44	64.34	52.94	61.76
IOW	73.16	81.49	79.52	64.24	47.86	70.18	66.25	72.37	73.29	73.03	70.18	82.89	79.84	62.27	79.55	72.02	54.45	56.72
Portsm	78.19	89.8	87.93	73.48	42.8	74.31	69.53	75.54	82.6	78.94	71.16	86.65	72.22	67.31	60.58	67.21	59.28	66.23
Salis	79.1	90.42	86.87	75.19	47.78	77.6	72.01	76.23	82.9	80.84	75.21	90.16	78.62	62.17	64.76	75.77	60.54	72.8
UoS	77.87	90.29	88.31	72.68	46.41	75.17	69.81	73.84	80.6	76.38	70.52	86.1	71.94	66.74	63.87	71.62	61.25	64.24
UHD	78.27	87.51	85.84	72.96	47.05	75.41	69.57	76.24	78.08	78.24	73.46	87.52	72.59	64.67	62.87	72.67	56.49	65.05

Excellence! (Green Outliers)

Dorset County Hospital
NHS Foundation Trust

- **General surgery Specialty and Core**– multiple areas, Educational Governance and Workload in **Surgery F1**
- Facilities in **Gastroenterology**
- Out of Hours Supervision, Educational Governance, Regional Teaching and Facilities in **Paediatrics** posts
- Teamwork, Supportive environment, Induction and Study Leave in **O+G specialty** posts, several others across all posts and GP posts
- Supportive environment in **Core Anaesthetics**
- Facilities in **Geriatrics**

- **Facilities across all of DCHFT posts (3rd year running)**

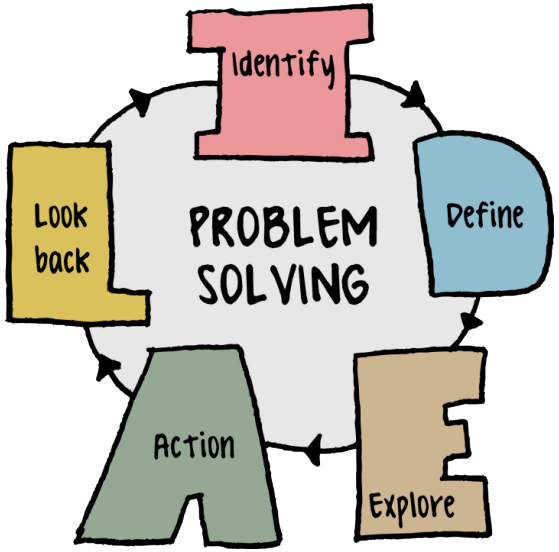
- Teamwork in **Cardiology**
- **Respiratory Posts** – Teamwork and Study Leave
- Overall satisfaction in **Anaesthetics Specialty** posts
- **GP F2** – feedback
- **Acute Medicine** – Reporting Systems, Educational Governance and Facilities
- **T+O posts** - facilities

Low Outliers (Red scores)

Dorset County Hospital
NHS Foundation Trust

- **Overall Local teaching -** Discussed at MEG 26/9/24. Each department challenged to maximise local teaching opportunities
- **Surgical F2** post
- Adequate experience, rota design **Paeds specialty posts** and local teaching in **Paeds all posts**
- Out of Hours Supervision and Rota Design in **Geriatrics**

- Regional Teaching in **Core Anaesthetics**
- Actions plans needed



Low Outliers (Red scores) – Surgery F2

Dorset County Hospital
NHS Foundation Trust

- New rota as of August 2024 (after GMC survey)
- Extra doctors as part of Foundation expansion
- New split to surgical nights to reduce workload
- Local teaching programme being instituted (across grades)

- National Education and Training Survey (NETS) (October/November) chance to assess impact of changes

Low Outliers (Red scores) – Paediatrics

Dorset County Hospital
NHS Foundation Trust

- Comprehensive review of learning opportunities and rota
- Adapted rota to ensure protected teaching time
- Recording of education content
- Regular dedicated sessions
- Full managerial and clinical cooperation to drive changes

Low Outliers (Red scores) – Anaesthetics

Dorset County Hospital
NHS Foundation Trust

- Regional teaching being discussed at Deanery/School level

Low Outliers (Red scores) – Geriatrics

Dorset County Hospital
NHS Foundation Trust

- Felt likely feedback represents tension between Geriatrics and on call medical duties

- Rota issues felt likely to represent issues with gaps (unfilled posts). Recent LED appointments likely to benefit this.

Comments

Dorset County Hospital
NHS Foundation Trust

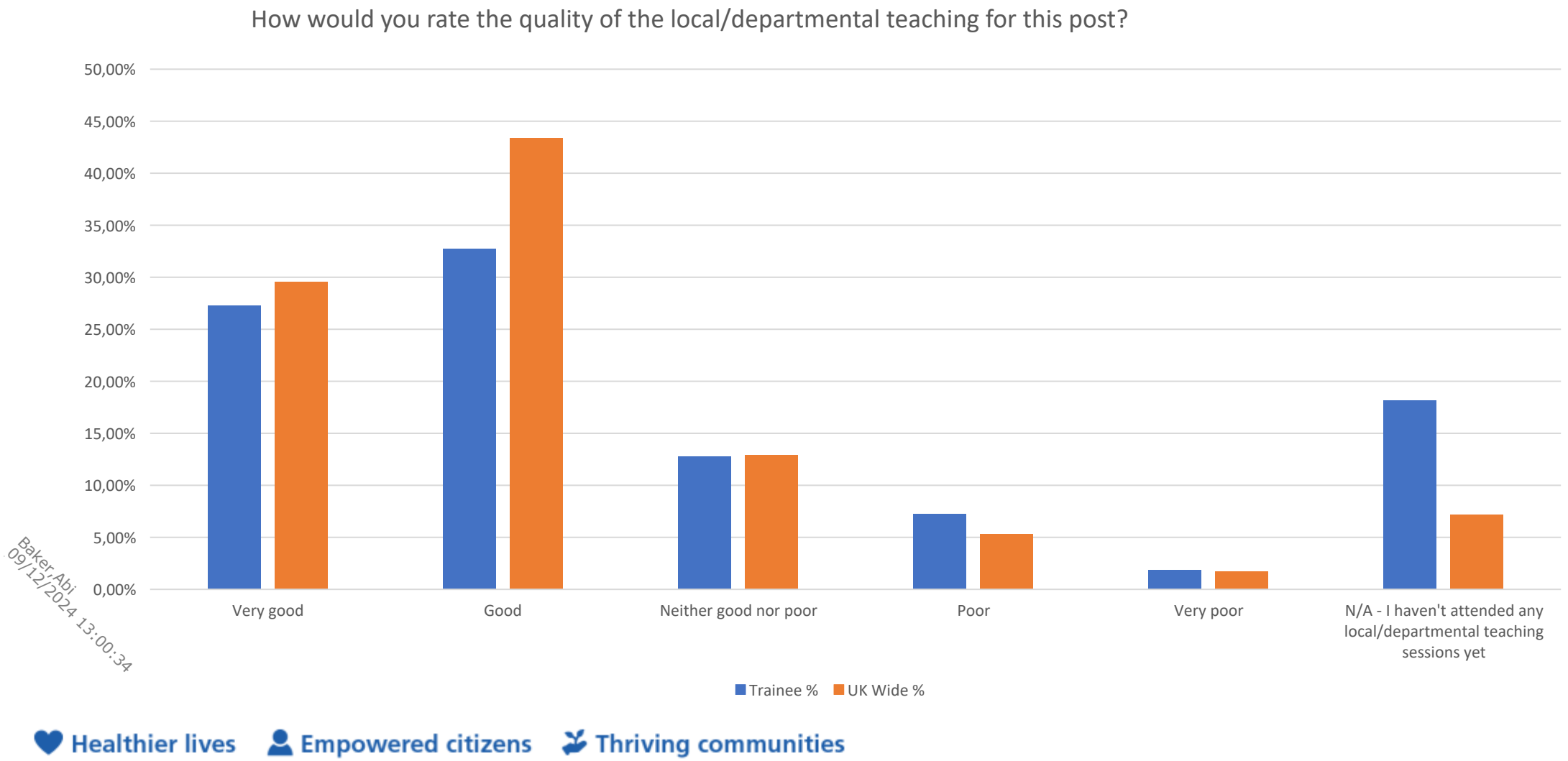
- Lots of positive comments in challenging circumstances, Greens outweigh reds

- Surgical F2 feedback very poor and concern re **overall local teaching score**

- **<u>Significant</u>** improvements seen in O+G and T+O posts

Trust wide Local Teaching responses breakdown (1)

Dorset County Hospital
NHS Foundation Trust



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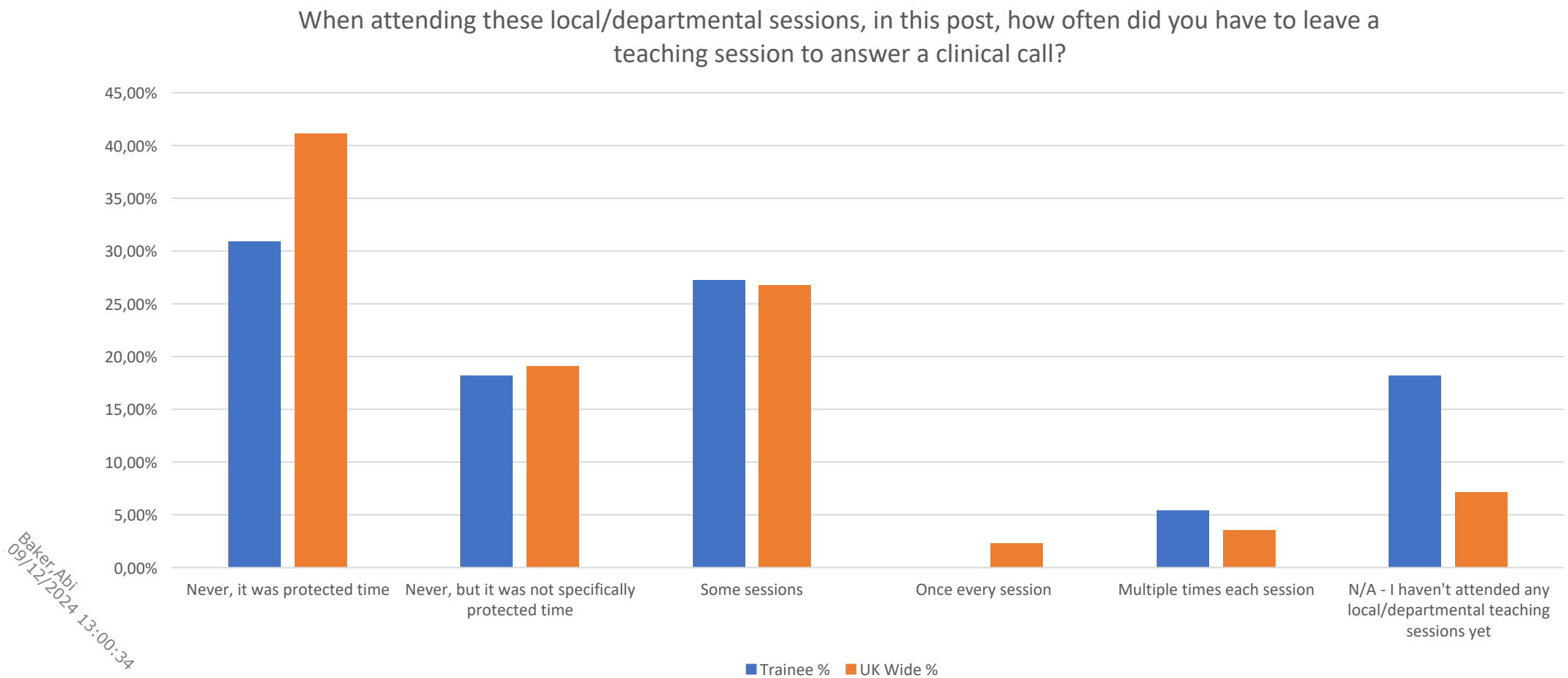
Trust wide Local Teaching responses breakdown (2)

Dorset County Hospital
NHS Foundation Trust



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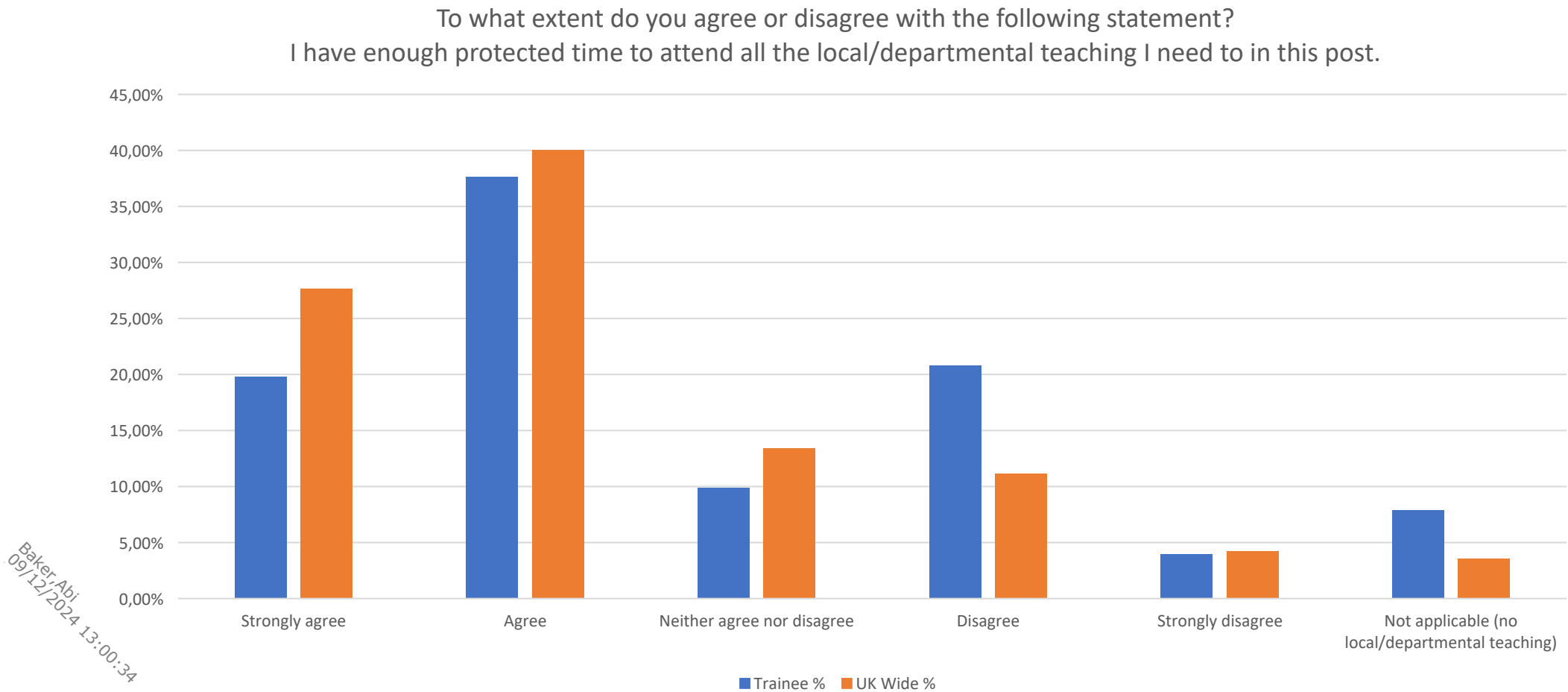
Trust wide Local Teaching responses breakdown (3)

Dorset County Hospital
NHS Foundation Trust



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Trainer Survey

Trainer Responses Comparison to Peers

Dorset County Hospital
NHS Foundation Trust

		2023	2024
Dorset County Hospital NHS Foundation Trust	Supportive Environment	73.05	72.2
	Educational Governance	70.45	64.49
	Professional Development	75.31	72.67
	Appraisal	56.65	53.54
	Support for Training	73.94	73.38
	Time to Train	60.11	59.39
	Rota Issues	48.91	49.24
	Handover	56.25	57.2
	Resources to Train	73.4	67.16
Salisbury NHS Foundation Trust	Supportive Environment	68.75	71.55
	Educational Governance	63.88	65.51
	Professional Development	74.11	75.41
	Appraisal	55.36	56.58
	Support for Training	73.88	74.23
	Time to Train	59.23	58
	Rota Issues	55.09	51.35
	Handover	67.5	64.44
	Resources to Train	69.64	70.72
University Hospitals Dorset NHS Foundation Trust	Supportive Environment	65.7	69.64
	Educational Governance	60.99	64.51
	Professional Development	71.56	73.2
	Appraisal	55.43	55.36
	Support for Training	68.54	70.61
	Time to Train	53	53.74
	Rota Issues	37.99	44.97
	Handover	61.34	59.31
	Resources to Train	65.31	63.95

Actions

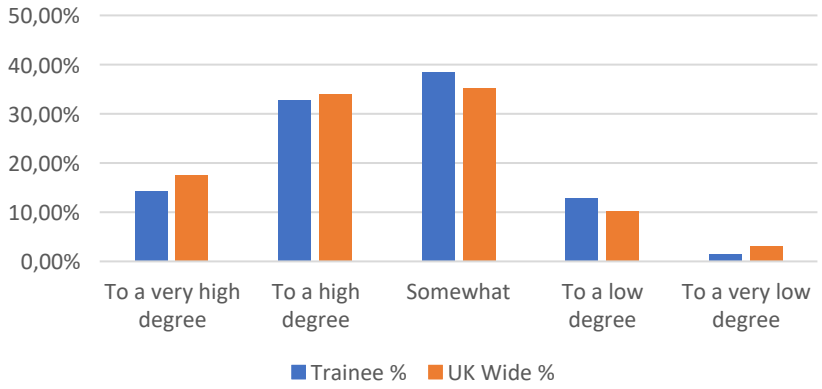
Dorset County Hospital
NHS Foundation Trust

- Dissemination of results – Clinical and Education Leads
- Applauding of positive results, sharing of best practice via Medical Education Group – meeting 26th September.
- Action plans to tackle issues with departments and divisions
- Next GMC Survey – April/May 2025

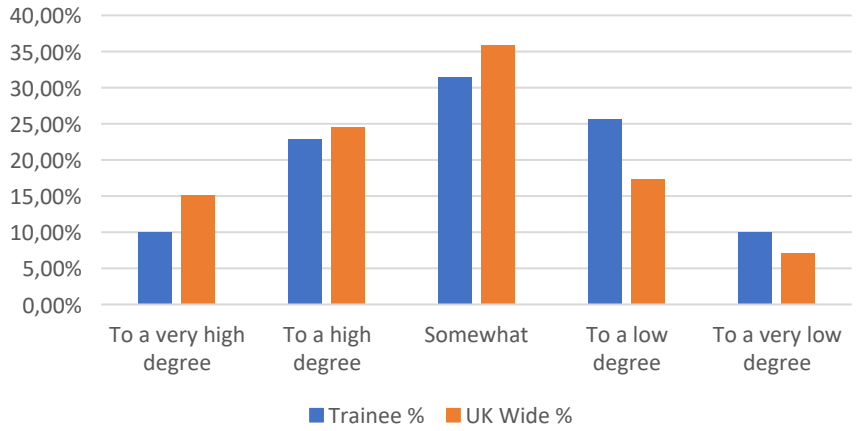
Burnout - DCH Trainees

Dorset County Hospital
NHS Foundation Trust

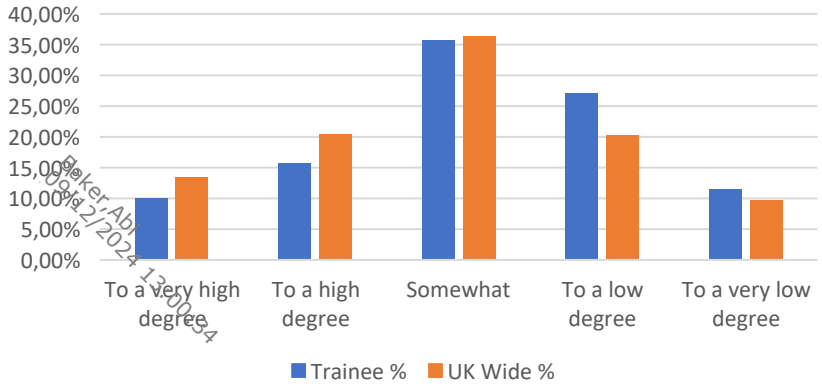
Is your work emotionally exhausting?



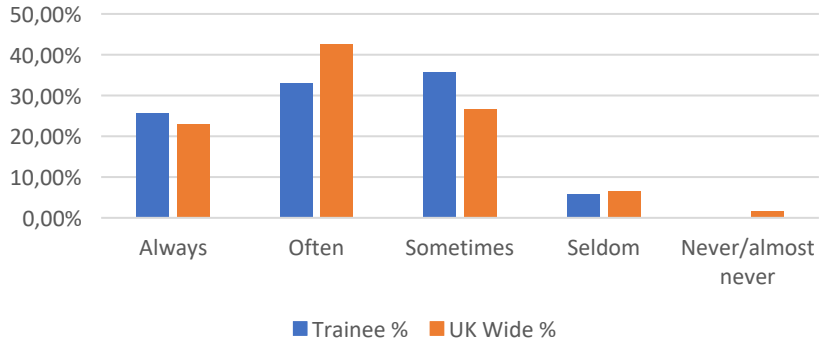
Do you feel burnt out because of your work?



Does your work frustrate you?



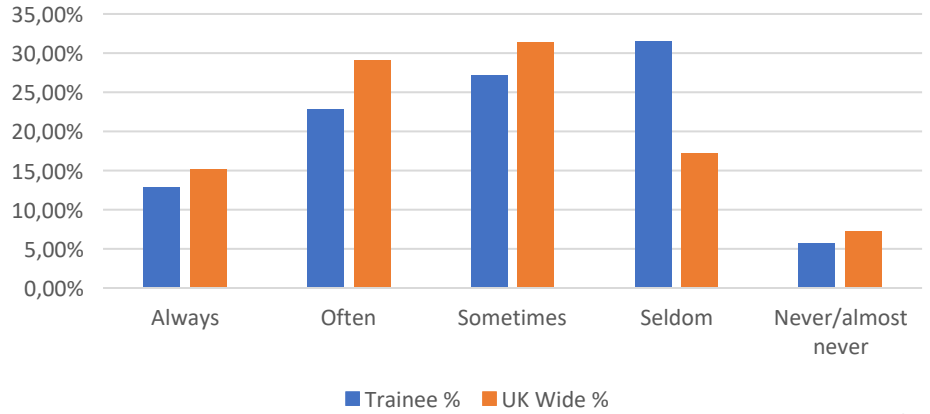
Do you feel worn out at the end of the working day?



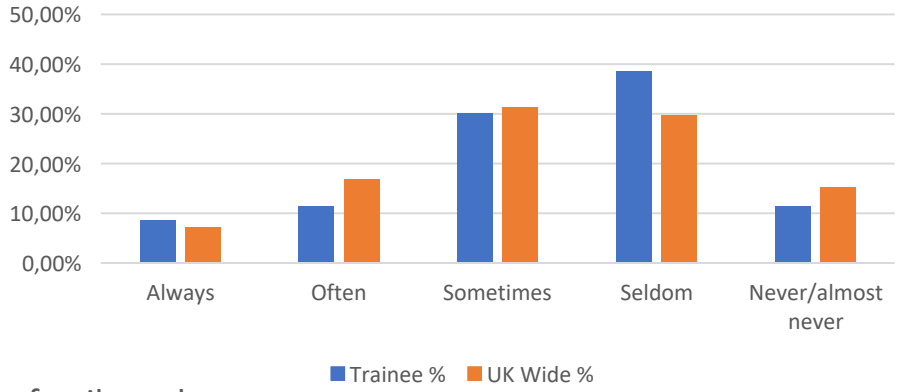
Burnout – DCH Trainees

Dorset County Hospital
NHS Foundation Trust

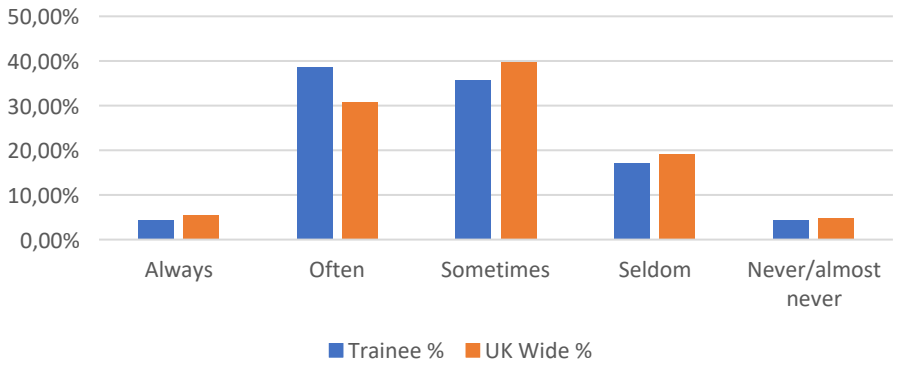
Are you exhausted in the morning at the thought of another day at work?



Do you feel that every working hour is tiring for you?



Do you have enough energy for family and friends during leisure time?



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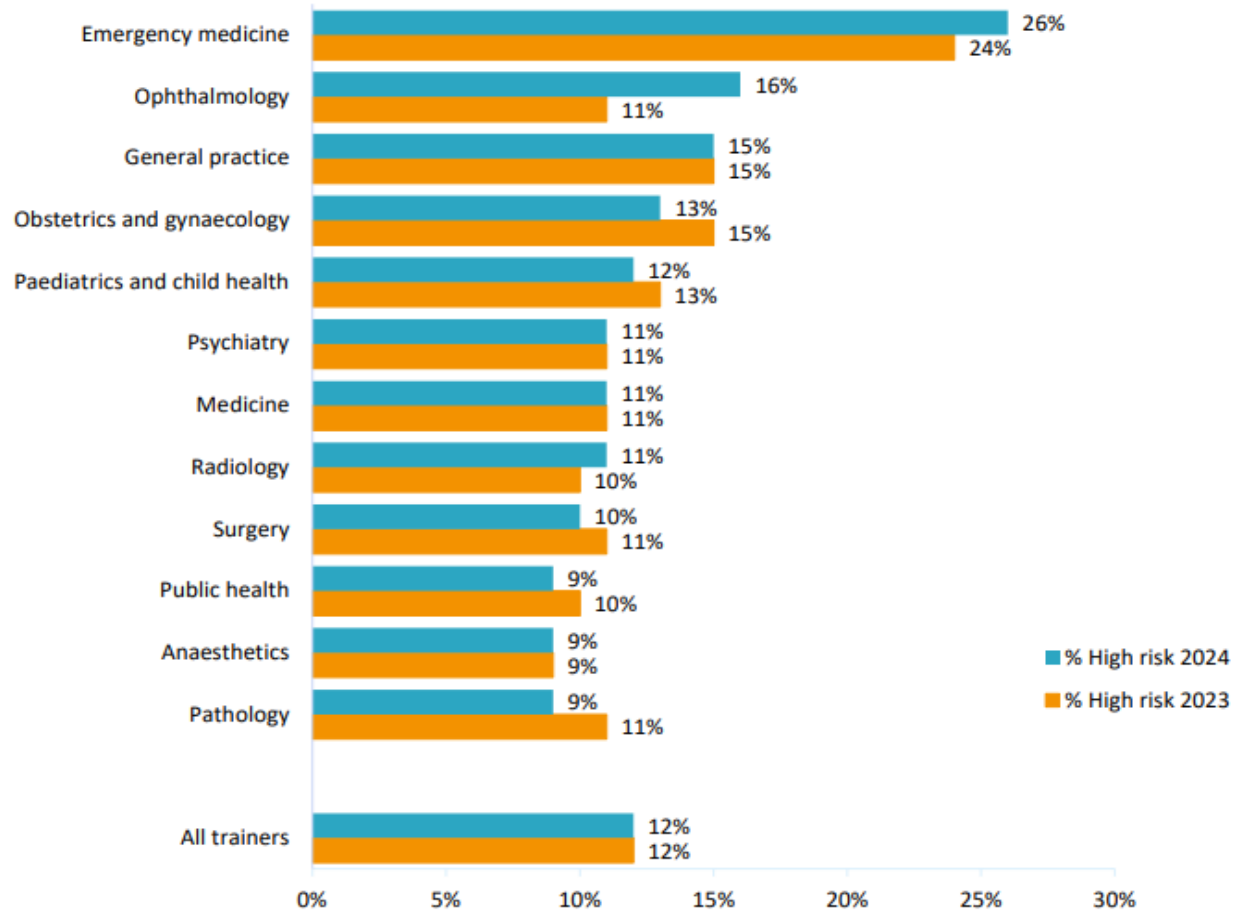
Trainers at high risk of burnout

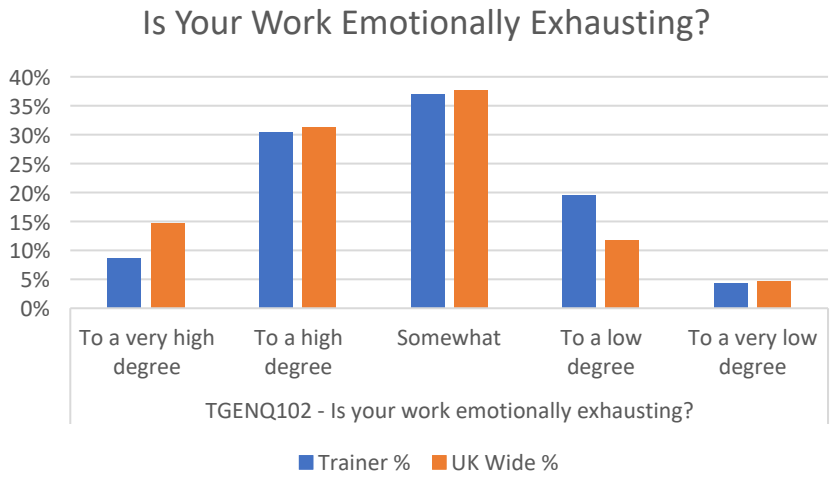
As in 2023 and 2022, 12% of all trainers were calculated to be at high risk of burnout, although some specialties did see a small increase (see Figure 12). These were emergency medicine (26% ↑2pp), ophthalmology (16% ↑5pp) and radiology (11% ↑1pp).

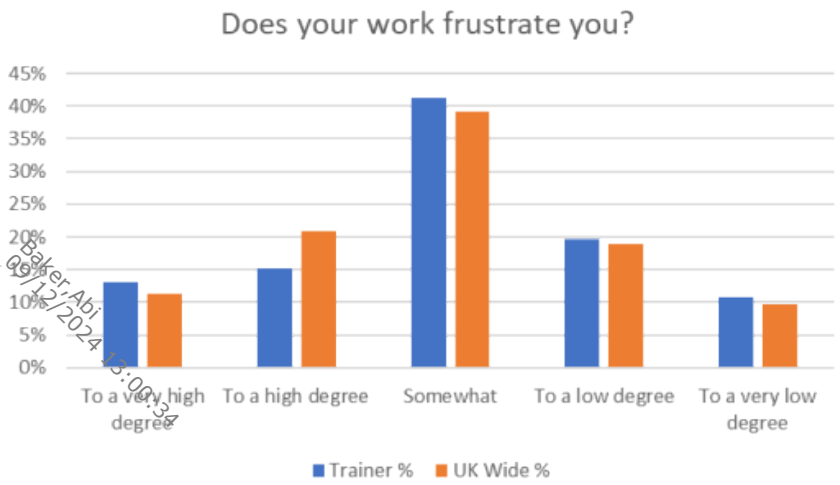
Figure 12: Trainers – Specialty variation at high risk of burnout, 2024 vs 2023

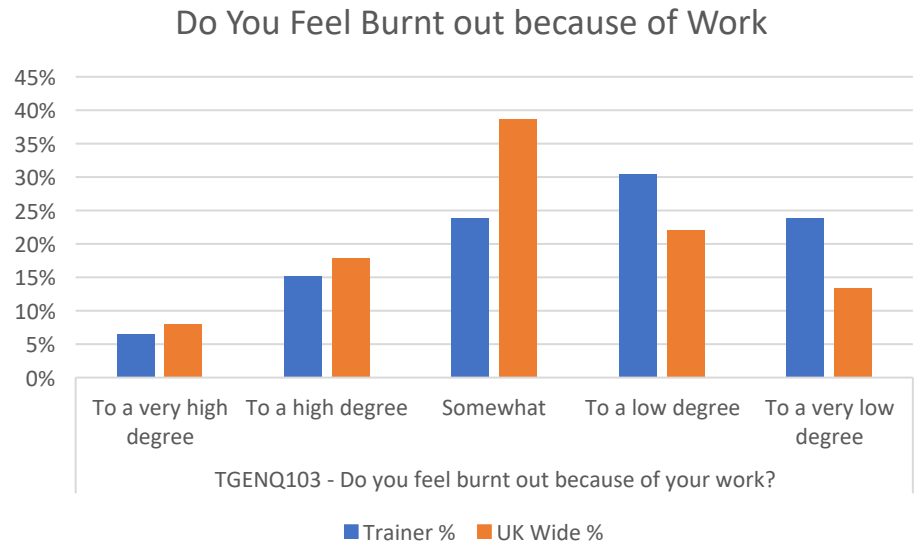


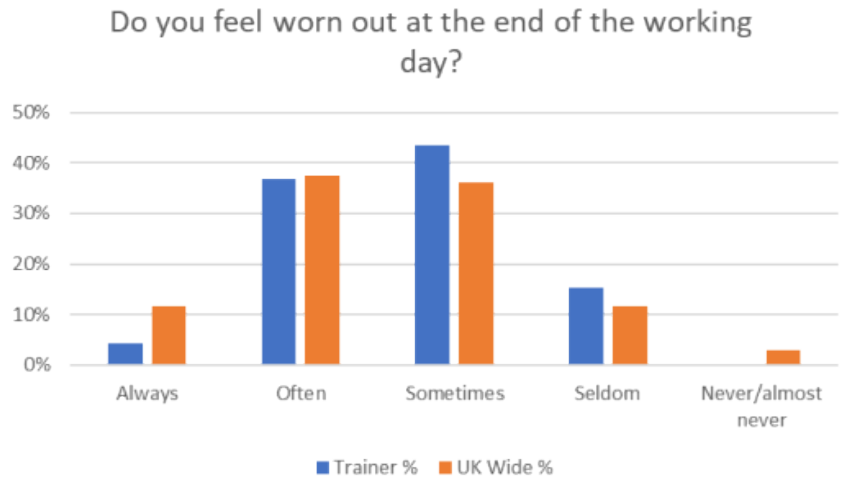
Burnout - DCH Trainers

Dorset County Hospital
NHS Foundation Trust









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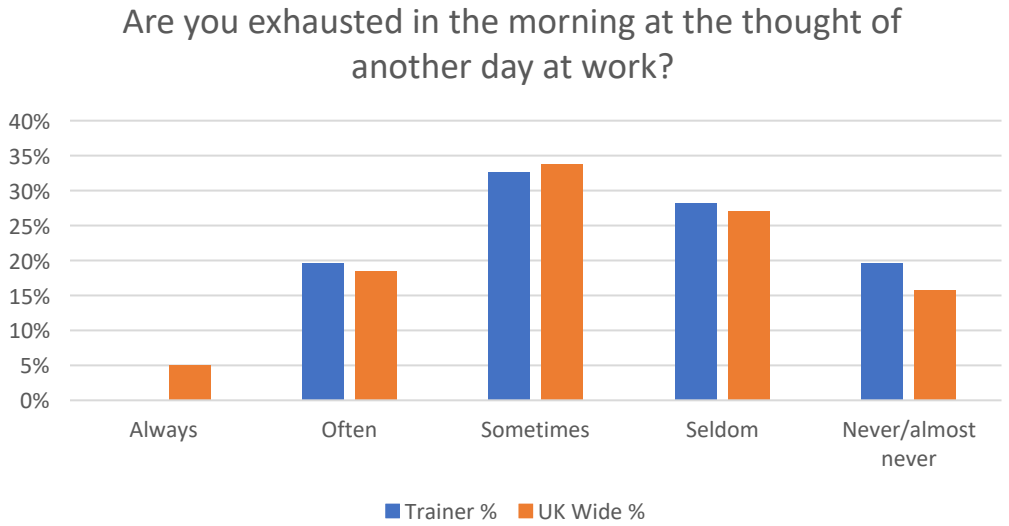
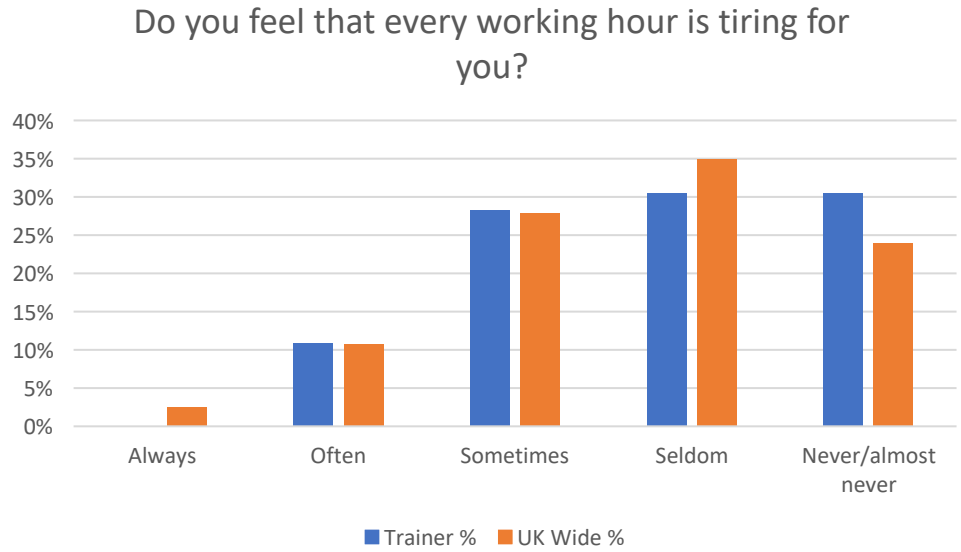
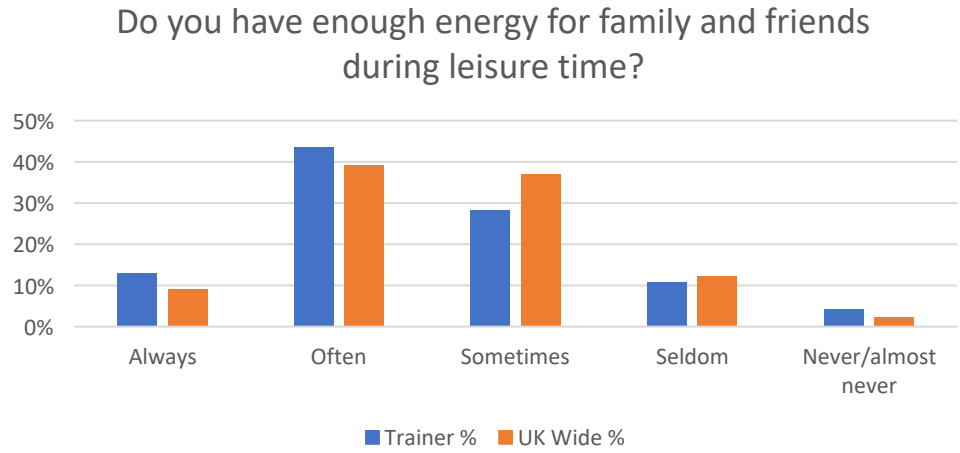
Burnout – DCH Trainers

Dorset County Hospital
NHS Foundation Trust







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Burnout - Comments

Dorset County Hospital
NHS Foundation Trust

- Continued high risk of burnout nationally, some specialties more than others – **Emergency Medicine** appears high risk for both trainees and trainers

- DCH **trainees** appears slightly less fatigued or at risk of burnout as compared to national numbers

- DCH **trainers** appear to demonstrate generally lower levels of fatigue and burnout as compared to the National averages, as in 2023

Actions

Dorset County Hospital
NHS Foundation Trust

- Disseminate results to departments
- Champion Greens and areas of success/improvement – share best practice
- Action Plans for Reds – submitted to MEG September 2024
- Consider additional resources to support Emergency Medicine given national data?

Dorset County Hospital
NHS Foundation Trust

Strategy Transformation and Partnerships Committee Assurance Report for the meeting held on 27 November 2024

Chair	David Clayton-Smith, Chair
Executive Lead	Nick Johnson, Chief Strategy, Transformation and Partnerships Officer
Quoracy met?	Yes
Purpose of the report	To assure the Board on the main items discussed by the Committee 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	• Subsidiary Company Outline Business Case approval • Electronic Health Record Outline Business Case update • New Hospital Programme

Key issues / matters discussed at the meeting	The committee received, discussed and noted the following reports: • Strategy Delivery Report (assurance) The Committee received the Strategy Delivery Report, with a focus on culture and engagement; development of metrics and dashboards and; programme and timeline for development of enabling plans. • One Transformation Approach Update (assurance) The Committee received an update on the One Transformation Approach including the strategic portfolios of change and key activity in the period. • Our Dorset Provider Collaborative (ODPC) Update (assurance) The Committee received a report on the development of the ODPC and an overview of the key portfolio areas and next steps. This included CANDo; shared services (procurement); workforce and agency – collaborative bank. • Subsidiary Company Outline Business Case (approval) The Committee received the Outline Business Case for the development of a subsidiary business case to deliver support services. Approval was given to proceed to the development of the full business case to be considered via the appropriate governance routes. • Health Innovation Wessex (HIW) (information) An update was provided on the progress made by HIW in Quarter 2. Key achievements across the 46 workstreams were reported. • Social Value Plan (assurance) The report provided an update on the key highlights of the DCH Social Value programme. It was noted that the Social Value Plan currently applies to DCH only, but a joint approach is to be progressed.

	• Electronic Health Record Outline Business Case Update (assurance)
	The Committee received an update on the development of the OBC for the EHR for Dorset and Somerset. The options for affordability were outlined to the members, and members were asked to endorse the proposed approach, with a further update to be provided to Board in December 2024 for approval.
	• Cyber Security Update (assurance)
	The Committee received an update on the cyber security related activities for DCH and DHC. A draft Cyber Security Strategy has been developed and led by Dorset ICB with input from DHC, DCH and UHD.
	• New Hospital Programme (NHP) Update (assurance)
	The Committee received updates on the DCH and DHC NHP project, including the financial positions.
	• Mental Health (MH) Portfolio – Children and Young People (CYP) (assurance)
	As part of its regular deep dives, the Committee received a presentation on the CYP MH Transformation Programme.
	• Assurance Reports (assurance)
	Received assurance reports from:
	  • Sustainability Working Group
	  • NHP Programme Board

Decisions made at the meeting	• Approval of Subsidiary Company Outline Business Case
Issues / actions referred to other committees / groups	• Nil

Dorset County Hospital
NHS Foundation Trust

Report to	Trust Board	
Date of Meeting	10 December 2024	
Report Title	DCH Social Value Report (6mth)	
Prepared By	Simon Pearson, Head of Charity & Social Value	
Approved by Accountable Executive	Nicholas Johnson, DCH Deputy Chief Executive	
Previously Considered By	Strategy, Transformation and Partnership Committee in Common, 27/11/2024	
Action Required	**Approval**	N
	Assurance	N
	Information	Y

Alignment to Strategic Objectives	Does this paper contribute to our strategic objectives? *Delete as required*	
Care	Yes	
Colleagues	Yes	
Communities	Yes	
Sustainability	Yes	
Implications	Describe the implications of this paper for the areas below.	
Board Assurance Framework	SR2: Culture; SR3: Workforce capacity; SR5: Estates; SR8: Transformation & Improvement	
Financial	'No implication'	
Statutory & Regulatory	'No implication'	
Equality, Diversity & Inclusion	As per DCH Social Value pledge	
Co-production & Partnership	As per DCH Social Value pledge	

Executive Summary

Dorset County Hospital Foundation Trust, as an anchor institution, commits to maximise the positive social value impact we have on our local communities, contributing to improving the economic, social and environmental well-being of the local population. Through our approach to delivering social value as an Acute Trust, we aim to reduce avoidable inequalities and improve health and wellbeing across our community. Our Social Value Pledge is available here: https://www.dchft.nhs.uk/about-us/social-value/

This paper presents a six-month update on key highlights for the DCH Social Value programme:

- Joint Social Value approach (DCH/DHC)
- Local Investment
- Local Employment/Training/Widening Participation
- Greener & Sustainable
- Estates Capital Projects: incl. Tilbury Douglas DCH NHP Social Value report
- Involving our Community
- Civic Partnerships
- Social Value Activity Report

Recommendation

Members are requested to:

- Receive the report for **information**

DCH Social Value Programme: Progress Report (6 month) Nov 2024

Our Social Value Pledge

Dorset County Hospital Foundation Trust, as an anchor institution, commits to maximise the positive social value impact we have on our local communities, contributing to improving the economic, social and environmental well-being of the local population. Through our approach to delivering social value as an Acute Trust, we aim to reduce avoidable inequalities and improve health and wellbeing across our community. Our Social Value Pledge is available here: https://www.dchft.nhs.uk/about-us/social-value/

This report presents an update with key highlights, reflecting the breadth of DCH's Social Value programme.

IMPACT Social Value Reporting: We continue to populate the IMPACT Social Value Reporting online platform with key DCH Social Value projects, activities and measures.

DCH/DHC Social Value approach: As per the new DCH/DHC Joint Strategy we have commenced discussions about embedding an approach to social value delivery at DHC, in line with DCH's social value programme.

Local Investment:

We commit to maximise local investment, recognising the social, economic and environmental benefits of buying locally when procuring goods and services. The table below presents the Trust's spend with local businesses, catering and 3rd sector suppliers for 23/24 and 24/25 (6mth):

Social Value pledge	Social Value activity	Measure (23/24)	Measure (24/25) *to 30.9.24*
Maximise Local Investment	Local Supplier (DT) spend	£6,869,068	£4,229,133
Maximise Local Investment	Local Catering spend	£273,045	£582,739
Maximise Local Investment	3rd Sector spend	£181,800	£118,699

Local supplier spend is on track to meet and potentially exceed the 23/24 baseline. There is a considered approach to how the Trust's social value goals are balanced against the benefits of economies of scale through local, regional, and national aggregated volumes. Despite work to utilise national frameworks to benefit from aggregated volumes, the Trust has managed to influence the areas of spend where there is limited opportunity in this regard. The Trust continues to receive enquiries from SME's who are interested in working with the Trust and

these are followed up and considered where viable opportunities exist. Categories of spend where this applies heavily are Estates Minor works, Facilities Services and Catering suppliers.

Local Employment/Training:

DCH's social value commitment to increase local employment and widening participation. We commit to increase employment and training opportunities for local people, especially from areas of high deprivation and unemployment.

Social Value pledge	Social Value activity	Measure (22/23)	Measure (23/24)
Increase Local Employment	Local Residents Employed	3,317	3,590
Increase Local Employment	Total Employees - % Local (DT) (Target 80%)_	81%	81%
Champion equality, diversity and inclusion	No. BAME Employees	604	799
Champion equality, diversity and inclusion	No. Disabled Employees	166	190
Increase Training opportunities	Apprentices Trained	163	196
Increase Training opportunities	Work Experience Placements	No programme due to Covid impact	113

Widening Participation:

Work Experience:
Our work experience has continued to grow since it's refresh and restart in June 2023. We have hosted more than 100 individuals in a variety of placements around the organisation. We have supported placements in Medical, Nursing, Therapies and Microbiology for students aged 14-19 from our local education providers and older individuals from our local community looking to join the NHS and wanting to have some exposure to our organisation to support their next steps.

Supported Internships:
We have now completed our second cohort of supported internships at DCH in partnerships with Weymouth College. 66% of students have gained employment following their placement and we are now developing and expanding our third cohort. We are now offering placements to a second education provider in the area, Southwest Regional Assessment Centre, to continue supporting young people with a special educational need or disability gain valuable experience in a workplace.

NHS Employability Skills and Careers Events:
We are continuing to offer our staff bespoke employability and careers skills sessions. We have developed this and are working in partnership with The Department of Work and Pensions to deliver sessions to underrepresented groups in our community. We have attended

sessions with Afghani Refugees based in Weymouth; individuals with a disability focusing on returning to work

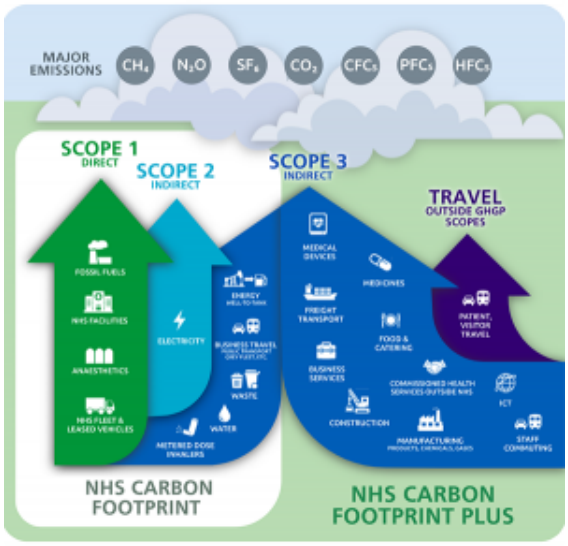
and an over 50s employment event. The team are actively attending careers events at our local education providers and have engaged with more than 1000 individuals in the last 12 months.

T-Levels:
We have now commenced our first Health T-Level industry placement with Weymouth College. We are currently hosting two students on their placements for 315 hours on Evershot and Mary Anning wards.

Support Worker Scholarship
We completed our fifth Support Worker Scholarship programme in July. The two-week programme includes an introduction to the care certificate, ward visits, clinical skills and values and employability sessions. Overall, we have supported 41 individuals into employment with a 12-month retention rate of 60%.

Greener & Sustainable:

Sustainability & Social Value
Sustainability encompasses environmental, social and governance areas of the trust's activities, with a focus on carbon reduction targets, Net Zero Carbon (NZC)and responsible use of environmental resources. The Trust's Green Plan is in review, and will set a pathway towards NZC. The NHS aim is to be the world's first net zero national health service and our carbon emissions are divided into Scope 1, emissions we directly control, and scope 2&3 that we indirectly control.



We have two targets:

- For the emissions we control directly (the NHS Carbon Footprint), we will reach net zero by 2040, with an ambition to reach an 80% reduction by 2028 to 2032;

- For the emissions we can influence (our NHS Carbon Footprint Plus), we will reach net zero by 2045, with an ambition to reach an 80% reduction by 2036 to 2039.

Carbon Footprint

The phrase 'you manage what you measure' resonates as DCHFT measuring goes beyond NHS England 2019/20 estimates of carbon emissions as now having our own carbon footprint baseline1 and measuring progress. NHSE report on the overall carbon footprint for Annual Reporting however it is useful to have this local measure. At present there are several wins but overall it is going in the wrong direction, meaning that we must increase initiatives.

In 2024 the Trust worked with GEP Consultants to develop a detailed Energy Strategy and a Decarbonisation Plan. The Decarbonisation plan includes a carbon footprint trajectory of how a range of initiatives such as insulation, solar, air source heat pumps, biogas, geothermal and ground source heat potential would reduce carbon emissions. This will require funding or price partnerships to achieve. The Sustainability and Energy group have successfully bid for Heat Network Development Funding for a feasibility of GSHP and Geothermal and has bid for Heat Network Efficiency Scheme Optimisation Study, if successful could lead to a capital application. This was cross referenced with the maintenance backlog.

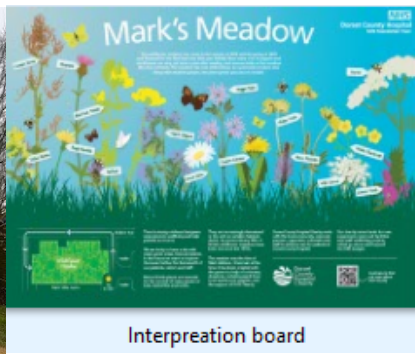
LED Light fittings project

The Sustainability Team at DCH have secured £20,000 from the National Energy Efficiency Fund in January 2024 to complete light replacement with LED. The Electrical team in Estates and Facilities Management have procured the LED fitting and started to install the fittings and lights. In 2019 part of a project with Centrica around 72% of lights were replaced with LEDs on wards and the main hospital 'streets.' This funding will be focused on remaining areas in Medical O/P, Education centre (parts), Hydrotherapy, Ortho O/P, the stairs of main hospital (north wing). This is estimated to be around 307 fittings, save around 1,535 kgCO2e per annum and around 146,200KWh, around £15,000pa.

[1] a carbon baseline functions as a historical record of greenhouse gas emissions produced during a specified period (typically a year) before new efforts to reduce emissions are initiated. This record then becomes a benchmark to compare against future emissions. https://earth.org/carbon-baseline-a-solution-for-uk-enterprises-to-help-achieve-net-zero/ The NHS uses a new baseline of 2019/20 with adjusted targets equivalent to reach net zero by 2040, by at least 47% by 2028-32, Carbon Footprint plus by 2045 and 73% by 2036-38.

Greenspaces and Biodiversity
The Trust has secured approximately £50,000 from NHS Charities Together for a Sensory Courtyard Garden opposite Special Care Dentistry in North Wing. This went out for tender and volunteer work parties have begun to clear rubbish and stack reusable stones and pebbles. The lockers were moved to let in light to the corridor and new disabled access doors are planned.

Interpretation boards and signs went up in 'Mark's Meadow' wildlife garden and a sightings board for recording wildlife seen.
Members of the Transformation team and Estates and Facilities took part in cross Dorset NHS Trust training in Biodiversity Net Gain legislation, organised by the Sustainability Manager.



Interpreation board

Food and Nutrition
The Catering team met the 2023 single-use plastics ban that focused on plastic forks, bowls, plates, and polystyrene cups with metal cutlery in restaurant and bamboo for takeaways. Furthermore, they are now examining reducing range of single use containers and cups, to reduce cost and carbon. A review of chemicals and disposables took place to look at eco and recyclable options.
Unused, but still very useable, meals are donated to staff who may need this support, by registering for the scheme.

Food waste baseline and accuracy percentage now being captured, weighing different streams and correlation with food waste collection, biodigester beyond capacity and in for repairs.

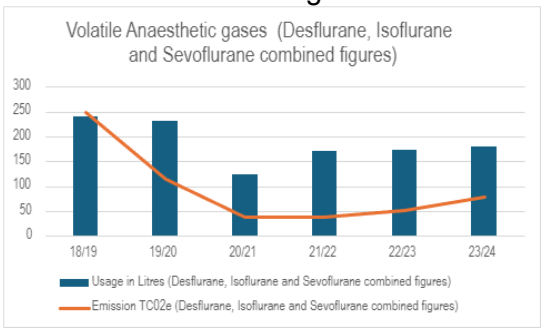
Managing the hotel
Housekeeping staff play a vital role with our Waste operatives and Waste co-ordinator to ensure our waste streams are correctly dealt with. A trial of ward hosts who will serve food and drink on crockery may contribute to reducing food waste and improving patient experience.

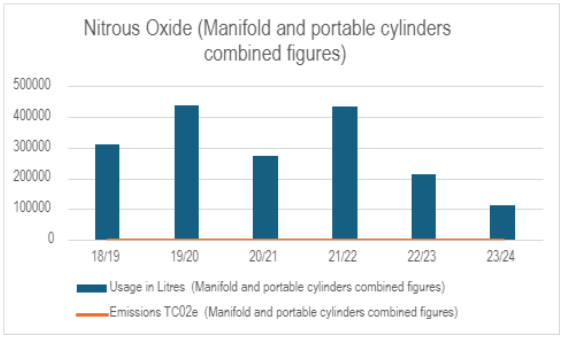
Waste
The Environment Agency has audited the Trust, instructing 2 actions and 3 recommendations. The actions centred around consignment notes and classification codes. EA also commented it was great to see waste management and sustainability

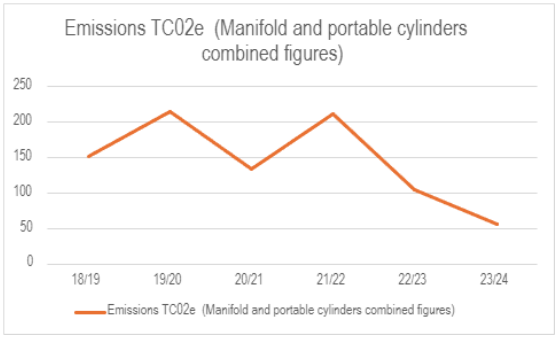
working together for joint outcomes. The trust is very close to achieving the NHS Clinical Waste Strategy targets of 60:20:20 (2), in August these were 59/28/13. Achieving the target reduces both cost and carbon emissions. Rehoming items has saved £3240 disposal costs and 92.5 tonne CO2e financial year to date.

Greener theatres

Meetings have taken place with surgical and anaesthetic staff to plan a presentation to theatre staff on the Greener Theatres Intercollegiate checklist. We are investigating countertop cut out recycling bins in this restricted space and have worked to reduce desflurane anaesthetic gas use and nitrous manifolds.

- 





Travel and transport

A Staff Low Carbon Travel FAQ document was published on the intranet in August, with a revised version released in September, with assistance from the Travel Team. A Staff Survey for the aid of developing a Green Travel Plan was conducted in July and August, gathering around 288 responses. We are currently in the process of developing a Green Travel Plan to support sustainable travel initiatives.

Supply Chain and Procurement

We have a sustainable procurement policy with 10% weighting for sustainability and social value and work to improve numbers of local Small to Medium Enterprises from which we procure. DCHFT is part of Dorset Public Sector Decarbonisation and Ecology Group where Dorset Council are hosting a post and project to look at public sector procurement in Dorset.

Adaptation

2 20% HTI (High-Temperature Incineration); 20% AT (Alternative Treatment); 60% OW (Offensive Waste). Decoding NHS England's 20-20-60 Waste Segregation Targets - Daniels Healthcare

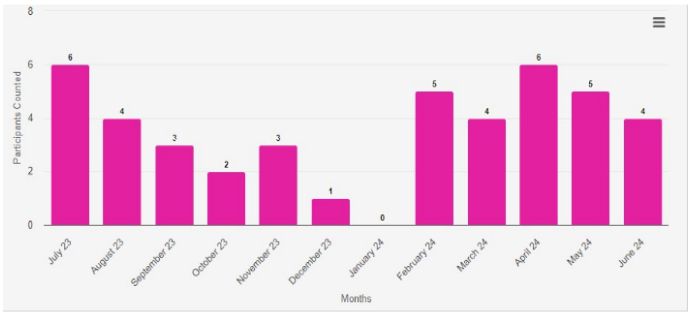
Sustainability, Emergency planning and Risk Management
met to discuss adaptation to climate change, with much already captured. The Sustainability Manager is working with NHS, Public Health, led by Dorset Council on Dorset-wide Climate Change Risk Assessment.

Everyone a Sustainability Champion
The trust has an EcoEarn Sustainability Actions pledge platform and a Sustainability Champions scheme. We feel everyone's actions can help with sustainability, and Induction coffee break sustainability engagements have probably contributed to the 24 new participants in the last 6 months.

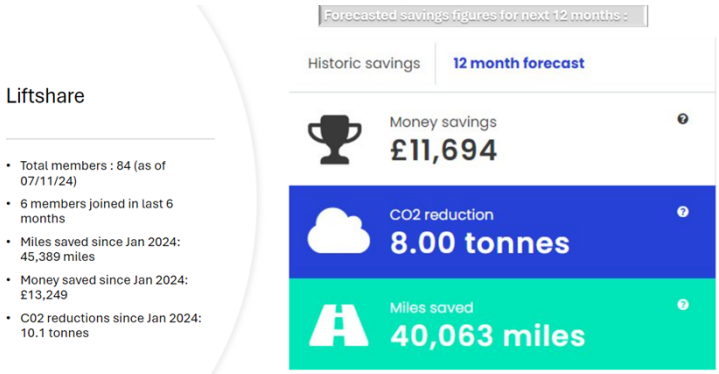
ecoearn

Ecoearn

- Data available till the end of June 2024
- 24 new participants since last 6 months
- Approximately 17 staff inductions and 400 engagements made with new staff (Average value)
- 203 participants (as of 30/06/24)



The Dorset NHS trusts came together in 2022 to run a Dorset NHS Liftshare Scheme and 6 members have joined in the last 6 months.



Tilbury Douglas have provided their initial mid-year Social Value Return on Investment report for DCH's NHP project, relating to the new build Emergency Department and Critical Care Unit. Please see the report enclosed. Measurement of the DCH NHP project's social value return on investment will continue throughout the project construction period.

Involve our Community:

A key principle of delivering social value is engagement with our stakeholders. Through its Patient and Public Engagement activity, DCH has an active role in engaging with our local community by listening to them, involving them and acknowledging their contributions.

Our commitment to involving our community includes:

- Engage with local residents and service users. To promote opportunities for gathering views, including those not heard or voiced.
- To provide feedback to the local community so they can see the results of their involvement.
- Ensure communities receive timely and appropriate information and communication.

During 2023/24 DCH held 19 Patient and Public Engagement events across our local community.

Civic Partnerships:

Promote partnerships between DCH and our civic community, implementing local activities which contribute to reducing inequalities and improving health and wellbeing for all.

DCH Charity

DCH Charity's purpose is to raise funds to enhance patient care and staff welfare.
The Charity's current major focus is its £2.5M Emergency and Critical Care Appeal which will fund enhancements in the new Emergency Department and Critical Care Unit such as, Critical Care paediatric bed space; Child & Adolescent Mental Health suite; Critical Care patient garden; medical equipment; staff rest facilities and artistic elements for both new units. The Appeal target has recently achieved its first major milestone reaching £500K.

Arts in Hospital

Arts in Hospital delivers social value by promoting civic partnerships between DCH, artists and our community. Please see the Arts in Hospital & Social Value report enclosed.

DCH Social Value Activity Report (May-Oct 2024): DCH's latest Social Value Activity Report is attached with this report. This includes a broad range of social value related articles.

Simon Pearson
Head of Charity & Social Value

Social Value Return on Investment - DCH Mid Year 2024

Theme	Outcome	TOMs Ref	Measures Explained	Units	Multiplier/Proxy Value	TD Figures	Social Value Return on Investment
Jobs *Promote Local Skills and Employment*	More local people in employment	NT1	No. of full time equivalent direct local (70 mile target as shown in SV Plan) employees (FTE) hired or retained for the duration of the contract	No. People FTE	£30 000,00	5,99	£179 700,00
	More opportunities for disadvantaged people	NT3	No. of full time equivalent local employees (FTE) hired and retained on the contract who are long-term unemployed (unemployed for a year or longer)	No. People FTE	£20 429,00		£0,00
		NT4a	No. of full time equivalent local 16-25 y.o. care leavers (FTE) hired on the contarct	No. People FTE	£15 382,90	0,05	£769,15
		NT6	No. of full time equivalent disabled local employees (FTE) hired or retained on the contract	No. People FTE	£16 605,00		£0,00
	Improved Skills	NT8	No. of staff hours spent on local school and college visits supporting pupils e.g. delivering career talks, curriculum support, literacy support, safety talks (including preperation time)	No. staff hours	£16,93	655,50	£11 097,62
		NT9	No. of weeks of training opportunities (BTEC, City & Guilds, NVQ, HNC - Level 2,3, or 4+) on the contract that have either been completed during the year, or that will be supported by the organisation until completion in the following years	No. weeks	£317,82		£0,00
		NT10	No. of weeks of apprenticeships or T-Levels (Level 2,3, or 4) provided on the contract (completed or supported by the organisation)	No. weeks	£251,79	116,00	£29 207,64
	Improved skills for disadvantaged people	NT11	No. of hours of 'support into work' assistance provided to unemployed people through career mentoring, including mock interviews, CV advice, and careers guidance	No. hrs (total session duration)*no. attendees	£105,58	64,50	£6 809,91
	Improved employability of young people	NT12	No. of weeks spent on meaningful work placements or pre-employment course; 1-6 weeks student placements (unpaid)	No. weeks	£194,50		£0,00
		NT13	Meaningful work placements that pay Minimum or National Living wage according to eligibility - 6 weeks or more (internships)	No. weeks	£194,50		£0,00
Growth *Supporting Growth of Responsible Regional Business*	More opportunities for local MSME's and VCSE's	NT15	Provision of expert business advice to VCSE's and MSME's (e.g. financial advice/legal advice/ HR advice / HSE)	No. staff expert hours	£101,00	112,50	£11 362,50
		NT17	Number of voluntary hours donated to support VCSE's (excludes expert business advice)	No. staff volunteering hours	£16,93		£0,00
		NT18	Total amount (£) spent in local (70 mile target as shown in SV Plan) supply chain through the contract	£	£0,67	1671476,37	£1 119 889,17
	Improving staff wellbeing and mental health	NT21	Equality, diversity and inclusion training provided both for staff and supply chain staff	No. hrs (total session duration)* no. attendees	£101,00		£0,00
Social *Healthier, safer, and more resilient communities*	More working with the community	NT28	Donations and/or in-kind contributions to specific local community projects (£ & materials)	£ value	£1,00	7650,00	£7 650,00
		NT29	No. hours volunteering time provided to support local community projects	No. staff volunteering hours	£16,93	149,00	£2 522,57
		NT29a	No. of hours volunteering time provided to support health-care related charity and community projects	No. staff volunteering hours	£16,93	20,00	£338,60
Environment *Decarbonising and safeguarding our world*	Carbon emissions are reduced	NT31	Savings in CO2e emissions on contract achieved through de-carbonisation (i.e. a reduction of the carbon intensity of processes and operations, specify how these are to be achieved) against a specific benchmark	Tonnes CO2e	£244,63		£0,00
	Air pollution is reduced	NT32	Car miles saved on the project as a result of a green transport programme or equivalent (e.g. cycle to work programmes, public transport or car pooling programmes, etc.)	Miles saved	£0,06	696,00	£41,76
	Safeguarding the natural environement	NT86	Volunteering time for environmental conservation & sustainable ecosystem	No. staff volunteering hours	£16,93		£0,00
						Total SVROI =	£1 369 388,91

Arts in Hospital and Social Value

Arts in Hospital contributes to promoting civic partnerships between DCH and our community, implementing local activities which contribute to reducing inequalities increasing opportunities and improving health and wellbeing for all.

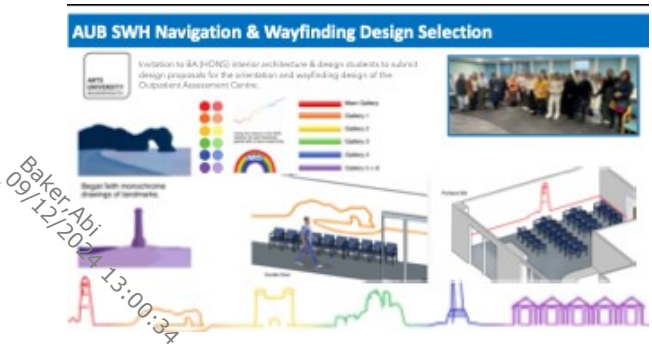
1. Our Art collection is a valued cultural resource, used by local schools and colleges to inform them of the use of Creative Health within the hospital environment. This engagement with the collection extends to our temporary exhibition space in which local students can volunteer to assist with the exhibition hang, gaining curatorial experience.

2. We collaborate with community art organisations, adding to our cultural offer and supporting the artistic community through promoting and sharing their work as part of our temporary exhibition programme. All work displayed is for sale, adding an economic benefit. We have positive working partnerships with Dorset Natural Landscape, Dorchester Camera Club and Health and Nature Dorset.

3. We employ and commission local and regional artists to produce work and deliver workshops, engaging with community outreach where possible. This extends to opportunities for art and design degree and master's students building Creative Health projects into their coursework. We are currently working with a student proposal for our new discharge lounge, having engaged with staff and patients, they have developed ideas and with support from AIH will install before Christmas. Previous student opportunities have included a mural installation in the Diabetes Centre following staff and patient engagement.

4. We have worked on several collaborative projects with higher education institutions within the county

- Wayfinding project with Interior Architecture degree students at Arts University Bournemouth, designing the new environment for South Walks House.
- Weymouth College Foundation students on a design for a Zine resource, creating an interactive toolkit that will help young people navigate their way from childhood to adulthood managing a long-term health condition. As well as support medical staff to engage with our young people.
- A level students from Budmouth and Hardyes Schools on an interior design project for the new restaurant refurbishment.



These opportunities give real life work experience for students equipping them with skills for employment within the healthcare, creative, and creative health industries.

5. Community intervention with our Creative Health Specialist working with patients with dementia and their families. Reducing strain on staff, carers and increasing wellbeing. This includes recruiting and training volunteer

‘Creative Health Ambassadors’. Providing skills training and wellbeing benefits for members of the wider community.

6. Future projects include working with Portland Prison and their learning facilitators to engage another hard-to-reach demographic within Dorset. Through this project we hope to facilitate prisoner engagement with the arts, building bridges between prisoners and community. With a focus on the wellbeing of individuals and communities as well as potential economic benefits. Artwork from this outcome will be exhibited within the hospital. We also plan to have an artist in residence in 2025.

Left: Local artist and brain injury survivor, Damian Clarke, working with Stroke patients to create artwork.

Right: Training volunteers – our Creative Health Ambassadors.

Suzy Rushbrook, DCH Arts in Hospital Manager

Our Social Value Pledge

NHS
Dorset County Hospital
NHS Foundation Trust

Social Value Activity Report

May - October 2024

We are very pleased to publish our latest edition of the Dorset County Hospital Social Value Activity Report. The report highlights some of the wide-ranging initiatives as part of the hospital's ongoing social value programme.

Dorset County Hospital is committed to maximising the positive social value impact we have on our local communities, contributing to improving the economic, social and environmental wellbeing of the local population.

The Trust's Social Value Pledge is available on our website at www.dchft.nhs.uk/about-us/social-value

For more information about DCH's social value commitments and how you can contribute and make a difference, please contact Simon Pearson, Head of Charity and Social Value, at simon.pearson@dchft.nhs.uk

Our Social Value Pledge

NHS
Dorset County Hospital
NHS Foundation Trust

Sustainability highlights

We're working with local students and organisations to transform a neglected courtyard into a sensory garden so our patients, staff and visitors can take a moment away from the busy hospital environment. Kingston Maurward College and Dorchester Men's Shed and Little Green Change are supporting us with the design and planting plan. The £45K project funded by NHS Charities Together.

The Trust is very close to achieving the NHS Clinical Waste Strategy targets in terms of reducing both costs and carbon emissions. Rehoming furniture and equipment alone has saved £ 3240 disposal costs and 92.5 tonne of CO2 emissions so far this year.

Interpretation boards and signs went up in 'Mark's Meadow' wildlife garden and a sightings board for recording wildlife seen on the main hospital site.

Carer's Passport

The Patient Experience team had a busy summer engaging with local people at various Primary Care Networks drop in and wellbeing events. They were promoting the Carer's Passport for unpaid carers when their cared for person becomes an inpatient to ensure carers are identified and their rights observed and supported.

Our Social Value Pledge

NHS
Dorset County Hospital
NHS Foundation Trust

Volunteer Activities

Our Volunteer Activity team provide opportunities for patients to engage in activities which can lead to improvements in their own wellbeing and potentially help them to leave hospital sooner. Activities include bingo, cooking, a game of cards or a friendly chat and we are now lucky enough to have five Pets as Therapy dogs visiting patients.

The team has arecently launched a new book trolley service and our volunteers have also been supporting the Arts in Hospital team to expand their creative health programme which uses art to improve patients' wellbeing.

Improving Tumbledown Farm

Members of our Strategic Estates team joined staff from our building contractors Tilbury Douglas and Blanchard Wells Ltd over the summer to volunteer at Tumbledown Farm in Weymouth. The team helped to improve their raised bed area and make it more accessible for people with mobility issues.

Healthcare Support Worker Vocational Scholarships

The Widening Participation team finished its fifth support worker scholarship in July. The two-week programme includes an introduction to the care certificate, ward visits, clinical skills and values and employability sessions. We have supported 41 individuals into employment with a one year retention rate of 60%.

Supported Internships

We have now supported two cohorts of internship students in partnership with Weymouth College. 66% of students have gained employment following their placement at DCH and we are now developing our third cohort. We are also offering placements to a second education provider in the area, the Southwest Regional Assessment Centre, to help young people with a special educational need or disability gain valuable experience in a workplace.

English and Maths

Our functional skills offering has now evolved to include virtual learning so we can support even more staff at DCH. The first staff members are now starting to undertake and pass their exams. We are also working together with Dorset HealthCare to provide places for their staff in our classes at DCH with individuals signed up to both courses. We are currently supporting 34 staff on English and Maths programmes and 37 have already completed their courses.

T Levels

We have now commenced our first Health T-Level industry placement with Weymouth College. We are currently hosting two students who will spend 315 hours on Evershot Ward and Mary Anning Unit as part of their course.

Report to	Trust Board	
Date of Meeting	10th December 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	STP Committee in Common 27th November 2024	
Action Required	**Approval**	No
	Assurance	Yes
	Information	No

Alignment to Strategic Objectives	Does this paper contribute to our strategic objectives	
Care	Yes	Yes
Colleagues	Yes	Yes
Communities	Yes	Yes
Sustainability	Yes	Yes
Implications	Describe the implications of this paper for the areas below	
Board Assurance Framework	SR7ODPC Board comprises of DCH, DHC, UHD and Dorset GP Alliance.	
Financial	SR6. ODPC expected to contribute to MTFP, and NHS Dorset's Intentions letter	
Statutory & Regulatory	When integrated care systems (ICS) were established, NHS England required all trusts providing acute and mental health services to be part of one or more provider collaboratives.	
Equality, Diversity & Inclusion	No implications for assuring this paper	
Co-production & Partnership	SR8. Transformation and Improvement. ODPC drives strategic, system level transformation	

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 Board.

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 in Q4, before system and region approval is sought. There is a dependency with the proposed wholly owned subsidiary company (subco).

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.

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 was held on 22nd November, with the the respectvie DCH/DHC and UHD Chairs and Chief Executives, along with a NED from each of the 3 Trusts. This will add further challenge and scrutiny to the ODPC. Quarterly meetings will subsequently take place.

4.3. The first dedicated ODPC Programme Director has been appointed, and took up their position on 2nd December.

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.

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.

5.4. The ODPC Board is currently determining its strategic framework and priorities, and how it relates with the new government's emerging thinking (e.g. Darzi; focused, clear priorities, A heavy focus on consequences for failure and rewards for good performance/improvement, Power moved from the centre to the local.

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: 3rd December 2024

8. Appendices

Appendix 1. ODPC Overview and Governance
Appendix 2 CANDo overview
Appendix 3. 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.

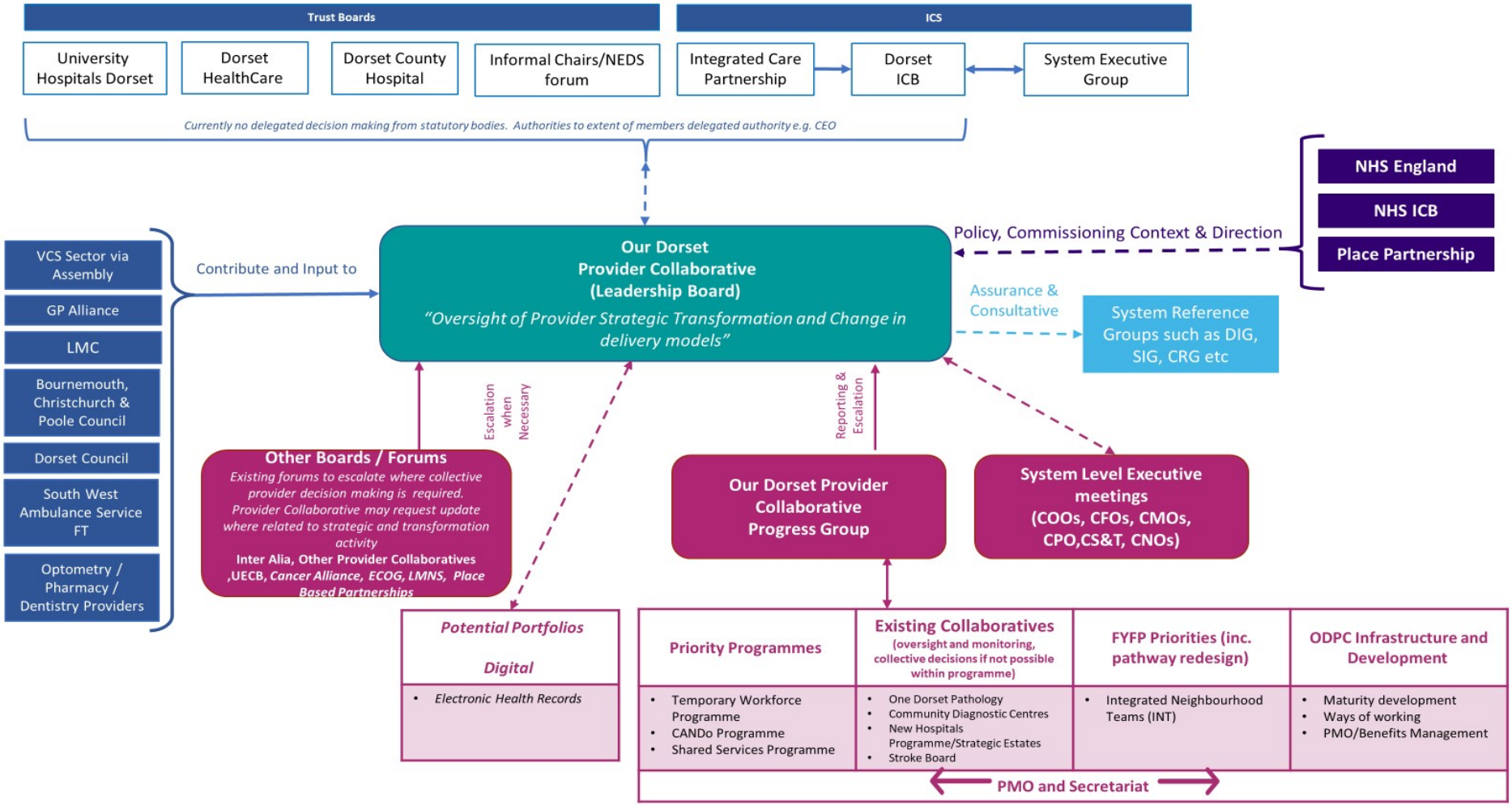
Compassion.
We ensure that compassion is central to the care we provide and respond with humanity and kindness to each person's pain, distress, anxiety or need.

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.

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

APPENDIX 3. RISK REGISTER

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

Dorset County Hospital
Dorset HealthCare

Report to	Dorset County Hospital Board of Directors	
Date of Meeting	10 December 2024	
Report Title	Strategy Enabling Plans update	
Prepared By	Paul Lewis – Director of Strategy & Improvement	
Approved by Accountable Executive	Nick Johnson - Deputy Chief Executive DCH Joint Chief Strategy, Transformation and Partnerships Officer	
Previously Considered By	Joint Executive Management Team 28 Nov 24. Progress update via highlight report. Strategy, Transformation and Partnerships Committee in Common 27 Nov 24. Paper for assurance.	
Action Required	**Approval**	N
	Assurance	Y
	Information	N

Alignment to Strategic Objectives	Does this paper contribute to our strategic objectives? *Delete as required*	
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	The Enabling Plans mitigate: SR1 – Safety & Quality – Clinical & Quality plan SR2 – Culture – People plan SR3 – Workforce capacity – People plan SR5 – Estates – Infrastructure plan SR6 – Finance – Finance plan SR9 – Digital – Digital plan SR10 – Cyber security – Digital plan	
Financial	The Finance plan will include the Medium Term Finance Plan	
Statutory & Regulatory	No implication	
Equality, Diversity & Inclusion	The people plan will directly affect ED&I	
Co-production & Partnership	Collectively the Enabling plans will involve partnership across both Trusts and with system partners	

Executive Summary

The Enabling Plans form a key part of the Joint Strategy implementation alongside the Culture, Communications and Engagement plan, the One Transformation Approach and the Joint Improvement Framework. There are five Enabling Plans: Clinical & Quality, Digital, People, Finance, and Infrastructure (Estates and Facilities).

Development of these plans is ongoing and remains on track for submission and approval by March 2025. Each plan has an assigned Senior Responsible Officer (SRO) and dedicated leads.

The Enabling Plans collectively support the delivery of the Strategic Objectives: Care, Communities, Colleagues, and Sustainability. They will also demonstrate:

- Their alignment with wider Trust objectives,
- Key internal actions and initiatives, and
- Collaboration across other Enabling Plans

Upon approval, the plans will transition to implementation, with monitoring, reporting, and escalation arrangements overseen by the Strategy, Transformation and Partnerships Committee in Common.

A paper was presented to the Strategy, Transformation and Partnerships Committee in November for assurance. Key discussion points included:

- The Clinical and Quality Plan as a Core Enabler: The plan was recognised as both a critical driver and an integral part of the organisation's core business. It was emphasised that planning efforts should explicitly account for its strategic importance.
- Aligning the Clinical and Quality Plan with the Trust's Vision: The importance of ensuring that the emerging themes of prevention, the health and wellbeing of the population and inequalities plan directly support the trust's overarching vision.

Identified Risks and Mitigations:

1. Alignment with Strategic Objectives: There is a risk that the plans may not fully address all Strategic Objectives. To mitigate this, a Driver Diagram will be developed to clearly map the contributions of each plan on a single page.

2. Isolated Development: There is a risk that plans could be developed in silos, missing opportunities for mutual reinforcement. To address this, regular facilitated meetings for plan leads will ensure updates are shared and collaboration is prioritised.

3. Enagement. The short project timeframe could make it hard to have meaningful engagement. To tackle this, work has started on mapping stakeholders to find ways to share resources and work together.

Appendix 1 summarises the development progress of the Enabling Plans, including a high-level project plan.

Recommendation

Members are requested to receive the report for **assurance**

Enabling Plans Update

1. Executive Summary

1.1. This paper provides an update for assurance to the committee on the development of Enabling Plans

The Enabling Plans are part of the Joint Strategy delivery vehicles, alongside the Culture, Communications and Enagement plan, the One Transformation Approach and the Joint Improvement Framework.

There are 5 Enabling Plans: Clinical and Quality, Digital, People, Finance and Infrastructure (Estates and Facilities).

Collectively the Enabling Plans directly contribute to the delivery of the Strategic Objectives; Care, Communities, Colleagues and Sustainability.

Development of the Plans is ongoing and they are on track to be submitted for approval by March 2025.

Once approved the plans will move into implementation. Ownership for each plan will sit within its existing Committee in Common, with the Strategy, Transformation and Partnership Committee in Common providing endorsement and oversight regarding strategic alignment, impact and benefits.

2. Introduction

2.1. The Joint Strategy 2024 – 2029 identifies the development and implementation of five Enabling Plans as one of the key drivers to achieving the Strategic Objectives of; Care, Communities, Colleagues and Sustainability. These Plans cover specific functions/disciplines across both Trusts. These are; Clinical and Quality, Digital, People, Finance and Infrastructure (Estates and Facilities).

2.2. Following the Working Together report to the committee in August 2024 this paper aims to provide assurance on the progress of the Enabling Plans to date, evidencing progress around the programme plan and development of the individual enabling plans including strategic alignment, engagement and connectivity of all five plans.

3. Enabling Plan Development

3.1 Enabling Plans

SROs and Leads have been identified for each Enabling Plan (Table 1), providing oversight and delivery of the individual plans.

Table 1

Enabling Plan	Lead	SRO
Clinical and Quality	Christian Verrinder/Helena Posnett	Lucy Knight, Alastair Hutchinson, Dawn Dawson
Digital	Jamie Smithson	Nick Johnson
People	Gemma Shone	Nicola Plumb
Finance	Claire Abraham/Sarah Day	Chris Hearn
Infrastructure	David Mclaughlin/Tristan Chapman	Chris Hearn

The Enabling Plans are being developed to coordinate efforts and where the opportunity presents to combine development with current ongoing plans and building on existing engagement/insights. Strategies/Plans are already in development for many of the areas and this work is being used as a springboard and catalyst to shaping and informing the Enabling Plans.

3.2 Contribution to the wider trust objectives

Initial discussions have been held with the Leads to identify how each Plan will contribute to all four strategic objectives. Driver diagrams for the four objectives have been developed and shared with the Leads to support these conversations and achieving delivery.

Alignment to the strategic objectives will form the foundation of the Enabling Plan structure. This will be achieved through use of common overarching questions that each Enabling Plan will respond to. As well as aligning to the strategic objectives, each Plan will provide a roadmap into our new ways of working as federated organisations; integrating community and acute care and mental and physical health.

A Strategy Dashboard is in development. This is a separate piece of work but will help inform the Enabling Plans and the Board Assurance Framework.

3.3 Key internal actions and initiatives

Each Enabling Plan will use a common report template share the same format and overarching questions. Each Enabling Plan will also answer specific questions relevant to their functional area.

The common overarching questions have been developed with the Leads. These have been created to demonstrate strategic alignment, mutual reinforcement (interdependencies) across the plans, and fit with the key themes of the Clinical and Quality Plan.

Overarching Questions (Under development)
1. How have we shaped this Plan? 2. How have we linked the plan to the Strategic Objectives? 3. What are our key Priorities/Objectives? 4. How will we align our priorities to key themes of the Clinical and Quality plan? 5. How are we supporting and aligning to the priorities in the other plans? 6. What impact will this have on : Patients, Carers, Staff and Communities 7. How will we measure progress?

Ongoing engagement with the Leads is allowing for refinement of these questions to ensure they provide the best fit for the Plans.

3.4 Collaboration with other enabling plans

Meetings with the individual Leads have been established with the Project Team, to provide both connectivity and cohesion across the plans. A designated Teams Channel is also providing an important shared space for joined-up thinking that continues outside the meetings.

Regular joint lead meetings have been established to facilitate a common understanding and an appreciation of the interdependencies across the plans. The aim is to coordinate activty, ensure alignment to the strategic objectives and to mitigate the identified risks.

4. Progress

4.1 – Plan development

Initially, each Enabling Plan had a different starting point. However, collectively, through coordination they are being brought together. This includes the key development phases and the approval process in March 2025.

Building on the Joint Strategy the Enabling Plans aim to provide functional detail for our patients, staff and partners to enable and support services to transform in line with the priorities of the organisations.

Initial discussions around the Clinical and Quality Plan have identified three areas to be explored further during engagement, these are:

- Prevention
- Health & Wellbeing of the Population we serve
- Inequalities

Work is underway to use plain English definitions to improve understanding, consistency and accessibility.

4.2 Stakeholder Engagement

Engagement and collaboration will be integral to the development of the Plans, with the programme plan allowing for development and refinement through the phased approach.

To seek plans approval by March 2025, the timeframe is challenging to conduct meaningful engagement. To mitigate this risk work has already started on identifying synergies in engagement efforts with the development of stakeholder mapping across the plans that will identify opportunities to join resources.

Key Forums and Stakeholder Groups have been identified to drive the discovery of existing insights and identify gaps in engagement. The broader engagement with our wider partners and community was completed as part of the Joint Strategy. These insights along with the 100 conversations which directly informed the ICP strategy and the 5-year joint forward plan will be used to direct any further engagement. This will allow an informed approach to engagement that will avoid duplication and maximise resources within a tight timeframe.

A designated Teams channel has been created to foster a culture of collaboration. It provides a shared space for engagement and a free-flowing opportunity to share ideas and feedback.

Development of the Clinical and Quality Plan will be led through the Clinical Leadership Group. The group's focus has been reframed to support the development of the plan, providing clinical engagement and a critical eye as the plan progresses. Members of the group will also be engaged for input into the other four plans.

5. Risks

5.1 Programme Risks

Alignment with Strategic Objectives. There is a risk that the together, the Enabling Plans will not contribute to all of the Strategic Objectives. To mitigate that risk, there will be a Driver Diagram produced showing how each plan contributes to each objective. Any gaps will be addressed early.

Isolated Development. There is a risk that the Enabling plans could be developed in isolation and miss the opportunity to be mutually supportive. To mitigate this risk, the plan leads will have regular facilitated meetings to share and receive updates.

Engagement. There is a risk that the challenging project timeframe could have an impact on achieving meaningful and credible engagement. To mitigate this risk work has already started on identifying synergies in engagement efforts with the development of stakeholder mapping across the plans that will identify opportunities to join resources.

6. Conclusion

Development of the Enabling Plans are ongoing with nominated Leads and SROs driving their development. The Transformation team are providing the coordination and planning to brings the plans together and ensure alignment with the Joint Strategy.

Progress to date is in line with the proposed programme plan and means the Plans are on track for approval by the Boards of Directors in March 2025.

The timeframe does present challenges for achieving credible engagement but will be monitored as a programme risk, with a mitigating plan in place.

Once approved the plans will move into implementation. Monitoring, reporting and escalation arrangements will be developed and agreed by this committee.

7. Recommendations

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

Emma Booker Project Manager
Date 19 Nov 24

8. Appendix

Appendix 1 – Plan on a Page

Appendix 1

Joint Strategy– Development of the Enabling Plans

Clinical and Quality	Digital	People	Finance	Infrastructure
SROs Alastair Hutchison, Dawn Dawson, Lucy Knight **Leads** Helena Posnett & Christian Verrinder **Update** Clinical Leadership Group re-framed to support development of the Plan **Emerging themes** Prevention Population Health Inequalities	**SRO** Nick Johnson **Lead** James Smithson **Update** Initial work underway since Sep 24 to develop Joint Digital Strategy/Roadmap	**SRO** Nicola Plumb **Lead** Gemma Shone **Update** People Strategies due for refresh March 25 creating an opportunity for a joint plan	**SRO** Chris Hearn **Lead** Sarah Day (DHC) Claire Abraham (DCH) **Update** Medium term financial plan development opportunity	**SRO** Chris Hearn **Lead** David McLaughlin (E&F) Tristan Chapman (Strategic Estates) **Update** Proposal outlining approach to govern and implement opportunities across both trusts

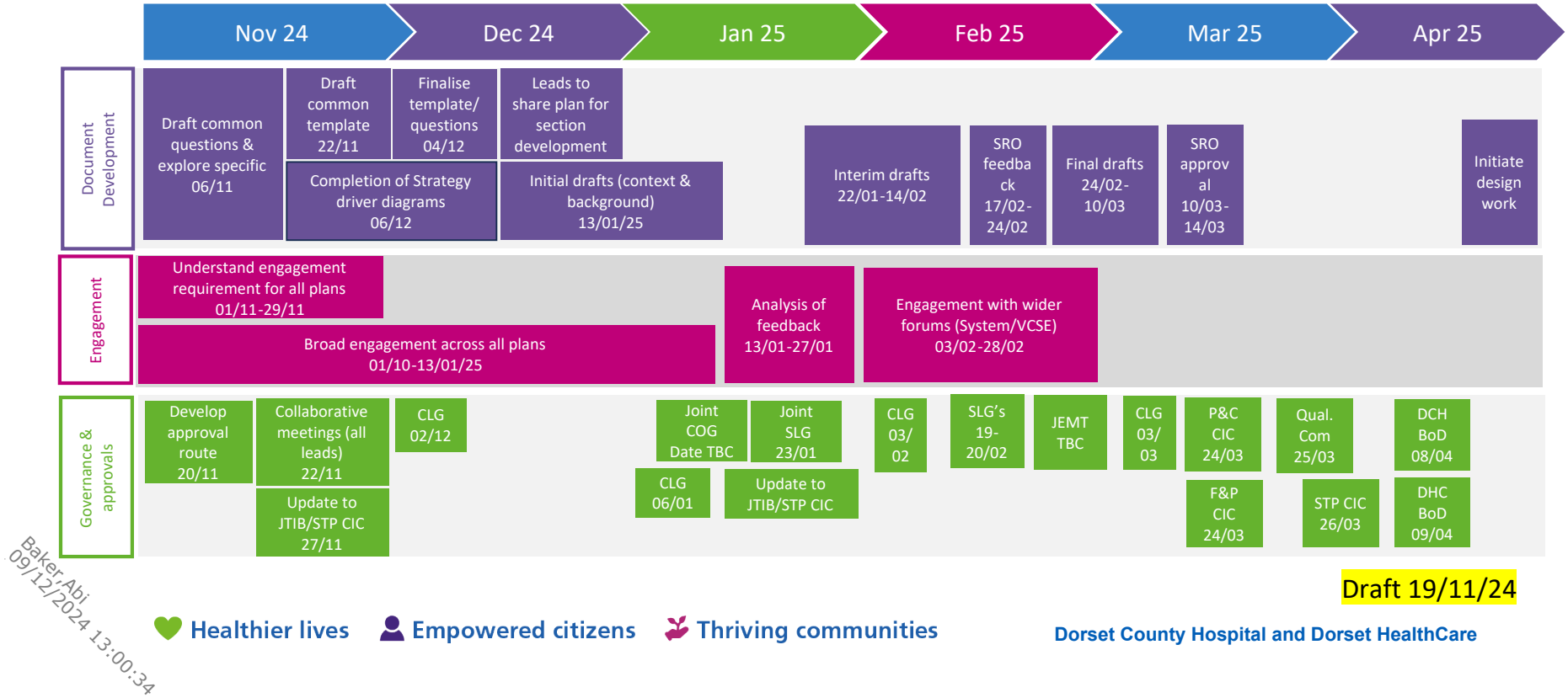
Risks to delivery:

1. Resource and capacity for leads to develop each plan in line with the timeline
2. Balancing timelines and engagement

Phase 1	Phase 2	Phase 3	Phase 4
Planning – Sep/Oct 24 • Agree approach • Identify and engage with leads • Develop draft development timeline • Develop timeline for approvals • Capture emerging themes for Clinical and Quality Plan	**Early development - Nov/Dec 24** • Develop common template • Agree questions which each plan should address (common/specific) • Understanding engagement requirements and timescales • Evidence impact on strategic objectives (driver diagrams) • Demonstrating cross functionality across plans	**Draft and refine Jan/Feb 25** • Complete Broad engagement and analysis • Draft wording • Cross reference with existing strategies • Develop and refine through stakeholder engagement including SLG, JEMT & partners • Share for final comment and amendments	**Finalise – Mar/Apr 25** • Produce final drafts for review and approval through subcommittees • Submit to STP CIC for endorsement • Submit to Boards for April meetings • Design work (pending approval)

Draft timeline – October 24

Plan on a Page



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Draft 19/11/24

Healthier lives Empowered citizens Thriving communities

Dorset County Hospital and Dorset HealthCare

DCH Charitable Funds Committee Assurance Report for the meeting held on 19.11.2024

Chair	Name Dave Underwood
Executive Lead	Name Nicholas Johnson
Quoracy met?	Yes
Purpose of the report	To provide assurance on the main items discussed and, if necessary, escalate any matter(s) of concern or urgent business.
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	• **DCH Charity Annual Accounts 23/24** - Annual Accounts 23/24 recommended to Board (Corporate Trustee) for approval.
Key issues / matters discussed at the meeting	The committee received, discussed and noted the following reports: • **CFC Minutes (18.9.24)** – approved as an accurate record. • **CFC Actions (18.9.24)** – Charitable Funds Committee ToR reviewed/updated. Committee agreed to appoint a Community co-opted member of the committee; who is not an agent of the Trust. Kathryn Harrison, DCH Governor invited and agreed to be the Community member. All other actions completed or in progress. **DCH Charity Financial Reports 24/25 (M6)** – reports were received. Total income as of end Sep £312,862. Major legacy pending. Unrestricted funds were £279,132 providing a surplus of £39,132 against the reserves target of £240,000. • **DCH Charity Risk Register (6-month review)** – all current risk ratings retained. • **DCH Charity Annual Accounts 23/24 / Auditor's report** – the committee were content with the accounts and auditor's report. Annual Accounts recommended to Board (Corporate Trustee) for approval. • **DCH Charity Business planning 25/26** – verbal report on planning process/timeline. DCH Business Plan 25/26 will come to Board (Corporate Trustee) in March 2025 for approval. • **£2.5M Capital Appeal (ED/CrCU) report (Nov 24)** – soon to announce £500K milestone. Major legacy pending – committee agreed on 18.9.24 to commit £500K of the legacy to the appeal once received, which would take the appeal total in excess of £1M. • **Fundraising & Communications report** – overview of current key fundraising activities and communications.

	• **Lillian Martin legacy update** – awaiting update from lead charity including latest valuation of land.
Decisions made at the meeting	• **Community co-opted member** - Committee agreed to appoint a Community co-opted member of the committee; who is not an agent of the Trust. Kathryn Harrison, DCH Governor invited and agreed to be the Community member.
Issues / actions referred to other committees / groups	• None

Quoracy and Attendance						
	Date 19.11.24	**Date**	**Date**			
Quorate?	Y					
Committee member name	Y Dave Underwood					
Committee member name	Y Chris Hearn					
Committee member name	Y Jo Howarth					
Committee member name	Y Anita Thomas					
Committee member name	Y Margaret Blankson					
Committee member name	Y Stephen Tilton					

Report to	Board of Directors, Part 1	
Date of Meeting	10 December 2024	
Report Title	DCH SubCo Performance Report	
Prepared By	Andrew Harris, Superintendent Pharmacist	
Approved by Accountable Executive	Nick Johnson, Claire Abraham (DCH SubCo Directors)	
Previously Considered By	DCH SubCo Ltd Board meeting, 23 October 2024 Finance and Performance Committee in Common, 25 November 2024	
Action Required	**Approval**	-
	Assurance	-
	Information	Y

Alignment to Strategic Objectives	Does this paper contribute to our strategic objectives? *Delete as required*	
Care	Yes	
Colleagues		No
Communities		No
Sustainability		No
Implications	Describe the implications of this paper for the areas below.	
Board Assurance Framework	SR1 Safety and Quality: the principal activity of the company is to provide outpatient pharmacy services to Dorset County Hospital NHSFT.	
Financial	No implication	
Statutory & Regulatory	No implication	
Equality, Diversity & Inclusion	No implication	
Co-production & Partnership	DCH SubCo Ltd continues to work with the shareholder (Dorset County Hospital NHSFT) in the provision of its services.	

Executive Summary

Fortuneswell Pharmacy has returned to cancer only related activity which is reflected in the reduced activity from August 2020, though cancer related activity is now climbing.

A review of dispensing activity was undertaken in June 2023 in conjunction with the Chief Pharmacist and Lead Cancer Nurse to identify activity that could be relocated elsewhere (main hospital pharmacy or community pharmacy) to manage the increasing workload.

All contractual KPIs year to date are green.

Incidents

No dispensing errors have left Fortuneswell Pharmacy in financial year 2024/25

Complaints

Nil

Keys Risks

- The original business was for a dedicated Cancer Services Outpatient Pharmacy with an estimated dispensing activity of ~700 items per month. Activity has steadily increased over the two year period and is now 1,400 per month, double the anticipated level of activity in the

original business case. There is now a risk the Outpatient Pharmacy would no longer meet the General Pharmaceutical Council (GPhC) premises standards if reinspected.

- Significant level of vacancies within the DCH Clinical Pharmacy Service impacting on ability of Superintendent Pharmacist to take Annual Leave. This also poses a potential for service disruption (reduced opening hours) in the absence of the superintendent pharmacist (both planned and unplanned).
- HM Treasury commenced a consultation in August 2020 on "VAT and the Public Sector: Reform to VAT refund rules". This has significant implications for the Public sector including the NHS which if the recommendation is implemented, would permit full refunds of the VAT incurred on all goods and services during the course of nonbusiness activities (full refund model). This represents a significant risk to the long term sustainability of the subsidiary company.

Recommendation

Members are requested to:

- Receive the report for **information**

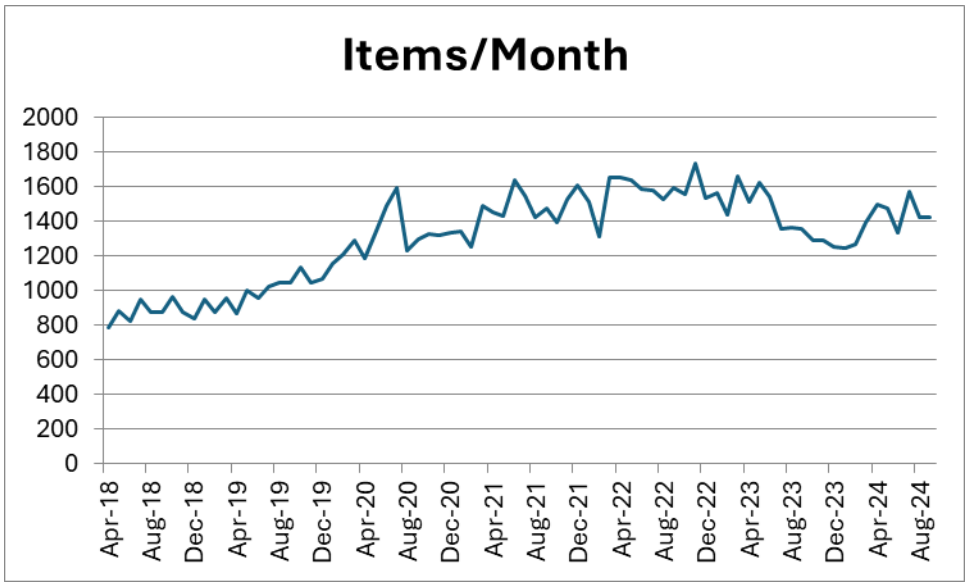
Performance Report

Andrew Harris
Superintendent Pharmacist
October 2024

Key Performance Indicators (KPIs)

	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24
Total Number of Customers per Month	172	147	129	169	176	144
Total Items Dispensed	1496	1478	1338	1575	1426	1422
Average Items/day	74.8	70.4	66.9	68.5	67.9	67.7
No. of same day Prescriptions	243	214	213	223	179	259
No. of Advance Prescriptions	493	506	413	549	351	385

Activity levels from April 2018 to current:



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

All contractual KPIs year to date are green.

Performance measure	Key Performance Indicator	Target performance	Green	Amber	Red	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24
Rate of dispensing errors detected post issue	Number of errors made per total volume of prescriptions dispensed that have LEFT the department	<2.0%	<1.0%	1.0-2.0%	>2.0%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Near Miss Monitoring	Number of errors made per total volume of prescriptions dispensed that have NOT LEFT the department	<2.0%				0.67%	0.88%	0.90%	0.95%	0.98%	0.91%
Availability of service	Responsible Pharmacist Availability	0	0 to 45 mins	45 to 90 mins	> 90 mins	0	0	0	0	0	0
Availability of medicines	The % of prescription items dispensed in full at the first time of presentation excluding manufacturer can't supply	98%	100% - 98%	97.9% - 96%	< 95.9%	99.47 %	99.80 %	99.78 %	99.49 %	99.23 %	99.86 %
MHRA Recall Assurance	100% of all SABs alerts, MHRA and Company-Led recalls are managed in accordance with Class status	100%				100%	100%	100%	100%	100%	100%
All Mosaiq advance prescription preparedthe day in advance of collection	The completion time should bethe day in advance of collection/ delivery to chemotherapy nurses.	>90%	100% - 90%	89.9% - 80%	<80%	97.6%	98.2%	96.9%	96.9%	96.0%	96.4%

The waiting time for dispensing prescriptions, during a monthly period shall be:
 	
(i) 30 minutes or less in respect of 95% of all prescriptions; and
 	
(ii) 20 minutes or less in respect of 80% of all prescriptions
	The time taken for a patient to wait for their prescription from the time they present it to the Pharmacy.	(i) 30 minutes or less in respect of 95% of all prescriptions
		
		(ii) 20 minutes or less in respect of 80% of all prescriptions
			For (i) Greater than or equal to 95%
			
			For (ii) Greater than or equal to 80%
				For (i) 80% - 94.9%
				
				For (ii) 65% - 79.9%
					For (i) Less than 80%
					
					For (ii) Less than 65%
						(i) 100%
						
						(ii) 100%
							(i) 100%
							
							(ii) 97.7%
								(i) 98.3%
								
								(ii) 97.5%
									(i) 99.3%
									
									(ii) 97.4%
										(i) 100%
										
										(ii) 97.7%
											(i) 100%
											
											(ii) 93.7%

Index of customer satisfaction	The patient overall satisfaction level		100% of Customers to be offered Customer Feedback Survey Monthly Reporting on KPIs to record; Total Number of Customers per Month Completion / Uptake Rate (%)			100%	100%	100%	100%	100%	100%
Number of complaints	The number of upheld complaints		1 or fewer complaints per quarter	0	0	0	0	0	0	0	0

Number of non-agreed non-formulary items supplied	Number of items that appear on total non-formulary supply report	0%	0% - 0.049%	0	0	0	0	0	0	0	0
Controlled drug management	Correct procedure against SOPs followed at all times	100%	No Tolerance			100%	100%	100%	100%	100%	100%
Provision of financial, clinical and management information	financial, clinical and management information to be provided within 5 working days following the end of the previous month	100%	100% - 99%	98.9% - 97.5%	< 97.5%	100%	100%	100%	100%	100%	100%
Waste/Expiry management*	Waste Costs below £200 per month - Stock waste to be managed	<£200	<£200			£14.84	£0.01	£0.00	£18.29	£0.00	£0.00

	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24
Month End Stock Value £k (i/c VAT)	266	374	357	407	263	337

Incidents
No dispensing errors have left Fortuneswell Pharmacy in financial year 2024/25

Complaints
Nil

Keys Risks

- The original business was for a dedicated Cancer Services Outpatient Pharmacy with an estimated dispensing activity of ~700 items per month. Activity has steadily increased over the two year period and is now 1,400 per month, double the anticipated level of activity in the original business case. There is now a risk the Outpatient Pharmacy would no longer meet the General Pharmaceutical Council (GPhC) premises standards if re-inspected.
- Significant level of vacancies within the DCH Clinical Pharmacy Service impacting on ability of Superintendent Pharmacist to take Annual Leave. This also poses a potential for service disruption (reduced opening hours) in the absence of the superintendent pharmacist (both planned and unplanned).
- HM Treasury commenced a consultation in August 2020 on "VAT and the Public Sector: Reform to VAT refund rules". This has significant implications for the Public sector including the NHS which if the recommendation is implemented, would permit full refunds of the VAT incurred on all goods and services during the course of non-business activities (full refund model). This represents a significant risk to the long term sustainability of the subsidiary company.

Report to	Board of Directors, Part 1	
Date of Meeting	10 December 2024	
Report Title	DCH SubCo Ltd Annual Report and Accounts 2023/24	
Prepared By	Mark Lovett, Financial Controller, & James Claypole, Deputy Financial Controller	
Approved by Accountable Executive	Claire Abraham, DCH SubCo Director	
Previously Considered By	DCH SubCo Ltd Board meeting, 23 October 2024 Finance and Performance Committee in Common, 25 November 2024	
Action Required	**Approval**	-
	Assurance	-
	Information	Y

Alignment to Strategic Objectives	Does this paper contribute to our strategic objectives? *Delete as required*	
Care	Yes	
Colleagues		No
Communities		No
Sustainability		No
Implications	Describe the implications of this paper for the areas below.	
Board Assurance Framework	SR1 Safety and Quality: the principal activity of the company is to provide outpatient pharmacy services to Dorset County Hospital NHSFT.	
Financial	The directors have adopted the going concern basis in the preparation of the accounts.	
Statutory & Regulatory	The Annual Accounts and Annual Reports have been prepared in accordance with UK accounting standards and applicable law (UK Generally Accepted Accounting Practice), including Section 1A of FRS 102 The Financial Reporting Standard applicable in the UK and Republic of Ireland.	
Equality, Diversity & Inclusion	No implications	
Co-production & Partnership	DCH SubCo Ltd continues to work with the shareholder (Dorset County Hospital NHSFT) in the provision of its services.	

Executive Summary

The Annual Accounts and Annual Reports for the year ending 31 March 2024 have been prepared in accordance with UK accounting standards and applicable law (UK Generally Accepted Accounting Practice), including Section 1A of FRS 102 *The Financial Reporting Standard applicable in the UK and Republic of Ireland*.

The Annual Reports and Accounts were audited by KPMG.
Papers included within this agenda item include:

- 2023/2024 DCH SubCo Limited Annual Report and Accounts
- Management Letter of Representation – for signing
- DCH SucCo Audit Report for the Board of Directors – to follow
- DCH SubCo Company tax provision report & computations

The Annual Reports and Accounts were presented to the DCH SubCo Ltd Board meeting on 23 October 2024 where they were approved. They are presented to the Finance and Performance Committee in Common today for information only.

Recommendation

Members are requested to:

- Receive the report for **information**

DCH Subco Limited
Annual report and financial statements
Registered number 10805151
31st March 2024

Contents

Directors' Report

Principal Activities and Going Concern

The principal activity of the company throughout the period was to provide outpatient pharmacy services. The directors have a reasonable expectation that the company has adequate resources to continue in operational existence for the foreseeable future, being a period of not less than 12 months from the date of this report. The directors do not foresee any liquidity issues as the company has regular cash inflows which will allow it to meet its liabilities as they fall due.

The entity received written confirmation from the Trust during October 2024 that it wished to continue to contract for it to provide pharmacy services to Dorset County Hospital for a further year until March 2026, which will continue to generate cash inflows.

For this reason, the directors have adopted the going concern basis in the preparation of the accounts.

Principal Place of Business

Dorset County Hospital NHS Foundation Trust

Williams Avenue

Dorchester

Dorset DT1 2JY

Business Review

The company was established in June 2017 and commenced trading in April 2018 and is a wholly owned subsidiary of Dorset County Hospital NHS Foundation Trust. The company's principal activity is to provide a dispensing service to the outpatients of the parent NHS organisation.

The company's revenue from dispensing drugs is entirely from the NHS parent Foundation Trust and its outpatients attending their hospital appointments, therefore there is minimal commercial or market risk with the company's principal activity.

The financial statements on pages 8 to 21 provide detailed information relating to the company, the operation of its business and the results and its financial position for the year ended 31st March 2024.

The company is governed by and compliant with all applicable pharmacy dispensing laws and regulations.

The company continues to trade, with two staff members in post continuing to provide pharmacy services to outpatients at Dorset County Hospital. The principal risk and uncertainty are if the Trust no longer wishes to trade with DCH SubCo Ltd, however this is unlikely where the Trust has confirmed that the contract to provide a dispensing service to the outpatients has been extended for two years. Further to this, plans have been approved to expand the outpatient pharmacy facility in order to provide more services to the parent NHS organisation.

Directors

The directors present their report with the audited financial statements of the company for the year ended 31st March 2024.

The directors who held office during the year were as follows:

Nicholas Johnson

Stephen Tilton

Claire Abraham.

No director received any remuneration from the company or any interest in the share capital of the company during the period. All of the directors are either directors or employees of the parent Trust.

Political Contributions

The company made no political donations and incurred no political expenditure during the year (2023: £nil).

Charitable Contributions

The company made no (£nil) charitable donations during the financial year (2023: £nil)

Dividends

The directors did not propose or pay any dividends in the year (2023: £nil).

Future Plans

The company will continue to provide a dispensing service to the outpatients of the parent NHS organisation.

Disclosure of information to auditor

The directors who held office at the date of approval of this directors' report confirm that, so far as they are each aware, there is no relevant audit information of which the company's auditor is unaware; and each director has taken all the steps that he/she ought to have taken as a director to make himself/herself aware of any relevant audit information and to establish that the company's auditor is aware of that information.

Small Company Provisions

This report has been prepared in accordance with the provisions in section 415a of the Companies Act 2006 applicable to companies entitled to the small companies' exemption.

External Auditor

Pursuant to Section 487 of the Companies Act 2006, the auditor will be deemed to be reappointed and KPMG LLP will therefore continue in office.

This report was approved by the board on 23 October 2024 and signed on its behalf.

Claire Abraham

Director

23 October 2024

STATEMENT OF DIRECTORS' RESPONSIBILITIES IN RESPECT OF THE DIRECTORS' REPORT AND THE FINANCIAL STATEMENTS

The directors are responsible for preparing the Strategic Report, the Directors' Report and the financial statements in accordance with applicable law and regulations.

Company law requires the directors to prepare financial statements for each financial year. Under that law they have elected to prepare the financial statements in accordance with UK accounting standards and applicable law (UK Generally Accepted Accounting Practice), including FRS 102 The Financial Reporting Standard applicable in the UK and Republic of Ireland.

Under company law the directors must not approve the financial statements unless they are satisfied that they give a true and fair view of the state of affairs of the Company and of the profit or loss of the Company for that period. In preparing these financial statements, the directors are required to:

- select suitable accounting policies and then apply them consistently;
- make judgements and estimates that are reasonable and prudent;
- state whether applicable UK accounting standards have been followed, subject to any material departures disclosed and explained in the financial statements;
- assess the Company's ability to continue as a going concern, disclosing, as applicable, matters related to going concern; and
- use the going concern basis of accounting unless they either intend to liquidate the Company or to cease operations, or have no realistic alternative but to do so.

The directors are responsible for keeping adequate accounting records that are sufficient to show and explain the Company's transactions and disclose with reasonable accuracy at any time the financial position of the Company and enable them to ensure that the financial statements comply with the Companies Act 2006. They are responsible for such internal control as they determine is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error, and have general responsibility for taking such steps as are reasonably open to them to safeguard the assets of the Company and to prevent and detect fraud and other irregularities.

INDEPENDENT AUDITOR'S REPORT TO THE MEMBERS OF DCH SUBCO LIMITED

Opinion

We have audited the financial statements of DCH Subco Limited ("the Company") for the year ended 31 March 2024 which comprise the statement of financial position, statement of comprehensive income, statement of changes in equity, statement of cash flows and related notes, including the accounting policies in note 1.

In our opinion the financial statements:

give a true and fair view of the state of the Company's affairs as at 31 March 2024 and of its profit for the year then ended;

have been properly prepared in accordance with UK accounting standards, including FRS 102 The Financial Reporting Standard applicable in the UK and Republic of Ireland; and

have been prepared in accordance with the requirements of the Companies Act 2006.

Basis for opinion

We conducted our audit in accordance with International Standards on Auditing (UK) ("ISAs (UK)") and applicable law. Our responsibilities are described below. We have fulfilled our ethical responsibilities under, and are independent of the Company in accordance with, UK ethical requirements including the FRC Ethical Standard. We believe that the audit evidence we have obtained is a sufficient and appropriate basis for our opinion.

Going concern

The directors have prepared the financial statements on the going concern basis as they do not intend to liquidate the Company or to cease its operations, and as they have concluded that the Company's financial position means that this is realistic. They have also concluded that there are no material uncertainties that could have cast significant doubt over its ability to continue as a going concern for at least a year from the date of approval of the financial statements ("the going concern period").

In our evaluation of the directors' conclusions, we considered the inherent risks to the Company's business model and analysed how those risks might affect the Company's financial resources or ability to continue operations over the going concern period.

Our conclusions based on this work:

we consider that the directors' use of the going concern basis of accounting in the preparation of the financial statements is appropriate;

we have not identified, and concur with the directors' assessment that there is not, a material uncertainty related to events or conditions that, individually or collectively, may cast significant doubt on the Company's ability to continue as a going concern for the going concern period.

However, as we cannot predict all future events or conditions and as subsequent events may result in outcomes that are inconsistent with judgements that were reasonable at the time they were made, the above conclusions are not a guarantee that the Company will continue in operation.

Fraud and breaches of laws and regulations – ability to detect

Identifying and responding to risks of material misstatement due to fraud

To identify risks of material misstatement due to fraud ("fraud risks") we assessed events or conditions that could indicate an incentive or pressure to commit fraud or provide an opportunity to commit fraud. Our risk assessment procedures included:

Enquiring of directors, the risk and audit committee, internal audit and inspection of policy documentation as to the Company's high-level policies and procedures to prevent and detect fraud, including the internal audit function, and the Company's channel for "whistleblowing", as well as whether they have knowledge of any actual, suspected or alleged fraud.

Reading Board and audit and risk committee minutes.

Using analytical procedures to identify any unusual or unexpected relationships.

Obtaining a copy of the Company's risk register

We communicated identified fraud risks throughout the audit team and remained alert to any indications of fraud throughout the audit.

As required by auditing standards, we perform procedures to address the risk of management override of controls, in particular the risk that management may be in a position to make inappropriate accounting entries. On this audit we do not believe there is a fraud risk related to revenue recognition because of the simple nature of revenue generated within the entity.

We did not identify any additional fraud risks.

In determining the audit procedures we took into account the results of our evaluation of some of the entity-wide fraud risk management controls.

We performed procedures including:

Identifying journal entries and other adjustments to test based on risk criteria and comparing the identified entries to supporting documentation. These included those posted to unusual accounts including unusual account combinations for journals posted that are posted to both revenue and cash.

Identifying and responding to risks of material misstatement related to compliance with laws and regulations

We identified areas of laws and regulations that could reasonably be expected to have a material effect on the financial statements from our general commercial and sector experience and through discussion with the directors and other management (as required by auditing standards), and from inspection of the Company's regulatory and legal correspondence and discussed with the directors and other management the policies and procedures regarding compliance with laws and regulations.

We communicated identified laws and regulations throughout our team and remained alert to any indications of non-compliance throughout the audit.

The potential effect of these laws and regulations on the financial statements varies considerably.

The Company is subject to laws and regulations that directly affect the financial statements including financial reporting legislation (including related companies legislation), distributable profits legislation and taxation legislation and we assessed the extent of compliance with these laws and regulations as part of our procedures on the related financial statement items.

Whilst the company is subject to many other laws and regulations, we did not identify any others where the consequences of non-compliance alone could have a material effect on amounts or disclosures in the financial statements.

Context of the ability of the audit to detect fraud or breaches of law or regulation

Owing to the inherent limitations of an audit, there is an unavoidable risk that we may not have detected some material misstatements in the financial statements, even though we have properly planned and performed our audit in accordance with auditing standards. For example, the further removed non-compliance with laws and regulations is from the events and transactions reflected in the financial statements, the less likely the inherently limited procedures required by auditing standards would identify it.

In addition, as with any audit, there remained a higher risk of non-detection of fraud, as these may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal controls. Our audit procedures are designed to detect material misstatement. We are not responsible for preventing non-compliance or fraud and cannot be expected to detect non-compliance with all laws and regulations.

Strategic report and directors' report

The directors are responsible for the strategic report and the directors' report. Our opinion on the financial statements does not cover those reports and we do not express an audit opinion thereon.

Our responsibility is to read the strategic report and the directors' report and, in doing so, consider whether, based on our financial statements audit work, the information therein is materially misstated or inconsistent with the financial statements or our audit knowledge. Based solely on that work:

we have not identified material misstatements in the strategic report and the directors' report;

in our opinion the information given in those reports for the financial year is consistent with the financial statements; and

in our opinion those reports have been prepared in accordance with the Companies Act 2006.

Matters on which we are required to report by exception

Under the Companies Act 2006 we are required to report to you if, in our opinion:

adequate accounting records have not been kept, or returns adequate for our audit have not been received from branches not visited by us; or

the financial statements are not in agreement with the accounting records and returns; or

certain disclosures of directors' remuneration specified by law are not made; or

we have not received all the information and explanations we require for our audit.

We have nothing to report in these respects.

Directors' responsibilities

As explained more fully in their statement set out on page [X], the directors are responsible for: the preparation of the financial statements and for being satisfied that they give a true and fair view; such internal control as they determine is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error; assessing the Company's ability to continue as a going concern, disclosing, as applicable, matters related to going concern; and using the going concern basis of accounting unless they either intend to liquidate the Company or to cease operations, or have no realistic alternative but to do so.

Auditor's responsibilities

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue our opinion in an auditor's report. Reasonable assurance is a high level of assurance, but does not guarantee that an audit conducted in accordance with ISAs (UK) will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of the financial statements.

A fuller description of our responsibilities is provided on the FRC's website at www.frc.org.uk/auditorsresponsibilities.

The purpose of our audit work and to whom we owe our responsibilities

This report is made solely to the Company's members, as a body, in accordance with Chapter 3 of Part 16 of the Companies Act 2006. Our audit work has been undertaken so that we might state to the Company's members those matters we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Company and the Company's members, as a body, for our audit work, for this report, or for the opinions we have formed.

Rees Batley (Senior Statutory Auditor)

for and on behalf of KPMG LLP, Statutory Auditor

Chartered Accountants

66 Queen Square

Bristol

BS1 4BE

23 October 2024

REGISTERED NUMBER: 10805151 (England and Wales)

STATEMENT OF COMPREHENSIVE INCOME FOR THE YEAR ENDED 31 MARCH 2024

	NOTE	Year ended 31 March 2024 £'000	Period ended 31 March 2023 £'000
Turnover	**2**	**5,254**	5,966
Cost of Sales		**(4,955)**	(5,645)
Gross Profit		**299**	321
Administrative expenses		**(179)**	(190)
Operating Profit		**120**	131
Interest receivable and other similar income		**27**	15
Profit on Ordinary Activities Before Taxation		**147**	**146**
Less Gift Aid		**-**	-
Taxation	**16**	**(35)**	(28)
Profit on Ordinary Activities After Taxation		**113**	**118**
Other Comprehensive Income		**-**	-
Total Comprehensive Income for the year		**113**	**118**

All activities relate to continuing operations.

The notes on pages 11 to 21 form part of these accounts

REGISTERED NUMBER: 10805151 (England and Wales)

STATEMENT OF FINANCIAL POSITION AT 31 MARCH 2024

	NOTE	31 March 2024 £'000	31 March 2023 £'000
Fixed Assets			
Tangible assets	6	-	-
		-	-
Current Assets			
Stocks	7	233	162
Debtors	8	524	112
Cash at bank and in hand	9	196	612
		953	886
Creditors: Amounts falling due within one year	10	(426)	(471)
Net Current Assets		528	415
Total Assets Less Current Liabilities		528	415
Creditors: Amounts falling due after more than one year	10	-	-
Net assets		528	415
Financed by			
Capital and Reserves			
Called up share capital	11	-	-
Profit and loss account		528	415
Total Equity		528	415

The financial statements on pages 8 to 21 have been prepared in accordance with the provisions applicable to small companies within Part 15 of the Companies Act 2006 and in accordance with Section 1A of FRS 102 *The Financial Reporting Standard applicable in the UK and Republic of Ireland (UK Generally Accepted Accounting Practice applicable to Smaller Entities)*.

The notes on pages 11 to 21 form part of these accounts. These financial statements on pages 8 to 21 were approved by the board of directors on 23 October 2024 and were signed on its behalf by

Claire Abraham, Director 23 October 2024

STATEMENT OF CHANGES IN EQUITY FOR THE YEAR ENDED 31 MARCH 2024

	Called up share capital £'000	Profit and loss account £'000	Total equity £'000
Equity at 1 April 2023	-	415	415
Profit for the year	-	**113**	**113**
Total comprehensive income for the period	-		
Equity at 31 March 2024	-	**528**	**528**
Equity at 1 April 2022	-	297	297
Profit for the period	-	118	118
Total comprehensive income for the period	-	415	415
Equity at 31 March 2023	-	415	415

NOTES TO THE ACCOUNTS

1. Accounting Policies

DCH Subco Limited (the "Company") is a company limited by shares and incorporated and domiciled in the UK.

These financial statements were prepared in accordance with Financial Reporting Standard 102. The Financial Reporting Standard applicable in the UK and Republic of Ireland ("FRS 102"). The presentation currency of these financial statements is sterling. All amounts in the financial statements have been rounded to the nearest £1,000.

The Company's parent undertaking, Dorset County Hospital NHS Foundation Trust, includes the Company in its consolidated financial statements. The consolidated financial statements of Dorset County Hospital NHS Foundation Trust are prepared in accordance with International Financial Reporting Standards as adopted by the EU and are available to the public and may be obtained from Dorset County Hospital NHS Foundation Trust, Williams Avenue, Dorchester, Dorset DT1 2JY. In these financial statements, the company is considered to be a qualifying entity (for the purposes of this FRS) and has applied the exemptions available under FRS 102 in respect of the following disclosures:

- Key Management Personnel compensation.

The Company proposes to continue to adopt the reduced disclosure framework of FRS 102 in its next financial statements.

In these financial statements, the company is considered to be a qualifying entity (for the purposes of this FRS) and has applied the exemptions available under FRS 102 in respect of the following disclosures:

- the requirements of Section 4 Statement of Financial Position paragraph 4.12(a)(iv):
- the requirements of Section 7 Statement of Cash Flows:
- the requirements of Section 3 Financial Statement Presentation paragraph:
- the requirements of Section 33 Related Party Disclosures paragraph 33.7.

The accounting policies set out below have, unless otherwise stated, been applied consistently to all periods presented in these financial statements.

Judgements made by the directors, in the application of these accounting policies that have significant effect on the financial statements and estimates with a significant risk of material adjustment in the next year are discussed in 1.12

1.1 Measurement Convention/Going Concern

The financial statements are prepared on the historical cost basis and on a going concern basis.

Notes to the Accounts – 1. Accounting Policies (Continued)

Going Concern

The directors have a reasonable expectation that the company has adequate resources to continue in operational existence for the going concern period, being a period of not less than 12 months from the date of this report. The directors have a planned budget and cashflow for the next 12 months with Dorset County NHS Foundation Trust and written confirmation has been received that they wish to recontract these services for a further year from the 1st April 2025. The directors do not foresee any liquidity issues as the company has regular cash inflows which will allow it to meet its liabilities as they fall due. Therefore these financial statements are prepared on a going concern basis.

1.2 Classification of financial instruments issued by the Company

In accordance with FRS 102.22, financial instruments issued by the Company are treated as equity only to the extent that they meet the following two conditions:

(a) they include no contractual obligations upon the company to deliver cash or other financial assets or to exchange financial assets or financial liabilities with another party under conditions that are potentially unfavourable to the company; and

(b) where the instrument will or may be settled in the company's own equity instruments, it is either a non-derivative that includes no obligation to deliver a variable number of the company's own equity instruments or is a derivative that will be settled by the company's exchanging a fixed amount of cash or other financial assets for a fixed number of its own equity instruments.

To the extent that this definition is not met, the proceeds of issue are classified as a financial liability. Where the instrument so classified takes the legal form of the company's own shares, the amounts presented in these financial statements for called up share premium account exclude amounts in relation to those shares

1.3 Basic financial instruments

Trade and other debtors/creditors

Trade and other debtors are recognised initially at transaction price less attributable transaction costs. Trade and other creditors are recognised initially at transaction price plus attributable transaction costs. Subsequent to initial recognition they are measured at amortised cost using the effective interest method, less any impairment losses in the case of trade debtors. If the arrangement constitutes a financing transaction, for example if payment is deferred beyond normal business terms, then it is measured at the present value of future payments discounted at the market rate of instrument for a similar debt instrument.

Interest-bearing borrowings classified as basic financial instruments

Interest-bearing borrowings are recognised initially at the present value of future payments discounted at a market rate of interest. Subsequent to initial recognition, interest-bearing borrowings are stated at amortised cost using the effective interest method, less any impairment losses.

Cash and cash equivalents

Cash and cash equivalents comprise cash balances.

Notes to the Accounts – 1. Accounting Policies (Continued)

1.4 Tangible fixed assets

Tangible fixed assets are stated at cost less accumulated depreciation and accumulated impairment losses. Where parts of an item of tangible fixed assets have different useful lives, they are accounted for as separate items of tangible fixed assets, for example land is treated separately from buildings.

Leases in which the Company assumes substantially all the risks and rewards of ownership of the leased asset are classified as finance leases. All other leases are classified as operating leases. Leased assets acquired by way of finance lease are stated on initial recognition at an amount equal to the lower of their fair value and the present value of the minimum lease payments at inception of the lease, including any incremental costs directly attributable to negotiating and arranging the lease. At initial recognition a finance lease liability is recognised equal to the fair value of the leased asset or, if lower, the present value of the minimum lease payments. The present value of the minimum lease payments is calculated using the interest rate implicit in the lease. Lease payments are accounted for as described at 1.10 below. The company assesses at each reporting date whether tangible fixed assets (including those leased under a finance lease) are impaired.

Depreciation is charged to the profit and loss account on a straight-line basis over the estimated useful lives of each part of an item of tangible fixed assets. Leased assets are depreciated over the shorter of the lease term and their useful lives. The estimated useful lives are as follows:

- information technology 5 years

Depreciation methods, useful lives and residual value are reviewed if there is an indication of a significant change since the last annual reporting data in the pattern by which the company expects to consume an asset's future economic benefits

1.5 Stocks

Stocks are stated at the lower of cost and estimated selling price less costs to complete and sell.

1.6 Impairment excluding stocks

Financial assets (including trade and other debtors)

A financial asset not carried at fair value through profit or loss is assessed at each reporting date to determine whether there is objective evidence that it is impaired. A financial asset is impaired if objective evidence indicates that a loss event has occurred after the initial recognition of the asset, and that the loss event had a negative effect on the estimated future cash flows of that asset that can be estimated reliably.

Non-financial assets

The carrying amounts of the Company's non-financial assets, other than stocks, are reviewed at each reporting date to determine whether there is any indication of impairment. If any such indication exists, then the asset's recoverable amount is estimated. The recoverable amount of an asset or cash-generating unit is the greater of its value in use and its fair value less costs to sell. In assessing value in use, the estimated future cash flows are discounted to

Notes to the Accounts – 1. Accounting Policies (Continued)

their present value using a pre-tax discount rate that reflects current market assessments of the time value of money and the risks specific to the asset.

1.7 Employee benefits

Defined contribution plans and other long term employee benefits

A defined contribution plan is a post-employment benefit plan under which the company pays fixed contributions into a separate entity and will have no legal or constructive obligation to pay further amounts. Obligations for contributions to defined contribution pension plans are recognised as an expense in the profit and loss account in the periods during which services are rendered by employees.

1.8 Provisions

A provision is recognised in the balance sheet when the Company has a present legal or constructive obligation as a result of a past event, that can be reliably measured and it is probable that an outflow of economic benefits will be required to settle the obligation. Provisions are recognised at the best estimate of the amount required to settle the obligation at the reporting date.

1.9 Revenue Recognition

Revenue comprises the value of goods supplied during the period to external customers and other group companies to the extent that there is a right to receive consideration and is recorded at the fair value of consideration received or receivable excluding value added tax.

All revenue is attributable to one class of business and arose in the United Kingdom.

1.10 Expenses

Operating lease

Payments (excluding costs for services and insurance) made under operating leases are recognised in the profit and loss account on a straight-line basis over the term of the lease unless the payments to the lessor are structured to increase in line with expected general inflation; in which case the payments related to the structured increases are recognised as incurred. Lease incentives received are recognised in profit and loss over the term of the lease as an integral part of the total lease expense.

Interest receivable and Interest payable

Interest payable and similar charges include interest payable, finance charges on shares classified as liabilities and finance leases recognised in profit and loss using the effective interest method, unwinding of the discount of provisions, and net foreign exchange losses that are recognised in the profit and loss account (see foreign currency accounting policy).

Other interest receivable and similar income includes interest receivable on funds invested.

Interest income and interest payable are recognised in profit and loss as they accrue, using the effective interest method. Dividend income is recognised in the profit and loss account on

Notes to the Accounts – 1. Accounting Policies (Continued)

the date the company's right to receive payments is established. Foreign currency gains and losses are reported on a net basis.

1.11 Taxation

Tax on the profit and loss for the year comprises current and deferred tax. Tax is recognised in the profit and loss account except to the extent that it relates to items recognised directly in equity or other comprehensive income, in which case it is recognised directly in equity or other comprehensive income. Current tax is the expected tax payable or receivable on the taxable income or loss for the year, using tax rates enacted or substantively enacted at the balance sheet date, and any adjustment to tax payable in respect of previous years.

Deferred tax is provided on timing differences which arise from the inclusion of income and expenses in tax assessments in periods different from those in which they are recognised in the financial statements. The following timing differences are not provided for: differences between accumulated depreciation and tax allowances for the cost of a fixed asset if and when all conditions for retaining the tax allowances have been met; and differences relating to investments in subsidiaries, to the extent that it is not probably that they will reverse in the foreseeable future and the reporting entity is able to control the reversal of the timing difference. Deferred tax is not recognised on permanent differences arising because certain types of income or e**x**pense are non-taxable or are disallowable for tax or because certain tax charges or allowances are greater or smaller than the corresponding income or expense.

Deferred tax is provided in respect of the additional tax that will be paid or avoided on difference between the amount at which an asset (other than goodwill) or liability is recognised in a business combination and deferred tax is measured at the tax rate that is expected to apply to the reversal of the related difference, using tax rate enacted or substantively enacted at the balance sheet date. Deferred tax balances are not unrelieved tax losses and other deferred tax assets are recognised only to the extent that is it probable that they will be recovered against the reversal of deferred tax liabilities or other future profits.

1.12 Accounting estimates and judgements

In the application of the Company accounting policies, management is required to make judgements, estimates and assumptions about the carrying amounts of assets and liabilities that are not readily apparent from other sources. The estimates and associated assumptions are based on historical experience and other factors that are considered to be relevant. Actual results may differ from those estimates and the estimates and underlying assumptions are continually reviewed. Revisions to accounting estimates are recognised in the period in which the estimate is revised if the revision affects only that period or in the period of the revision and future periods if the revision affects both current and future periods.

As the company does not have a significant asset base and most business is either transacted in cash or with its parent, Dorset County Hospital NHS Foundation Trust, it is not considered that there are any critical accounting judgements required in preparing the Company's accounts.

Key sources of estimation uncertainty

There are no key assumptions concerning the future, or other key sources of estimation uncertainty at the balance sheet date, that have a significant risk of causing a material adjustment to the carrying amounts of assets and liabilities within the next financial period.

Notes to the Accounts

2. Turnover

	Year ended 31 March 2024	Period ended 31 March 2023
	£'000	£'000
Sales of Goods	**5,254**	5,966
Total turnover	**5,254**	5,966
By activity:		
Sale of Drugs	**5,254**	5,966
	5,254	5,966

3. Auditor's remuneration

	Year ended 31 March 2024	Period ended 31 March 2023
	£'000	£'000
Audit of these financial statements	**6**	5

4. Staff numbers and costs

	Year ended 31 March 2024	Period ended 31 March 2023
	Total Number	Total Number
Other	**2**	2
Total	**2**	2

The aggregate payroll costs of these persons were as follows:

	Total	Total
	£'000	£'000
Salaries and wages	**82**	70
Social security costs	**8**	8
Contributions to defined contribution plans	**3**	3
Total Net Staff Costs	**93**	81

Notes to the Accounts

5. Directors Remuneration

There was no Directors remuneration in the year ended 31 March 2024.

6. Tangible assets

	Information Technology £'000	Total £'000
Valuations/Gross Cost at 1 April 2023	**8**	**8**
Other acquisitions	**-**	**-**
Valuation/Gross cost at 31 March 2024	**8**	**8**
Accumulated depreciation at 1 April 2023	**(8)**	**(8)**
Depreciation charge for the year	**-**	**-**
Accumulated depreciation at 31 March 2024	**(8)**	**(8)**
Net book value at 31 March 2024	**-**	**-**

	Information Technology £'000	Total £'000
Valuations/Gross cost at 1 April 2022	8	8
Other acquisitions	-	-
Valuation/Gross cost at 31 March 2023	8	8
Accumulated depreciation at 1 April 2022	(6)	(6)
Depreciation charge for the year	(2)	(2)
Accumulated depreciation at 31 March 2023	(8)	(8)
Net book value at 31 March 2023		

7. Stocks

	31 March 2024 £'000	31 March 2023 £'000
Raw materials and consumables	233	162
	233	162

Notes to the Accounts

8. Debtors

	Total 31 March 2024 £'000	Total 31 March 2023 £'000
Current		
Amounts owed by group undertakings	**445**	-
Other Debtors	**78**	111
Prepayments and accrued income	**2**	1
	525	**112**

9. Cash and Cash equivalents

	31 March 2024 £'000	31 March 2023 £'000
Cash at bank and in hand	196	612
	196	612

10. Creditors

Creditors: amounts falling due within one year	**31 March 2024 £'000**	31 March 2023 £'000
Current		
Trade creditors	**146**	131
Amounts owed to group undertakings	**74**	199
Other creditors	**207**	141
Deferred Tax	**0**	0
Total Current Liabilities	**426**	471
Creditors: amounts falling due after one year		
Non-Current		
Deferred Tax	**-**	-
Total Non-Current	**-**	-
Total Trade and Other Payables	**426**	471

Notes to the Accounts

11. Share Capital	**31 March 2024**	31 March 2023
	£	£
Allotted, Called up and Fully Paid Shares		
On issue at 1 April – 1 ordinary share of £1 each	1	1
Issued for cash		
On issue at 31 March - fully paid	1	1

The company has 1 ordinary share with a value £1 on issue at 31 March 2024 which is fully paid.

12. Carrying amount of financial instruments

	31 March 2024	31 March 2023
	£'000	£'000
The carrying amounts of the financial assets and liabilities include:		
Assets measured at cost less impairment	**641**	612
Liabilities measured at cost less impairment	**219**	330

Assets comprise of Cash at bank and in hand and amounts owed by group undertakings. Liabilities comprise of Trade creditors and amounts owed to group undertakings.

13. Operating leases

	31 March 2024	31 March 2023
	£'000	£'000
Non-cancellable operating lease rentals are payable as follows:		
Less than one year	**8**	7
Between one and five years	**8**	7
Later than five years	**-**	-
Total	**8**	**14**

Lease payments for the year were £7,673

14. Ultimate parent company

The Company is a subsidiary undertaking of Dorset County Hospital NHS Foundation Trust, which is the ultimate controlling party as the owner of the Company. The consolidated financial statements of this group are available to the public and can be obtained from the Company Secretary, Dorset County Hospital NHS FT, Williams Avenue, Dorchester, Dorset, DT1 2JY.

Notes to the Accounts

15. Subsequent events

There were no events subsequent to the balance sheet date requiring disclosure in these financial statements.

16. Tax Reconciliation

	Year Ended 31 March 2024 £'000	Period Ended 31 March 2023 £'000
UK Corporation tax		
Tax on profit on ordinary activities	35	28
	35	**28**

The current tax charge for the period is calculated using the standard rate of corporation tax in the UK of 25% (2023 - 19%) on the estimated assessable profit for the year. The total charge for the year can be reconciled to the accounting profit as follows:

	£'000	£'000
Analysis of tax charge for the period		
Current Tax		
UK Corporation tax on profits for the period	35	28
Total Current Tax	**35**	**28**
Deferred Tax		
Origination and reversal of timing differences	-	-
Effect of changes in tax rates	-	-
Total Deferred Tax	**-**	**-**
Total Tax on profit on ordinary activities	**35**	**28**

	Year Ended 31 March 2024 £'000	Period Ended 31 March 2023 £'000
FRS102 reconciliation of current tax charge		
Profit on ordinary activities before tax	147	146
Less Gift Aid	-	-
Profit/(loss) on ordinary activities before tax after Gift Aid	147	146
Tax on profit at standard rate of 25% (2023: 19%)	37	28
Effects of:		
Effects of group relief/other reliefs	(2)	-
Tax rate changes	-	-
Tax Charge for the Period	**35**	**28**

DCH SubCo Ltd
Williams Avenue
Dorchester
Dorset
DT1 2JY

KPMG LLP
66 Queen Square
Bristol
BS1 4BE

23 October 2024

Dear Rees

This representation letter is provided in connection with your audit of the financial statements of DCH SubCo Limited ("the Company"), for the year ended 31 March 2024, for the purpose of expressing an opinion:

i. as to whether these financial statements give a true and fair view of the state of the Company's affairs as at 31 March 2024 and of the Company's profit or loss for the financial year then ended;
ii. whether the financial statements have been properly prepared in accordance with UK accounting standards including FRS 102 The Financial Reporting Standard applicable in the UK and Republic of Ireland ("FRS 102"); and
iii. whether the financial statements have been prepared in accordance with the requirements of the Companies Act 2006.

These financial statements comprise the Statement of Financial Position, Statement of Comprehensive Income, Statement of Changes in Equity and notes, comprising a summary of significant accounting policies and other explanatory notes.

The Board confirms that the representations it makes in this letter are in accordance with the definitions set out in the Appendix to this letter.

The Board confirms that, to the best of its knowledge and belief, having made such inquiries as it considered necessary for the purpose of appropriately informing itself:

Financial statements

1. The Board has fulfilled its responsibilities, as set out in the terms of the audit engagement dated 26 April 2021, for the preparation of financial statements that:

   i. give a true and fair view of the state of the Company's affairs as at the end of its financial year and of its profit or loss for that financial year;
   ii. have been properly prepared in accordance with UK accounting standards including FRS 102; and
   iii. have been prepared in accordance with the requirements of the Companies Act 2006.

The financial statements have been prepared on a going concern basis.

2. The methods, the data and the significant assumptions used in making accounting estimates and their related disclosures are appropriate to achieve recognition, measurement or disclosure that is reasonable in the context of the applicable financial reporting framework.

3. All events subsequent to the date of the financial statements and for which section 32 of FRS 102 requires adjustment or disclosure have been adjusted or disclosed.

Information provided

4. The Board has provided you with:

   - access to all information of which it is aware, that is relevant to the preparation of the financial statements, such as records, documentation and other matters;
   - additional information that you have requested from the Board for the purpose of the audit; and
   - unrestricted access to persons within the Company from whom you determined it necessary to obtain audit evidence.

5. All transactions have been recorded in the accounting records and are reflected in the financial statements.

6. The Board confirms the following:

   i) The Board has disclosed to you the results of its assessment of the risk that the financial statements may be materially misstated as a result of fraud.

   Included in the Appendix to this letter are the definitions of fraud, including misstatements arising from fraudulent financial reporting and from misappropriation of assets.

   ii) The Board has disclosed to you all information in relation to:

   a) Fraud or suspected fraud that it is aware of and that affects the Company and involves:
      - management;
      - employees who have significant roles in internal control; or
      - others where the fraud could have a material effect on the financial statements; and

   b) allegations of fraud, or suspected fraud, affecting the Company's financial statements communicated by employees, former employees, analysts, regulators or others.

In respect of the above, the Board acknowledges its responsibility for such internal control as it determines necessary for the preparation of financial statements that are free from material misstatement, whether due to fraud or error. In particular, the Board acknowledges its responsibility for the design, implementation and maintenance of

internal control to prevent and detect fraud and error, and we believe we have appropriately fulfilled those responsibilities.

7. The Board has disclosed to you all known instances of non-compliance or suspected non-compliance with laws and regulations whose effects should be considered when preparing the financial statements.

8. The Board has disclosed to you and has appropriately accounted for and/or disclosed in the financial statements, in accordance with section 21 of FRS 102 all known actual or possible litigation and claims whose effects should be considered when preparing the financial statements.

9. The Board has disclosed to you the identity of the Company's related parties and all the related party relationships and transactions of which it is aware. All related party relationships and transactions have been appropriately accounted for and disclosed in accordance with section 33 of FRS 102.

   Included in the Appendix to this letter are the definitions of both a related party and a related party transaction as we understand them and as defined in FRS 102.

10. The Board confirms that:

    a) The financial statements disclose all of the matters that are relevant to the Company's ability to continue as a going concern, including the key risk factors, assumptions made and uncertainties surrounding the Company's ability to continue as a going concern as required to provide a true and fair view and to comply with FRS 102.
    b) No material uncertainties related to events or conditions exist that may cast significant doubt upon the ability of the Company to continue as a going concern.

This letter was tabled and agreed at the meeting of the Board of Directors on 23 October 2024

Yours faithfully,

Claire Abraham
Director of DCH Subco Limited

Criteria for applying the disclosure exemptions within FRS 102

- The Company discloses in the notes to its financial statements:
  a) A brief narrative summary of the disclosure exemptions adopted; and
  b) The name of the parent of the group in whose consolidated financial statements its financial statements are consolidated, and from where those financial statements may be obtained

Financial Statements

A complete set of financial statements (before taking advantage of any of the FRS 102 exemptions) comprises:

- *a statement of financial position as at the end of the period;*
- *a statement of comprehensive Income for the period;*
- *a statement of changes in equity for the period;*
- *notes, comprising a summary of significant accounting policies and other explanatory information.*

FRS 102 permits an entity either to present (i) separately a Profit and Loss account and a Statement of Other Comprehensive Income or (ii) a combined Profit and Loss Account and Other Comprehensive Income.

Material Matters

Certain representations in this letter are described as being limited to matters that are material.

FRS 102 states that:

Omissions or misstatements of items are material if they could, individually or collectively, influence the economic decisions of users taken on the basis of the financial statements. Materiality depends on the size and nature of the omission or misstatement judged in the surrounding circumstances. The size or nature of the item, or combination of both, could be the determining factor.

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Bristol
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United Kingdom

Tel +44 (0) 7876 854 886

Private & confidential
Board of Directors
DCH Subco Limited
Dorset County NHS Foundation Trust
Williams Avenue
Dorchester
Dorset
DT1 2JY

23 October 2024

Dear Subco Board of Directors,

DCH Subco Limited 2023-24 Financial Statements

This letter presents our key findings from our audit of the 2023-24 accounts of DCH Subco Limited (Subco). It supports the opinions and conclusions that we are required to provide you with to comply with the requirements of ISA 260 Communication of Audit Matters with Those Charged with Governance (ISA 260), in this case DCH Subco Limited Board, at the time when they are considering the financial statements.

Our audit was designed to consider whether the financial statements of DCH Subco Limited give a true and fair view of its state of affairs as at 31 March 2024 and of its results for the year to 31 March 2024 and that the financial statements have been properly prepared in accordance with UK Generally Accepted Accounting Practice applicable to Smaller Entities (being Section 1A of FRS 102 The Financial Reporting Standard applicable in the UK and Republic of Ireland ("Section 1A of FRS 102");

Our independence

ISA 260 requires us to communicate at least once a year regarding all relationships between KPMG and DCH Subco Limited that may be reasonably thought to have a bearing on our independence. We made enquiries of KPMG teams providing services to DCH Subco Limited and are not aware of any relationships which present independence issues. No non-audit fees have been paid to KPMG LLP by DCH Subco Limited in the year ended 31 March 2024. A statement of our independence is included in appendix one.

Audit approach and findings

We highlight significant findings in respect of the significant risks that we identified in our audit planning stage. We have dealt with them as set out in the right hand column:

Significant risks		Audit area	Our findings from the audit
Significant risk area required by ISAs	**Fraud Risk from Revenue Recognition**	Professional standards require us to make a rebuttable presumption that the fraud risk from revenue recognition is a significant risk. Material misstatement due to fraudulent financial reporting relating to revenue recognition often results from an overstatement of revenues through, for example, premature revenue recognition or recording fictitious revenues. It may result also from an understatement of revenues through, for example, improperly shifting revenues to a later period.	Due to the simplistic nature of the revenue stream within the SubCo, we have rebutted the presumed fraud risk.
	Fraud risk from management override of controls	Professional standards require us to communicate the fraud risk from management override of controls as significant. This is because management is typically in a unique position to perpetrate fraud because of its ability to manipulate accounting records and prepare fraudulent financial statements by overriding controls that otherwise appear to be operating effectively.	Our audit methodology incorporates the risk of management override as a default significant risk. In line with our methodology, we carried out appropriate substantive procedures, including over journal entries and accounting estimates. Our procedures did not identify any issues relating to management override of controls.

Summary of Findings

Based on the audit work completed, we can confirm to the Board that the financial statements:

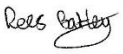
- give a true and fair view of the state of the company's affairs as at 31 March 2024 and of its profit for the year then ended;

- have been properly prepared in accordance with UK Generally Accepted Accounting Practice applicable to Smaller Entities (being Section 1A of FRS 102 The Financial Reporting Standard applicable in the UK and Republic of Ireland ("Section 1A of FRS 102"); and
- have been prepared in accordance with the requirements of the Companies Act 2006.

We identified no audit adjustments or control deficiencies.

We are expecting to sign the financial statements of the entity once final reviews of our audit work papers have taken place.

Yours Faithfully



Rees Batley

Partner

Appendix One – Statement of Independence

The purpose of this Appendix is to communicate all significant facts and matters that bear on KPMG LLP's independence and objectivity and to inform you of the requirements of ISA 260 (UK and Ireland) Communication of Audit Matters to Those Charged with Governance.

Integrity, objectivity and independence

Professional ethical standards require us to provide to you at the completion stage of the audit a written disclosure of relationships (including the provision of non-audit services) that bear on KPMG LLP's objectivity and independence, the threats to KPMG LLP's independence that these create, any safeguards that have been put in place and why they address such threats, together with any other information necessary to enable KPMG LLP's objectivity and independence to be assessed.

This letter is intended to comply with this requirement and facilitate a subsequent discussion with you on audit independence and addresses:

- General procedures to safeguard independence and objectivity;
- Independence and objectivity considerations relating to the provision of non-audit services; and
- Independence and objectivity considerations relating to other matters.

General procedures to safeguard independence and objectivity

KPMG LLP is committed to being and being seen to be independent. As part of our ethics and independence policies, all KPMG LLP directors and staff annually confirm their compliance with our ethics and independence policies and procedures including in particular that they have no prohibited shareholdings. Our ethics and independence policies and procedures are fully consistent with the requirements of the FRC Ethical Standard.

As a result we have underlying safeguards in place to maintain independence through:

- Instilling professional values
- Communications
- Internal accountability
- Risk management
- Independent reviews.

We are satisfied that our general procedures support our independence and objectivity.

There are no other matters that, in our professional judgement, bear on our independence which need to be disclosed to DCH Subco Limited Board members.

Independence and objectivity considerations relating to the provision of non-audit services

We have considered the fees paid to us by the Company for professional services provided by us during the reporting period. Our audit fee in relation to the audit of DCH Subco Limited in 2023-24 was £5,700 and we have provided no non audit services to the Company.

Audit matters

We are required to comply with ISA (UK and Ireland) 260 Communication of Audit Matters to Those Charged with Governance when carrying out the audit of the accounts.

ISA 260 requires that we consider the following audit matters and formally communicate them to those charged with governance:

- Relationships that may bear on the firm's independence and the integrity and objectivity of the audit engagement lead and audit staff.
- The general approach and overall scope of the audit, including any expected limitations thereon, or any additional requirements.
- The selection of or changes in, significant accounting policies and practices that have, or could have, a material effect on the Company's financial statements.
- The potential effect on the financial statements of any material risks and exposures, such as pending litigation, that are required to be disclosed in the financial statements.
- Audit adjustments, whether or not recorded by the entity that have, or could have, a material effect on the Company's financial statements.
- Material uncertainties related to event and conditions that may cast significant doubt on the Company's ability to continue as a going concern.
- Expected modifications to the auditor's report.
- Other matters warranting attention by those charged with governance, such as material weaknesses in internal control, questions regarding management integrity, and fraud involving management.
- Any other matters agreed upon in the terms of the audit engagement.

We continue to discharge these responsibilities through our attendance at audit committees, the annual audit letter and, in the case of uncorrected misstatements, through our request for management representations.

Disagreements with management about matters that, individually or in aggregate, could be significant to the Company's financial statements or the auditor's report. These communications include consideration of whether the matter has, or has not, been resolved and the significance of the matter.

Confirmation of audit independence

We confirm that as of 16 October 2024, in our professional judgement, in relation to the audit of the financial statements of the Company for the financial year ending 31 March 2024, we confirm that there were no relationships between KPMG LLP and the Company, its directors, senior management and its affiliates that we consider may reasonably be thought to bear on the objectivity and independence of the audit engagement lead and audit staff.

This report is intended solely for the information of the DCH Subco Limited Board and should not be used for any other purposes.

We would be very happy to discuss the matters identified above (or any other matters relating to our objectivity and independence) should you wish to do so.

DCH Subco Limited

Corporation Tax Computations

based on the accounts for the year ended 31 March 2024

DCH Subco Limited

year ended 31 March 2024

INDEX

DCH Subco Limited

year ended 31 March 2024

Adjustment of profit and tax payable

A

Adjustment of profit:

		Computation	Per return
Profit before tax	D, J2, J3	£ 147,479	
Adjustments for balance sheet items:			
Loan relationships	A1	(27,326)	
Trading income profit/(loss)		£ 120,153	£ 120,153
Non trading loan relationship income:			27,326
Loan relationships	A1	27,326	
Total taxable profits		£ 147,479	£ 147,479

Tax payable:

Financial year 2023, at 25% on £ 147,479 (CTA 2010 s19 based on 0 associate(s))		£ 36,869.75
Less marginal relief	J3	(1,537.82)
Tax due		£ 35,331.93

HMRC mandatory disclosure
Company is a member of a partnership No

Loan relationships

A1

		Income (expense) arising this period	(Taxable)/ deductible	(Taxable)	Deductible
Non trade					
Bank interest and similar income receivable	below D	£ 27,326	A £ (27,326)	£ (27,326)	

Trading adjustment

Amount taxable as trading income		£ -
Credited/charged to I/S etc.	above D	(27,326)
Charged/(Credited) to Other comprehensive income		-
Net adjustment	A	£ (27,326)

Income statement

D

Details of (income) and expenditure:

Turnover		£ (5,254,312)
Cost of sales		4,954,970
Gross profit		£ (299,342)
Administrative expenses	D1	179,189
Profit from operations		£ (120,153)
Interest and similar income	A1	(27,326)
Profit before tax	A, J2, J3	£ (147,479)

Administrative expenses

D1

Details of (income) and expenditure:

		Total
Accountancy, legal and professional fees	D2	£ 13,393
Bank charges		378
Course fees		1,165
Other deductible office costs		6,457
Premises insurance		13
Printing, post and stationery costs		853
Rent, rates and service costs		7,673
Service Level Agreement for support services §1		54,850
Trade subscriptions		1,739
Wages and salaries		92,668
Total	D	£ 179,189

§1 The Service Level agreement is between Dorset County Hospital NHS Foundation Trust and DCH Subco Limited. The support services include staffing, ICT, human resources, risk management services and financial services.

Accountancy, legal and professional fees

D2

Details of (income) and expenditure:

		Total
Audit, accountancy and tax service costs		£ 5,700
Corporation tax advice		6,480
EY VAT E-Filer tool		650
Licence costs		163
Payroll service		400
Total	D1	£ 13,393

Tax Account - FRS102

J

Details of (assets and payments) and liabilities and receipts:

	B/F per accounts	Receipts/ (Payments) and other credits	Charged/ (credited) to I/S	C/F per accounts
Current tax:				
Corporation tax payable				
Current year		£ -	below J2 £ 35,332	J2 £ 35,332
Year to 31 March 2023	£ 28,034	(28,034)		-
	below £ 28,034	below £ (28,034)	above below J2 £ 35,332	above below J2 £ 35,332
Deferred tax:				
Total	above £ 28,034	above £ (28,034)	above J3 £ 35,332	above £ 35,332

Account Disclosures - FRS102 J2

Tax - FRS102

			Prior Period
Current tax:			
UK corporation tax on profits for the period	J	£ 35,332	£ 28,034
Total current tax	below	£ 35,332	£ 28,034
Deferred tax:			
Origination and reversal of timing differences		£ -	£ (317)
Effect of changes in tax rates		-	(100)
Total deferred tax		£ -	£ (417)
Total tax per income statement	above below	£ 35,332	£ 27,617

The charge for the year can be reconciled to the profit per the income statement as follows:

Profit for the period	A, D, J3	£ 147,479	£ 145,881
Tax on profit at standard UK tax rate of 25.00% (2023: 19.00%)		£ 36,870	£ 27,717
Effects of:			
Effects of group relief/ other reliefs	J3	(1,538)	-
Tax rate changes		-	(100)
Tax charge for the period	above below	£ 35,332	£ 27,617
Income tax expense reported in the income statement	above	£ 35,332	£ 27,617

NOTE TO THE ACCOUNTS - BALANCE SHEET AMOUNTS

		31 Mar 2024	31 Mar 2023
Current liabilities:			
Corporation tax	J	£ 35,332	£ 28,034
		£ 35,332	£ 28,034
Deferred tax (assets) / liabilities:			
Provision at start of period		£ -	£ 417
Deferred tax charge to income statement for the period		-	(417)
Provision at end of period		£ -	£ -

Proof of tax

J3

		Gross	Tax rate		Net		Effects of group relief/ other reliefs
Profit / (loss) per accounts	A, D, J2	£ 147,479	25.00%		£ 36,870		
Total tax charge per income statement					J 35,332		
Difference to explain					£ (1,538)		
Other adjusting items:							
Effect of marginal relief				below A	£ (1,538)		£ (1,538)
Total reconciling items				above	£ (1,538)	J2	£ (1,538)

Report to	Board of Directors, Part 1	
Date of Meeting	10 December 2024	
Report Title	Wessex Health Partners Annual Review 2023/24	
Prepared By	Wessex Health Partners	
Approved by Accountable Executive	Professor Alastair Hutchison, Chief Medical Office/Executive Lead for Research	
Previously Considered By	Research Steering Committee, 18th July 2024 Quality Committee, 4th November 2024	
Action Required	**Approval**	N
	Assurance	N
	Information	Y

Alignment to Strategic Objectives	Does this paper contribute to our strategic objectives? *Delete as required*	
Care	Yes	
Colleagues		No
Communities	Yes	
Sustainability	Yes	
Implications	Describe the implications of this paper for the areas below.	
Board Assurance Framework	SR6 Finance SR7 Collaboration SR8 Transformation and Improvement	
Financial	WHP term 2 2025-28 funding currently being considered by founding partners	
Statutory & Regulatory	No implication	
Equality, Diversity & Inclusion	No implication	
Co-production & Partnership	The annual review reports against WHP annual plan - WHP Strategic alliance supports collaborative networking, seed-funding opportunities and access to opportunities for DCH to build research capability and capacity across Wessex.	

Executive Summary

Wessex Health Partners, a strategic alliance of health and care organisations, Universities and Health Innovation in Wessex, aims to accelerate, through partnership working, improvement in health and care through research, innovation and training.
Over recent years, the WHP founding partners have been increasingly working together. Further to approval of a business case in 2022/23 and appointment of the Chair and Managing Director, 2023/24 marked the first operational year of the strategic alliance.
The WHP Board approved the inaugural WHP annual in June 2023. This annual review reports progress against the annual plan.

The first operational year of the WHP strategic alliance has seen the founding partners formalise arrangements and start to embed research and innovation into the new health and care landscape. All of the founding partners have fully engaged with the range of opportunities afforded by greater partnership working. Significant progress has been made in laying the necessary foundations on which to build future work and there have been some early successes, particularly with collaborative funding applications. The reputation of the WHP regional approach to research and innovation is growing with promotion of our strategic alliance at regional, national and international events and through representations made to the Sinker Review: Research and Innovation System.

Recommendation

Members are requested to:

- Receive the report for **information**

WESSEX HEALTH PARTNERS

Wessex Health Partners Annual Review 2023/24

Executive Summary

Wessex Health Partners, a strategic alliance of health and care organisations, Universities and Health Innovation in Wessex, aims to accelerate, through partnership working, improvement in health and care through research, innovation and training.

Over recent years, the WHP founding partners have been increasingly working together. Further to approval of a business case in 2022/23 and appointment of the Chair and Managing Director, 2023/24 marked the first operational year of the strategic alliance.

The WHP Board approved the inaugural WHP annual in June 2023. This annual review reports progress against the annual plan.

Key highlights 23/24

- **WHP collaboration agreement signed** by all 15 **partners,** formalising the strategic alliance.
- WHP **governance structure** established, and **core team** appointed.
- WHP core team **engaged** with **founding partners** through site visits and regular meetings building relationships and understanding of research and innovation expertise and challenges.
- **Wessex health and care systems R&I culture and governance** developments include:
    - **WHP/Integrated Care System workstream** established supporting ICBs to meet their leadership responsibility and statutory obligation to 'maximise the benefits of research and innovation' resulting in a number of **'firsts'** for example.
        - Regular **ICB support** of **research funding applications** and **deployment of innovation**
        - **Dorset ICB Research Strategy** aligned with WHP strategy published.
        - **HIOW ICB** R&I board paper and commitment to **R&I strategy, maturity matrix** and developing a learning health system.
        - **R&I 'hard-wired'** into **governance structure** of ICBs/ICSs e.g. NHS Dorset Strategic Objectives Oversight Committee, HIOW Strategy Leads, NHS Dorset and HIOW Women's Health Hub Programme Boards.
- **Pan-Wessex collaborative funding application success**
    - **36** Wessex collaborative **funding bids** received WHP support, resulting in **10 successful** applications with combined value of > **£22M** and a **return on investment** (ROI) of **1:15.**
    - Launched **WHP/WEMN** pilot for **seed-funding,** resulting in **21 collaborative expressions of interest** involving all of the WHP founding partners and allocation of **>£220k** of funding to **15 successful applications**.
- **Wessex R&I Infrastructure developed**
    - Established **Wessex Experimental Medicine Network (WEMN)**
    - Transition of **Wessex Research Hubs and Buses** oversight to WHP commenced.
    - **Wessex REACH** and **wider review** delivered
    - **NIHR Wessex Applied Research Collaboration (ARC) SWOT** delivered

- **Pan-Wessex network development and learning events**
    - **Wessex Genomics Workshop** with Health Innovation Wessex.
    - **Wessex Integrated Care, Population Health, Research and Innovation Event**
    - Established **Clean Air South** with Sustainability and Resilience Institute, University of Southampton
- **Regional response to national R&I ecosystem review**
    - NHS Innovation Ecosystem Review Programme (Sinker Review).
- P**rofile of WHP** strategic alliance increased through communications activities and regional, national, and international meetings and conferences.

Summary and conclusion

The first operational year of the WHP strategic alliance has seen the founding partners formalise arrangements and start to embed research and innovation into the new health and care landscape. All of the founding partners have fully engaged with the range of opportunities afforded by greater partnership working. Significant progress has been made in laying the necessary foundations on which to build future work and there have been some early successes, particularly with collaborative funding applications. The reputation of the WHP regional approach to research and innovation is growing with promotion of our strategic alliance at regional, national and international events and through representations made to the Sinker Review: Research and Innovation System.

Contents

1 Purpose

The purpose of this paper is to appraise the Wessex Health Partner (WHP) Steering Group /Board on the progress made in 2023/24 in delivering the WHP Board approved WHP Annual Plan 2023/24.

The paper will be presented to the WHP Steering Group and WHP Board and will be provided to partners to update their organisations as required. The paper will also be published in a suitable format through the WHP communications channels. The paper has informed the WHP Annual Plan 2024/25.

Whilst noting this review, the Steering Group/Board is reminded that that the WHP strategic alliance is an enabler for founding partners to work in partnership out with the involvement of the WHP core team. As this paper reports progress against the annual plan, it does not reflect the full extent of the partnership working across the WHP strategic alliance.

2 Introduction and Background

WHP is the region's strategic alliance of the NHS organisations, Universities and Health Innovation Wessex (Figure 1). The WHP common purpose is '*working in partnership, to accelerate better health & care through research, innovation and training'.* WHP brings together world-leading expertise to work alongside and in partnership with our communities, local authorities, voluntary sector organisations and industry.

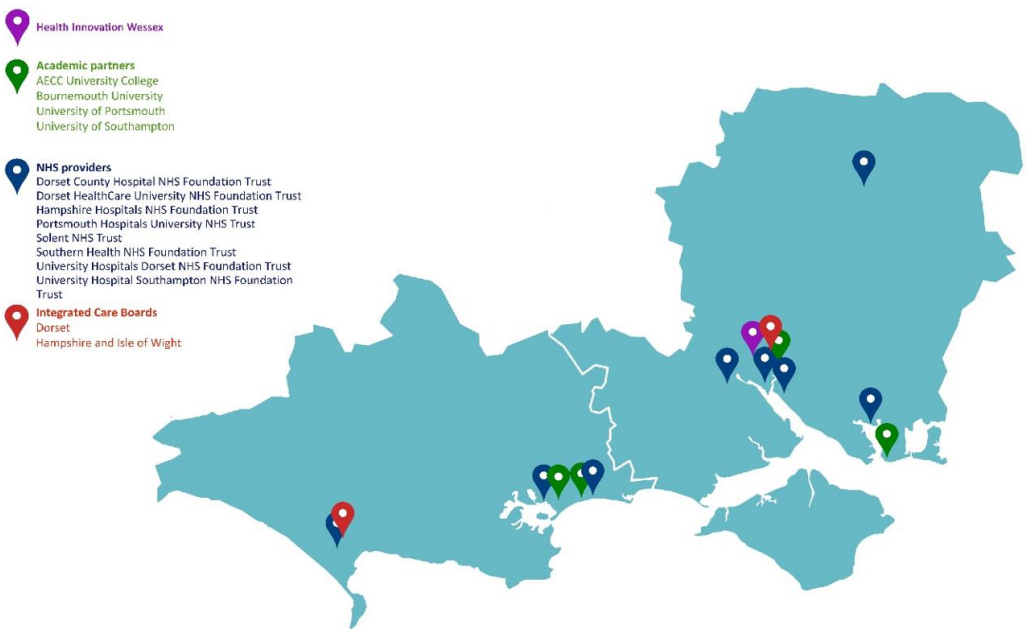


Figure 1: WHP Founding Partners

Whilst elements of the strategic alliance have been working informally for a number of years, the Boards and Councils of the WHP Founding Partners approved the WHP Business Case to formally establish WHP in 2022/23, following which the Chair, Managing Director and core team were appointed. The 2023/24 annual review reports on the first full operational year of the formal WHP strategic alliance.

3 WHP Annual Plan 2023/24

The WHP Annual Plan 2023/24 was developed by the WHP senior leadership team (SLT), in consultation with the WHP founding partners and wider stakeholders, during the first quarter of the WHP year (1st April-31st March). The plan, which received WHP Board approval in June 2023, set out activities within 5 strategic workstreams against the core ambitions, mission and vision of WHP, Figure 2.

Vision

A thriving regional partnership improving population health & patient outcomes with global impact.

Mission

Working in partnership, to accelerate better health and care through research, innovation and training.

Ambitions

To improve the region's collective ability to tackle the greatest challenges facing the Wessex health and care system.

To generate greater collaborative and interdisciplinary research and speed the development and adoption of innovation at scale.

Strategic workstreams:

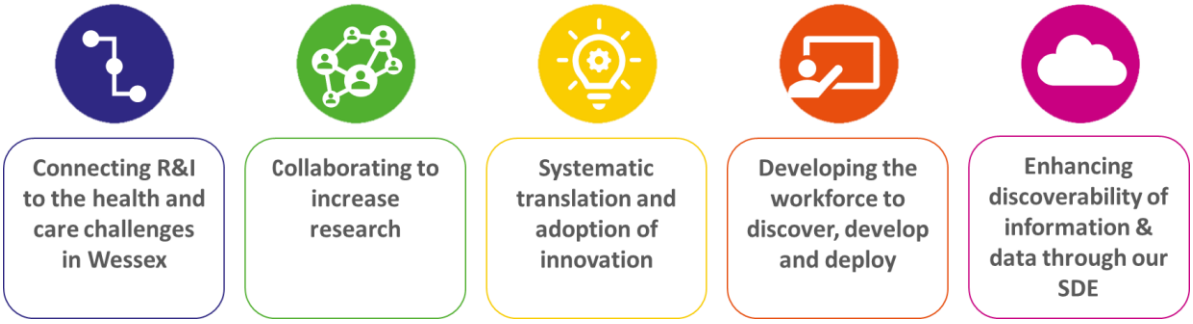


Figure 2: WHP Vision, Mission, Ambitions and Strategic Workstreams

In addition, the annual plan set out activities to develop the WHP governance, operational structure, business support and communications functions.

4 Key highlights 23/24

Below are key highlights from 2023/24 for the WHP strategic alliance, including a number of 'firsts' for the region.

- **WHP collaboration agreement signed** by all 15 **partners,** formalising the strategic alliance.
- WHP **governance structure** established, and **core team** appointed.
- WHP core team **engaged** with **founding partners** through site visits and regular meetings building relationships and understanding of research and innovation expertise and challenges.
- **Wessex health and care systems R&I culture and governance** developments include:
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- **Regional response to national R&I ecosystem review**
    - NHS Innovation Ecosystem Review Programme (Sinker Review).
- P**rofile of WHP** strategic alliance increased through communications activities and regional, national, and international meetings and conferences.

These highlights are expanded in the further detail provided in the Strategic Workstream section (section 6).

5 Measuring Success

A measurement of the success of WHP depends on the value perceived and realised by the founding partners – different factors will have importance for the various organisations. A review of activity against the annual plan for 2023 / 24 (summary in section 6: Strategic Workstreams) demonstrates delivery against the annual plan. Recognising that 2023/24 was the first year of operating and data collection systems are in development, Figure 3: WHP in numbers summarises available data and illustrates the extent of the reach and depth of some of the activity that has taken place over the year.

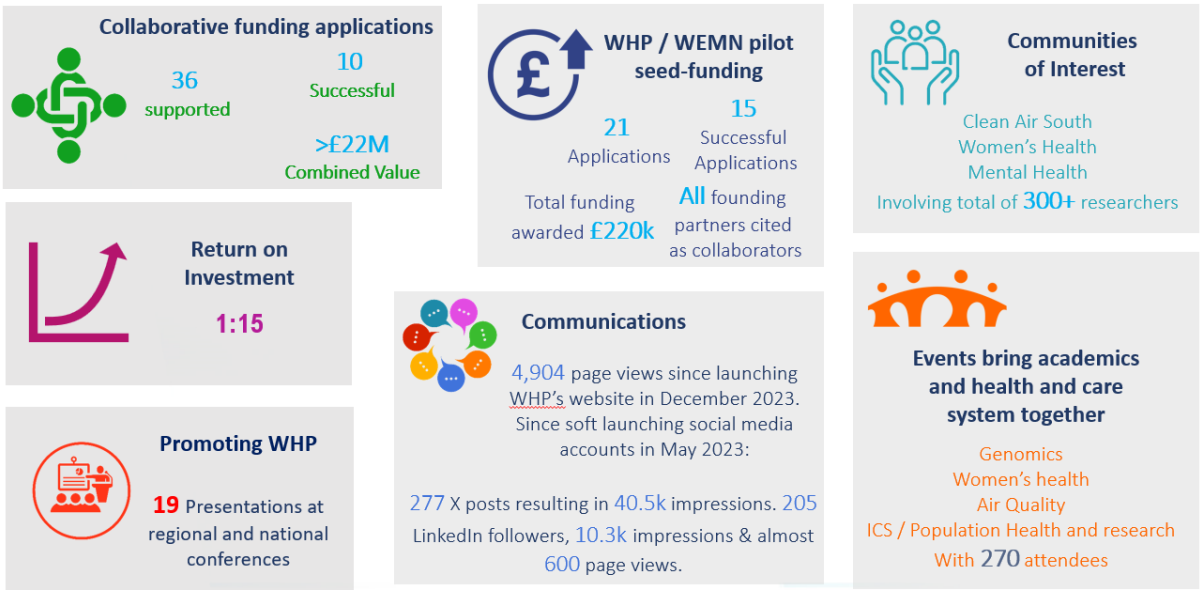


Figure 3: WHP in numbers

A large element of the work of the strategic alliance has been to build relationships and structures that will over time deliver a more cohesive Wessex research and innovation delivery engine. This work is 'in progress' with the ambition and current progress being describable. To identify the areas where founding partners are recognising the value being added by the actions of WHP, we asked WHP Board and Steering Group members to articulate the 'value-add' they are experiencing. A summary of responses is provided in Figure 4.

Supporting collaborative bid development

- WHP and WEMN seed-funding pilot call: 21 applications to build collaborations and develop further funding submissions.
- Provision of support for collaborative funding bids: cascading of opportunities and coordination of potential collaborators. Support for regional strategic bids.
- Forming of Communities of interest for future funding opportunities.

Developing the culture and environment to promote research activities across Wessex

- WHP and WEMN seed-funding pilot call: 21 applications to build collaborations and develop further funding submissions.

Developing approaches to introduce and bring research into health and care system strategic plans and activities.

- Promoting networking and collaboration opportunities across founding partners
- Bringing together researchers and the health and care system leaders, providing opportunities to build relationships, understand each other's needs, and identify potential opportunities and connectivity.
- Shared learning.
- Running events and networks to facilitate jointly tackling the 'wicked' issues.

Developing a single Wessex voice

- Articulation of a common ambition and collective voice.
- Jointly able to tackle 'wicked' and 'sticky' issues.
- Development of a single window (website) into Wessex research and innovation activities.
- Maintain an environment to encourage Wessex-wide collaboration.

Developing the Wessex-wide research and innovation infrastructure

- Partnership to provide foundations, oversight, and coordination to jointly provide a single research and innovation infrastructure to support existing Wessex structures (e.g. Wessex SNSDE; Wessex Research Hubs and Buses; NIHR infrastructure, HIW) and develop new approaches for joint working (e.g. horizon scanning; implementation of REACH review recommendations for capacity and capability building)

Promotion of WHP with Founding Partner Boards

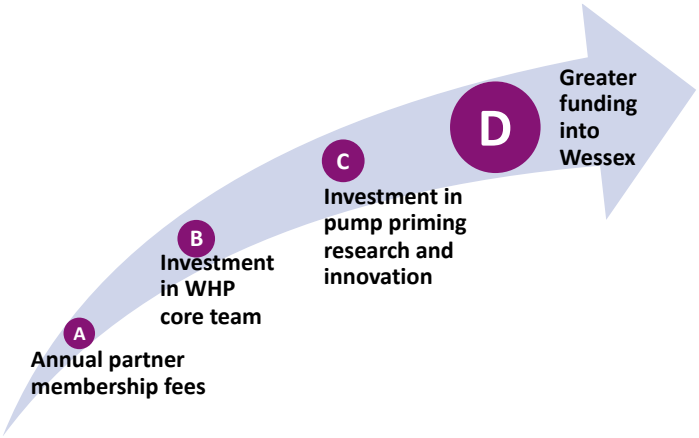
- Engage with founding partners and with key stakeholders to promote the value of WHP to partner Boards

Figure 4 Founding Partner responses: Added Value of WHP

5.1 Return on Investment

The WHP business case described the potential return on investment (ROI) for the establishing the WHP strategic alliance. The potential ROI was based on evidence from the similar academic health partnership, Bristol Health Partners (BHP). The BHP ROI for a 5-year period, based on a total investment of £2.1m was £19.1m, equating to a ratio of 1:9.

At the end of 2023/24 the, the total WHP investment was £1.5m and successful grant applications confirmed at >£22m, giving a ROI of 1.15, exceeding BHP.



Achieving a ROI, which exceeds BHP after 1 year of operating is highly positive, however there is considerable work to be done to ensure this ROI remains consistent in future years. As detailed in the 2024/25 annual plan, this includes further development of the culture, relationships and infrastructure that facilitate pan-Wessex collaborative research funding applications and deployment of innovations, for example:

- Cascading of opportunities and coordination of potential collaborators across the strategic alliance.
- Providing support for regional strategic bids.
- Forming of Communities of interest for future funding opportunities
- Hosting events and networking opportunities to facilitate the building of relationships and identification of potential joint ventures.

6 Strategic Workstreams

The WHP strategy has aligned the WHP activities into 5 strategic workstreams:

1. Connecting research and innovation to the health and care challenges in Wessex
2. Collaborating to increase research.
3. Systematic translation and adoption of innovation
4. Developing the workforce to discover, develop, and deploy.
5. Enhancing discoverability of information and data through our Secure Data Environment

A summary of the activities by strategic workstream, RAG rated to indicate progress against the 2023/24 annual plan, is provided in Figure 5: Summary of 2023/24 activities by strategic workstream.. A detailed review of the work completed, split into the activity descriptors listed in this table, is provided in this section.

Activity 2023/24	Strategic Workstream
ICB/WHP Maximising value of research workstream	1
ICP/WHP population health need workstream	1
Wessex: System challenges / population health need event	1
WHP Academic Themes	1
Horizon scanning / funding opportunities	1,3
Discover, develop deploy (3D)	
commissioned programmes	1,2,3
response programmes	1,2,3
Convene/support pan-Wessex funding applications	1,2
Wessex Experimental Medicine Network	2
WHP Research hubs and buses	2
WHP Secure data environment	2,4
Wessex Expo event	2
Support LAs NIHR Health Determinant Research Collaboratives	2,3
Web resource of R&D capacity and capability/repository of expertise	2,3,4
Engaging industry strategy	2,3
Translation and adoption - a system approach workstream	3
Pilot approach focussed on system challenge	3
Review activities across Wessex and consider potential regional offer for:	
• Support for innovators	3,4
• R&I capacity building	4
Strategic review of Wessex REACH	4
Strategic Review of Wessex Patient Involvement Network	4
Deliver one peer review	4
Deliver SDE year 1 plan	1,2,3,4,5

Figure 5: Summary of 2023/24 activities by strategic workstream.

6.1 Connecting R&I to the health and care challenges in Wessex

Our ambition is to improve the region's collective ability to tackle the greatest challenges facing the health and care systems in Wessex. As partners, we each have knowledge and expertise which combined offers the opportunity to deliver greater impact, addressing health inequalities, improving outcomes and ensuring the quality and sustainability our future health and care services. Together, we will create an environment in which we collectively improve our knowledge and shared understanding of the challenges and align our research and innovation activities to the areas of need. We will promote a culture of collaboration across organisational boundaries and with patients and the public, supported by more systematic ways of working together to deliver impact.

6.1.1 ICB/WHP Maximising value of research workstream

The strategic alliance has established the WHP/Integrated Care Board (ICB) workstreams to scope and progress WHP role in supporting the ICBs the meet their statutory obligation to maximise the benefit of research.

The Health and Care Act 2022 (the Act) contains the biggest reforms to the NHS in nearly a decade, laying the foundations to improve health outcomes by joining up NHS, social care and public health services at a local level and tackling growing health inequalities. As part of the reforms, Integrated Care Boards have a new statutory responsibility to maximise the benefits of research. Through the strategic alliance of WHP, we are supporting NHS Dorset and HIOW ICB in their role developing thriving research and innovation ecosystems.

- The WHP core team supported NHS Dorset to develop their ICB research strategy, aligned to the WHP strategy. NHS Dorset has introduced a Strategic Objectives Oversight Committee, with representation from the WHP core team and Health Innovation Wessex, to provide assurance that the strategic aims of the NHS Dorset in relation to research and innovation are being delivered. NHS Dorset has;
    - Informed the WHP academic themes.
    - worked with the WHP core team to make new pan-Wessex connections and with wider stakeholders e.g. Ministry of Defence
    - Led and been a partner on funding applications with new Wessex partners.
    - Identified previously unknown Wessex research relevant to the NHS Dorset health and care priorities.
- The WHP core team is working HIOW ICB at a strategic level, supporting R&I conversations at ICB Board level and developing a research and innovation 'maturity matrix'. The matrix will signal expectations and support partners in HIOW ICS to develop a mature research and innovation eco-system. More specifically, HIOW ICB has enabled the research and innovation community to join HIOW ICP assemblies and specific work streams, improving the knowledge of the R&I community on the population health need and enabling partners to explore approaches for integrating research and innovation. For example, members of the WHP core team are on the Women's Health Hub Programme Board and Working Group.

Both Integrated Care Boards consulted with WHP on their 5-year Joint Forward Plans, accepting amendments to include research and innovation.

6.1.2 ICP/WHP population health need workstream

The WHP strategic alliance has worked with the HIOW and Dorset ICBs and ICPs to understand their system health and care challenges, to ensure that the work of WHP is aligned to helping to address these key priorities.

Previously there has not been a formal approach to bring researchers into the conversations setting the local strategies to address these issues. Through WHP we have started to trial different approaches to bring stakeholders together, while we jointly learn the most effective ways.

Approaches have included:

- identifying researchers whose work is aligned with the priority area, and bringing this cohort together to hear and understand the challenges being faced as well as sharing the research they are involved with (e.g. HIOW ICP Assemblies).
- making introductions between ICB leads and key academics where known research interests may inform solutions for addressing the priority (e.g. obesity in children NHS Dorset)
- completing a review of all of the research conducted in key areas of work to inform Programme Boards on the potential of research to offer some solutions to the challenges being faced by Women's Health Hubs in both HIOW and Dorset

6.1.3 Wessex: System challenges / population health need event

During the year, the WHP core team worked with partners to identify key individuals from across Wessex with expertise and interest in population health need. Subsequent to forming a steering committee, in March 2024, WHP hosted the Wessex Integrated Care, Population Health, Research and Innovation Event, bringing together academic and health and care leaders from across Wessex to understand the role of population health to prioritise the local health and care strategies and to provide research focus within Wessex. The day included an overview of the population health management tools utilised across Wessex. The event promoted a lot of discussion and networking opportunities, building relationships and enthusiasm to jointly address the local challenges across Wessex. Next steps include working with the Wessex Experimental Medicine Network/NIHR Southampton BRC, Wessex Applied Research Collaboration and stakeholders on increase the accessibility and understanding of population health intelligence to inform research and innovation.

6.1.4 WHP Academic Themes

A role of the WHP strategic alliance is to enable pan-Wessex collaboration to develop novel research or conduct research on a scale greater than would be possible for individual partners working alone. This will be achieved through the identification and allocation of support/funding in response to an open call for applications and commissioned activities within WHP Academic Themes. It is anticipated that responsive and commissioned activities will increasingly align as WHP matures.

Our academic themes seek to address:

- challenges identified by Wessex's health and care systems, and/or
- global challenges where we have particular world-leading expertise.
- utilising our academic strengths from more than one centre
- working together in collaborations that do not currently exist.

The ambition is to have national and international impact and a realistic plan to obtain external investment. Scoping followed by initial consultation completed in 2023/24 identified themes as having potential. In 2024/25, the WHP core team will support a programme of work to scope the themes in more detail, leading to the development of inter and intradisciplinary pan-Wessex collaborations, submission of funding

applications and the initiation of research activities by founding partners and wider stakeholders. The academic themes will have a research, not service design, focus.

Four draft academic themes have been agreed by the WHP Board as well as some cross-cutting themes that will be key considerations for each of the academic themes. The draft academic themes are:

Air Quality: to identify and target modifiable co-morbidities that are made worse in areas of poor air quality (e.g. respiratory disease; cardiovascular disease (particularly hypertension).

Services Health: to address approaches to better serve serving and ex-service personnel at risk of mental illness and addictions (gambling, drugs, alcohol).

Inequalities and Multimorbidity: for populations living in areas with health inequalities. Consider approaches for those at risk of morbidity and mortality from disease caused by alcohol and / or obesity.

Genomics: work with relevant experts to develop approach using genomics to limit the adverse effects of polypharmacy in older people.

Cross-cutting themes:

Population data: to inform, design and deliver better health. Utilisation of resources available nationally and locally to understand the local population and health need.

HealthTech: to ensure latest technology is considered and appropriately included in the research undertaken.

Further consultation and scoping will take place in 2024/25.

6.1.5 Horizon Scanning / funding opportunities

In line with the WHP annual Plan during 2023/24, the WHP core team worked with teams within founding partners to explore and determine how to improve the identification of funding opportunities that might be suitable for pan-Wessex and support to teams to increase collaboration. The work delivered in 2023/24, which provides the foundation for further development, included;

- Launching the call for expressions of interest (EOI) to allocate seed funding for cross-organisational, inter-disciplinary teams to support 'discover, develop, deploy' (3D) programmes. (see section 6.2.1)
- Providing WHP support for collaborative funding applications focussed on the needs of our population e.g. NIHR Health Determinants Research Collaboratives (see section 6.2.26.2.5)
- Establishing 'communities of interest' in areas identified as key priorities for the health and care system, where it is known there will be future national funding opportunities launched (see section 6.2.2)
- Establishing 'horizon scanning' process to identify and communicate funding opportunities. Where needed, convene pan-Wessex interdisciplinary teams to respond to specific calls (see section 6.2.2)

6.2 Collaborating to increase research

Funders of research, innovation and training, increasingly emphasise the importance of collaboration and impact. We will enable more deliberate and timely coordination and development of funding applications at the level of the Wessex region and therefore access a greater range of opportunities where collaboration strengthens applications and larger population sizes are required. Our approach will harness local strengths and address clear priorities. Our cross-organisational and inter-disciplinary 3D teams with their potential to rapidly and substantially benefit local people and communities, will appeal to funding bodies. We will provide seed-funding to support growth of existing and new programmes. We will support wider stakeholders, for example, local authorities to engage in research and innovation and develop their capacity and capability.

6.2.1 Discover, develop, deploy: commissioned and response programmes

One of the key elements of the WHP Business Case was to invest in seed-funding and supporting research and innovation activities responding the key regional challenges and opportunities. The WHP seed- funding call aims to support researcher and innovators from across Wessex to form new collaborations with colleagues in other founding partner organisations with the ambition of developing joint applications for further funding opportunities and hence bring more research and innovation investment into Wessex as new as building relationships to expand the research being carried out across Wessex. A further aim of the seed-funding call is to support the forming of new collaborations that more effectively join up the discover, develop, deploy pipeline, accelerating innovation adoption.

With the launch of the Wessex Experimental Medicine Network (see section 6.2.8) and associated increase in funding available (provided by NIHR Southampton BRC), the opportunity was taken to combine the WHP funding call with the WEMN funding call, providing a single front door for applicants followed by an internal triage process.

The pilot WHP /WEMN funding call for expressions of interest (EOIs) was launched in February 2024. There is WHP funding available of £200k, plus £50k available from the WEMN. Twenty-one applications were received from WHP partner organisations, meeting the deadline of 28th March 2024. All 15 founding partners were cited as collaborators in one or more of the applications, with the leads for the 21 applications coming from 7 of the WHP founding partners. A total of £572,369 was requested by applicants, ranging from under £5k to £129k.

Of the 21 applications submitted, 15 applications were awarded funding whilst 6 applications were not considered suitable to WHP/WEMN funding and therefore unsuccessful.

The breakdown of the funding available, awarded and carried forward as a result of being unallocated on this occasion is provided in Table 1.

	Funding available	Funding awarded	Funding carried forward
WEMN	£50,000	£49,800	£200
WHP	£200,000	£170,048	£29,952
Total	**£250,000**	**£219,848**	**£30,152**

Table 1: WHP/WEMN funding available and awarded 2023/24

Figure 6: Extent of collaborations identified in the EOIs recommended for award 2023/24Figure 6 below illustrates the extent of pan-Wessex collaborations identified in the EOIs recommended for award.

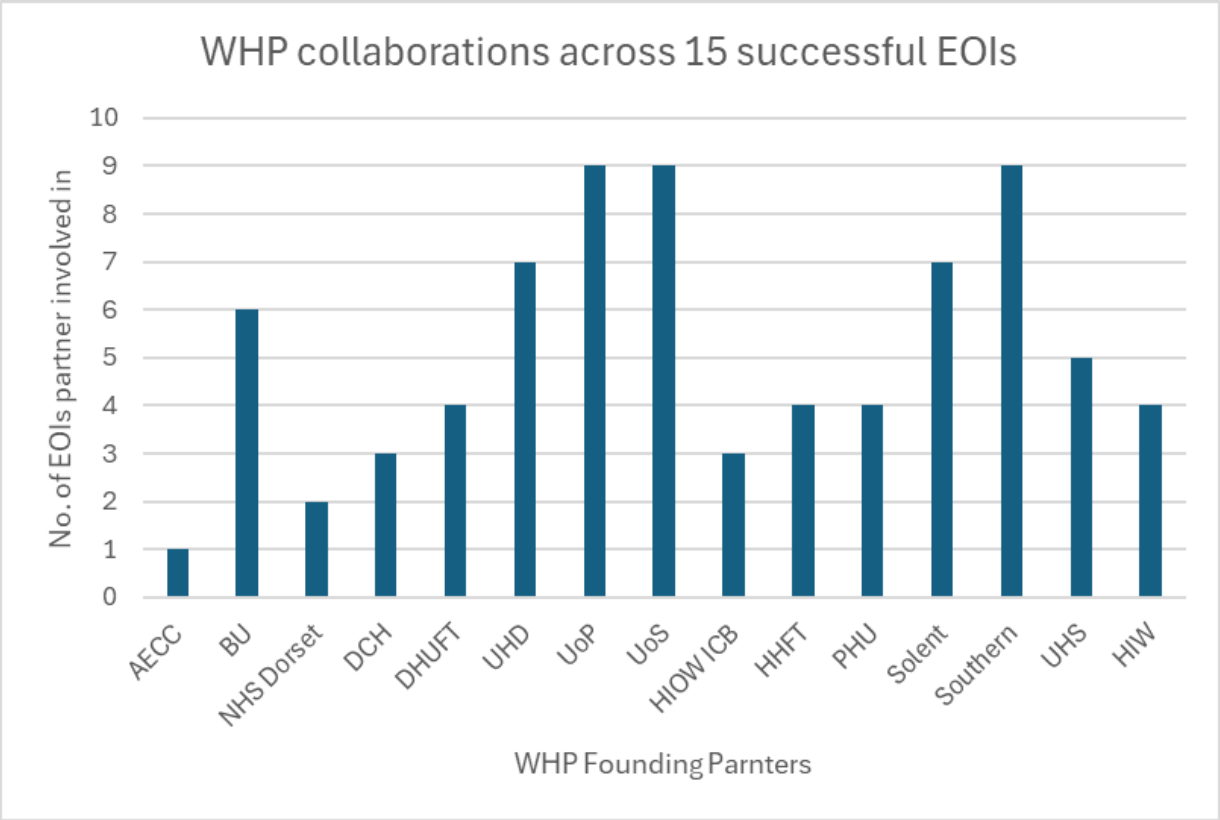


Figure 6: Extent of collaborations identified in the EOIs recommended for award 2023/24

6.2.2 Convene / support pan-Wessex funding applications

A key ambition of the WHP strategic alliance is to increase the number of successful pan-Wessex collaborative funding applications. During 2023/24, the WHP core team provided support to 36 funding application involving WHP founding partners. Of these, 32 applications were led by a WHP founding partner and 4 were led by a collaborating wider stakeholder. All WHP founding partners led or collaborated in at least 4 funding applications, Figure 7.

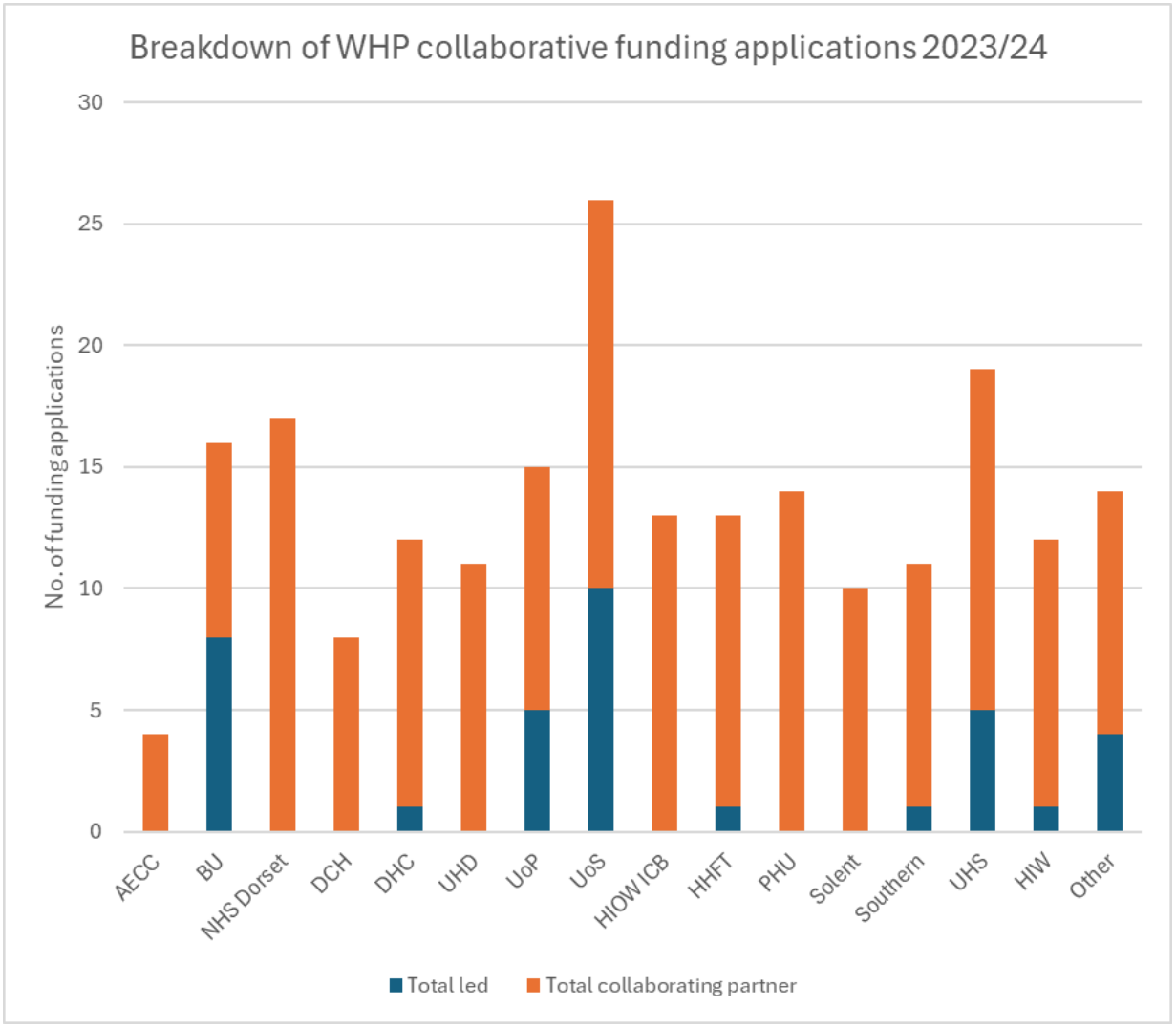


Figure 7: Breakdown of partners leading and collaborating on funding applications 2023/24

Of the 36 applications, 10 have had successful outcomes with a total funding amount of more than £22M, 6 are pending outcome of either expressions of interest (EOI) or full applications following successful EOI, 1 is still under development, 14 have been unsuccessful and 5 decided not to proceed. The status of funding applications per WHP founding partners is shown in Figure 8.

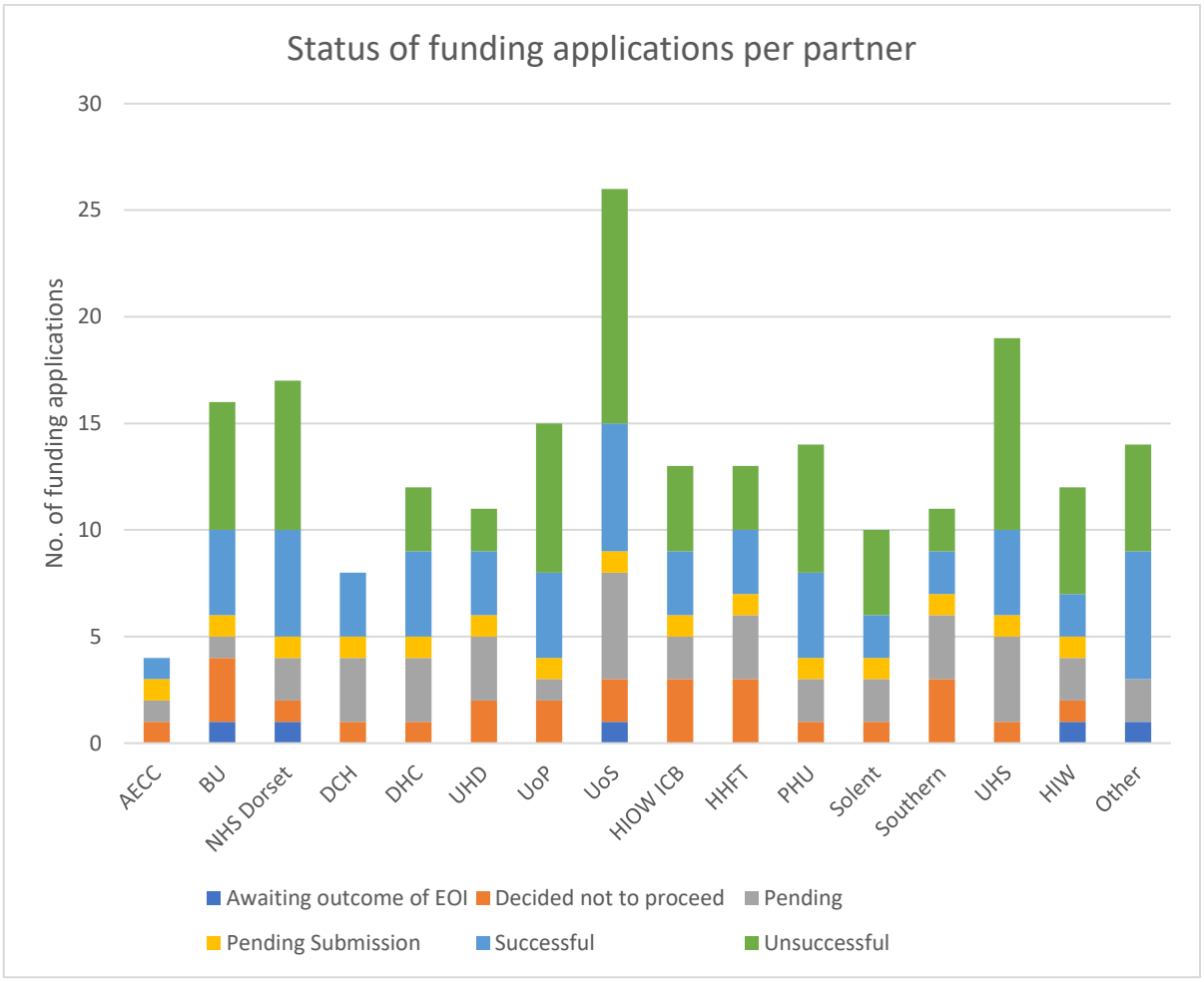


Figure 8: Status of funding application per partner

WHP has provided a range of support to these bids, depending on individual requirements. Examples of the support that has been provided include:

- Aligning potential competitors both within Wessex and external to Wessex to secure the most competitive funding application e.g. Two NIHR INSIGHT bids, NIHR RRDN hosting, NIHR Maternal Health Inequalities
- Facilitating intelligence gathering to inform major infrastructure applications e.g. NIHR Wessex ARC, NIHR RRDN
- Introducing founding partners to collaborators in other institution leading to funding applications e.g. NHS Dorset and CRUK Clinical Trials Unit
- Working with R&I leads within founding partners to shape applications e.g. Innovate UK Regulatory Science Network grant.
- Critiquing funding applications e.g. NIHR HDRCs Southampton and Portsmouth
- Providing supporting letters, submitted with funding applications, outlining the strategic alliance within Wessex, the commitment to working together to deliver research and innovation and highlighting alignment of the intent of the funding applications with the ambitions of WHP.

A summary of the funding bids supported by the WHP core team is in Appendix 1.

6.2.3 Communities of Interest

There have been a number of opportunities during the year to identify individuals with a research interest in specific topic areas, and to bring these people together to either:

- discuss the potential for developing a collaborative bid submission,
- consider future funding opportunities and jointly prepare for a collaborative approach,
- provide research knowledge and expertise to address a health and care system need.

The shape and role of these groups is developing and will vary. However, it is envisaged that they will develop into 'Communities of Interest' (COI) that will continue evolve.

Examples of work to date are outlined in the table below:

Research Topic Area	Activity
Mental Health	University of Southampton (UoS) and ARC Wessex identified the NIHR Mental Health Research Group funding opportunity. As this funding was not available to organisations already significantly involved in mental health research but was looking for collaboration between organisations to develop further expertise, a meeting was held inviting partner representatives with an interest in mental health research. At this initial meeting it was agreed that Bournemouth University would apply for NIHR Mental Health Development Award funding with support from UoS and ARC Wessex. This application was not successful, but work is continuing to develop a Wessex-wide mental health COI. HIOW ICP also ran a Mental Wellbeing Assembly in September 2023. Through WHP joint working with the ICP the opportunity was offered to the identified mental health research community to attend this meeting to enable the researchers to better understand the challenges within the health and care system, and to consider approaches to more closely integrate research into the work of the ICP. As mental health and wellbeing is a key priority across both ICBs WHP is keen to continue to support the development of this Community of Interest
Women's Health Hubs	During 2023 NHS England has provided funding to all ICBs to set up Women's Health Hubs. Through joint working with HIOW ICB and NHS Dorset, the opportunity was Identified to bring the expertise from the research community into the discussions around this development. WHP identified academics working within the Women's Health arena and has included this emerging Community of Interest in conversions with the Women's Health programme boards. In response to the Women's Health programme boards, WHP has led on the development of a paper reviewing all of the women's health research that has been carried out in Wessex over the last 5 years. In parallel, HIW are reviewing innovations relevant to women's health. This work will be presented to both ICB Women's Health programme Boards in early 2024/25 with the aim of highlighting research that could influence the

	work of the women's health hubs, as well as identify areas for future research and collaborative working.
Air Quality / Net Zero	WHP worked with Health Innovation Wessex (HIW) to develop a joint Net Zero funding application in August 2023. For this bid, individuals with research interests in Net Zero and healthcare were identified. With emerging funding opportunities for air quality research, these contacts were further refined to identify those with a specific interest in air quality and health. WHP working with the UoS Sustainability and Resilience Institute (SRI) held a call with these contacts to understand the potential interest of joint working to develop themes for future funding applications. This was followed up by a workshop in January where research themes and questions were identified along with commitment for future working and the forming of a COI. This COI, Clean Air South (currently 80 members), is now planning its ongoing activity and plans for developing collaborative funding submissions to address local priorities as opportunities arise.

6.2.4 Horizon-Scanning for funding opportunities

Funders of research, innovation and training, increasingly emphasise the importance of collaboration and impact. Each WHP partner has knowledge and expertise which combined offers the opportunity to deliver greater local and global impact, address health inequalities, improve outcomes and ensure the quality and sustainability of our future health and care services and promote economic growth. As one did currently exist, it was agreed to develop a Wessex-wide approach to identify and enable more deliberate and timely coordination and development of funding applications at the level of the Wessex region and therefore access a greater range of opportunities where collaboration strengthens applications and/or larger population sizes are required.

A Horizon Scanning Group has been convened consisting leads from each founding partners with the responsibility for carrying out horizon scanning of funding opportunities in each partner organisation. This group will meet quarterly with the focus of:

- operationalising a joint approach to identify and share funding opportunities suitable for Wessex-wide collaboration;
- identifying gaps in the funding opportunities that are currently reviewed (e.g. disease specific charities) and agree how to jointly include in the Wessex horizon scanning approach;
- understanding any infrastructure requirements for implementing the process.

6.2.5 Support Local Authorities NIHR Health Determinant Research Collaboratives

The NIHR Health Determinant Research Collaborative (HDRC) bids from both Southampton and Portsmouth were key strategic funding submissions during 2023/24. If successful, the learning from these collaborations would be key in understanding how to effectively work with local communities to understand and address local health issues. This work would also develop relationships to support future collaborative research across our communities.

The WHP Chair and Managing Director provided significant support to the development of these applications, enabling strong relationships to be built with the local authority leads for this work.

Both HDRC bids were successful, with Southampton receiving full funding and Portsmouth receiving a development grant with the aim of moving to full funding in 2025.

6.2.6 Web resource of research and development capacity and capability / repository of expertise

A key part of the WHP website is a listing of the WHP Founding Partners and links to each website to facilitate access to the detail of the strengths and offerings of each organisation.

Recognising that the strength of the WHP strategic alliance is in the depth and detail of the expertise within each organisation, and that it is this level of detail that is difficult for individuals to easily access, WHP has facilitated a number of approaches to support this need:

Requests for specific research expertise or capability sent to the WHP core team who have shared with key WHP stakeholders for wider input;

Development of contact lists for topics and communities of interest that WHP has actively worked on during the year. These contact lists have been shared within these groups to encourage cross organisation working;

Facilitation of meetings of individuals from across the WHP founding Partners to support requested input for potential collaborations.

The WHP core team has explored requests for a repository of all relevant research expertise from across Wessex. This is an extensive request considering all of the areas of expertise this would include, and the updating that would be required to keep up to date. Therefore during 2024/25, the core team aim to develop a mapping of the structures and links in each of the founding partners (and other key relevant organisations within Wessex) that can provide guidance to the relevant expertise in each organisation.

6.2.7 Engaging industry strategy

Recognising the importance of engaging industry and the overall contribution of life science research and innovation to economic growth, with 2023/24, working with HIW, the WHP SLT has engaged with the Local Enterprise Partnership (LEPs) in Wessex. Within Hampshire, WHP hosted with HIW and the M3 LEP, a workshop with a wide range of stakeholders to discuss the potential of the life sciences, and specifically human health, to economic growth within the region. The workshop established that that stakeholders are keen to work together to realise the potential, with further worked planned in 2024/25. Within Dorset, the Dorset LEP is taking forward the OneHealth Enterprise Network, with representation from WHP engaged on the steering group.

In addition, the WHP SLT has linked to the CEO of Yorkshire and Humber Health Innovation Network and opened discussions to share learning and contacts to attract R&I commercial partnerships and investment, building on the already excellent innovation development and deployment work of HIW, to also include discovery research.

6.2.8 Wessex Experimental Medicine Network

The National Institute of Health and Care Research (NIHR) funds the NIHR Southampton Biomedical Research Centre (BRC) to develop and deliver experimental medicine research. NIHR are increasingly expecting BRCs

to collaborate with partners, especially organisations that do not have a BRC, and focus research on meeting the local population health need.

In 2023/24, NIHR Southampton BRC developed, with the WHP founding partners, proposals to establish the Wessex Experimental Medicine Network (WEMN). WEMN has been seen from the outset as a component of WHP, important to delivering the WHP strategic ambitions including securing future Academic Health Science Centre status. WHP and the Southampton BRC, working together will ensure the future successful delivery of the WEMN through Wessex-wide strategic collaboration and partnership working with the NIHR Southampton BRC is providing access to BRC infrastructure, expertise and pump-prime funding.

The joint WHP/WEMN funding call was launched in Q4 of 2023/24 and received 21 expressions of interest. Applications are currently being reviewed and will be notified in Q1 2024/25.

6.2.9 Wessex Research hubs and buses

The Wessex Research Hubs were established to rapidly deliver the COVID-19 vaccine research. Initially funded by NIHR and established by NIHR Wessex Clinical Research Network (CRN) the hub model has and continues to be highly successful providing a unique and attractive model for commercial and non-commercial research that is strategically important for UK life sciences research and Wessex.

With the transition from NIHR CRNs to the new NIHR Regional Research Delivery Networks, from 1st October 2024 Wessex CRN will no longer exist which put the future of the Wessex Research Hubs at risk. Given the strategic importance of the Wessex Research Hubs, members of the WHP core team have worked with colleagues across the region to agree short and medium plans for the hubs with a view to ensuing the hubs are sustainable in the longer terms including securing agreement for the Wessex Research Hubs to migrate to come under the oversight of Wessex Health Partners.

The transition to this new governance structure, facilitating oversight of the work of the Wessex Research Hubs and Buses by the WHP founding partners will take place over Q1 and Q2 for 2024/25.

6.2.10 Secure Data Environment

See section 6.5

6.2.11 Wessex Expo Event

In March 2024, WHP supported the inaugural Responsible Innovation in Health Technology Event, led by the UoS in collaboration with partners in Wessex and wider stakeholders, including guest speakers from Canada. The event showcased existing expertise and potential in Wessex and provides a strong platform for future working. Early success includes securing an Innovate UK funding for Wessex to develop and lead a national HealthTech Regulatory Science Network. The successful delivery of this UKRI funded network will strengthen the region's ability to secure future funding and expand activities in research and innovation in HealthTech.

6.3 Systematic translation and adoption of innovation

The rapid and effective adoption of proven innovations at scale is a major challenge in health care. Health care is rich in evidence-based innovations, yet even when such innovations are implemented successfully in one location, they often disseminate slowly - if at all. With its core purpose of taking ownership of the 'Discovery, Development, Deployment' pathway WHP can deliver greater adoption at scale across Wessex.

6.3.1 Translation and adoption – a system approach workstream

Understanding the health and care needs and priorities, aligning these with the identification of relevant research and innovation, and providing real world evaluation and evidence for the potential benefit of these solutions is key to deliver greater adoption at scale across Wessex. The initiatives enabled by the WHP strategic alliance in 2023/24 have focussed on developing the foundations needed to increase partnership working across the 'discover, develop, deploy' pipeline. Of particular note is the work with the HIOW and Dorset ICBs (6.1.1 ICB/WHP Maximising value of research workstream) and wider stakeholders in the ICP (6.1.2 ICP/WHP population health need workstream) including local authorities and local enterprise partnerships (6.2.7 Engaging industry strategy).

The WHP support of external funding applications and the WHP pump-prime funding call are enhancing existing and providing new opportunities for collaboration between our discovery and development activities to deployment (the 3Ds) (6.2.1 Discover, develop, deploy: commissioned and response programmes, 6.2.2 Convene / support pan-Wessex funding applications) and our Communities of Interest span the '3Ds' (6.2.3 Communities of Interest).

Delivery of the Wessex Secure Data Environment (SDE) as part of the National SDE is an important initiative to support expansion of Real World Evaluation studies, conducted by HIW and other WHP founding partners (6.5.1 Deliver SDE year 1 plan).

Of particular importance is our response to the national NHS Innovation Ecosystem Review. Commissioned by the CEO of NHS England, Amanda Pritchard and Chaired by Roland Sinker CBE, CEO of Cambridge University Hospitals NHS FT, the Sinker review is seeking to address ongoing challenges in the adoption and spread of innovation and drive improvements in the health innovation ecosystem. With HIW, the WHP SLT has contributed to the review though workshops, submission of a localities review in response to a call and direct communication with the Chair, promoting our WHP strategic alliance approach and prompting direct engagement with the national team. As the review continues, we continue the dialogue with the national team, raising the profile and reputation of Wessex with the aim of securing increased national support and funding.

6.4 Developing the workforce to discover, develop and deploy

Workforce challenges are prevalent across the health and care in Wessex and globally. Organisations that empower and support their workforce to engage in research, innovation and training attract and retain staff and deliver better outcomes. Our future workforce will require very different knowledge and skills to discover, develop and deliver innovative health and care services. WHP will work with partners to understand the knowledge, skills, and attitudes required across Wessex, the current training provision and develop collaborations to expand and enhance the offer.

6.4.1 Review activities across Wessex and consider potential regional offer for: support to innovators; Research and innovation capacity building

During the year, the WHP core team has supported a number of Wessex-wide workshops and training sessions focussed on developing the research and innovation community including two *'Understanding Intellectual Property to Create Health Impact'* events led by our partners, Health Innovation Wessex.

6.4.2 Strategic review of Wessex REACH

With the NIHR incubator funding for Wessex REACH coming to an end in December 2023, the WHP Board commissioned a strategic review of Wessex REACH and other national or Wessex-based resources supporting the development of health and care research capability and capacity. As well as reviewing the work of the Wessex REACH incubator against the proposal that NIHR funding had been provided for, a second part of this strategic review was to understand the research workforce challenges that NHS Trust organisations are experiencing across Wessex to understand the support and infrastructure required across Wessex to address these needs. To understand these research workforce challenges, all Wessex NHS Trust R&D leads were invited to take part in interview to understand:

- The research workforce challenges in their Trust
- Where they currently go for support / gaps
- What they would like to see in the future

A report was produced (Wessex REACH and wider Review Report) which outlined the outputs of this review and made recommendations for the support required to develop the capacity and capability of the research workforce across Wessex. These recommendations considered the current and planned services and support provided both nationally and within Wessex, new structures providing support that are planned to be implemented over the next six months, and potential gaps in the current and planned provision.

Five key recommendations were made in the report. These recommendations consider all individuals who are interested in developing knowledge and skills to enable them to conduct research within the health and care setting, or in following an academic career, initially as an early career researcher (ECR). There are no limits to the settings included (e.g. acute hospitals, community care, primary care, social care, voluntary sector) or the profession (e.g. doctors, nurses, pharmacists, allied health professionals, clinical scientists, methodologists, data scientists etc).

Topic	Recommendation
To increase research championship by NHS executive teams	Prepare the case to support embedding research in the NHS. WHP to support R&D leads to run campaign with leadership teams to raise awareness about the benefits of research participation: improved quality of care; better recruitment and retention; increased financial income
For those individuals who want to do research as part of their role	Provide signposting to existing materials and courses and new structures being developed. For example: NIHR: API scheme, PIPP scheme, Credential, NIHR Learn courses (e.g. GCP training and others), Local Infrastructure: e.g. Trust R&D departments, RRDN, RRLO, ARC Wessex, BRC Local organisations: courses run across Wessex NHS and HEIs
For those individuals who want to pursue an academic career	Wessex-wide approach to identify potential candidates for development to an academic career (NIHR Academy offering) Signposting to development and funding opportunities Potential to provide offering like SOAR across Wessex if funding available
To support all organisations to become research active	Develop and encourage approach to encourage mentoring between organisations and individuals across Wessex to develop research participation in currently underserved organisations
Communications and signposting	Signposting to research training and development sources and opportunities. Development and ongoing maintenance would need funding and resourcing

These recommendations will be considered as part of the WHP 2024/25 annual planning process, and plans for progressing across Wessex made with the WHP partners and related infrastructure. In the short term the Wessex REACH website will be reviewed by the WHP core team with key elements to be retained and made available across Wessex. Longer term plans are dependent on emerging national changes being driven by NIHR through the new Regional Research Delivery Networks.

6.2 Strategic review of Wessex Patient Improvement Network

WHP supported a strategic review, with the Wessex NIHR Directors, of the Wessex Public Involvement Network (Wessex PIN). Historically founded by the Wessex NIHR Directors Wessex PIN is a network of Patient and Public Involvement and Engagement professionals. The network has plans to continue and is linked in with similar groups across Wessex. Wessex NIHR Directors have indicated that they would consider an application from Wessex PIN for continued funding. Wessex NIHR Directors are also considering what the NIHR infrastructure needs going forward.

6.4.3 Deliver one peer review

One of the WHP founding partners expressed interest in commissioning an external peer review, of their R&D function to share learning and support development. This was also of interest to other founding partners. The organisation subsequently requested that the review be delayed until 2024/25 to allow the recruitment of key resource to take place.

6.5 Enhancing the discoverability of information and data

The Wessex Secure Data Environment (SDE) forms part of the Southern Collaborative SDE (SNSDE) and will provide a secure infrastructure for researchers in the NHS and our regional partners, enabling access

integrated multi-modal data from various sources, including electronic health records, imaging, pathology, genomics, and research cohorts. The SDE will make data more accessible, less fragmented, and of higher quality, while also gaining public and patient support for health data research.

6.5.1 Deliver SDE year 1 plan

SDE phase three funding was agreed, and the memorandum of understanding signed with NHS England. This allowed budget to be released for the year 1 plan to be delivered (2023/24) and plans to be developed for year 2 (2024/25).

The SDE team has worked with WHP founding partners to identify regional data assets and to map priority datasets to be included in the early SDE development work. The proof-of-concept build has been successfully completed, and a pilot run between UHS and UoS. Exemplar research projects have been identified to be included in the SDE during 2024/25.

A key element of the SDE programme is a stakeholder and public engagement programme.

The Wessex SDE programme is working closely with the SDE national programme and is part of a Southern SDE Consortium to develop common approaches and processes.

7 WHP Governance and Operational Structure

A key deliverable of 2023/24 was to secure approval of the 15 founding partners to a single collaboration agreement. This was achieved and all founding partners have now signed the agreement which covers the first 3-year funding period, ending on 31st March 2025.

The WHP governance structure has been established in accordance with the collaboration agreement. The operational structure necessary to deliver 2023/24 plans has also been established and will evolve as programmes develop.

- The Terms of Reference were agreed, and regular meetings established for the WHP Board and WHP Steering Group.
- All founding partners are represented by a member of their Executive Team (or delegate) on the WHP Board.
- The WHP Steering Group includes representation from senior members of their respective leadership teams responsible for research and/or innovation, as well as representatives from Wessex NIHR and other research and innovation infrastructure in the region.
- Governance arrangements for Wessex wide programmes that come under WHP oversight will continue to develop in line with the programmes. To date arrangements for the Wessex Secure Data Environment [SDE] have been agreed and established as were the arrangements for the time limited Wessex REACH review. The Wessex Experimental Medicine Network [WEMN] are agreed in principal and in the process of being operationalised as staff come into post. The transition arrangements for the Wessex Research Hubs are agreed.

In addition, members of the WHP SLT represent the WHP strategic alliance on a number of Boards and Steering Committees of partner organisations aligned to the strategic ambitions of WHP.

Examples include:

- Health Innovation Wessex Board (non-voting)
- NIHR Wessex ARC Partnership Board
- NIHR Wessex CRN Partnership Board
- NIHR Wessex CRN Executive Group
- Wessex Research Hubs Board
- Wessex NIHR Director's (Chair)
- Wessex R&D Leadership Group
- Wessex Experimental Medicine Centre Steering Committee
- NHS Dorset Strategic Objectives Committee
- Dorset OneHeath Network Steering Group
- Clean Air, South Steering Group
- HIOW ICB Strategy Leads
- HIOW Women's Health Programme Board (HIW represent WHP on equivalent Board in Dorset
- UoP/PHU/UoS/UHS HealthTech Board
- Pharma Contract Management Group (PCMG) Assembly Steering Committee

8 Business Support, Communications and Finance Functions

The business support, including finance and communications, functions are provided to WHP under a service level agreement with Health Innovation Wessex (HIW).

As legal hosts of WHP, the HIW corporate policies and procedures have been reviewed and where applicable adopted unchanged. Policies and procedures in need of amendment are in the process of being updated.

8.1 Communications

A full review of the communications activities is provided in the WHP Communications Annual Review (see appendix 2). Key highlights include:

- Visiting all founding partner sites
- Convening founding partner and R&I communications leads for a series of planning and strategy meetings to introduce WHP, develop relationships and co-produce communication plans and outputs.
- Developing strategic communications goals as well the WHP communications plan for delivery in 2024/25.
- Developing and launching the WHP website, achieving 4,904 page views
- Commissioning a brand strategy review and commencing work to take forward the findings and recommendations.
- Promoting the work of the WHP strategic alliance and its founding partners across a range of channels, including social media, newsletters, regional media and events.
- Representing WHP at national and international events and research steering committees.

8.2 Finance

The membership income for the year was £925k representing fees from 15 members plus some arrears from the previous year. Expenditure for the year was £558k predominately for the leadership team, communications and charges for back office services provided by Health Innovation Wessex. The net in-year underspend of £367k is being carried forward and included in the financial plan for 2024/25. Although £200k was committed to the WHP Funding call (see section 6.2.1) (in 23/24, this spend will occur in 24/25).

The 3 year financial position; outturn for years 1 (22/23) and 2 (23/24) and the Plan for year 3 (24/25), is shown in Appendix 3.

9 Risks and Issues

The key risks, mitigations and risk levels are provided below.

Risk description:	WHP fails to demonstrate sufficient impact and value to partners
Mitigation:	The annual plan for 2024/25 will be agreed by the WHP Board by the start of Q1 2024/25. Delivery of the annual plans will be overseen by the WHP steering committee and WHP Board. An annual review will be presented to the WHP steering committee and Board annually and the end of each financial year. Evaluation of the impact of the first three-year period for WHP will be presented to the WHP Board in Q2 2024/25.
Risk level, with mitigation	Low

Risk description:	Due to ICS and health and care system workload pressures and funding constraints, some partners are not able to fully engage with and support the work of WHP
Mitigation:	The annual plan for WHP is structured to ensure that is aligned with and supports the requirements and priorities of the ICSs and the wider health and care system.
Risk level, with mitigation	Low

Risk description:	In order to maximise the potential impact of the WHP strategic alliance, The small WHP SLT represent the WHP strategic alliance on a number of Boards and Steering Committees of partner organisations aligned to the strategic ambitions of WHP. There is a risk that the WHP SLT is spread too thin to be able to represent as broadly as would be optimal
Mitigation:	The role of WHP SLT member on boards and steering committees across Wessex is prioritised to where the greatest support and impact will be realised.
Risk level, with mitigation	Medium

Risk description:	WHP fails to secure funding for a 2nd term
Mitigation:	An options paper will be presented to WHP Board by the beginning of Q2 in 2024/25 with a decision requested from founding partners by the end of Q2.
Risk level, with mitigation	Medium

Appendix 1: Summary of Wessex collaborative funding applications supported by WHP core team

Funding Body	Title of project	Lead applicant	Lead Org	Collaborating Partners	Final outcome	Total grant awarded	WHP added value
NIHR	Health Determinants Health Collaboration (HDRC) Southampton	Debbie Chase	SCC	UoS, HIOW ICB, Non-FP	Successful	£5,000,000	Participated in writing workshops, drafting and editing application. Connected relevant individuals and teams. Provided letter of support for submission. Assisted in preparations for interviews.
NIHR	Health Determinants Health Collaboration (HDRC) Portsmouth	Helen Atkinson	PCC	NHS Dorset, UoP, Non-FP	Successful	£250,000	Supported drafting through review and comments for edits in application. Connected relevant individuals and teams. Provided letter of support for submission.
NHSE	Wessex Cancer Vaccine Launchpad	Karen Underwood Simon Crabb	UHS	DCH, DHC, UHD, UoS, HHFT, PHU, UHS,	Successful	0	WHP strategic alliance and Wessex Research Hubs included in application showing strength of collaboration in region, and important to NIHR.
NHSE	Data for R&D Sub-national Secure Data Environment (SNSDE)	Chris Kipps	UHS	All FPs	Successful	£7,800,000	Wessex SDE only possible through NHS organisations in Wessex agreeing to work together on this national strategic programme. Wessex region provides the necessary 3million population and Wessex-wide governance arrangements.
NHSE	ICR Research Engagement Network - Cohort 2 (REND2)	Helena Posnett	DHUFT	NHS Dorset, DHC, HIW, Non-FP	Successful	£91,000	At request of lead applicant, met to discuss application resulting in agreement of how WHP could support including attending funding application review meetings and provision of a letter of support, providing NIHR assurance on the strength of collaboration in region and important aspect of the award.

Funding Body	Title of project	Lead applicant	Lead Org	Collaborating Partners	Final outcome	Total grant awarded	WHP added value
UKRI	The Wessex Regulatory Science and Innovation Network - bridging the gap between healthcare technology and regulatory science in Medical Technology with a focus on Frontier Science, Personalised Medicine, and Global Health Advancements	Cheryl Metcalf	UoS	UoP, UoS, PHU, UHS	Successful	£34,000	Determined with lead applicants the scope of the call, our regional strengths and the shape of the funding application. Supported drafting the application. WHP cited in the application including the WHP MDs role in Chairing the Steering Group for a successful award.
NIHR	INSIGHT: Inspiring Students into Research Round 1 (UoS)	Clare Foster Lindsay Cherry Jo Turnbill	UoS	UoP, UoS, HIOW ICB, HHFT, PHU, Solent, SHFT, UHS, Non-FP	Successful	£2,658,480	At request of applicants who wished to lead the bid, acted as a neutral party approaching all relevant Wessex NHS and HEI partners to secure support for a bid led by the Wessex HEI leads, placing the leads in a stronger position to negotiate the overall leadership with HEI outside of the Wessex region. Introduced collaborators across Wessex. Advised on draft applications. Provided letter of Support.
NIHR	INSIGHT: Inspiring Students into Research Round 1 (BU)	Carole Clark	UWE	BU, NHS Dorset, DCH, DHC, UHD, Non-FP	Successful	£2,800,000	At request of leads within Dorset, acted as a neutral party approaching relevant Wessex NHS and HEI partners to secure support for Wessex components of final application, placing the leads in a stronger position to negotiate role in application with HEI outside of the Wessex region. Introduced collaborators across Wessex which shaped the programme. Advised on draft applications. Provided letter of Support.
UKRI	Research and partnership hubs for health technologies	Gordon Blunn	UoP	NHS Dorset, UoP, UoS, HIOW ICB, HHFT, PHU, Solent, UHS	Unsuccessful		Review and input into bid submission. Met with bid leads to understand how WHP could best support and made introductions. Letter of support provided

Funding Body	Title of project	Lead applicant	Lead Org	Collaborating Partners	Final outcome	Total grant awarded	WHP added value
UKRI	Research and partnership hubs for health technologies	Michael Boniface	UoS	NHS Dorset, DCH, DHC, UHD, UoS, HIOW ICB, HHFT, SHFT, UHS, HIW	Pending		Met with bid lead and made introductions to potential partners. Letter of support provided
UKRI	Future of Healthful Work	MC Schraefel	UoS	UoS	Pending		Met with bid lead to understand the proposal, and how WHP could best support. Letter of support provided.
Alzheimer's Society Doctoral Training Centres (DTC)	Doctoral Training Centres	Michele Board Jane Murphy	BU	BU, NHS Dorset, UoS, SHFT	Unsuccessful		Introduced collaborators
UKRI	Adolescent Health Study Call for study sites	Mary Barker	UoS	UoS, UHS, Non-FP	Pending		Provided supporting wording for EOI and links to data sources for numbers of 8-18 years olds in Wessex and number of Schools. Attended bid team meetings for WHP input as relevant. Connections made.
NIHR	REFRESH study: nutRition intervEntions For malnouRished oldEr adultS in care Homes	Jane Murphy Mary Higgens	BU	BU, UoS, Non-FP	Successful	£3,500,000.00	Met with bid lead. Letters of support not accepted as part of bid, so WHP support included in bid information.
NIHR	Healthtech Research Centres (HRC)	Tom Wilkinson	UoS	UoP, UoS, PHU, UHS	Unsuccessful		Introduced collaborators
UKRI	MRC biomedical data science leadership awards: outline	Samuel Robson	UoP	UoP, UHS	Unsuccessful		Introduced collaborators

Funding Body	Title of project	Lead applicant	Lead Org	Collaborating Partners	Final outcome	Total grant awarded	WHP added value
NIHR	OLS Cancer Mission: Early Cancer Diagnosis Clinical Validation and Evaluation	Jocelyn Walters	UoS	NHS Dorset, DHC, UHD, UoS, HIOW ICB, UHS, HIW, Non-FP	Unsuccessful	N/A	WHP made initial introduction between researcher and CTU leading to CTU developing a collaborative bid
RCN	RCN Foundation Chair in Adult Social Care Nursing	Sam Porter	BU	BU, DHC, UoS, UHS	Unsuccessful	N/A	Letter of support provided
UKRI	Connecting Capability Fund: Short-term preparatory funding	Cheryl Metcalf Phil Jewell	UoP	UoP, UoS, PHU, UHS, HIW	Unsuccessful	N/A	Introduced potential collaborators, advised on drafts of application and provided letter of support provided.
UKRI	UKRI Creating Opportunities Trial Accelerator Fund	Shirlene Oh	HHFT	HIOW ICB, HHFT, SHFT	Decided not to proceed	N/A	Introduced potential collaborators.
UKRI	UKRI Creating Opportunities Trial Accelerator Fund	Peter Phiri	Southern Health	HIOW ICB, HHFT, SHFT	Decided not to proceed	N/A	Introduced potential collaborators.
UKRI	People Planet Parks	Karen Llewellyn	Bristol Health Partners	NHS Dorset, Non-FP	Unsuccessful	N/A	Introduced potential collaborators.
NIHR	Mental Health Research Development Award	Steve Trenoweth	BU	BU, NHS Dorset, DHC, UoS, Solent, SHFT	Unsuccessful	N/A	Co-hosted (with ARC Wessex) a Wessex-wide call with Mental health clinicians and researchers from across WHP Founding Partners to agree approach NIHR Mental Health Research Group funding. Agreed to develop bid for the Research Development fund instead. Resulted in a collaborative bid with BU leading and mentoring support from UoS. Letter of support provided.

Funding Body	Title of project	Lead applicant	Lead Org	Collaborating Partners	Final outcome	Total grant awarded	WHP added value
DoH	NHS AI Call Bid	Anoop Chauhan	UoP	UoP, PHU	Unsuccessful	N/A	Introduced collaborators
UKRI	Pathways to Health through Culture of Neighbourhoods (P2H2)	Joanna Sofaer	UoS	UoS, HIOW ICB, HHFT, UHS, Non-FP	Unsuccessful	N/A	Introduced potential collaborators, provided information for bid and provided letter of support provided.
NHSE	Greener NHS: Stimulating collaboration between NHS staff and academics towards a more sustainable healthcare	Emma Williams	HIW	BU, NHS Dorset, UoP, UoS, HIOW ICB, HHFT, PHU, Solent, UHS, HIW	Unsuccessful	N/A	Bid co-developed with Wessex AHSN. Contacted WHP Founding Partners to identify researchers working in the Netzero field. Contacted researchers to understand areas of expertise to include in bid. Successful EOI. Funding was withdrawn by NHS Greener due to other priorities so full bid never submitted
UKRI	Developing a new treatment option for people living with depression	Ala Yankouskaya	BU	BU, UHD, UoP	Decided not to proceed		Bid leads contacted WHP for advice on how best to proceed.
NIHR	NIHR Mental Health Research Groups	Steve Trenoweth	BU	BU, UoS	Decided not to proceed	N/A	Co-hosted (with ARC Wessex) a Wessex-wide call with Mental Health clinicians and researchers from across WHP Founding Partners to agree approach for Mental health Research Group funding. Decided better approach for BU to apply for MH Development Award funding in collaboration with UoS.
UKRI	Realising the Health co-benefits of the transition to net zero - UKRI	NA	UoS	All FPs	Decided not to proceed		Co-hosted meeting (with UoS SRI) with researchers from across Wessex working in this field (identified through WHP partners.) Meeting decided not to proceed with bid but to build on network for future. Has resulted in the formation of the Clean Air South Network with focus of developing research collaborations for future funding opportunities.

Funding Body	Title of project	Lead applicant	Lead Org	Collaborating Partners	Final outcome	Total grant awarded	WHP added value
Dementia Research UK	Veterans and Dementia Project	Michele Board	BU	BU, NHS Dorset	Successful	£20,000	Introduced collaborators
UKRI	Multidisciplinary healthtech impact accelerator	Phil Jewell	UoP	BU, UHD, UoP, UoS, PHU, Solent, UHS, HIW, Non-FP	Unsuccessful	N/A	Introduced potential collaborators, advised on drafts of application and provided letter of support provided.
NIHR	Wessex ARC 2026-	Cathy Bowen	UHS	All FPs	Pending Submission		WHP supported ARC Wessex preparation for funding call for future ARC by carrying out a 'SWOT' of the current ARC Wessex.
NIHR	ARC Wessex application for KM fellows	Alison Richardson	UHS	All FPs	Pending		Reviewed draft funding application.
NIHR	NIHR Infrastructure capital investment	Karen Underwood	UHS	DCH, DHC, UHD, UoS, HHFT, PHU, Solent, SHFT, UHS	Pending		WHP founding partners worked together coordinated by UHS to align funding application(s)
UKRI	OneHealth Enterprise Network	Cheryl Metcalf	UoS	BU, NHS Dorset, UoS, HIW, Non-FP	Unsuccessful		The MD of WHP and a selection of the WHP founding partners are on the OneHealth Steering Group. The WHP strategic alliance was cited in funding applications to show strength of collaboration in the region.
UKRI	OneHealth Enterprise Network	Professor Robert Britton	BU	BU, NHS Dorset, UoS, HIW, Non-FP	Awaiting outcome of EOI		The MD of WHP and a selection of the WHP founding partners are on the OneHealth Steering Group. The WHP strategic alliance was cited in funding applications to show strength of collaboration in the region.

Wessex Health Partners (WHP)

2023/24 annual review – communications

Introduction and background

This document outlines the communications, engagement and marketing activities delivered by the WHP core comms team in 2023/24, in partnership with founding partner and research and innovation (R&I) communications leads across the Wessex region.

The WHP core comms team, which consists of a Senior Communications and Strategy Manager (0.2 whole time equivalent) and a Senior Communications Officer (0.4 WTE), were appointed in April 2023.

Working with the wider WHP core team, they began work to establish and develop a communications function for WHP. This included the development of communications goals and priorities for 2023/24, as well as the set up of channels and the creation of corporate materials and processes.

Communications goals and priorities

In May 2023, the WHP core team developed six overarching strategic communications goals, to which all activity was aligned:

1. Founding partners value and feel part of WHP and act as advocates for the alliance
2. The WHP core team, working with partners, promotes the works of the alliance and its founding partners using effective public relations activities to enhance organisational reputations and deliver added value.
3. WHP is known for its strategic priorities and the partners collectively demonstrate excellence in research, innovation and health and care education.
4. WHP offers, and is recognised for, its thought leadership
5. WHP's communications are collaborative, inclusive and impactful
6. Communication and engagement activities help prepare the ground for a future Academic Health Science Centre application.

In June 2023, key communications projects and priorities for 2023/24 were also agreed. These have been included in Figure 1 and assigned a RAG (red, amber, green) rating to track progress.

Figure 1 – RAG rated communications projects for 2023/24

Project/objective	RAG	Explanation (red & amber)
Develop a communications plan, ensuring alignment with the strategic framework and business objectives.		
Establish a WHP communications network, hosting the first meeting by 30 September 2023.		
Work collaboratively to produce at least two case studies to host on the WHP website by 31 March 2024.		Whilst a number of case studies are in development and/or the pipeline, only one was published on the WHP website in 2023/24. This is because projects/activities needed more time to develop and evolve in order to formulate case studies. This will be taken forward in 2024/25, with an ambition to publish a minimum of eight case studies.
Develop a WHP communications toolkit, including corporate stationery and marketing materials by 30 September 2023.		
Commission, develop and launch a new website for WHP.		
Develop and launch a monthly WHP newsletter by 30 September 2023, growing engagement to achieve 300 subscribers and an average open rate of 30% by 31 March 2024.		A newsletter proposal and content plan was developed in May 2023, however plans for a newsletter were subsequently paused to allow WHP more time to develop its communications plan and channel strategy. Plans will be taken forward in 2024/25, with an ambition to launch the newsletter by the end of quarter two.
Conduct a review of corporate branding by 31 March 2024.		

2023/24 key activity summary

A summary of key activities delivered in 2023/24 is included below. The activities have been grouped by workstream for ease of reporting.

WHP recognises professional, corporate communications as a vital strategic function, integral to the achievement of its vision, mission and ambitions.

The success of activities delivered in 2023/24 has led to plans to invest in the communications team in 2024/25. The planned increase in resource will support an expansion of activity and the delivery of the 2024/25 WHP communications plan.

Strategy and planning

In 2023/24, we:

- Developed strategic communications goals in partnership with communications leads and the core team, setting the direction of travel for our work.
- Developed the 2024/25 WHP communications plan, which includes objectives, audiences and channels, as well as a detailed tactical delivery plan with measures and milestones.
- Supported the development of the WHP annual plans for 2023/24 and 2024/25.
- Set up and implemented a planning grid to facilitate the management of communications activities each week.
- Created a dashboard for capturing communications metrics and impacts
- Created and maintained a database of communications leads across Wessex. The communications team also supported discussions with external suppliers to explore setting up a stakeholder engagement system for WHP.
- Developed a WHP consent form and a process for gathering and recording the consent of individuals who participate in communications activities.
- Supported the creation of the 2023/24 WHP annual report.

Governance

In 2023/24, we:

- Delivered written and/or verbal communications updates at all Board and Steering Group meetings.
- Developed a sign off process for communications outputs within the core team

- Facilitated partnership working and co-production, seeking feedback and guidance from the core team and the wider partnership for communications and engagement activities.

- Liaised with WHP's host, Health Innovation Wessex (HIW), to ensure communications procedures and processes are aligned with General Data Protection Regulation.

Brand strategy and identity

In 2023/24, we:

- Enhanced WHP's existing brand guidelines, including the development of new logo variations and the selection of new corporate fonts to improve accessibility.

- Used the existing brand guidelines to develop a suite of corporate materials to support operational and promotional activities. This included business stationery such as slide sets, letterheads and digital business cards, as well as other assets including infographics, regional maps and social media cards.

- Filmed and edited corporate videos and an animation. Developed briefs and liaised with videographers to work up a plan and gather quotes for three corporate video projects, which will now be taken forward in 2024/25.

- Planned and delivered a brand strategy workshop with external agency, Frost Creative, for the core team and communications representatives from across the partnership to explore ways of developing and strengthening the WHP brand to achieve maximum impact on behalf of partners.

  The workshop was followed by one to one interviews with Steering Group members to gather intelligence to inform the development of our brand identity and strategy in 2024/25.

  The findings from the workshop and interviews were summarised in a report, which was presented to the WHP Board and Steering Group in quarter four.

  The WHP core comms team supported Frost Creative to progress work to develop a new brand strategy and identity for WHP. This work will continue in 2024/25. Frost Creative used the findings report and feedback to develop several brand concepts, which the comms team presented to the WHP Board for feedback and approval in March 2024.

- Protected the reputation of WHP and its partners through consistent implementation of the brand identity across all channels and assets.

- Acted as point of contact for all brand queries, reporting and/or escalating opportunities, issues or challenges as necessary.

Website

In 2023/24, we:

- Worked with the core team, the wider partnership and external web developers to design a new website for WHP. The process took place over a number of months and involved desk research, benchmarking and detailed site mapping.

- Created a content plan for the new website and commenced work to write the copy and source visual/multimedia assets.

- Worked with the web developers to ensure that all content is relevant, optimised for search engines, aligned with brand values and compliant with Web Content Accessibility Guidelines (WCAG 2.2).

- Soft launched the site in October 2023, providing the opportunity for Steering Group members and communications leads from across the partnership to provide feedback and ideas. This was reviewed and implemented throughout November 2023.

- Launched the new site in December 2023, providing a channel to showcase the achievements of founding partners and the WHP strategic alliance.

  Since its launch, the site has received 1,584 active users, creating 4,904 page views and resulting in 13,594 events (number of interactions on a page).

  The top viewed pages for 2023/24 were:
  - The team
  - About us
  - Vision, mission and strategic workstreams

  Development of the site continued following the launch and included the publication of 10 news stories and the creation of content for new sections, such as ‘Our programmes’.

  WHP has a number of plans to further improve the site, with phase 2 web development commencing in 2024/25.

Partner and stakeholder engagement

In 2023/24, we:

- Convened founding partner and R&I communications leads for a series of planning and strategy meetings and one to ones, introducing WHP, developing relationships and co-producing communication plans and outputs.

- Continued regular meetings and engagement with founding partner and R&I infrastructure comms leads throughout 2023/24, including attendance of regional meetings such as the

NIHR Wessex Comms Network and the University of Southampton Medicine Comms Network.

- Facilitated promotion of WHP across partner channels, including features in newsletters, on websites and in corporate literature such as magazines.

- Joined the Wessex Secure Data Environment Citizens Engagement working group, attending meetings and contributing to keys projects, such as the development of Terms of Reference and its website.

- Supported the Wessex Research Buses design project, joining working group meetings to represent WHP and advise on brand compliance.

- Supported the development of the Wessex Research Hubs and Buses website, offering detailed feedback on the design and content.

- Worked collaboratively with NIHR communications leads and HIW to develop a brochure to explain the R&I ecosystem in Wessex for Hampshire and Isle of Wight Integrated Care Board.

- Worked with NIHR Southampton Biomedical Research Centre (BRC) communications colleagues to develop promotional literature about the Wessex Experimental Medicine Network.

Campaigns and media relations

In 2023/24, we:

- Officially launched WHP by leading a coordinated PR campaign across owned and partner channels. The campaign launched on Wednesday 13 March and was supported by partners both on and following this date to tie in with communication schedules.

  The campaign used the finalising of the collaboration agreement as a platform for formally launching the strategic alliance.

  WHP marked the campaign across its own channels with a news article, promotional activity on social media and a cake cutting event. The news article achieved a total of 93 views and there were over 100 visitors to the WHP website on the day of the launch. The top performing social media post of the campaign was on LinkedIn. It received 2,691 impressions, 101 link clicks and 79 reactions.

  The WHP core comms team helped partners to support the campaign by creating a communications toolkit. This included a template news article, copy for newsletters and editable social media graphics. This enabled comms leads to create bespoke and personalised content for their organisation's channels, extending campaign reach. The toolkit received positive feedback from communications colleagues.

- Strengthened WHP's profile through media relations activities delivered in collaboration with partners. WHP featured in three local media outlets (Dorset Echo, Hampshire Chronicle and Bridport and Lyme Regis News) in 2023/24, offering a potential reach of tens of thousands.
- Created a proposal and content plan for a WHP newsletter, which will now be taken forward in 2024/25. In 2023/24 we launched a WHP mailing list, which has achieved 83 signs ups as a result of promotion at events.
- Utilised WHP's corporate channels to amplify and support the activity of founding partners and R&I infrastructure. This included supporting key health and awareness and R&I campaigns such as #Red4Research, International Clinical Trials Day and the NIHR's #ShapeTheFuture campaign. WHP's 2023 #Red4Research post achieved 391 impressions on X, whilst its LinkedIn post promoting the launch of Wessex Research Buses achieved 1,685 impressions, 70 reactions, 165 clicks and an engagement rate of 14.6%.

Social media

In 2023/24, we:

- Developed a draft channel strategy and content plan for WHP's social media accounts. This will be reviewed and further developed in 2024/25.
- Soft launched accounts on X (Twitter) and LinkedIn, helping to build brand awareness, increase reach and position WHP as a thought leader.

  Since soft launching accounts in May 2023, WHP has gained 354 followers on X and created and published 277 posts. The account has also achieved 40.5k impressions (the number of times that posts have been seen on timelines). In quarter four, WHP's X posts had 12.3k impressions, 32 link clicks, 39 shares and 148 likes.

  WHP's LinkedIn page has gained 205 followers since launching it May 2023. In 2023/24, it achieved 10.3k impressions, almost 600 page views and more than 400 post reactions.

  With additional communications resource, our social media presence will grow in 2024/25.
- Undertook daily social media monitoring to identify chances to engage, emerging trends and opportunities for thought leadership. This included scanning partner and stakeholder channels for relevant content to amplify.

Events

In 2023/24, we:

- Ensured a WHP presence at key partner and stakeholder events, supporting promotional stands and developing materials to support outreach and engagement. Some of the events supported by the core comms team are included below:

- Southern Health NHS Foundation Trust research conference
- Weymouth Research Hub launch
- NIHR Southampton Biomedical Research Centre open day
- NIHR Clinical Research Network Wessex under-served communities showcase event
- Launch of Wessex Research Buses
- Hampshire and Isle of Wight Integrated Care Partnership Assembly

- Offered communications support for events hosted by WHP, including our workshops on genomics and air quality. This involved publishing news articles and social media promotion.

- Supported the Wessex Integrated Care, Population Health, Research and Innovation Learning Event in March 2024, coordinating photography and videography, as promotional post event comms.

Questions

For questions about the plan, please contact Kim Appleby, Senior Communications and Strategy Manager, on kim.appleby@hiwessex.net or enquiries@wessexhp.org.uk.

Appendix 3: The 3 year financial position; outturn for years 1 (22/23) and 2 (23/24) and the plan for year 3 (24/25)

WHP Income & Expenditure £	2021/22 (Y0) Actual	2022/23 (Y1) Actual	2023/24 (Y2) Actual	2024/25 (Y3) Plan	Total
Surplus / (loss) c/f		**(37,723)**	**499,277**	**866,011**	
Income					
Membership Fees: founding members		550,000	700,000	650,000	1,900,000
Membership Fees: arrears			125,000	25,000	150,000
Membership Fees: new			100,000	50,000	150,000
Scoping Fees		70,000			70,000
Total Income	**0**	**620,000**	**925,000**	**725,000**	**2,270,000**
Expenditure by Function					
Set up Costs	37,723	71,704	23,550	20,000	152,977
Leadership Team			314,118	385,199	699,317
Communications Service		4,314	33,897	104,740	142,951
Business Support and Events Service		5,976	67,102	74,615	147,693
HR and Finance Service		398	69,851	63,962	134,211
Office Costs		608	14,784	20,696	36,088
Programmes			34,965	546,333	581,298
Contingency			0	375,466	375,466
Total Expenditure	**37,723**	**83,000**	**558,267**	**1,591,011**	**2,270,000**
In-Year Surplus / (Deficit)	**(37,723)**	**537,000**	**366,734**	**(866,011)**	
Cumulative Surplus / (Deficit)	**(37,723)**	**499,277**	**866,011**	**(0)**	

Report to	Board of Directors, Part 1	
Date of Meeting	10th December 2024	
Report Title	Health and Safety (incl. Fire and Water) Compliance Report	
Prepared By	Jason Chambers, Health & Safety Manager	
Approved by Accountable Executive	Chris Hearn	
Previously Considered By	Finance and Performance Committee in Common 25th November 2024	
Action Required	**Approval**	N
	Assurance	N
	Information	Y

Alignment to Strategic Objectives	Does this paper contribute to our strategic objectives? *Delete as required*	
Care	Yes	
Colleagues	Yes	
Communities		No
Sustainability	Yes	
Implications	Describe the implications of this paper for the areas below.	
Board Assurance Framework	SR1 Quality and Safety	
Financial	no implication	
Statutory & Regulatory	Statutory Reporting	
Equality, Diversity & Inclusion	Equality Act – Concerns with access across the Main Hospital site for people with reduced mobility	
Co-production & Partnership	no implication	

Executive Summary

The report provides assurance and information on Health and Safety (incl. Fire and Water) Compliance.

There is a separate Fire Safety Report. This report includes data for September and October 2024 extracted from the Datix electronic risk management reporting database and Occupational Health Reports detailing significant incidents and referrals relevant to Health and Safety issues.

There were no issues to include in this report on compliance from safety groups that report into the Health, Safety, Fire & Security Group, such as water, ventilation and electrical groups.

Reports from Occupational Health provide additional information to provide assurance that RIDDOR incidents and inoculation injuries are low and similar to previous months. Additional communication and training required to make sure they are all are reported on the incident reporting system.

Second hand smoke from cigarette smokes entering the Day Surgery Unit Operating Theatres was raised by the Anaesthetic Clinical Lead to the H&S Manager in November. This is an example of the need to address smoking on hospital site, particularly with Tobacco and Vapes likely leading to expansion of no smoking area around hospitals. Occupational health of staff, patients and visitors as well as fire safety concerns.

Problems of accessibility from multistorey car park for staff, patients and visitors with mobility issues due to present route.

Concerns were raised at Finance and Performance Committee in common with regards to the reports of smoking near the Day Surgery Intakes. Signage is appropriate, but smoking does still occur. Health and Safety Committee will seek to review the policy and systems in place.

Recommendations

- Government consultation on Tobacco and Vapes Bill, extension of smoke free legislation in England to outdoor areas such as hospital grounds. Proactive approach recommended. Strategic plan with more resources likely required to meet new legislation; proactive approach recommended rather than reactive.

- Lack of reasonable adjustments under the Equality Act 2010 and public sector equality duty for accessibility of the Trust multistorey car park for disabled people up to the hospital. Presently the route is to steep and crosses to many roads for people with reduced mobility. Accessibility and Inclusion Plan across the site recommended, particularly to include access to the NHP.

Recommendation

Members are requested to:

- Receive the report for **information**

Health & Safety Report

3.09.2024 – 30.10.2024

1. Executive Summary

The Health, Safety, Fire & Security Group acts as the Trust Health and Safety Committee. The reporting structure for this Group has been revised to report to the Finance and Reporting Committee (FPC).

A Fire Safety Report has been written and accompanies this report.

2. Introduction

2.1 The Trust uses the Datix Risk Management software to record any incidents that occur on site. Reporting is actively encouraged to assist in maintaining patient and staff safety. Incidents can be reported by anyone who has access to the Trust Intranet via a link.

2.2 Health & Safety incidents are identified from the incident description through screening by the Risk Management Department and forwarded to the H&S Manager.

3. Significant incidents

3.1 Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR) 2013 reported Incidents

3.1.1 These Regulations require employers to report specified workplace incidents. RIDDOR is the law that requires employers, and other people in charge of work premises, to report and keep records of:

- work-related accidents which cause deaths
- work-related accidents which cause certain serious injuries (reportable injuries)
- work-related accidents which prevents the employee from working or change in duties for 7 or more days
- diagnosed cases of certain industrial diseases; and
- certain ‘dangerous occurrences’ (incidents with the potential to cause harm)

3.1.2 For the period 01.09.2024 – 30.10.2024, 3 incidents were RIDDOR reported.

- 1 was a patient fall and fracture,
- 2 were staff injuries required more than 7 days off work, pulled muscle and fractured thumb.

3.2 Needlestick Injuries

	Sep 2024	Oct 2024	Total
Injury - DIRTY health care sharps	1	0	1
Injury - SHARPS - NON health care (patient etc)	1	2	3
Near Miss - Dirty sharp possible risk	2	0	2
Total	4	2	6

3.2.1 For the period 01.09.2024 – 30.10.2024, 6 sharp/needlestick injuries have been reported on incident reporting system.

September 2024 – 4 incidents reported,

- 1 was a DCH staff injury,
- 1 was sharp's bin incident,
- 2 for same incident, involving Insight Security injured.

3.2.5 Numbers that attended occupational health for sharps needlestick injuries

From Occ. Health Report in September there were 6 DCH referred (2 not reported on Datix)

- 24/09/24 Incident 22/09 – Dermatology. Medical student, suturing and caught finger with needle (stated not reported).
- 30/09/24 – Incident 28/09 – Doctor NSI following cannulation, Mary Anning (stated not reported)

September Reported Activity Occ. Health for Blood Borne Virus Exposure Incidents

	Apr 2024	May 2024	June 2024	July 2024	Aug 2024	**Sept 2024**	% change on previous month	Q1 24/25	**Q2 24/25**
Blood Borne Virus Exposure incidents reported	6	6	3	6	9	**6**	**-40%**	15	**21**

3.4 Significant Incidents

3.4.1 DCH98220 COSHH Formalin near miss on 27/8/2024

On the 27/8/2024, a Porter was sent to Histology with 3 placenta specimens... The porter was carrying all 3 specimen buckets in their arms as well as a bagged specimen (orange topped pot). The 3 bucket specimens were not bagged, and the porter was not offered a trolley or a spill kit for the transport of the specimens. The buckets would have contained at least 2 litres of formalin in each specimen. The specimens were checked and accepted into the laboratory. The porter was advised of the risks of carrying specimens that have large quantities of formalin within in container. The porter stated they didn't know what they were carrying was potentially hazardous as they had not been made aware when picking up the specimens.

Actions:

- Processes checked and system for monitoring improved which includes area which generates the specimen, processes for transport and receiving department.
- COSHH Risk Assessment and Safe System of Work Template reviewed and updated, with additionally training. This will be audited by H&S Manager.

3.4.2 DCH98014 COSHH DSU formalin spill, Day Surgery Unit 3rd September

Positive example of near miss, COSHH training and use of spill kit proved effective.

3.4.3 DCH98771 car crash into tree MSCP, entry access on 25th September

Car crashed into tree on the entry lane into MSCP, reported to transport hub, Transport Lead attended, driver had gotten out and placed themselves on the back seat in their car, very shocked by incident and in pain. Transport team called 2222 to get the medical team down. Transport team redirect traffic and closed off the entry lane, medical team attended and took driver to ED.

3.4.1 Estates works, operational, capital and strategic

3.4.2 Colposcopy Lletz procedure room issues

The current location for colposcopy is in a small room located in the Women's Health department in East Wing. A capital project for an additional colposcopy room to increase clinical capacity which is soon to start, highlighted the inadequacies of ventilation in this room, it has no windows or mechanical ventilation. Clinical staff working in this room, can be up to four and a patient, have reported symptoms indicating poor air quality.

Procedures involving diathermy, Lletz procedure, have been stopped in this room and are taking place in Theatres temporarily. This is causing disruption to Theatre scheduling and backlog of patients.

Estates Operational and Projects Teams as well as H&S Manager are assisting to find solution which will be compliant with legislation, guidance and best practice.

3.4.3 Bockhampton site H&S and Fire outstanding issues

New stores site is soon to open but some outstanding issues about ingress and egress of the building for employees and visitors.

Fire exit at rear of building has surface at back uneven and not complete to accommodate safe evacuation.

3.5 Accessibility across main hospital site

Concerns that the Trust could be found to lacking in making reasonable adjustments under the Equality Act 2010, and public sector equality duty for accessibility, with the Trust multistorey car park for disabled people up to the hospital. Presently the route is to steep and crosses to many roads for people with reduced mobility. Accessibility and Inclusion Plan across the site recommended, particularly to include access to the NHP.

3.6 Smoking on main hospital around buildings

Occupational health of staff, patients and visitors as well as fire safety concerns. Second hand smoke from cigarette smokes entering the Day Surgery Unit Operating Theatres was raised by the Anaesthetic Clinical Lead to the H&S Manager in November. This is an example of the need to address smoking on hospital site, particularly with Tobacco and Vapes Bill likely leading to expansion of no smoking area around hospitals.

3.7 Training & Inspection

Continues and increased with whole day of health and safety training provided as part of the preceptorship programme. Within last two months two sessions have taken place with 64 new clinical staff undertaking training.

COSHH & H&S training continues every two months, and H&S Manager has in last 18 months trained 78 COSHH Assessors and 45 Health and Safety Representatives. Bi-monthly training for these courses provided by the H&S Manager have been organised for 2025/26 and are available for booking via ESR.

Now that Departments have COSHH Assessors and H&S Reps they have been able to review and update their risk assessments and audit them. Now that this has taken place, the inspection of the department / area health and safety management system can resume.

Inspection of annual audit started in October 2024 and will continue with a programme of inspections of all clinical areas, over the next 5 months. This is an important part of the 'Review & Monitoring' of the Trust Safety Management System and role of the H&S Manager. Takes place every three years and was last done in 2021.

4. Conclusion

There does appear to be some underreporting of needlestick injuries on the incident reporting system compared to the number referred to Occupational Health.

Where incidents are reported there predominately appears to be good actions and learning identified. The COSHH incident does indicate the importance of review and

monitoring to ensure that they are carried through to completion and become embedded.

Review of smoking on and around the hospital site is recommended

5. Recommendation

Further details from Occupational Health to be obtained routinely on employees referred for sharps injuries, so that the incident reporting system can be checked, risk understood, and appropriate approach taken, such as training.

Estates & Facilities, including the Portering service, needs to be included in this year's H&S inspection of their safety management system. Before this inspection takes place, it is recommended that Estates and Facilities review its risk assessments, COSHH risk assessments and Safe System of Working.

Review of smoking on and around the hospital site is recommended. Restricting access out to area outside DSU air intake as initial mitigation.

Review of accessibility across site, with strategic accessibility and inclusion plan recommended.

The Board are requested to:

- To note the incident and types of incidents reported with a view to assessing whether any action can be taken to support the workforce
- Request any further assurances

Name and Title of Author:

Jason Chambers, Health & Safety Manager

Date: 15/11/24

1. **Appendices**
   1.1. Appendix 1

Health, Safety, Fire & Security Group Assurance Report for the meeting held on Tuesday 5th November 2024

Chair	Vacant Vice-Chair Jason Chambers
Executive Lead	Chris Hearn
Quoracy met?	Yes
Purpose of the report	To provide assurance on the main items discussed and, if necessary, escalate any matter(s) of concern or urgent business.
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	• Government consultation on Tobacco and Vapes Bill, extension of smoke free legislation in England to outdoor areas such as hospital grounds. Proactive approach recommended. Currently staff complaints, particularly Bridport Road entrance with second hand cigarette smoke entering Day Surgery Unit Operating Theatres. Plan to restrict access to this area but will only push problem to another part of Hospital site. Strategic plan with more resources likely required to meet new legislation; proactive approach recommended rather than reactive. • Lack of reasonable adjustments under the Equality Act 2010 and public sector equality duty for accessibility of the Trust multistorey car park for disabled people up to the hospital. Presently the route is to steep and crosses to many roads for people with reduced mobility. Accessibility and Inclusion Plan across the site recommended, particularly to include access to the NHP.
Key issues / matters discussed at the meeting	The committee received, discussed, and noted the following reports: • Health & Safety Report • Fire Safety Report & Action Plan • Security Management Guidance
Decisions made at the meeting	• Ratification of policies; Lone Working policy, Working at Height Policy.

	• Restriction of access into and out of the Bridport Road staff exit through change of security cotag access, signage and communication plan.
Issues / actions referred to other committees / groups	• Patient Safety Committee for input into a strategic plan for likely change of legislation over extension of smoke free on hospital grounds. • Wayfinding Group for input into strategic plan for accessibility and inclusion for disabled people across the site including car parks and NHP.

Dorset County Hospital
Dorset HealthCare

Report to	Board of Directors, Part 1	
Date of Meeting	10 December 2024	
Report Title	**Slavery and Human Trafficking Statement**	
Prepared By	Perry Spender, Head of Procurement, Dorset HealthCare Louise Brereton, Head of Procurement, Dorset County	
Approved by Accountable Executive	Chris Hearn Chief Finance Officer	
Previously Considered By	Finance and Performance Committee in Common, 25 November 2024	
Action Required	**Approval**	Y
	Assurance	N
	Information	N

Alignment to Strategic Objectives	Does this paper contribute to our strategic objectives? *Delete as required*	
Care		No
Colleagues		No
Communities		No
Sustainability		No
Implications	Describe the implications of this paper for the areas below.	
Board Assurance Framework	SR6: Finance	
Financial	Financial Penalties imposed for non-compliance.	
Statutory & Regulatory	Modern Slavery Act 2015 – requirement to make an annual statement. The Secretary of State may seek an injunction to compel the organisation to issue a statement - if this injunction is not complied with the organisation will be in contempt of a court order, which is punishable by an unlimited fine.	
Equality, Diversity & Inclusion	Equality Act 2010, Modern Slavery Act 2015	
Co-production & Partnership	Working with suppliers and contractors.	

Executive Summary

Section 54 of the Modern Slavery Act 2015 requires organisations over a certain size to publish a slavery and human trafficking statement each year which sets out the steps it has taken to ensure there is no slavery or trafficking in its supply chains or its own business, or states that it has taken no such steps. Statutory guidance states that we should publish a statement regarding slavery and human trafficking within 6 months of the organisation's financial year-end, and that this should also include the date that the financial year ended.

This slavery and human trafficking statement is made on behalf of Dorset County Hospital NHS Foundation Trust ("DCH"), and Dorset HealthCare University NHS Foundation Trust ("DHC") pursuant to section 54 of the Modern Slavery Act 2015 (the "Act") for the financial year ending on 31 March 2025.

Board approval of the statements is required to demonstrate that Dorset County Hospital NHS Foundation Trust and Dorset HealthCare University NHS Foundation Trust have met their legal requirements. Both organisations are currently compliant with this standard and both organisations have a statement published on their website pages.

Recommendation

Members are requested to:

- **Approve** for publication

Slavery and Human Trafficking Statement

This slavery and human trafficking statement is made on behalf of Dorset County Hospital NHS Foundation Trust ("DCH"), pursuant to section 54 of the *Modern Slavery Act 2015* (the "Act") for the financial year ending on 31 March 2025.

Our Organisation

Dorset County Hospital was established in 1991 as part of a long–term project to bring together all the local services for acutely ill patients onto one hospital site. Our hospital, just outside Dorchester town centre, was completed in 1997.

We were awarded Foundation Trust status in June 2007.

Our busy, modern hospital provides a full range of district general services, including an Emergency Department, and links with satellite units in five community hospitals.

We are the main provider of acute hospital services to a population of around 300,000, living within Weymouth and Portland, the west and north of Dorset, and Purbeck. We also provide renal services for patients throughout Dorset and South Somerset; a total population of 850,000.

Our 3,500 members of staff work across various locations, including the main hospital in Dorchester, GP surgeries, schools, residential homes, people's own homes and in the community hospitals.

Our Approach

Dorset County Hospital are committed to acting responsibly and upholding our high ethical standards. We have a zero-tolerance approach towards any form of modern slavery and human trafficking, and we expect our suppliers to subscribe to a similar principle. This is clearly stated on our website.

The steps we have taken during the current financial year in relation to combating modern slavery and human trafficking are as follows:

In relation to our ***supply chains***, which include the sourcing of all products and services necessary for the provision of high-quality health care to our patients:

- We expect and require all of our suppliers to comply with all local, national and (where applicable) international laws and regulations and to have suitable anti-slavery and human trafficking policies and processes in place.
- Our point of contact is preferably with a UK or EU company, who may also be required to comply with the requirements of the Act or similar legislation in other EU states.
- Most of our purchases are against existing supply contracts or frameworks which have been negotiated under the NHS Standard Terms and Conditions of Contract which have the requirement for suppliers to have suitable anti-slavery and human trafficking policies and processes to be in place.

- We expect each entity in the supply chain to, at least, adopt 'one-up' due diligence on the next link in the chain, as it is not practical for us (and every other participant in the chain) to have a direct relationship with all links in the supply chain.
- We expect all those in our supply chain and contractors to comply with our Trust values.
- We will not support or deal with any business knowingly involved in modern slavery and human trafficking. All suspicions of modern slavery and human trafficking will be reported to the relevant authority.
- We will consider modern slavery issues when making any procurement decisions.
- We ensure that our subsidiary companies and joint venture companies comply with the commitments in this statement.

In relation to ***strategic partnerships and relationships*** we enter:

- We expect all of our strategic partners to comply with all local, national and (where applicable) international laws and regulations and have suitable anti-slavery and human trafficking policies and processes in place.
- We expect all our strategic partners to share our values.

In relation to ***due diligence and risk management*** (other than our supply chains):

- We undertake appropriate pre-employment checks and require our agencies on approved frameworks to do the same.
- We protect staff from poor treatment and/or exploitation and comply with all respective laws and regulations including fair pay rates and terms of conditions of employment.
- We consult and negotiate with Trade Unions on proposed changes to employment, work organisation, and contractual relations.
- We require staff to make declarations of interest where this is relevant to their job role or grade.

In relation to our ***policies and procedures***, which set the tone for how we as an organisation operate:

- We have clear procurement and contract management policies.
- We have a clear policy on Standing Financial Instructions, which covers NHS Contract for the provision of NHS Services.
- We have clear schemes of delegation in place for authorising expenditure.
- We have a clear Freedom to Speak up and Whistleblowing Policy that applies to all individuals working for our Trust and is published on our intranet site. If there are any genuine concerns about any wrongdoing or breaches of the law, including modern slavery laws, these concerns can be raised in confidence and without fear of disciplinary action.

In relation to the ***training of our staff:***

- Our training for staff includes how to recognise and respond to indicators of human rights abuses. It includes examples of red flags specific to our industry, explain our reporting procedures for suspicions and promote an organisation wide sense of responsibility.
- We have teams responsible for safeguarding of adults and children, to whom staff are responsible for reporting of concerns and who train staff on how to recognise issues of concern.

This statement will be reviewed annually and made available on our website.

Board approval to publish this statement was received on (date to be added)

Matthew Bryant
Chief Executive Officer, Dorset County Hospital NHS Foundation Trust